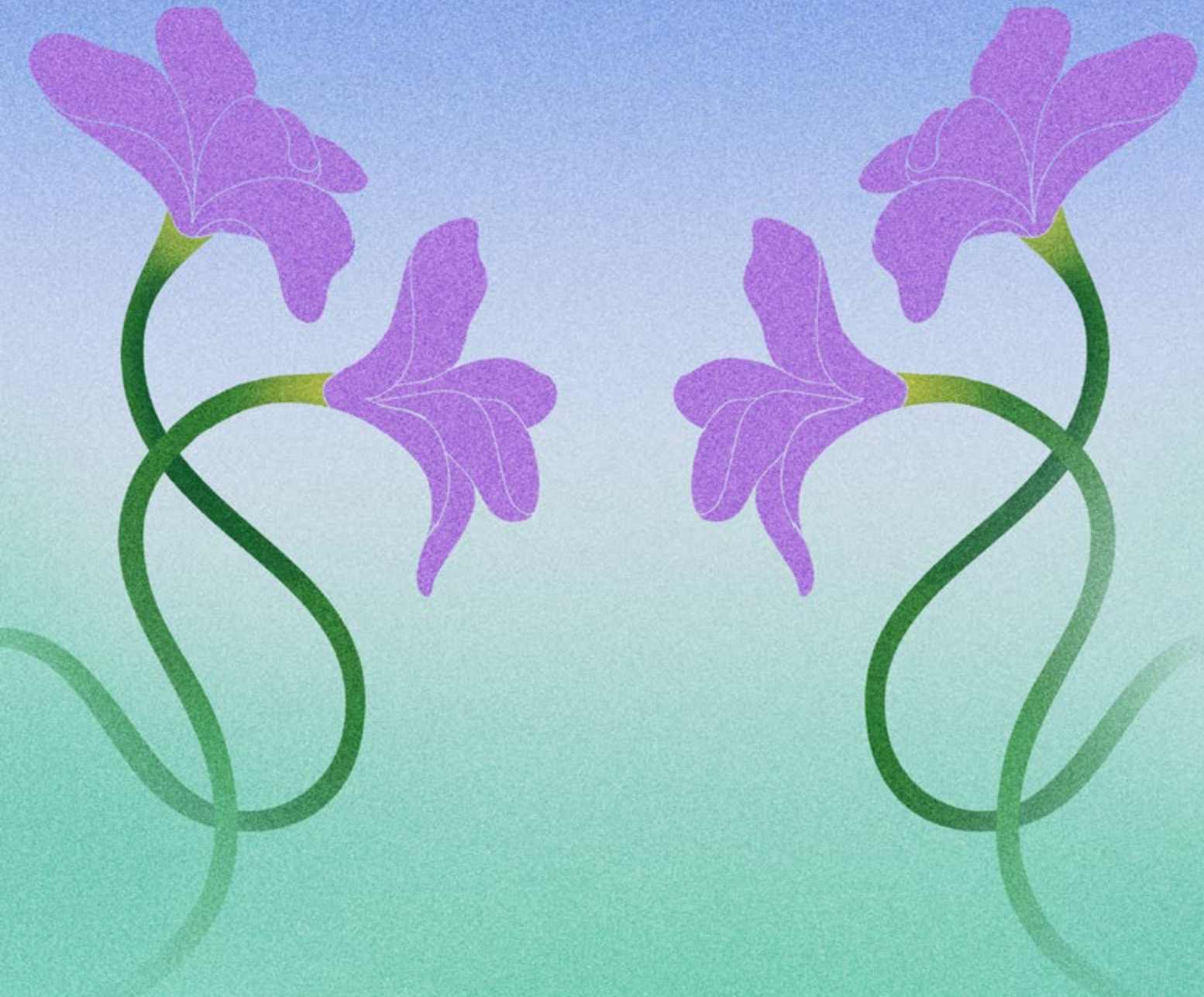
Report on *Multi-Stakeholder Consultations* on *Youth Mental Health* and *Suicide Prevention* in Sikkim



CMH Centre for Mental Health Law & Policy

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Acknowledgements

The Sikkim Integrated Service Provision and Innovation for Reviving Economies (INSPIRES) team is greatly indebted to the Hon'ble Chief Minister of Sikkim, *Shri Prem Singh Tamang* (*Golay*) for his visionary leadership, guidance and support in bringing the Sikkim INSPIRES program to life.

We are grateful to the Hon'ble Minister of Health and Family Welfare of Sikkim, *Shri G. T. Dhungel* for his effective leadership in developing Sikkim's mental health system.

We wish to thank *Shri V B Pathak*, IAS (Retd), former Chief Secretary, Government of Sikkim, for his constant encouragement to the Sikkim INSPIRES team and his commitment to prioritise the well-being of the people of Sikkim.

The team extends their deepest gratitude to *Shri Ravindra Telang,* IAS, Chief Secretary, Government of Sikkim for being a strong advocate for mental health and taking a proactive approach to addressing mental health challenges in Sikkim.

The Sikkim INSPIRES team acknowledges with profound gratitude the contributions of *Shri Rinzing Chewang Bhutia,* IAS, Secretary, Planning and Development Department, Government of Sikkim for his astute guidance to the team for building successful partnerships, and for his unwavering support.

We are thankful to *Shri M Bharani Kumar,* IAS, former Secretary of the Health and Family Welfare Department, Government of Sikkim for his encouragement to prioritise mental health in the state. His concerted efforts have provided the momentum to develop a roadmap to strengthen Sikkim's mental health system.

The team expresses deep gratitude and appreciation to all participants of the multi-stakeholder consultations including representatives of the Central and State Governments, eminent mental health and suicide prevention experts, civil society organisations, media, self-help groups, educators, youth and other key stakeholders who contributed by sharing their insights and recommendations.

This report would not have been possible without the people of Sikkim and persons with lived experience who shared their personal accounts of having or supporting those with mental health challenges, their valuable stories and insights, and who exemplify hope and courage. We thank you for your willingness to share which adds greatly to this effort.

Lastly, we thank the team at the Centre for Mental Health Law & Policy, Indian Law Society, Pune for tirelessly providing their technical expertise and assistance to the Sikkim INSPIRES team in facilitating the multi-stakeholder consultations and developing this report. Their unwavering support has been instrumental in helping us develop a roadmap to realise our shared vision for mental health and well-being in Sikkim.

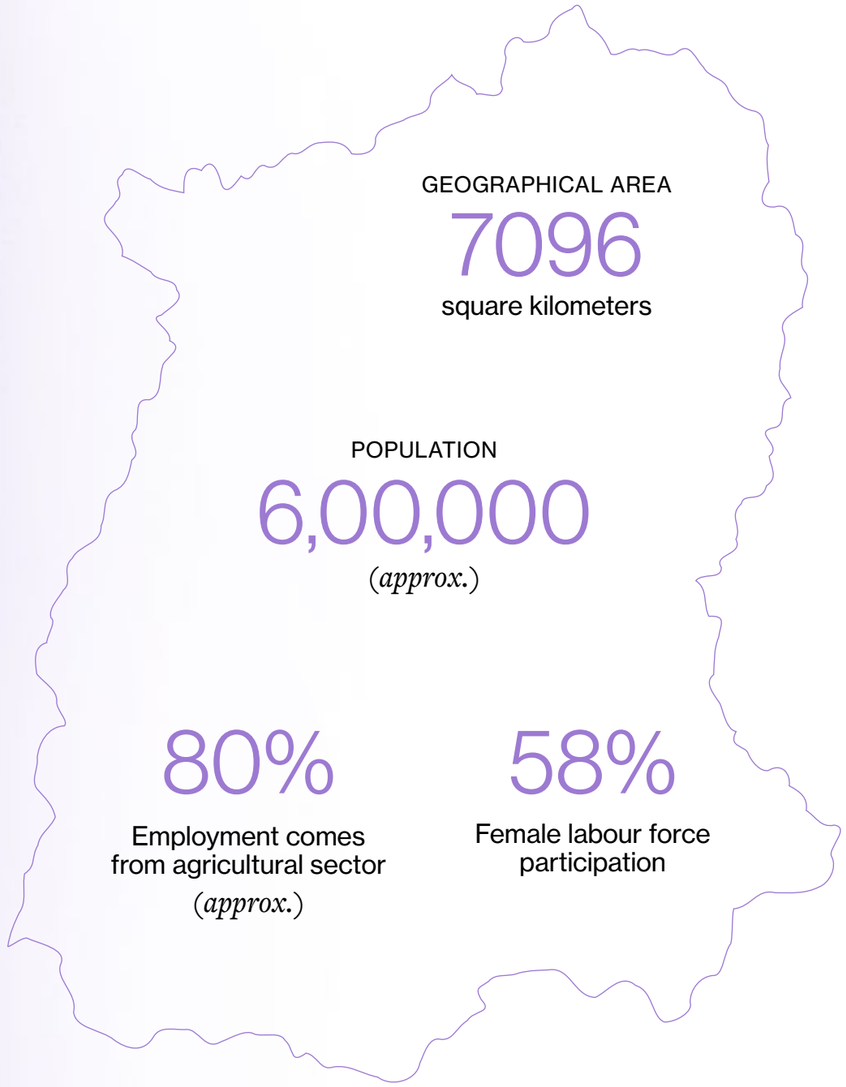
Suggested Citation:
Planning & Development Department & Health & Family Welfare Department, Government of Sikkim (2025, May). *Report on Multi-Stakeholder Consultations on Youth Mental Health and Suicide Prevention in Sikkim.*

Contents

Glossary

AFHC	Adolescent Friendly Health Clinics
CMHLP	Centre for Mental Health Law & Policy, Indian Law Society
DIKSHA	Digital Infrastructure for Knowledge Sharing
DMHP	District Mental Health Programme
HFWD	Health & Family Welfare Department, *Government of Sikkim*
PDD	Planning & Development Department, *Government of Sikkim*
SWD	Social Welfare Department, *Government of Sikkim*
WCSDWD	Women, Child, Senior Citizen, and Divyangjan Welfare Department, *Government of Sikkim*
ED	Education Department, *Government of Sikkim*
IEC	Information, Education & Communication
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
MEL	Monitoring, Evaluation & Learning
MHCA	Mental Healthcare Act, 2017
MoHFW	Ministry of Health & Family Welfare
NCERT	National Council of Educational Research & Training
NCRB	National Crime Records Bureau
NEP	National Education Policy, 2020
NGO	Non-Governmental Organisation
NMHS	National Mental Health Survey, 2016
OBC	Other Backward Classes
PDO	Program Development Objectives
RKSK	Rashtriya Kishor Swasthya Karyakram
SADA	Sikkim Anti-Drugs Act, 2006
SC	Scheduled Castes
SCERT	State Council for Educational Research & Training
SHWP	School Health & Wellness Programme
Sikkim INSPIRES	Sikkim Integrated Service Provision and Innovation for Reviving Economies Program
ST	Scheduled Tribes
ToC	Theory of Change
WSA	Whole School Approach

1. Introduction



Sikkim, a state in the northeast of India has a unique geographical, cultural, and economic identity. Sikkim is one of India's smallest states both in terms of population (approximately 6 lakhs) & area (7096 sq. km)[1]. As a hill state, it is known for its syncretic culture, geographical landscape, biodiversity and for hosting the majestic *Kanchenjunga,* the highest peak in India and the third highest on Earth.

