A RAPID ASSESSMENT OF CHILD AND ADOLESCENT MENTAL HEALTH & PROTECTION NEEDS AND SERVICES IN MEGHALAYA

TOWARDS A POLICY AGENDA

MAY - JUNE 2022

FOR

DEPARTMENT OF HEALTH & FAMILY WELFARE, GOVERNMENT OF MEGHALAYA

BY

SAMVAD

Support, Advocacy and Mental health interventions for children in Vulnerable circumstances And Distress

A National Initiative & Integrated Resource for Child Protection, Mental Health & Psychosocial Care

DEPT. OF CHILD AND ADOLESCENT PSYCHIATRY
NATIONAL INSTITUTE OF MENTAL HEALTH & NEUROSCIENCES (NIMHANS), BANGALORE

SUPPORTED BY MINISTRY OF WOMEN & CHILD DEVELOPMENT, GOVERNMENT OF INDIA

Acknowledgements

June 2022

At the outset, we would like to express our gratitude to the Hon. Minister of Women and Child Development, Mrs. Smriti Zubin Irani, for her vision and steadfast support, which has culminated in this collaborative effort between SAMVAD and the Government of Meghalaya. Indeed, it is this vision and support from the Ministry of Women and Child Development, Government of India, that has enabled SAMVAD to engage in learning collaborations that facilitate knowledge creation and dissemination on critical aspects of child mental health, protection and psychosocial care.

We are deeply grateful to the Hon. Minister of Health & Family Welfare, Government of Meghalaya, Mr. James Sangma for inviting the SAMVAD Team to conduct this rapid assessment and provide key recommendations for the development of a comprehensive State Mental Health Policy i.e., a 'Care, Protection And Socio-Emotional Well-being Policy For Children And Adolescents'. We are privileged to be executing the Hon. Minister's vision for mental health, particularly in the context of children and adolescents. Indeed, without the Hon. Minister's passionate commitment to a State Mental Health Policy, such a massive state-wide effort would not come to fruition.

We would also like to acknowledge the unwavering support extended to the SAMVAD Team by the Department of Health & Family Welfare, Government of Meghalaya, that ensured a productive field visit, and has culminated in this report. Our special thanks to Mr. Sampath Kumar, Principal Secretary, Department of Health & Family Welfare, who was responsible for initially briefing the SAMVAD Team on the Government's proposal to develop a state-wide mental health policy. This critical meeting and Mr. Kumar's continued support laid the foundation for this immense initiative.

Finally, this document and foundation for Meghalaya's 'Care, Protection And Socio-Emotional Well-being Policy For Children And Adolescents, would not have been possible, but for the valuable time and inputs so generously provided by various government and non-government and community-based stakeholders and functionaries. We trust that their voices have amplified those of children and adolescents in order that the latter may receive critical protection and psychosocial support through their formative years.

Aakanksha Kulkarni, Project Officer (Care & Protection)

Kritii Tikku, Project Officer (Mental Health)

Saurabh Shashi Ashok, Project Officer (Policy and Law)

Sheila Ramaswamy , Technical & Operational Lead

Dr Shekhar Seshadri, Advisor (SAMVAD) & Former Senior Professor, Dept. of Child & Adolescent Psychiatry, NIMHANS)

Dr John Vijay Sagar (P.I. (SAMVAD) & Head, Dept. of Child & Adolescent Psychiatry, NIMHANS)

SAMVAD

(Support, Advocacy & Mental health interventions for children in Vulnerable circumstances And Distress)

(A National Initiative & Integrated Resource for Child Protection, Mental Health, & Psychosocial Care)

Dept. of Child and Adolescent Psychiatry, NIMHANS, Bangalore

Supported by Ministry of Women & Child Development, Government of India

Glossary

ANM – Auxiliary Nurse Midwife

ASHA – Accredited Social Health Activist

CBO – Community-Based Organisations

CCI – Child Care Institution

CHC – Community Health Care/Community Health Centre

CICL – Children in Conflict with the Law

CNCP – Children in Need of Care and Protection

CWC – Child Welfare Committee

DCPO – District Child Protection Officer

DEIC – District Early Intervention Centre

DMHP – District Mental Health Programme

DRC – District Resource Centre

ECCD – Early Childhood Care and Development

ICDS – Integrated Child Development Scheme

ICPS – Integrated Child Protection Scheme

IEC – Information Education Communication

JJB – Juvenile Justice Board

NIMHANS – National Institute of Mental Health and Neuro Sciences

NMHP – National Mental Health Programme

PHC – Primary Health Care/Primary Health Centre

POCSO – Protection of Children from Sexual Offences Act, 2012

PTSD – Post-Traumatic Stress Disorder

RBSK – Rashtriya Bal Swasthya Karyakram

RKSK – Rashtriya Kishor Swasthya Karyakram

List of Contents

List of Contents

List of Contents

A. BACKGROUND & RATIONALE

Comprising of 7 districts, 39 sub-districts, 22 Towns and 6,839 villages, according to the 2011 census data, Meghalaya has a population of 29,66,889, of which nearly 80% lives in the rural areas (Government of Meghalaya, 2017). Located in the north eastern part of India, with hilly terrain, and the consequent challenges of transportation and communication, there is an uneven distribution of health facilities across the state. This, along with a lack of trained professionals, especially in the field of mental health, adversely impacts access to quality mental healthcare. The need for mental healthcare services, however, is tremendous, given that the North Eastern context continues to be impacted by vulnerabilities such as poverty, and (cross-border) drug in-flow from Myanmar and Bangladesh on the one hand (Hasan & Tawfeeq Alee, 2018), along with the problems of domestic violence and family dysfunction that, contrary to popular belief, are also incident in the matrilineal tribal societies of Meghalaya (Slong & Ropmay, 2011).

Such social milieus make for Adverse Childhood Experiences (ACEs), which are known to place children and adolescents, an already vulnerable population, at enormous risk for mental health problems (Fox et al., 2015), (Sheffler et al., 2020). Since a large proportion of mental illness is attributable to childhood adversity, including the transgenerational transmission of childhood adversity, it is critical for a state to address the care, protection and socio-emotional and mental health issues of children and adolescents (Scott et al., 2010). Indeed, in Meghalaya, the consequences of childhood adversity are reflected specifically through the prevalence of child abuse and neglect, teenage pregnancy and substance abuse.

According to the National Family Health Survey (NFHS-5), 2019-2020, while a very high proportion of children between 6 to 17 years attend school in Meghalaya (91%), the number drops sharply to 79 percent for children aged 15-17 years. Some of the reasons attributable to school dropout issues are teenage pregnancy and substance use, both identifiable as prominent adolescent health concerns in the state. 7% of adolescents between 15 and 19 years have begun child-bearing, with the proportion of child-bearing adolescents/ women being 12 times higher in those who have had no schooling (International Institute for Population Sciences (IIPS) and ICF., 2021).

A country-wide study conducted for the National Commission for Protection of Child Rights, to assess the pattern, profile and correlates of substance use among children in India, showed that Meghalaya had the highest substance use (specifically of tobacco and heroin) in the country (Dhawan et al., 2017). Such indicators are concerning to say the least, and strongly reflective of prevalent child and adolescent mental health problems, not only relating to socio-emotional difficulties but also to the paucity of sexuality and life skills education in adolescents.

In recognition of the mental health implications of the above issues, both in terms of causes and consequences, the Dept. of Health and Family Welfare, Government of Meghalaya, under the leadership of the Hon. Minister of Health & Family Welfare, invited SAMVAD, a national initiative & integrated resource for child protection, mental health, & psychosocial care, to support the Government of Meghalaya with the drafting of a State Mental Health Policy. SAMVAD, located in the Dept. of Child and Adolescent Psychiatry, National Institute of Mental Health & Neurosciences (NIMHANS), Bangalore, and supported by Ministry of Women & Child Development, Government of India) has a mandate to enhance child and adolescent psychosocial well-being, particularly of children in difficult circumstances, through promotion of integrated approaches to mental health and protection.

Consequently, with a view to informing and making recommendations for the State Mental Health Policy, SAMVAD undertook a rapid assessment of Child and Adolescent Mental Health & Protection Needs and Services in Meghalaya. Engaging with key stakeholders, working in various types of services relating to children, namely in the areas of community development, early childhood care, health, education, welfare and protection, SAMVAD's assessment helped to acquire a contextual understanding of child mental health issues in the state, analysing existing services and gaps and challenges, but also identifying potential opportunities for support and development of child and adolescent mental health interventions and services. The findings and recommendations described in this report are thus expected to feed into a blue print and road map for the sections on child and adolescent mental health policy of the overall state mental health policy—or what, in order to avoid the stigma associated with mental health, will be referred to in the policy document as 'Care, Protection and Socio-Emotional Well-Being Policy for Children and Adolescents'.