With favourable climatic conditions that support agriculture, horticulture, and forestry, Sikkim was certified by the Ministry of Agriculture & Farmers' Welfare, *Government of India* as the world's first fully organic state in the year 2016. The agriculture sector in the state continues to employ nearly 80% of the population.The state also has one of the highest rates of female labour force participation in the country at 58%, with more than half the women in the age group of 15–29 being engaged in agriculture and related jobs[2,3].

Sikkim has the highest per capita income in the northeastern states and economically is one of the fastest growing states in India[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.

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[4]. As citizens of one of India's fastest growing states, Sikkimese youth have the potential to contribute to the overall development in Sikkim, particularly in developing a sustainable economy.

In 1975, Sikkim transitioned from a monarchy to joining India as its 22nd state, and since has undergone significant transformation across political, social, economic and cultural landscapes, while maintaining its unique 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 also affect the state of mental health and suicides in Sikkim.

State of Mental Health & Suicides in Sikkim

In 2022, the National Crime Records Bureau (NCRB) reported a total of 1,70,924 deaths by suicide (nationally) with Sikkim having the highest rate of suicide of 43.1 (number of suicides per 1,00,000 population) in comparison to the national suicide rate of 12.4 per 1,00,000 population[5]. *This was the highest rate recorded in India in over 56 years.*

Since 2008, Sikkim has consistently reported the highest suicide rates among all states in India. However, this high rate may also be attributable to Sikkim's small population, among other factors. NCRB reports attribute nearly 75% of suicides to singular causes. However, suicides do not occur in isolation and are often a result of extreme distress caused by an inter-play of various factors in a person's life such as unemployment, substance use, financial issues, relationship problems, physical/emotional/sexual abuse etc.

In 2022, Sikkim's unemployment rate for youth (aged 15-29) was at 13% in comparison to the national average of 29%[6]. However, 27% of youth suicides (aged 21-30) were due to unemployment[7]. Sikkim also has high prevalence rates of opioid use (more than 10%), and cannabis use (2.9%) in comparison to the rest of India[8]. There is also a high prevalence of mental health conditions such as bipolar disorder and eating disorders in Sikkim[9].

While there are high rates of suicides and mental health concerns in India and Sikkim, the treatment gap (percentage of people who require treatment but do not receive the same) remains as high as 86%[10]. While estimates suggest that there are 2.3 psychiatrists per 1,00,000 population in Sikkim, the state lacks other trained mental health professionals such as psychologists or psychiatric social workers[11].

In India, mental health is approached through a predominantly *biomedical* model, with an excessive focus on diagnosis and curative treatments through medication by mental health professionals. Closing the mental health care gap in India and in Sikkim requires a shift from the biomedical model to a *biopsychosocial* model, addressing the need to look at mental health inclusive of both health and social-care related outcomes, focusing on also addressing the social determinants of mental health and suicides[12].

Sikkim INSPIRES

Sikkim Integrated Service Provision and Innovation for Reviving Economies Program

Sikkim INSPIRES is a flagship initiative of the Government of Sikkim, supported by the World Bank. Sikkim INSPIRES aims to deliver improved economic opportunities and boost economic inclusion for women and youth. Sikkim INSPIRES aims to do this through collaboration and capacity building through the achievement of *Program Development Objectives* (PDOs):

1. Strengthened state systems for inclusive growth
2. Improvement of employment linkages for women & youth in priority sectors
3. Enhanced delivery of enabling services for economic inclusion of women & youth in Sikkim[13]

(Sikkim INSPIRES aims to train, upskill, and provide jobs for nearly 3,00,500 women and youth in priority sectors)

In 2023, under Sikkim INSPIRES, the Government of Sikkim and the World Bank carried out a baseline assessment through a quantitative survey and qualitative interviews to understand the supply and demand side efficiencies in Sikkim's labour market, with a particular focus on women and youth[14].

Although the report primarily focused on employment in Sikkim, findings showed that 6% of youth in Sikkim reported experiencing symptoms of anxiety or depression during the last two weeks at the time of the baseline assessment. The report suggested that these conditions can impact young people's prospects in the job market.

In this context, through different activities, PDO 3 of Sikkim INSPIRES seeks to enhance access to quality mental health services to address barriers to employment. The *Planning & Development Department* (PDD) and the *Health & Family Welfare Department* (HFWD), Government of Sikkim through Sikkim INSPIRES will support the capacity strengthening of mental health care professionals, work with community members to increase identification of mental health conditions, pilot community-based interventions for mental health, and integrate and strengthen the delivery of life-skills curriculum in educational settings[2].

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

In pursuance of the above objectives, Sikkim INSPIRES has collaborated with the **Centre for Mental Health Law & Policy, Indian Law Society** (CMHLP) to co-create a road map for developing, implementing and strengthening youth mental health and suicide prevention related initiatives in Sikkim.

CMHLP was founded in the year 2007 and 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 intersectoral approach to focus on mental health and suicide prevention through implementation research, law & policy strengthening, and capacity building. Accordingly, CMHLP is providing technical support to Sikkim INSPIRES to identify & develop evidence-based interventions and strategies for mental health & suicide prevention.

The development of an action plan for mental health and suicide prevention requires an assessment of the current mental health landscape in Sikkim and consensus building with diverse government and non-government stakeholders to identify key priorities areas, review existing evidence and best practices and develop strategies for the same.

During Sept 2024–Dec 2024, Sikkim INSPIRES & CMHLP jointly conducted formative scoping activities and multi-stakeholder consultations with diverse stakeholders to understand Sikkim's mental health landscape and develop a roadmap to strengthen mental health and suicide prevention services in the state.

This report synthesises data, insights and strategic recommendations that emerged from the formative scoping activities and consultations conducted with stakeholders in Sikkim and nationally.

Chapter 2 of the report details the methodology of conducting the formative scoping and multi-stakeholder consultations with government and non-government stakeholders (including youth and persons with lived experience).

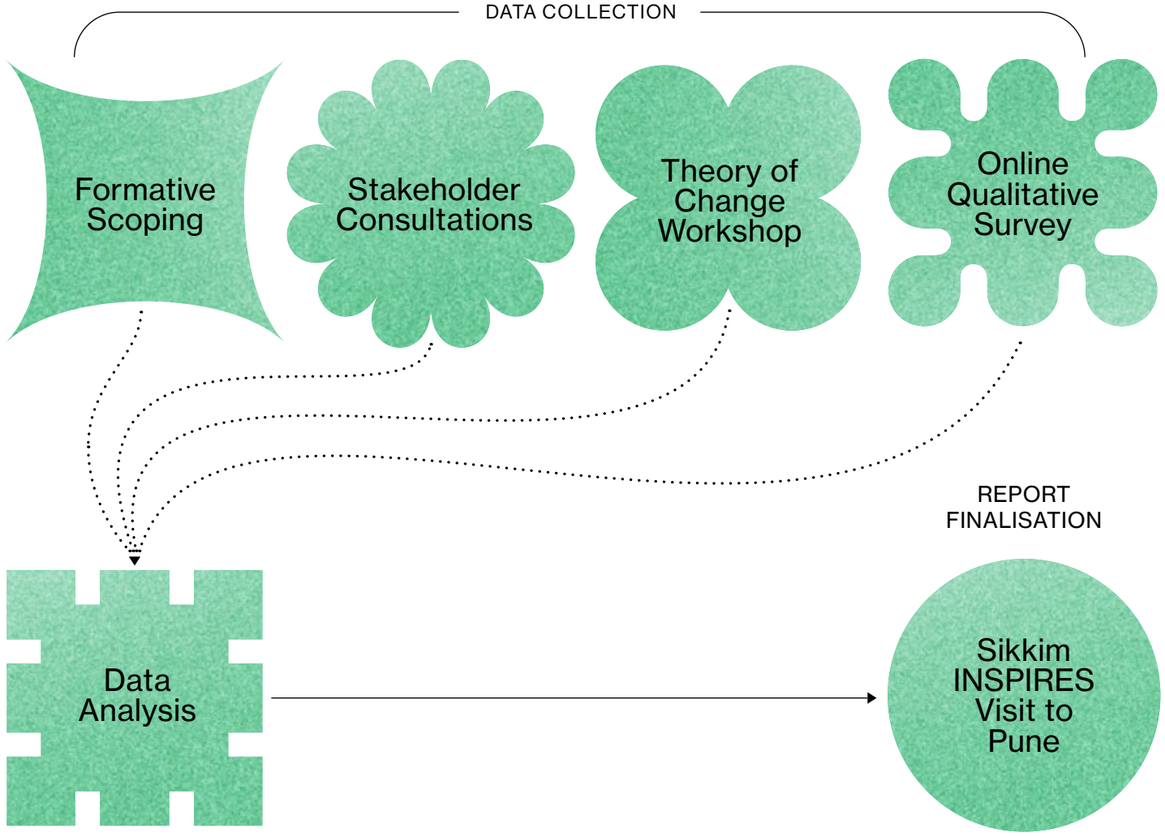
Chapters 3 & 4 discuss the insights, priority areas and suggestions identified by participants during the formative scoping, consultations and Theory of Change workshop.

Chapter 5 discusses strategic recommendations for mental health and suicide prevention interventions in Sikkim drawing from the wide-ranging consultations conducted with multiple stakeholders and review of existing evidence and best practices in India and across the world.