B. OBJECTIVES OF THE RAPID ASSESSMENT

THE SPECIFIC OBJECTIVES OF THE ASSESSMENT WERE TO:

1. Understand child and adolescent protection and mental health-related concerns in Meghalaya

2. Examine the services available to children and adolescents with regard to preventive-promotive and curative mental health, and the gaps thereof

3. Identify potential stakeholders and opportunities for implementation of child and adolescent protection and mental health programs and services.

4. Develop a detailed report on the above issues, along with state and context-specific recommendations, to inform the state mental health policy, specifically the policy on care, protection and socio-emotional well-being for children and adolescents.

C. METHODOLOGY

C.1. SELECTION OF RESPONDENTS

In the light of the need to ensure that the understanding obtained on child and adolescent protection and mental health concerns reflected multiple service provider perspectives, and contexts, the **inclusion criteria** for respondents were:

- Administrative or implementation role and function in a child/adolescent protection, development and/or mental health related service or program.
- Serving in primary, secondary or tertiary levels of child services, primarily in government agencies or civil society agencies recommended by the state government.

Consequently, the assessment undertook to draw respondents from four broad categories of stakeholders, namely:

- State Departments directly engaged in child services, namely the Departments of Health and Family Welfare, Social Welfare and Education.
- State departments engaged with communities, and consequently interfacing with children, in specific functions, namely Departments of Home, Community & Rural Development and District Council Affairs.
- Legal and judicial personnel engaged in implementing child laws
- Non-governmental agencies (including public-private partnerships)

Within the concerned departments or agencies, the specific programs and schemes serving the protection and mental health-related needs of children were identified, including the stakeholders responsible for delivering these services. Refer to Table 1 below for details on the State Department, program/scheme/initiative/agency and position/designation of the respondents.

Table 1: Stakeholders Participating in Key Informant Interviews

State Department	Program/Scheme/Initiative/Agency	Position/Designation
Health and Family Welfare	Community Health Centres	ASHA Workers (5) Medical Officer (2) Community Nurse Supervisor (1) Data Entry
	District Mental Health Program	Psychiatrists (4) Psychologists (4) Social Workers (5) Community Nurse (2) Psychiatric Nurse (4) Nodal Officer (2) District Program Officer
	District Early Intervention Centre (DEIC) under Rashtriya Bal Swasthya Karyakram (RBSK)	Social Worker Nurses (2) Audiologist Psychologist Paediatrician Special Educator Data Entry Operator Lab Technician Dental Staff (2)
	Rashtriya Bal Swasthya Karyakram (RBSK) Mobile Team	Medical officer (AYUSH) (1) Staff Nurses (2)
	Rashtriya Kishore Swasthya Karyakram (RKSK)	Counsellors (2)

State Department	Program/Scheme/Initiative/Agency	Position/Designation
Health and Family Welfare	Meghalaya Institute of Mental Health & Neurosciences (MIMHANS)	Clinical Psychologist Nurses (4) Psychiatric Social Workers (2) Psychiatrist Additional Superintendent
	North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS)	Senior Residents (2) Junior Resident Clinical Psychologist Psychiatrist
	State Mental Health Authority	Chief Executive Officer Psychiatrist
	District Health Society	District Medical Health Officer (2) Inspector of Physical Health Officer, National Program for Control of Blindness District Nodal Officer, National Program for Prevention & Control of Cancer, Diabetes, Cardio-Vascular Diseases & Stroke
	Government school Government-Aided Schools (3)	Principals School counsellor School teachers Parents
Education	Samagra Shiksha Abhiyan (SSA)	State Management Information Systems (MIS) Officer State Coordinator (SSA)
	Directorate of School Education & Literacy	Officer, Children with Special Needs Deputy Director, Directorate of School Education State Pedagogy Coordinator
	Directorate for Higher & Technical Education	Joint Director Deputy Director (2)