2. Methodology

A multi-pronged approach was adopted to understand the current context of youth mental health & suicides in Sikkim.

The methodology comprised formative scoping interviews, an online qualitative survey, multi-stakeholder consultations, and a theory of change workshop with key government and non-government stakeholders. This section explains each of the above-mentioned components in detail.



Formative Scoping

CMHLP's team carried out formative scoping interviews and field visits in Gangtok and Pakyong. The field visits and scoping interviews were conducted to:

1. Understand Sikkim's current mental health landscape including stressors impacting youth and protective factors for young people.
2. Identify key stakeholders within government departments who implement programs on mental health and suicide prevention and understand implementation related challenges.

The team conducted **10 interviews** with stakeholders working across government departments (refer Table 1). The detailed lines of enquiry of the interviews and field visits are included in Annexure A.

TABLE 1

Stakeholders interviewed during formative scoping and field visits

DESIGNATION & PROGRAM	DEPARTMENT
Additional Director National Health Mission	Health & Family Welfare Department
Additional Director School Health & Wellness Programme (SHWP)	Health & Family Welfare Department
Psychiatrist District Mental Health Programme (DMHP)	Health & Family Welfare Department
Case Workers and Program Officers One Stop Centre	Social Welfare Department
Additional Director Rashtriya Kishor Swasthya Karyakram (RKSK)	Health & Family Welfare Department & Education Department

Stakeholder Consultations

The PDD and HFWD, Government of Sikkim hosted Multi-Stakeholder Consultations on Youth Mental Health & Suicide Prevention under Sikkim INSPIRES on the 9th and 10th of September 2024 in *Gangtok,* Sikkim. The objective of the multi-stakeholder consultations was to consult key stakeholders (n=100) at the national and state-level to identify priority areas, institutional gaps and best practices for advancing mental health and suicide prevention in Sikkim.

Day 1

PARTICIPANTS

- Policymakers from the Government of India and the Government of Sikkim
- Mental health & suicide prevention experts across India

On Day 1, consultations were held in the form of panel discussions (n=3) with policymakers from the Government of India and the Government of Sikkim as well as mental health and suicide prevention experts across India (n=12). The consultations focused on three primary themes:

1. Identifying mental health problems and factors that contribute to/affect young people's mental health in Sikkim
2. Addressing challenges in developing and implementing mental health and suicide prevention policies
3. Exploring good practices to develop a comprehensive mental health/suicide prevention strategy for Sikkim

The consultations also included brainstorming sessions with the participants (comprising civil society organisations, young people, mental health professionals, media and other stakeholders) to identify priority areas and potential collaborations for interventions on youth mental health and suicide prevention in Sikkim.

Day 2

PARTICIPANTS

- Self-help groups & NGOs
- Media professionals; social media influencers
- Health care workers
- University and school-level educators
- School/college students
- People with lived experience

On Day 2, consultations were held with civil society and youth representatives comprising self-help groups (SHG), NGOs, media professionals, social media influencers, health care workers, university and school-level educators, school/college students and people with lived experience of mental health conditions and suicide. The consultations focused on three primary themes:

1. Factors impacting youth mental health and suicides in Sikkim
2. Current institutional and governmental gaps to address mental health
3. Strategies to address mental health and suicide prevention in Sikkim through facilitated discussions and experience/story sharing from participants

Youth and people with lived experience participating in the consultation shared insights and stories of personal experiences and challenges experienced in the context of mental health and suicides in Sikkim.

The detailed lines of enquiry of the consultations are included in Annexure B.

Theory of Change Workshop

Following the multi-stakeholder consultations, a Theory of Change (ToC) workshop was conducted with a smaller group of key stakeholders such as policymakers, mental health professionals, CSOs, NGOs, students, and lived experience experts who had attended either of the previous consultations.

Theory of Change is a tool to explain how interventions facilitate change & help in achieving desired outcomes[15].

The ToC was co-designed with key stakeholders to develop a comprehensive framework that outlined outcomes, interventions, and pathways for an intersectoral and integrated youth mental health and suicide prevention program in Sikkim. A rapid synthesis of the consultation was carried out and stakeholders were presented with a list of contributing factors on youth mental health and suicide.

The ToC involved active involvement and participation of the key stakeholders. Through a prioritisation exercise, stakeholders initially identified key contributing factors of youth mental health/suicide which require immediate action in Sikkim. Stakeholders were provided with a long list of contributing factors (around 25), which were identified based on a rapid synthesis of the multi-stakeholder consultations. Stakeholders identified five key contributing factors and priority areas to focus on.

A theory of change framework was developed with outcomes, activities, and pathways based on the five priority areas identified by the participants to help inform a roadmap for mental health and suicide prevention under Sikkim INSPIRES. Further details on the ToC workshop can be found in Section IV.

Online Qualitative Survey

While the formative scoping and consultations were aimed to understand perspectives from key stakeholders within the government & civil society, an online qualitative survey was conceptualised with the aim to invite insights and perspectives of citizens. Accordingly, a multi-lingual qualitative survey was circulated online by the PDD to invite responses from the public on three questions:

1. What are the factors impacting youth mental health & suicide prevention in Sikkim?
2. What are current institutional and governmental gaps to address mental health and suicide in Sikkim?
3. What are the key strategies to address mental health and suicide prevention in Sikkim?

The survey received a total of 84 responses where 64% respondents identified as female. More than half the respondents were from the city of Gangtok, while the remaining respondents were from other districts in Sikkim such as Pakyong, Namchi, and Gyalshing.

Almost all respondents were Nepali speakers (94%), with more than half of the respondents knowing both Hindi and English (70%). Higher proportion of respondents were government staff (53%) while students comprised a smaller proportion of the responses (11%). Most respondents were university-level graduates (90%), with 42 postgraduates and 34 graduates. Only a small group of respondents identified as belonging to a marginalised community (22%) and specifically mentioned belonging to tribal or caste-based communities, including the Bhutia community, Lepcha community, OBC (Other Backward Classes), Scheduled Tribes (ST), and Scheduled Caste (SC). A little over half of the respondents identified as having lived experience of mental health problems, while the remaining responded "no" to the same.

A detailed visualisation of the demographic characteristics can be found on the next page (refer Table 2). The online survey questions are included in Annexure C.

TABLE 2
Demographic breakup of qualitative survey respondents

GENDER

Female
Count: 54 (64.3%)

Male
Count: 30 (35.7%)

EDUCATION

Graduate
Count: 34 (40.50%)

Postgraduate
Count: 42 (50%)

Other
Count: 8 (9.50%)

OCCUPATION

Government Staff
Count: 45 (53.60%)

Student
Count: 9 (10.70%)

Other
Count: 20 (23.80%)

MARGINALISED COMMUNITY

Yes
Count: 18 (21.40%)

No
Count: 66 (78.60%)

LIVED EXPERIENCE

Yes
Count: 42 (50%)

No
Count: 34 (40.50%)

Prefer not to say
Count: 8 (9.50%)

PLACE OF RESIDENCE

Gangtok City
Count: 55 (65.50%)

District Areas
Count: 29 (34.50%)

Data Analysis

Data collected through formative scoping interviews and field visits, online qualitative survey, and the multi-stakeholder consultation was analysed using a thematic synthesis approach by two researchers. The thematic synthesis involved:

1. Two researchers familiarising with the consultation notes.
2. Coding the data based on emergent themes.
3. Generating descriptive themes and sub-themes after data coding was completed.

The descriptive themes were generated after grouping similar codes into specific sub-themes which represent contributing factors of youth mental health and suicide (*n*=25) through a rapid synthesis process.

These sub-themes were then organised into six broader themes representing categories of the 25 contributing factors. The table on the next page shows the themes and sub-themes that emerged from the responses of the participants across the formative scoping activities and consultations (*refer Table 3*).

TABLE 3
Themes and sub-themes generated from the data analysis

1. Policy & Service Gaps

a. Lack of support for young adults
b. Lack of inclusive policies/services for youth with disabilities
c. Lack of access to mental health services and resources
d. Gaps in reliable data on suicides and attempted suicides
e. Nutrition
f. Unemployment and financial instability
g. Substance use and addictions
h. Lack of access to physical spaces
i. Natural disasters and geographical challenges
j. Gaps in governance

2. Education

a. School level policies
b. Academic pressure and career guidance
c. Needs of out of school/ college youth
d. Relationships with teachers and peers
e. Sexual and reproductive health rights

3. Stigma & Discrimination

a. Stigma and discrimination of mental health problems
b. Stigma and discrimination due to gender, sexuality & other identities
c. Fear of losing cultural identities

4. Changing Lifestyles

a. Technology and social media
b. Reduced community interactions

5. Family & Relationship-related issues

a. Community gaps
b. Romantic relationships and domestic violence
c. Bullying and peer pressure
d. Family problems & communication gaps

6. Individual factors

a. Inability to cope with stressors
b. Physical illness

Sikkim INSPIRES visit to Pune

SIKKIM INSPIRES TEAM (n = 11)

Representatives from

- Planning & Development Department
- Health & Family Welfare Department
- Education Department
- Rural Development Department
- District Collector, Namchi district
- Self-help group representatives
- Media professionals
- Young people

Report Finalisation

The Sikkim INSPIRES team visited CMHLP's teams in Pune, Maharashtra and Mehsana, Gujarat between the 2nd and 5th of December 2024. The Sikkim INSPIRES team comprised key government stakeholders from the PDD, the HFWD, Education Department (ED), the Rural Development Department, and the District Collector of Namchi district along with civil society stakeholders such as self-help group representatives, media professionals, and young people (n=11).

The objectives of the visit were to

1. Present findings of the formative scoping and multi-stakeholder consultations.
2. Discuss evidence-based interventions and best practices on mental health and suicide prevention.
3. Discuss priority areas and create a roadmap for developing mental health and suicide prevention interventions under Sikkim INSPIRES.

The team also had the opportunity to visit the district of *Mehsana,* Gujarat and observe the implementation of **Atmiyata** and **SPIRIT** (*Suicide Prevention Implementation Research Initiative*), two community-based interventions being implemented by CMHLP.

3. Insights

from Formative Scoping, Online Qualitative Survey, & Multi-Stakeholder Consultations

This section describes the key descriptive themes that highlight drivers impacting youth mental health and suicide as reported by the participants during the consultations. *Drivers* are aspects of a person and their environment, which can increase vulnerability to mental health problems and suicide.