State Department	Program/Scheme/Initiative/Agency	Position/Designation
Social Welfare	Anganwadi	Anganwadi Supervisors (5) Anganwadi Workers (6) Child Development Program Officer (2)
	-	Commissioner for Persons with Disability
	Integrated Child Protection Scheme (ICPS)	District Child Protection Officers Child Care Institution Probation Officers, Counsellors & Social Workers (from Care & Protection Homes/Observation Homes/Place of Safety) Protection Officer-Institutional Care Protection Officer-Non-Institutional Care Chairperson & Members of Child Welfare Committee Juvenile Justice Board Member Juvenile Justice Magistrate
	Other Officials	Assistant Director, Care & Protection Director, Women's Cell
	One Stop Centre (OSC)	Manager Case Worker Counsellor
	Assistant Development Commissioner Office	Block Development Officer

State Department	Program/Scheme/Initiative/Agency	Position/Designation
Community & Rural Development	District Council	Executive Officers (3)
District Council Affairs	Special Juvenile Police Unit (SJPU)	
Home	-	Deputy Commissioner (3)
Other	State Commission for Protection of Child Rights (SCPCR)	Chairperson
	High Court of Meghalaya	Special Court Judge
		Chief Metropolitan Magistrate/ Juvenile Justice Magistrate
	Federation of Traditional Village Leaders	Village Headman (4) (also President and General Secretary of Federation)
	Indian Institute of Public Health*	Director
Other Agencies for Collaboration	Faith	Administrative Staff, Counsellors, Special Educators & Other Mental Health Professionals
	Routes	Administrative Staff, Counsellors, Special Educators & Other Mental Health Professionals
	Bethany	
	Mary Rice	
	San-Ker	
	Kripa Foundation*	
	North East Network	

*Agencies with public-private partnership

C. METHODOLOGY

C.2. ASSESSMENT SITES

Since time was limited, and the terrain challenging to traverse, the districts that were in some proximity to Shillong, namely East Khasi Hills, West Jaintia Hills, West Khasi Hills and Ri Bhoi, which were also more easily accessible were included in the assessment for the team's travel. However, other districts, of North Garo Hills, East Garo Hills, South Garo Hills, West Garo Hills, South West Garo Hills, East Jaintia Hills, South West Khasi Hills and Eastern West Khasi Hills were also represented in group interviews conducted with DMHP nodal officers, from across the state, when officials from those districts were able to travel to meet with the SAMVAD team and participate in the assessment.

C.3. METHODS

A qualitative methodology was then employed to conduct the rapid assessment, through the use of key informant interviews and group interviews*. Although the latter can be a challenging method to employ, given the available time-frame, and the need to engage with multiple stakeholders, often from the same scheme/program/service, group interviews were successfully conducted because of careful planning of interviews, and systematic development and use of data collection tools.

JOINT PLANNING AND COORDINATION WITH STATE DEPARTMENT OF HEALTH AND FAMILY WELFARE

Prior to its visit to the state, the SAMVAD team engaged intensively with the Dept. of Health and Family Welfare, acquainting the concerned officers with the transdisciplinary approach that the team would adopt in its assessment exercise. The SAMVAD team and the Dept. of Health thus jointly prepared the list of stakeholders to be interviewed (as erstwhile described), and the Department planned and enabled the meetings and interviews accordingly, facilitating requisite permissions from other departments and agencies.

*The interview schedules developed by the SAMVAD Team are available on request

C. METHODOLOGY

DEVELOPMENT OF TOOLS

Qualitative tools, namely interview schedules, were developed for use with different respondent stakeholders. Broadly, a list containing a set of structured questions were prepared, to serve as a guide for interviewers, with a focus on the following areas and themes of child work and services:

- Child and adolescent protection concerns (psychosocial risk and vulnerability)
- Consequent child and adolescent emotional, behavioural, learning and development problems
- Access and availability of child protection and mental-health related programs, schemes and services
- Nature and type of services, programs and interventions provided—including gaps and challenges
- Strengths and potential opportunities for inclusion, expansion or improvement in programs and services (to better meet children's contextual needs)

*Interview schedules were adapted, as necessary, to the specific roles and functions of individual stakeholders and respondents.

C.4. DATA COLLECTION

The SAMVAD team visited Meghalaya for a period of a week, engaging with stakeholders through key informant and group interviews. Each interview lasted for about an hour with the completion of an average of 8 interviews per day. The team completed 44 interviews, including 11 key informant interviews and 33 group interviews. Data collected through interviews were recorded through field notes—comprising of the information provided by the respondents as well as follow-up notes with the interviewer's observations and interpretations immediately upon the conclusion of each interview.