This section also highlights the strategies/recommendations to address youth mental health and suicide prevention as proposed by the participants.

1. Policy & Service Gaps

This theme addresses gaps in systemic policies, programs and services which are not addressing the mental health related needs & preferences of different demographic groups.

[a] Lack of Support for Young Adults

Several programmatic interventions and policies such as the SHWP and the RKSK target children and adolescents and address their health and well-being. Similarly, such protection measures exist for employed individuals as well as senior citizens. However, there are no programs or government-led mental health and suicide prevention programs that address the health and well-being of young people aged 18 to 25.

[b] Lack of Inclusive Policies/Services for Youth with Disabilities

Youth with disabilities are unable to access disability specific services, which compounds their difficulties and distress. Further, there is a lack of trained professionals who understand and can provide affirmative mental health support to youth with disabilities. Affirmative support ensures that health care providers respect and validate the lived experiences of the person.

[c] Lack of Access to Mental Health Services & Resources

Participants reported that the state does not have adequate trained professionals (particularly psychiatrists and psychologists) who are equipped to provide mental health support. Professionals are also not trained to provide mental health support to specific groups (e.g., caregivers, people from the LGBTQI+ community, etc). Most people continue to remain unaware of where or how to access mental health services, particularly in rural areas.

While there are social awareness campaigns and Information, Education & Communication (IEC) materials available, such sources are found to be insufficient and, in many ways, ineffective as many still hold stigmatising beliefs about mental health. Service users with access to the District Mental Health Programme (DMHP) for treatment either do not have access to free medicines being prescribed (due to lack of availability) or are unable to afford the medication from pharmacies. In several cases, service users are also unable to afford treatment due to financial difficulties.

[d] Gaps in Reliable Data on Suicides and Attempted Suicides

Participants reported there is a gap in data collection and surveillance of suicide and suicide attempts, in terms of reliably measuring suicides and attempted suicides. This often leads to an inaccurate depiction of the rate of suicides in the state. Furthermore, at the service level there are administrative and structural delays to identify, assess risk, and provide support to those having suicidal thoughts or plans, where health professionals are not trained to provide appropriate support to individuals and community health-care workers are overburdened.

Furthermore, participants, particularly policymakers and representatives from NGOs mentioned how the Central Government's policies and programs should be adapted to address the cultural context of Sikkim and its diverse population.

[e] Nutrition

Participants reported that youth in Sikkim across different social groups experience poor nutrition or malnutrition due to lack of access to nutrient rich diets and, in other cases, due to diet culture. Young people are also increasingly exposed to and consuming processed food, leading to poor nutrition.

[f] Unemployment and Financial Instability

In Sikkim, rates of unemployment are high. Young people prefer government jobs or do not have access to opportunities for upskilling in their careers. Moreover, young people do not have opportunities to explore different career paths.

Participants expressed that although the government has programs that aim to build skills in young people, there is a need for updated programs that address skills relevant to the changing job markets. Similarly, participants alluded to challenges relating to the changing infrastructure, administrative, and financial difficulties faced by the tourism industry in Sikkim. With a large population of Sikkim reliant on tourism, these challenges have led to increased unemployment which has also led to an increase in anxiety and other mental health conditions.

[g] Substance Use & Addictions

Participants shared that Sikkim has high rates of substance use with young people using substances as early as the age of 13. The Sikkim Anti-Drugs Act, 2006 (SADA) was enacted to tackle Sikkim's high rates of substance use. In its current form, participants mentioned this Act is unsuitable to address the needs of the state and its increasing rate of substance use.

While state-run rehabilitation centres are functional, they have limited resources, and face challenges in providing comprehensive and personalised care. Although NGOs run rehabilitation centres, they lack trained human resources and/or funds necessary to run them. More importantly, there is a need for more measures to help people reintegrate into society post treatment and rehabilitation.

[h] Lack of Access to Physical Spaces

There is a lack of access to green or natural spaces such as parks and other recreational spaces within the city of Gangtok and beyond. Even if physical spaces exist, there are limited options that are accessible; most physical spaces or recreational spaces require funds for development and maintenance.

[i] Natural Disasters and Geographical Challenges

Sikkim is prone to natural disasters and other geographical challenges. These events are frequent and unpredictable and have been on the rise due to climate change. Repeated exposure to such challenges creates distress amongst the population. Heavy landslides during monsoons lead to roads being blocked for 3-4 months in a year, which leads to individuals feeling confined.

[j] Gaps in Governance

Participants reported that there is a lack of intersectoral collaboration within government departments and between government departments and other key stakeholders in Sikkim. Several departments work on mental health and related initiatives in silos.

This leads to implementation challenges for existing programs and reduced collaboration for programs on mental health and suicide prevention. Participants also highlighted budget allocations for mental health are inadequate. Although the state has policies and programs to address mental health/suicide, there is a need for robust mechanisms to monitor or supervise their implementation.

Participants highlighted that the success of mental health-related programs is often dependent on efforts of individuals within departments/ministries who take the lead in development and implementation. Such programs should be sustainable in the long-term.

TABLE 4
Key strategies identified by participants to address policy & service gaps

PRIORITY AREAS	KEY STRATEGIES
Lack of Support for Young Adults (18-25 Years)	• **Creating opportunities and communities:** Create opportunities to increase social connectedness through popular platforms such as youth parliaments, college clubs and other activities. This allows for youth to create and be part of supportive communities. • **Skill building programs:** Develop skill building programs for youth. These programs should address and build capacity of youth for personal and professional development.
Lack of Access to Mental Health Resources & Services	• **Mental healthcare through formal and informal services:** Develop human resources by training and building capacity of community health workers such as ASHA workers. Mental health support can also be provided through formal and informal peer support services – cooperatives, self-help groups, college students can be trained to identify and provide support to other youth in distress. Religious leaders have a direct linkage with community members and can be trained to provide awareness and support. • **Strengthening existing services:** To address the lack of access to services, the government can strengthen existing tele mental health services or create a hybrid system of services – in person support supplemented by online or tech-based support. • **Inclusive mental health services:** Mental health services should be inclusive and affirmative (particularly for those with marginalised identities), accessible (geographical, financial etc.), and youth friendly. Services can also integrate art and dance-based therapies. • **Shifting focus from screening and diagnosis:** The current mental health system has a heavy focus on screening and diagnosis. A robust strategy should be developed to ensure that there is referral and follow-up for service users beyond screening.
Gaps in Reliable Data on Suicides and Attempted Suicides	• **Collecting reliable data:** In comparison to other states, Sikkim has a better-developed reporting system for suicides. However, to ensure that quality interventions are developed and implemented, there is a need to focus on the collection of reliable data. Consolidated and reliable data on suicides will help identify nuances and key areas of suicide to address. • **Interventions for impulsive suicides:** Interventions that specifically address impulsive suicides should be developed. • **First responders for suicides:** In cases of deaths by suicide, the first responders are police officials. Being first responders can be extremely distressing for the police. Better support mechanisms should be developed for police to address this distress.
Unemployment & Financial Instability	**Developing opportunities and skill building programs:** To help young people harness opportunities beyond government jobs, the government should develop programs that build skills relevant to the 21st century. Programs can focus on developing new and youth-centric vocational skills such as tattooing, hairdressing etc. The government should also create more avenues/generate more opportunities for jobs through various schemes.
Substance Use & Addictions	• **Regulatory interventions:** The government should consider implementing a policy to limit the number of alcohol stores that are functional and serve customers. • **Reintegration post treatment:** The government should develop a skill development program specifically for individuals who have completed treatment. • **Interventions focusing on protective factors:** Interventions and policies should be contextualised, appropriate, and non-judgmental. They should focus on developing protective factors (such as creating better systems of support) which can prevent mental health problems and distress. • **Interventions to address tech/social media addictions:** Some young people may be vulnerable to experiencing addiction to the internet, online gaming, and social media. Interventions should be developed to address such issues.
Lack of Access to Physical Spaces	**Increasing access to physical spaces:** Develop parks, green spaces, and other recreational spaces for public to have access to nature. These spaces can also be used for outdoor activities and sports that can further lead to creating new communities.

PRIORITY AREAS	KEY STRATEGIES
Gaps in Governance	• **Inter-departmental convergence:** Effective implementation of mental health and suicide prevention-related policies/programs requires increased collaboration and policy-level convergence between different departments within the government. Inter-departmental convergence must be envisioned at the state, district, and sub-district levels. For example, convergence between the Education Department (ED), Sports & Youth Affairs Department (SYAD), Health & Family Welfare Department (HFWD) can be beneficial to implement sports-related mental health programs in schools. • **Monitoring, evaluation & learning (MEL) framework:** An MEL framework should be developed to track the implementation and progress of policies/programs, its effectiveness and learnings to better future initiatives. A special body with relevant stakeholders should be constituted to carry out the developed MEL framework. • **Contextualising policies to Sikkim:** Policies/programs developed by the Central Government should be adapted to the context of Sikkim. A co-design or co-development approach with a range of stakeholders (policymakers, health care workers, lived experience experts etc.) should be taken to develop appropriate and contextually relevant mental health/suicide prevention-related policies/programs. • **Political commitment for programs:** Continuity and sustainability of long-term programs requires political commitment.

2. Education

This theme addresses issues, challenges and gaps present in the education system in Sikkim, with a focus on schools and school students.

[a] School Level Policies

Students do not have access to counsellors in schools and are unaware of where or how to access support when needed. Participants also added that several schools in Sikkim also do not have physical spaces or playgrounds for students to use.

[b] Academic Pressure & Career Guidance

Participants shared that many students in school are unaware of different career paths and are uncertain about future career opportunities. With the state dependent on tourism jobs and government jobs, young people lack career options to explore. Students in schools and colleges face extreme pressure from academic institutions and family members to excel academically.

[c] Needs of Students who are Dropouts

Sikkim currently has a high rate of students who drop out from school and do not continue their education.

[d] Relationships with Teachers & Peers

Teachers play a very important role in students' lives and can offer them the informal mental health support that they require. However, teachers are severely overburdened with teaching duties, administrative responsibilities as well as other government-related tasks, and further stretched to take on additional work.

[e] Sexual & Reproductive Health Rights

Participants reported that Sikkim has high rates of teenage pregnancies which need to be addressed. Further, young mothers are often stigmatised by their families and community, may not complete their education and face difficulties to reintegrate into society post-pregnancy.

TABLE 5
Key strategies identified by participants to address drivers related to education

PRIORITY AREAS	KEY STRATEGIES
School Level Policies	• **Availability of school counsellors:** The government should ensure that every school has trained school counsellors to help and support students. Teachers can work in tandem with the school counsellors to provide students with mental health support. Aside from providing professional support, counsellors can help train students as peer supporters to help other students access informal support from their peers. • **Social awareness in schools:** Schools can be used as a space to raise social awareness (on topics of gender, sexuality, mental health etc.) amongst students. Schools can also be spaces to build emotional resilience and values in children (developing core values, moral reasoning etc.). • **Engaging with community members:** Schools can engage with community members and raise awareness on mental health through *nukkad nataks* or by collaborating with local artists. School management committees can also engage with community members regularly. • **Strengthening adolescent health programs:** The government should focus on strengthening the implementation of the Rashtriya Kishor Swasthya Karyakram (RKSK) and the School Health and Wellness Programme (SHWP). Schools should establish mentorship structures for peer educators under RKSK.
Academic Pressure & Career Guidance	**Fostering co-curricular talents:** Students' talents (outside of academic talents) should be fostered. Schools can establish zero periods which focus on co-curricular activities such as drama, music etc.
Needs of out of school/ college youth	**Reintegration of students who have dropped out:** The government can work with NGOs to help with reintegrating out of school students back to school. For students who are unable to join schools again, governments can support them financially and help them access the support they need to join schools. In cases where this is not feasible, the government should develop vocational training programs for students to build skills that can facilitate employment.

PRIORITY AREAS	KEY STRATEGIES
Sexual & Reproductive Health Rights & Education	**Supporting young mothers:** With higher rates of teenage pregnancy in Sikkim, several young mothers require support for reintegrating themselves back in society. The government should work towards developing programs that focus on providing education or livelihood opportunities for young mothers.
Relationship with Teachers & Peers	**Teachers as informal supporters for students:** Teachers are well-positioned community members – they act as guides and role models to students and are well respected by community members. Such teachers should be trained and equipped to provide emotional support to students. Teachers can work in tandem with the school counsellor.

3. Stigma & Discrimination

This theme highlights how stigma and discrimination due to mental health problems and social identities in Sikkim have an adverse impact on people.

[a] Stigma & Discrimination of Mental Health Problems

There are prevalent myths and misconceptions around mental health conditions, with mental health and suicide often being linked to superstitions, black magic, and other supernatural elements. This primarily arises due to a lack of awareness and information on mental health and suicide as there is a lack of public discourse or advocacy for mental health. People refuse to access mental health services or reach out for help due to stigma.

[b] Stigma & Discrimination due to Gender, Sexuality & Other Identities

Some participants reported that people in Sikkim regularly deal with racism and discrimination across the country due to their identity, cultural practices or appearance. Within Sikkim, people with darker skin tones are further discriminated against and often hear derogatory remarks against them. There is also a lack of understanding and acceptance of different gender and sexuality identities. The LGBTQI+ community deals with exclusion, social isolation, and discrimination due to cis-gendered heterosexual norms.

[c] Fear of Losing Cultural Identities

Some participants expressed concerns about losing their cultural identities as a consequence of changes brought about by economic development.

TABLE 6
Key strategies identified by participants to address drivers related to stigma & discrimination

PRIORITY AREAS	KEY STRATEGIES
Stigma & Discrimination of Mental Health/Illness	• **Mental health promotion:** Mental health promotion activities such as sensitisation sessions and mental health literacy campaigns should be continuous and not single day events. These spaces can be used to speak about mental health in a constructive manner. • **Collaboration with religious leaders:** Religious leaders have a direct linkage with community members and can be trained to provide awareness & support.

4. Changing Lifestyles

This theme addresses the impact of changing lifestyles and increasing technological usage in Sikkim.

[a] Technology & Social Media

Traditional media comprising newspapers and television cover sensitive topics of mental health and suicide in a sensational manner, often leaving those who consume such forms of media extremely distressed. While it is now easier to be digitally connected in a globalised world, social media has shown to have a detrimental effect on young people as they deal with cyberbullying, peer pressure, addiction, and other digital issues. For example, participants reported social media platforms are being used for blackmail or extortion purposes.

[b] Reduced Community Interactions

Some participants reported that since Sikkim is a society in transition, many individuals are adopting different lifestyles. Some are focused on living more individual lives, leading to fewer interactions with families, and communities.

TABLE 7
Key strategies identified by participants to address drivers related to changing lifestyles

PRIORITY AREAS	KEY STRATEGIES
Technology & Social Media	• **Digital safety practices:** Government departments can promote digital safety practices and create information resources that point youth towards safe content. Similarly, they can collaborate with social media influencers to create awareness on various topics such as mental health, suicide, and even different government policies and engage with the public. • **Building career opportunities in content creation:** Government departments can also work with private organisations to set up content creation organisations which helps in building further career opportunities for youth.

5. Family, Relationship & Community Issues

This theme highlights some of the common family, relationship, community issues in Sikkim.

[a] Family Problems & Communication Gaps

Participants mentioned that in Sikkim, many young people experience family conflicts and abusive environments at home. Parental divorce and separation cause severe distress to young people. Within family environments, young people often deal with parents or caregivers engaging with substance use and alcohol addictions.

Growing up in such an environment leads to anxiety among young people. Young people also highlighted that they lack support from their family in both academic and personal fronts. Parents have high expectations from young people to achieve academic excellence and create strict environments within their homes.

Participants also reported that parents and families often create comparison between youth and scold children for not meeting their expectations.

[b] Community Gaps

Although communities are well connected and are often available to support other community members, there are lack of support structures within communities. Moreover, stigma around mental health prevents community members from reaching out for support.

[c] Romantic Relationships & Domestic Violence

A significant driver of distress in young people is conflicts in romantic relationships and breakups.

[d] Bullying & Peer Pressure

Young people at schools and colleges regularly experience bullying and peer pressure. Bullying is particularly distressing for young people from marginalised communities (gender, sexuality, religion etc.).

TABLE 8
Key strategies identified by participants to address drivers related to family, relationship & community issues

PRIORITY AREAS	KEY STRATEGIES
Community Gaps	• **Community-based events for mental health awareness:** Organise community-based events to raise awareness on mental health. Sensitisation and advocacy can be done by collaborating with local artists, schools, and using video campaigns. • **Community members as informal supporters:** Train community members to provide informal peer support, such that community members can lean on each other for support.
Family Problems & Communication Gaps	• **Supporting families and their mental health:** Families, particularly parents require support from their community. The first step for families/parents is to understand the importance of mental health. Young people, schools, and other adults can work together to create awareness among families/parents about mental health and its importance. Families/parents can also be provided with counselling sessions to receive support to address any issues that they may have (such as substance use or addressing family conflicts). • **Effective communication within families:** To communicate better and to understand young people and children, community events or programs on effective communication between parents and children can be organised by schools or local community organisations.

6. Individual Factors

This theme highlights factors associated with an individual and their environment that affect their mental health.

[a] Inability to Cope with Stressors

Participants reported that some young people grow up in overprotective environments or strict households with less autonomy. This leads to challenges in developing interpersonal skills or coping mechanisms. It was reported that some young people may find it difficult to deal with loss and failure or other difficult situations.

With constant comparison between youth and high levels of competition and pressure in school and home environments, young people may develop insecurities and low self-confidence.

There are also limited opportunities in Sikkim for young people to explore their interests or hobbies. Young people are also more aware of mental health as opposed to previous generations but are not motivated to take support from peers or professionals.

[b] Physical Illness

Physical health and mental health are interconnected. Physical health problems, particularly terminal illnesses (such as cancer) and chronic health problems (such as tuberculosis) affect the mental health of individuals.

TABLE 9
Key strategies identified by participants to address drivers related to individual factors

PRIORITY AREAS	KEY STRATEGIES
Inability to Cope with Stressors	• **Resilience-building and life-skills programs:** Several nationwide NGOs work on resilience-building and life-skills programs for school-going children. Such programs can be contextualised and implemented in Sikkim. • **Activities for promoting well-being:** Mental health and well-being can be promoted in youth through different activities such as encouraging youth to explore their hobbies, meditation exercises, and encouraging a positive outlook in life. • **Sports-based and creative programs:** Sport-based activities, meditation, and creative programs should be used to promote mental well-being and help young people cope with stress.

4. Theory of Change *Workshop*

Following the multi-stakeholder consultations, a *Theory of Change* (ToC) workshop was conducted with a select group (n=24) of representative stakeholders including policymakers, mental health professionals, representatives from CSOs and NGOs, students, and lived experience experts.

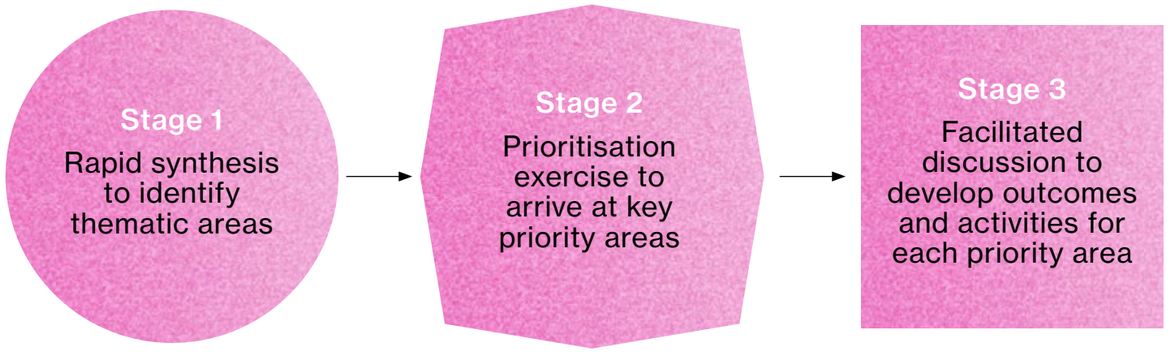
What priority areas to focus on in the next five years?

What changes or outcomes are desired for each of these priority areas?

What activities or programs are required to implement to reach these desired outcomes?