C.5. DATA ANALYSIS

The team collated the field notes according to the categories and sub-categories of the respondents interviewed and organized the data into information focusing on three key themes, as relevant to the assessment, and also to drawing out recommendations for policy:

(a) Existing programs and schemes/ including descriptions of objectives, target populations served, services provided, requisite skills and training provided for implementation;

C. METHODOLOGY

(b) Gaps and challenges in services (as stated by the respondent and observed by the SAMVAD team)

(c) Potential opportunities for integrating and incorporating or strengthening the child and adolescent protection and mental-health related components of the program/service.

Recommendations for the 'Care, Protection and Socio-Emotional Well-Being Policy for Children and Adolescents', in terms of the roles, functions and capacity building needs for (each group of) services and stakeholders, were developed based on an analysis of the three themes.

*Interview schedules were adapted, as necessary, to the specific roles and functions of individual stakeholders and respondents.

D. FINDINGS AND ANALYSIS

D.1. PRIMARY LEVEL

- Anganwadi
- Community Health Centre (CHC)
- Village Headman/ Rangbah Shnong
- Block Development Officer

D.1.1. ANGANWADI WELFARE CENTRES (AWC)

EXISTING SERVICES AND SYSTEMS

Over 520 anganwadis service approximately 430 villages. There are some villages across districts that do not have an anganwadi of their own for each catchment. Each anganwadi serves a population of 350 people.

The number of children attending the anganwadi range from 30 to 65 children between the ages of 0 to 6 years. Each Anganwadi is staffed with one anganwadi worker and one anganwadi helper.

The daily activities in anganwadis range from assembly, prayer, cleaning their anganwadi space, followed by various activities like colouring, drawing, identification of common objects, alphabets and numbers. Upon enquiring about socio-emotional teaching in anganwadis, it was reported that while stories are narrated to children through picture cards, not enough emphasis is laid on the processing of these stories. The learning within anganwadis is focused primarily on cognitive development.

The following were the overarching domains discussed with the Anganwadi workers in the interviews:

- Nutrition
- Emotional And Behavioural Concerns Of Children
- Developmental Issues In Children
- Child Abuse

D.1.1. ANGANWADI

ISSUES AND KEY FINDINGS

ISSUE	KEY FINDINGS
Nutrition	• Anganwadi workers provide children with a meal plan. • They use the POSHAN tracker in districts where connectivity is available, for Severe Acute Malnutrition (SAM) children. They reported an average of 2-3 cases of SAM children per Anganwadi catchment. • Food consisting of barley, wheat, *suji,* vegetables and rice is given to children. The Anganwadi workers reported that the children are given food based on the staple provided by the government, which may be standardised. They expressed the need for food that is contextual to the region children are from, as they eat it readily and it is beneficial for their health.
Emotional and behavioural concerns of children	• The most common concerns regarding children's behaviour had to do with 'naughty' behaviours like scribbling on desks and non-adherence to rules. In cases of difficult behaviours, the anganwadi workers intervene by speaking to the parents regarding the issue. • During the COVID lockdown, the anganwadis were engaged in providing relief and ration to families. • When probed about their knowledge on emotional and behavioural concerns of children due to violence, abuse and other concerns at home, they reported that they are not aware of what goes on within homes. The general belief was that unless such an issue is reported, it does not fall within the gambit of their role.

D.1.1. ANGANWADI

ISSUES AND KEY FINDINGS

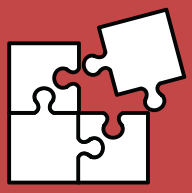
ISSUE	KEY FINDINGS
Developmental issues in children	• Certain children have difficulty catching up with their peers or are slow to develop skills and learn. They believe that the possible causes for the same could be unwillingness to learn or certain disabilities in children. • Anganwadi workers and helpers assist children who find it difficult to cope or are slow learners by giving them more time and letting them do their work at their own pace. • Anganwadi workers assist children and their families with disability certification. A local school is appointed to assist with the provision of the certificates, while the ASHA workers and anganwadi workers work together to supply the schools with a list of children requiring disability certification in their community. The children are then referred to district hospitals twice a year. • During the COVID lockdown, the anganwadis were engaged in providing relief and ration to families.

D.1.1. ANGANWADI

ISSUES AND KEY FINDINGS

ISSUE	KEY FINDINGS
Child Abuse	• Childline is a resource the anganwadis were aware of with regard to child abuse cases. • They reported not having worked on cases of abuse or sexual violence towards children, as it hasn't been reported to them. • With regards to their knowledge and experience on child abuse, specifically child sexual abuse, it was reported that they had no experience of working on child abuse or sexual abuse cases. • Adolescent girls are provided food as well as medical assistance, with the support of ASHA workers. • Due to a rise in teenage pregnancies, the ASHA workers and Anganwadi workers engage adolescents in conversations around safety practices, family planning and abstinence from sex. • The anganwadi workers reported that they are yet to receive training or capacity building on areas of child mental health and child protection.

D.1.1. ANGANWADI



GAPS AND CHALLENGES IN SERVICES

Imperative for anganwadis to identify developmental, mental health and protection issues in younger children

Lack of training to anganwadi workers in basic-level standardised assessments for developmental, mental health and protection concerns

Non-formal education is a critical part of the Integrated Child Development Scheme (ICDS) and offers a promising opportunity to interface with a large number of young children within communities through the anganwadi system. Therefore, one of the key functions should be to **identify children with disability or developmental delays**. Related to this, is also the opportunity for anganwadi staff to identify children with mental health and protection issues which impact development. The linkages between early childhood abuse, neglect, emotional and behavioural problems, and subsequently, mental health issues need to be explored here.

Anganwadi workers, therefore, require training in identification and assessment of the aforementioned issues, standard operating procedures in the context of the law, and a general understanding of vulnerability of children and their roles in that context.

D.1.1. ANGANWADI

POTENTIAL OPPORTUNITIES

Anganwadi workers can be provided training through district agencies like the District Job Training Centres where they receive other training, by equipping them with skills and simple screening checklists for protection concerns in children as well as mental health and developmental issues. These skills must cover an understanding of child development, assessments, emotional and behavioural concerns of children, communication skills, mental health issues and life skills training along with a brief understanding of child related laws.

Considering that protection and early child development are critically connected and impact each other, Anganwadi workers can also be assisted in convergence with district agencies like the District Child Protection Unit (DCPU), to work with village authorities to identify, assist and refer vulnerable children and families to the respective schemes and other health institutions for further interventions.

D.1.2. COMMUNITY HEALTH CENTRE

EXISTING SERVICES AND SYSTEMS

The Community Health Centre (CHC) caters to over 63 villages and a population of over thirty-seven thousand. The predominant services available in the CHCs are: i) Out-Patient Department (OPD) Services; ii) In-patient Department (IPD) Services; and iii) Maternal and Child Health Department (MCH) Services.

The Medical Officer reported that they see close to 140-150 patients in a day. They see the highest caseload on Mondays, Saturdays and Market Days. That is the time when most people visit the CHC. The COVID pandemic reportedly led to a considerable decrease in the number of patients accessing the CHC's services, with less than 60 patients per day. The following are the staff present in the CHC: 4 Doctors (allopathic doctor, dentist, dentistry surgeon and a pediatrician); 2 Supervisors; 8 Staff nurses; 1 Pharmacist; 2 Laboratory technicians; 1 Radiographer; 4 Grade-4 female staff; 8 Grade-4 male staff.

Health Seeking Behaviours

It was reported that people do tend to seek allopathic treatment as opposed to the prevailing notion that they seek traditional medicine. However, given differing field reports with regard to health-seeking behaviours, it is difficult to generalise these findings from the concerned CHC.

Child-related services

Over 2.3% of the referrals with regard to child patients come to CHCs by Accredited Social Health Activists (ASHA). Their referrals constitute over 8-9% of the caseload that comes to the CHC. The most common cases pertaining to children that come to the CHC are: diarrhoea, anaemia, typhoid, pneumonia, vaccinable diseases, enuresis, and accidental injuries in children.

When children come in with injuries that are accidental, the medical officer reported that they enquire in detail about the circumstances that led to the injuries. They also reported that they rely heavily on forensic evaluations of the injuries and the circumstances that the child and family narrate, especially in cases where their narratives and the nature of injuries don't align. The CHCs do not have a protocol, protection policy or standard operating procedure to identify and address protection issues in children.

D.1.2. COMMUNITY HEALTH CENTRE

EXISTING SERVICES AND SYSTEMS

However, there is recognition that children face abuse within communities and families, and that enuresis and injuries are concerns that require to be identified and addressed by the professionals in CHCs.