Theory of Change (ToC) is a tool to explain how interventions facilitate change and help in achieving outcomes at a systems level. The ToC workshop involved a facilitated discussion with key stakeholders to co-develop a comprehensive framework that outlined desired outcomes and corresponding interventions or activities for an intersectoral and integrated youth mental health and suicide prevention program in Sikkim.

The ToC workshop was conducted in-person and in English, with some participants who spoke in Nepali, and required active involvement and participation of the stakeholders. The agenda of the ToC workshop is included in Annexure B. The workshop was conducted in three stages, described below.



Stage 1

Rapid synthesis to identify thematic areas

Prior to the workshop, the CMHLP team conducted a rapid synthesis of the discussions held during the multi-stakeholder consultations to summarise a list of contributing factors of youth mental health and suicide identified by stakeholders. The synthesis resulted in a list of 25 contributing factors, which were then further grouped into broader themes. While some factors may be common across different themes, factors were grouped into themes based on relevance. The list of 25 contributing factors is below (Table 10):

TABLE 10
List of 25 contributing factors of youth mental health and suicide used during the ToC workshop

CATEGORIES	CONTRIBUTING FACTORS
Systemic (Governance, Policy & Service Gaps)	• Lack of support for young adults (18 to 25 years) • Lack of inclusive policies/services for youth with disabilities • Lack of access to mental health services and resources • Nutrition (malnutrition, lack of a nutritious diet) • Unemployment (e.g., lack of opportunities, over reliance on government jobs) • Substance use and addictions • Lack of access to physical spaces • Natural disasters & geographical challenges
Education	• Academic pressure & career guidance • Needs of out of school/college youth • Relationships with teachers and peers • Teenage pregnancies (sexual and reproductive health rights)
Stigma & Discrimination	• Stigma/discrimination of mental health • Stigma/discrimination due to sexuality, gender and other identities • Fear of losing cultural identity
Changing Lifestyles	• Technology & social media • Reduced community interactions
Family, Relationship & Community Issues	• Breakup of romantic relationships • Domestic violence • Vulnerability of young mothers • Bullying & peer pressure • Family problems & communication gaps (scolding, comparison etc.)
Individual Factors	• Inability to cope with stressors • Physical illness • Financial issues

Stage 2

Prioritisation exercise to arrive at key priority areas

During the workshop, stakeholders were presented with the list of contributing factors.

The CMHLP team facilitated an initial discussion to ensure all stakeholders understood the factors identified and any disagreements or discrepancies with the factors were resolved. The stakeholders were then asked to individually reflect on the list of 25 factors to rank the top ten factors that they considered as priority to be addressed by the Government of Sikkim.

Individual ranking sheets from each participant were consolidated to unfold the ten highest ranking priority areas by stakeholders as priorities requiring immediate action from the Government of Sikkim. The ten key priority areas are as follows:

FIRST PRIORITISATION

Identifying ten key priority areas

- Substance use & addictions
- Family problems & communication gaps
- Stigma/discrimination of mental health
- Unemployment
- Inability to cope with stressors
- Academic pressure & career guidance
- Reduced community interactions
- Lack of support for young adults
- Lack of access to mental health services and resources
- Technology & social media

After the identification of the ten key priority areas, a brief discussion was held to capture stakeholder's feedback, where stakeholders expressed their reflections on the prioritisation process as well as their feedback on the priorities identified. Post the brief discussion, the process was repeated to conduct a second round of prioritisation to identify the top five priority areas requiring immediate action from the Government of Sikkim. The five priority areas are listed below:

SECOND PRIORITISATION

Identifying five key priority areas

- Family problems & communication gaps
- Enhancing coping & emotional resilience among young people
- Changing lifestyles
- Stigma/ discrimination of mental health
- Substance use & addictions

Stage 3

Facilitated discussion to develop outcomes and activities for each priority area

In the third stage of the workshop, participants were guided through the process and objectives of developing a theory of change.

Through a facilitated discussion, for each of the five priority areas participants co-developed a comprehensive framework to outline outcomes and interventions/activities to inform the development of an integrated youth mental health and suicide prevention program in Sikkim.

The outcomes and corresponding interventions/activities developed for all five key priority areas are summarised below.

Family problems & communication gaps

Outcome 1

Developing parenting capacities to enable mental well-being of children

Activity 1

Conduct formative research (i.e., situation analysis) to identify where and how parents may be engaged to provide their inputs in co-designing programs with young people on parenting techniques and effective communication.

Activity 2

Develop and conduct sensitisation programs on mental health and suicide prevention through multiple channels (e.g., art, social media, or schools).

Activity 3

Build capacities of religious leaders and other community leaders/associations to influence parents to better address or mediate mental health issues.

Activity 4

Develop informative resources in multiple formats (i.e., visual, audio etc.) for parents and young people to navigate family conflicts and improve mental health.

Outcome 2

Enable parents and caregivers to address their own problems and seek support when necessary

Activity 1

Build capacities of functionaries (e.g., panchayats, self-help groups, samaj, retired persons within communities) to provide support to parents going through difficulties or problems.

Activity 2

Strengthen existing referral linkages to sources of mental health support such as primary health centres, district mental health hospitals etc.

Enhancing coping & emotional resilience among young people

Outcome 1

Strengthening existing life-skills programs in schools to help young people cope with stressors

Activity 1

Institutionalise life-skills programs through government policies.

Activity 2

Develop a convergence mechanism to ensure life-skills programs are delivered in a coherent manner across various stakeholders & functions.

Activity 3

Identify gaps in implementation, monitoring and evaluation of life-skills programs & carry out impact analysis to revise programs accordingly.

Activity 4

Create mechanisms to strengthen referral linkages to primary health centres, district mental health hospitals, and NGOs to fill existing service gaps.

Activity 5

Develop or strengthen peer support platforms as part of existing life-skills programs.

Outcome 2

Enhancing the ability of young people within communities to deal with stressors/be emotionally resilient

Activity 1

Create or leverage existing community spaces in urban and rural areas where young people can engage in activities for support and recreation (for sports, yoga and exercise, or art), and use these as spaces to build connection, develop coping skills, and obtain informative resources.

Activity 2

Build capacities of community stakeholders (e.g., gram panchayats, gym instructors, retired persons) within existing recreational spaces and harness opportunities such as the health melas to provide information or referrals.

Activity 3

Develop volunteer or peer support programs for young people, while strengthening their capacities to be engaged in peer support.

Activity 4

Highlight and promote successful initiatives and good practices within the community (e.g. Readers Association) as examples of community engagement.

Changing lifestyles

Outcome

Promote sustainability

Activity 1

Develop programs led by young people to facilitate community engagement within and between communities through recreation and sports-related activities to shift focus from social isolation, excessive digital use, and materialism.

Activity 2

Celebrate and incentivise behaviours to promote sustainability.

Activity 3

Create or harness existing platforms and avenues for promoting Sikkim's traditional practices and heritage.

Activity 4

Identify ways to integrate traditional art, design, and practices in public spaces.

Stigma & discrimination of mental health

Outcome 1

Mental health is normalised among communities

Activity 1

Foster regular discussion on mental health among young people in daily conversations.

Activity 2

Address stigma (judgment and bias) around mental health among health professionals.

Activity 3

Integrate mental health within school curricula (e.g., activity-based life-skills education in schools and colleges).

Activity 4

Develop dedicated programs for suicide prevention.

Activity 5

Build awareness through social media, cultural events using performative & fine arts.

Activity 6

Reframe harmful language on mental health problems.

Outcome 2

Community elders have a changed outlook on mental health

Activity 1

Build sensitisation programs for older generations in spaces where they come together as a community.

Activity 2

Design activities to address isolation and bring together older members of communities.

Activity 3

Implement interventions to sensitise elders about mental health and enhance well-being of young people.

Activity 4

Equip and empower panchayat groups to identify and support community members.

Substance use & addictions

Outcome 1

Interventions to address reasons for substance use

Activity 1
Conduct assessments to identify vulnerable groups and reasons for substance use.

Activity 2
Promote recreational activities and community engagement for young people.

Activity 3
Foster positive peer interactions as sources of support, particularly for school students to prevent substance use.

Activity 4
Build parent-child relationships for a supportive and caring home environment.

Activity 5
Identify high risk groups, plan and implement evidence-based interventions.

Outcome 2

Improved reintegration into society post treatment

Activity 1
Develop skilling programs and enhance job opportunities to facilitate reintegration in society post treatment.

Activity 2
Equip people with lived experiences with skills to provide peer support.

Activity 3
Focus on strengthening existing family counselling services and building community support during recovery.

Activity 4
Address social stigma among communities around rehabilitation centres.

Activity 5
Organise community events to bridge the gap between rehabilitation centres and community members.

5. Strategic Recommendations

Building from the strategies identified by key stakeholders during the formative scoping, multi-stakeholder consultations, online qualitative survey and ToC workshop, this section proposes *key strategic recommendations* supported with existing evidence and best practices from other contexts for developing an intersectoral and collaborative road map for advancing mental health and suicide prevention in Sikkim.

{1} Develop an integrated mental health and suicide prevention strategy

Mental health and suicide prevention are critical issues of development and governance that require coordinated intersectoral and multistakeholder strategies. The WHO recommends every country adopt a rights-based strategy for mental health as an essential and powerful tool to address mental health at the population level[16]. At the national level, India has developed and adopted the National Mental Health Policy 2014 (NMHP), the Mental Healthcare Act, 2017 (MHCA) and the National Suicide Prevention Strategy 2022 (NSPS)[17, 18, 19].

To further contextualise the mental health policies to local contexts in India, some states such as Chhattisgarh, Gujarat, Kerala, and Meghalaya have adopted state-specific strategies and plans for mental health and suicide prevention. Similarly, it is recommended that Sikkim develop an intersectoral and rights-based strategy with a state-specific vision to guide mental health and suicide prevention work in the state.

The strategy should include key strategic action areas and outcomes for mental health and suicide prevention, which may range from improvements in the organisation and quality of service delivery for mental health to models of community care.

The strategy shall be inclusive and representative in ensuring convergence in practices to protect, promote, and support the diverse mental health needs of individuals in the state. The strategy should build on the stakeholder insights in this report as obtained through formative scoping activities and best practices and recommendations from various national and international contexts, including guidance on rights-based and suicide prevention strategies by the WHO[16].