In some cases, because the communities are close knit, the medical officer also learns about the actual circumstances behind the injuries of children by speaking with important members of the community like the Village Headman. The village administration and governance systems are culturally idiosyncratic in nature, with the community being closely linked. The Village Headman plays a crucial role in the village and community, especially considering that he is elected by the community and works closely with the traditional leaders in the community. The Village Headman, in this regard, serves as a cultural bridge between village residents and the CHC. The Headman, therefore, facilitates a lot of the work of the CHC within the community and is also a key informant in cases of child abuse and other issues.

The COVID pandemic also played a significant role in bringing CHCs and communities closer. Vigilance increased and communities' trust was built as a consequence of the CHC's work, during the outbreak, to provide COVID-related medical assistance and other critical medical assistance.

Programs of the CHC

The CHC runs medical camps and awareness programs within the community, and in the CHC, aside from the regular work undertaken by the Centre. The awareness campaigns cover a range of social concerns including teenage pregnancy, leprosy and tobacco awareness. The Auxiliary Nurse and Midwife (ANM) also conducts home visits to engage with families within the communities on these issues. The Medical Officer and supervisor provide the ANMs with certain targets for home visits per week. The ANMs subsequently conduct different awareness and medical drives within these target households. They also have a Health Calendar and plan events that lead up to the main calendar events. For example, they conduct different activities around deworming and health that lead up to 'Deworming Day'.

D.1.2. COMMUNITY HEALTH CENTRE

CHILD RELATED ISSUES AND CONCERNS

ISSUE	KEY FINDINGS
Teenage Pregnancy	Teenage pregnancy is a concern that the CHC deals with on a regular basis. An observation made is that despite Meghalaya being a matrilineal society, patriarchal beliefs regarding reproductive health and family, contribute to early marriage of adolescent girls. Cases of early marriage or cohabitation of adolescents, in this regard, are common. This constitutes what is commonly referred to as 'unplanned marriages'. Early pregnancy among adolescents is, therefore, common, as are concerns and issues of maternal mortality. Most teenage pregnancies, according to the CHC, stem from early marriages. However, there have been cases of children being impregnated due to penetrative sexual abuse (not marriage) that were detected and identified during treatment at the CHC. One of the ways in which the CHC addresses the issue of teenage pregnancy is to call special meetings at Anganwadi Centres for young mothers, as they access the Anganwadi services for nutritional support. The staff bring these women together to discuss issues they cannot otherwise easily discuss, like concerns regarding menstruation, pregnancy and reproductive health. They use different Information Education Communication (IEC) materials provided by the Ministry of Health & Family Welfare, Government of India, to facilitate discussions on these issues.

D.1.2. COMMUNITY HEALTH CENTRE

CHILD RELATED ISSUES AND CONCERNS

ISSUE	KEY FINDINGS
Child Sexual Abuse	Child sexual abuse cases, according to the CHC, are primarily identified through vigilance during treatment for other physiological issues, for which the child approaches the CHC. However, very few cases of sexual abuse are identified. A CHC reported that they noticed a 7-year-old child having recurring Urinary Tract Infections (UTI). Upon further investigation, they found out that the child had been sexually abused and that she was 1 of 3 such cases in the village that had the same perpetrator. There is a paucity of knowledge and understanding around the different aspects of child sexual abuse, including, but not limited to, identification, first level responses and socio-legal interventions. The CHC staff are aware that the POCSO Act is the law that addresses sexual abuse, but are unaware of how to operationalise it in the context of their own roles.
Children with Disabilities	Not a lot of work is done in the CHC on developmental and other disabilities in children. There is a paucity of District Early Intervention Centers (DEICs), which cater to large populations across many districts. In case a child with seemingly developmental issues comes to the CHC, they take history of the child, conduct activities to evaluate basic indicators, with developmental issues assessed predominantly through their observations. They do not refer to check-lists or screening tools to comprehensively assess children with developmental issues.