{2} Improve availability and access to mental health services

Integration of mental health in primary and secondary care

States across India (including Sikkim) have a vast treatment gap between the number of people who require care and those who receive it. Evidence shows mental health conditions, particularly in low-resource settings, are more effectively diagnosed and treated in primary care settings when compared to psychiatric settings[20]. Thus, the WHO recommends integrating cost-effective, feasible and affordable evidence-based mental health services into primary care as the most viable way of closing the treatment gap. Successful integration of mental health care in primary care in Sikkim will involve training for primary healthcare workers or at all levels (including non-specialist health workers from sub-centres/health and wellness centres) to provide inclusive and affirmative care for mental health conditions as well as make appropriate referrals to secondary and tertiary care units (i.e., community health centres, district hospitals and state hospitals)[21]. This is aligned with existing practices of the WHO mhGAP intervention, which provides non-specialist health care staff with the knowledge and skills to deliver interventions for priority mental, neurological & substance use disorders[22].

Adopt models of community mental health care

Peer-support or non-specialist care are evidence-based strategies to reduce mental health and social care gap in communities[23]. Such strategies involve trained and experienced volunteers who provide support to others in similar contexts in their recovery journey and have been found to be effective as psychosocial interventions for common mental health conditions.

An example of such a practice is Atmiyata, a low-cost community-led and evidence-based intervention that complements the public health system in India, recognised as a best practice by WHO in 2021[24]. Atmiyata is a high impact, sustainable and scalable model that can be adapted to suit specific geographical and social contexts[23, 24].

Strengthen referral pathways for mental healthcare at the state-level

A robust network of services with effective referral systems is necessary for appropriate function of any health system[20]. Thus, for integration of mental health in primary care and models of community-mental health care to be effective in Sikkim, strong health systems with active referral mechanisms to secondary and tertiary care (e.g., referrals to the DMHP, district or state hospitals, private health practitioners and organisations providing support to specific vulnerable groups) are critical. Active referral mechanisms and pathways are essential for severe cases requiring specialised care as well as an important link for the support and supervision of primary healthcare workers.

{3} Improve suicide data surveillance on attempted suicides and suicide deaths

Reduction in rates of suicide should be a key focus area for Sikkim. High-quality surveillance data on suicide and self-harm (including rates, methods and vulnerable groups) is critical for developing evidence-based suicide prevention strategies. The state should consider a review of the existing surveillance system for suicide in Sikkim and develop community surveillance systems for data collection and triangulation. The WHO has published a best-practices resource manual on community-surveillance systems for collecting data on suicides and attempted suicides which can be adapted to suit specific social and geographical contexts[25].

{4} Suicide prevention interventions

The LiveLife implementation guide for suicide prevention (2021) developed by the WHO recognises intersectoral, multi-stakeholder and coordinated strategies for suicide prevention[26]. Given the high rates of suicide in Sikkim, the following strategies are recommended.

Gatekeeper training for specialised groups

The LiveLife guide recognises capacity building of gatekeepers or community workforce in early identification, assessment, management and follow-up of suicide risk as a strategic intervention for suicide prevention[26]. In the context of suicide prevention, gatekeepers refer to community members and non-specialists who regularly engage with community members through their profession or role in the community and can be trained with skills to identify and support individuals who are contemplating suicide.

Specialised gatekeeper training courses may be adapted for a range of community groups, including healthcare professionals, law enforcement officials (including police, armed forces and paramilitary forces), educators (including school or college teachers), parents and families, and community stakeholders such as self-help groups. Gatekeeper training has been shown to improve knowledge, attitudes and skills of teachers and other community stakeholders in early identification and referrals[27, 28]. An example of scaling gatekeeper training intervention for school teachers (ENGAGE) has been implemented in Chhattisgarh via an e-course through DIKSHA, a teacher training e-learning platform managed by the State Council for Educational Research & Training (SCERT)[29]. Similar scalable models may be adapted in Sikkim.

Targeted interventions for vulnerable groups

Specific population groups may be vulnerable to mental distress or suicide due to structural inequalities associated with their socio-economic status, occupation, life experiences, etc. This includes people belonging to LGBTQI+ communities, women facing domestic violence, individuals working in high-stress conditions, first-line responders in crisis situations (e.g., medical professionals and police personnel) or persons with a history of mental health conditions. In addition to population-level efforts on suicide prevention, selective and indicated interventions (such as interventions to provide access to safe, inclusive and queer-affirmative mental health care for persons from LGBTQI+ communities) should focus on vulnerable groups and their specific contexts[26].

Media engagement for suicide prevention and stigma reduction

The media plays an important role in shaping public opinion, behaviours and attitude around suicide. Evidence shows a strong association between media reporting of suicide and a rise in suicide due to imitation, whereas appropriate dissemination of information such as dispelling myths on suicide and providing accurate information by the media are essential in promoting help-seeking behaviour[30]. The WHO guide for media professionals has shared guidelines for responsible media reporting, which may be adapted for media organisations in Sikkim. This will involve working closely with representatives from the media as important allies in suicide prevention by building capacity of media professionals for 1) responsible reporting and dispelling myths on suicide and 2) setting up monitoring and evaluation systems to measure violations of media reporting guidelines and ensure better reporting[30].

{5} Improve mental well-being and suicide prevention in educational institutions

Adopt whole-school approach to learning environments to focus on holistic learning, safety and well-being

To strengthen education environments at a structural level, principles of the Whole School Approach (WSA) may be adapted in educational settings in Sikkim. The WSA is a collaborative approach that focuses on the entire school system to develop a safe, inclusive and caring school environment which holds all stakeholders in the school ecosystem including family members accountable for promoting the physical, academic, and mental well-being of all students[31].

In schools, this will entail a concerted approach to creating a safe and inclusive school environment, establish safety and well-being policies (including anti-discrimination and anti-bullying policies), ensure early identification, support and referral of students at-risk of mental health problems; promote extra-curricular activities to enhance critical developmental skills beyond academic performance, help students build connections and supportive relationships with teachers and their peers and ensure inclusive and accessible infrastructure for engaging and enjoyable learning. The WSA is recommended by UNESCO to be adapted for all types and levels of education systems & will be relevant to enhance education systems in Sikkim as well[31].

Strengthen existing social and emotional learning and life-skills programs in education settings

Social and emotional learning (SEL) and life-skills education in schools help students learn and practice skills on emotional regulation and interpersonal behaviours that improve students' academic performance, mental wellness, and personal and societal connectedness across their lifespan[32]. In Sikkim, life-skills education in schools is implemented by the Health & Family Welfare Department in collaboration with the Education Department through the Rashtriya Kishor Swasthya Karyakram (RKSK) and the School Health and Wellness Programme (SHWP). While the SHWP entails an integrated approach to life-skills through 11 modules including emotional well-being and mental health, it is recommended to include a module on suicide prevention and strengthen existing modules on mental health to take an interdisciplinary and multi-sectoral approach.

Further, ensuring life-skills programs are delivered in a uniform, comprehensive and sustainable manner and ensuring regular monitoring and evaluation of such programs is crucial to maintain quality and impact.

Peer support mechanisms

Peer support for young people is critical in a system with barriers to accessing formal mental health services. Young people, with appropriate training and guidance, may effectively act as peer supporters and offer a safe space for other young people who are experiencing challenging circumstances to openly share their feelings and receive support.

Increasingly recognised as a valuable approach to bridging the mental health care gap, peer support—when combined with appropriate safety and training measures and referral pathways to higher-level services—has been associated with building greater trust among young people seeking help. Peer support can offer developmentally and culturally appropriate support, validate adverse experiences, and provide real-life examples that recovery is possible[33, 34].

Outlive is a youth suicide prevention program which trains youth volunteers to provide chat-based peer support to young adults in distress or contemplating suicide, through a web-based app[35]. Outlive has been recognised as a good practice example of participatory approaches to service design for young people in the guidance package published by WHO and UNICEF[36]. Similar models of volunteer-based peer support may be adapted for Sikkim.

Peer education mechanisms in schools and communities

The RKSK program utilises a peer education model where peer educators provide information and resources to young people on six thematic areas, including mental health & substance misuse.

The implementation of the peer educator program and training modules should be reviewed and strengthened as required.

Career guidance for students

Schools should take a multi-pronged approach to career guidance to ensure career preparedness without undue pressure to help school students realise their full potential. Integrating career awareness and guidance into the school curriculum will provide mentorship and help students identify feasible career pathways for themselves and develop vocational skills and competencies.

Where possible, it is recommended to engage families and relevant teachers in career development sessions and decisions. Existing provisions for vocational education through the Samagra Shiksha Scheme and the guidance of the National Education Policy, 2022 (NEP) may be strengthened to suit the state-level needs in Sikkim[37, 38].

{6} Strengthen substance use prevention, treatment and rehabilitation interventions

Policy- and population-level interventions for substance use prevention and harm reduction

Substance use has a complex impact on the overall health and development of communities. Substance use has a significant impact on mental health, where substance use disorders occur with mental health conditions, including increased risk of suicidal behavior. The WHO recommends comprehensive population-level prevention interventions for substance use prevention, treatment and harm reduction[39]. Given the high rates of alcohol and substance use in Sikkim, it is recommended to review relevant policies and their implementation in the state, including the Sikkim Anti-Drug Act, 2006 to develop policies centred around harm reduction practices, such as limitations on the promotion of psychoactive substances for new and existing users. This may involve review of the number of licenses or points of sale for alcohol (including bars and casinos) and strict regulations on advertising of alcohol and other substances, including on social media[40].

Strengthen existing deaddiction and rehabilitation services

In addition to substance use prevention efforts, the WHO recognises provision of services as a key strategy for treatment of substance use disorders[39]. For Sikkim, this will entail a review of the quality of care in existing deaddiction and rehabilitation services and facilities to ensure services are effective, accessible, affordable and integrated with primary care. To maintain the standards of quality of care, it is recommended to regularly upgrade existing services and infrastructure available for treatment of substance use disorders including capacity building of service providers and protocols[40]. To spread awareness and increase access to existing services in Sikkim, informative resources may be disseminated through outreach activities and public awareness campaigns.

Social reintegration post treatment and rehabilitation

Social reintegration is an essential part of the recovery process of substance use disorders. However, people recovering from substance use disorders are often directly or indirectly deprived of their right to health, education, work and struggle to reintegrate into society due to social stigma and discrimination[39]. To encourage sustained recovery and prevent the relapse of substance use disorders, key stakeholders at the state-level must prioritise a coordinated and comprehensive network for recovery services, modelled on social assistance and protection. This shall include options for safe housing and assisted/independent living, and appropriate assistance for non-stigmatising opportunities for employment and recreation (including appropriate vocational training and skilling programs)[41].

Peer-support to aid recovery and prevent relapse of substance use disorders

Peer support networks and community support have made significant contributions to aid recovery and prevent relapse among persons with lived experience of substance use disorders. Peer support, in a structured and supervised manner, may be encouraged to supplement the care received under existing health and rehabilitation services[40].

{7} Strengthening families and community

Family-based interventions for mental health

Families play a crucial role in the physical, emotional and mental health of children and young people. Supportive home environments facilitate healthy development, whereas unstable home environments (including exposure to parental violence, family trauma or substance use) are linked to lower self-esteem, depression and anxiety in children and young people[41]. Evidence shows that when parents are supported and enabled to carry out good parenting practices, there is positive impact on the mental well-being of both the parents and their children[42]. Family-based interventions for mental health and well-being include interventions focused on positive parenting and communication and interventions focused on parental well-being [43, 44]. In Sikkim, family-based interventions may be co-developed and delivered through community leaders, panchayats and self-help groups.

Capacity building of community members on mental health and suicide prevention

Panchayat members, religious leaders, community elders and self-help groups play a critical role in the development of communities. Thus, capacity building and literacy interventions using creative and engaging tools is critical to activate community stakeholders for developing and implementing mental health and suicide prevention interventions. Such methods can include serious games such as storytelling, simulation and role-playing, facilitated solutioning or other models of skill-building and adult learning. A pilot test of such engagement strategies with community representatives (including Panchayat groups) in Chhattisgarh used to these tools identify pathways to address community-level challenges and make policy processes more accessible to participants[43].

{8} Community development for improved mental health & suicide prevention

Improve access to natural spaces for recreation and community activities

Access to public spaces, particularly green spaces, is conducive to mental well-being. Studies have found positive mental health associated with nature as well as green spaces characterised by recreational and sporting activity[44]. The protective role of green spaces has been contrasted with confined spaces and unplanned land use as detrimental to youth mental health[45]. Thus, to improve general well-being and promote access and use of public spaces, Sikkim should invest in protecting existing green or natural spaces or creating new spaces for recreation which are accessible to all.

Develop dedicated youth spaces or centres for community building

Young people benefit from dedicated youth-friendly spaces as hubs to gather for social connection, recreation and skill development. Such spaces may also act as a resource for coping with life challenges and may be aptly suited for young people to receive and provide formal or informal peer support for problem solving. The youth-friendly spaces may be located in cafes, malls, gyms and sports centres or public parks and libraries. These spaces may also facilitate access to opportunities for skill development with support and collaboration of existing government initiatives such as the Niyukti Kendras implemented by the Skill Development Department, Government of Sikkim.

Promote cultural and sports-based activities and interventions to build community engagement and well-being

Arts-based practices and community sports clubs are evidence-based strategies for promoting mental well-being of young people in communities across contexts[46, 47]. In India, sports-based interventions, have been piloted in multiple contexts, including for life-skills education and prevention of substance-use. The interventions have involved a structured program centered around a team sport with physical activity and life-skills education for coping with life's adversities, building self-esteem and developing

healthy relationships[48]. Similar sports or cultural and arts-based interventions should be developed and implemented in Sikkim.

Communication and dissemination of information on mental health

Information, Education and Communication (IEC) materials used in government programs should be reviewed to debunk common myths related to mental health and suicides in the community. The informative resources should be updated to ensure the messages, content, and presentation are accurate, up to date, relevant and engaging for maximum uptake by the target audience.

{9} Skill development and employment for persons with psychosocial disabilities

Under the UN Convention for Rights of Persons with Disabilities (2006) persons with psychosocial disabilities have a right to participate in work on an equal basis as others. For persons with mental health conditions, access to appropriate employment opportunities can significantly contribute to recovery, inclusion, and social functioning with improved confidence and sense of purpose[49].

To adequately support persons with mental health conditions to participate fully and equitably in work, the WHO recommends the use of:

1. Reasonable accommodation at work to adapt working environments with the capacities, needs and preferences of the worker.
2. Return to work programs to enable workers to successfully resume and sustain employment after an absence associated with their mental health condition.
3. Supported employment initiatives to enhance vocational opportunities and economic participation for individuals with severe mental health conditions[49].

Thus, ensuring provisions for employment for persons with mental health conditions should be prioritised in Sikkim.

{10} Monitoring and evaluation

Monitoring and evaluation are core components of an effective health system. Regular audits of the implementation of existing state-level programs and services are necessary to objectively measure whether the programs have achieved their intended objectives.

To ensure delivery of quality services and effective use of resources, regular external evaluations and audits of state level programs on mental health and suicide prevention should be conducted for identifying gaps and strengthening implementation (e.g., the District Mental Health Programme for quality of services and level of outreach; and the implementation of programs focused on youth such as the SHWP, the RKSK and Adolescent Friendly Health Clinics for their uptake and relevance for young people).

{11} Further research for interventions

There is limited research on successful and sustainable interventions for mental health and suicide prevention in Sikkim and it is critical to build the local and contextual evidence-base to ensure interventions are relevant and sustainable.

This may involve research in the form of:

1. Intervention-development and testing to better understand the mental health needs and impact of interventions for specific population groups.
2. Prospective and longitudinal studies to evaluate the long-term impact of an intervention.
3. Implementation and evaluation studies to evaluate the sustainability and scalability of interventions.

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Annexure A
Formative Scoping Interviews

Guiding themes used for formative scoping interviews with key stakeholders. Stakeholders include representatives from government departments and program officers (DMHP, etc), healthcare or service providers, NGO representatives, college youth, community members/leaders.

Awareness and perceptions on mental health

- Level of awareness and perceptions of mental health conditions in the community
- Significance of mental health concerns in community

Community needs and stressors

- Common stressors experienced among specific population groups (e.g., young people)
- Community needs around the social and structural determinants of mental health, including infrastructure, public facilities and finances/ employment opportunities

Availability of care

- Coping mechanisms and formal/ informal care facilities available to community members
- Community perceptions of government programs and NGO-run programs

Existing programs and facilities

- Programs listed under various departments (e.g., HFWD, SWD) including health care, counselling centres, deaddiction, helpline numbers and youth-focused programs, skilling programs
- Scope of mental health under various public programs and associated gaps in addressing mental health

Implementation status of existing programs and facilities

- Implementation status of the DMHP (and associated deaddiction services, half-way homes), including resources, infrastructure, outreach, strengths and limitations

Access (including referral pathways) for support services

- Enablers and barriers experienced by various community members (including young people) to access mental health care services and barriers
- Referral pathways for secondary and tertiary support services and programs used by service providers

Annexure B
Agenda for Multi-Stakeholder Consultations

9 September 2024

AGENDA
Government Stakeholders Consultation

TIME	OVERVIEW
9:45–10:00 AM	Introduction to Sikkim INSPIRES
9:45–11:00 AM	Inaugural Address
11:00–11:15 AM	*Tea*
11:15–12:15 PM	**Expert Panel 1** Drivers impacting youth mental health and suicide prevention
12:15–1:15 PM	**Expert Panel 2** Addressing institutional and policy gaps for youth mental health & suicide prevention
1:15–2:15 PM	**Expert Panel 3** Good practices and strategies for addressing youth mental health and suicide prevention
2:15–3:15 PM	*Lunch*
3:15–4:15 PM	**Brainstorming Session 1** Identifying priority areas for youth mental health and suicide prevention in Sikkim
4:15 PM–5:00 PM	**Brainstorming Session 2** Developing stakeholder collaborations and partnerships for interventions on youth mental health and suicide prevention in Sikkim
5:00 PM–5:15 PM	*Summary & Vote of Thanks*

10 September 2024

AGENDA
Civil Society Stakeholders Consultation

TIME	OVERVIEW
10:00–10:30AM	Introduction & Welcome
10.30–11.30 AM	**Session 1** Drivers impacting youth mental health and suicide prevention in Sikkim • Overview of risk factors and protective factors • Roundtable discussion
11.30–11.45 AM	*Tea*
11.45–1. 1 5PM	**Session 2** Addressing institutional & policy gaps for addressing youth mental health and suicide prevention in Sikkim • Overview of institutional and policy gaps • Roundtable discussion
1.15–2.15 PM	*Lunch*
2.15–3.45 PM	**Session 3** Good practices & strategies for addressing youth mental health and suicide prevention in Sikkim • Overview of good practices & strategies • Roundtable Discussion
3.45–4.30 PM	*Summary & Wrap-up*

12 September 2024

AGENDA
Theory of Change Workshop

TIME	SESSION
10.00–10.15AM	Context Setting Introduction and brief on the agenda
10.15–10:45 AM	**What is Theory of Change?** Presentation on theory of change process and key elements (impact, outcomes, activities, assumptions)
10.45–11.00 AM	**Synthesis of Consultations & Key Priority Areas** Present the key priority areas based on synthesis of consultations with government and civil society
11.00–11.15 AM	*Tea break*
11.15–2.00 PM	**Finalising Priority Areas** Finalise priority areas based on feedback from participants.
2.00–3.00 PM	*Lunch break*
3.00–4.00PM	**TOC Session: Identifying Outcomes and Activities for Priority Areas** Facilitated discussion with participants to identify TOC outcomes for each of the five priority areas and activities.
5.00–5.30 PM	*Summary & feedback*

Annexure C
Online Survey Questionnaire

Sikkim INSPIRES: Youth Mental Health and Suicide Prevention

ONLINE SURVEY

1. Name
2. Email Address
3. Gender
4. City/District/Village
5. Which group do you most identify belonging with?
   - Non-Governmental Organisation
   - Educational faculty
   - Government staff
   - Student
   - Private employment
   - Not employed
   - Prefer not to say
   - Any other _____
6. Do you identify as having lived experience of mental health problems?
   - Yes
   - No
   - Prefer not to say
7. If you identify as a member of any marginalised or socio-economically disadvantaged group, please state here.
8. List any three factors that impact youth mental health and suicides the most in Sikkim.
9. List any three gaps (in institutions or government programs) that should be addressed for improving young people's mental health in Sikkim.
10. List any three strategies or activities for improving youth mental health and suicide prevention in Sikkim.