D.1.2. COMMUNITY HEALTH CENTRE

LINKAGES AND CONVERGENCE

STAKEHOLDERS	LINKAGES AND CHALLENGES
District Mental Health Program (DMHP)	It was reported that, on average, for 5 CHCs, there is one DMHP point of contact that approaches them and works with them. The dearth of DMHPs across all districts, coupled with a shortage in the staff, leads to less support and assistance for mental health issues, and indeed, referrals of children even if they are identified. The DMHP collaborates with the CHC for awareness programs within the community that the CHC provides services to. The following are the awareness programs that they conduct in collaboration with the CHC: i) Awareness against drug abuse; ii) Suicide Prevention; iii) Teenage Pregnancies; iv) Child Sexual Abuse; v) Physical Abuse. These programs are conducted in committee halls in the villages. These programs are held in collaboration with the CHC and DMHP. They mobilise the community for these purposes with the help of the Village Headman, ASHA workers and Anganwadi workers.
District Early Intervention Centres (DEIC)	A common challenge to having developmental screening services available in CHCs, according to the staff, is a shortage in staff as well as the paperwork and additional time that goes into registering the data. Upon enquiry of the presence of DEICs and their work with the CHC, it was informed that it would be helpful if the DEICs made periodic visits to the CHC for potential screenings and other developmental issues, instead of referral by the CHC to the DEICs. The reason for this suggestion, is owing to the fact that there are limited DEICs, which may create barriers to families who may be required to travel long distances to access the DEICs. Children with disabilities need to be transported across long distances and difficult terrain, in a crowded public service vehicle, which is detrimental to the parents' motivation to approach the DEICs and continue treatment.

D.1.2. COMMUNITY HEALTH CENTRE

LINKAGES AND CONVERGENCE

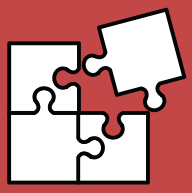
STAKEHOLDERS	LINKAGES AND CHALLENGES
District Early Intervention Centres (DEIC) (Contd.)	It was also informed that the Rashtriya Bal Swasthya Karyakram (RBSK) did provide mobile health teams before the COVID pandemic, however, they were only responsible for screening. Further treatment or interventions were not provided. The mobile teams currently provide COVID vaccination and support. It was reported that the CHC observes that these mobile teams are overburdened, in many ways, by their work in schools and communities across the state.
Village Headman	The Village Headman is a very crucial stakeholder for all service providers, in regards to mobilising communities. The CHC also maintains a close relationship with the Village Headman. This collaboration helps them to mobilise communities for awareness programs and any other intervention they do within the community. Additionally, from a protection perspective, the village headman is also a crucial source of information regarding daily occurrences in the village. For example, from a child protection perspective, when the doctor at the CHC suspects that injuries on a child seem suspicious and indicative of abuse, he/she contacts the village headman to better understand the context of the child and the background of the injuries.

D.1.2. COMMUNITY HEALTH CENTRE

LINKAGES AND CONVERGENCE

STAKEHOLDERS	LINKAGES AND CHALLENGES
Childline & Community Based Organisations	Childline is working in many districts of Meghalaya, including the aspirational district of Ri Bhoi. They work with the Social Welfare Department, through the District Child Protection Unit (DCPU). CHC doctors also refer children to community-based organisations that work on issues relevant to children. However, not many organisations exist that presently work with child protection and mental health concerns in the communities.

D.1.2. COMMUNITY HEALTH CENTRE



GAPS AND CHALLENGES IN SERVICES

A challenge pertaining to convergence has been with regard to the screening, assessment and treatment of children with disabilities, according to the CHC staff. A strong network is required to be built among the DEIC, CHC and the District Resource Centre (DRC). Periodic visits of the DEIC to the CHC is also important considering travelling and other logistical challenges with regard to the terrain and financial condition of parents of children with disabilities.

SAMVAD's understanding of the possible gaps and challenges in the services of the CHC is a lack of training and capacity building of staff, along with equipping them with an easy, brief assessment proforma and check-lists for screening of children with disability.

Given that one of the challenges reported by the CHC staff pertains to identification of abuse, there appears to be a knowledge gap in the area of child protection and mental health. This gap extends to lack of awareness of the dynamics of these issues, and consequently, an inability to assist affected children even when abuse is reported or identified.

Another aspect raised by participants is the confusion with their roles in POCSO cases. There is a lack of knowledge about sexual abuse, as well as operationalising the POCSO Act in their capacity as duty bearers. SAMVAD's understanding of the gaps and challenges, in this regard, also pertains to capacity-building, to bridge knowledge gaps on technical information on sexual abuse, as well as their role in implementing POCSO.

D.1.2. COMMUNITY HEALTH CENTRE

POTENTIAL OPPORTUNITIES

Given the many functions of the CHCs, including the running of various vertical programs pertaining to primary health, it may be difficult for the CHCs to engage extensively in interventions for child mental health and protection. However, given their regular contact with the community, through their clinic-based services, as well as their outreach (through ASHA workers), their contribution to child mental health and protection would be critical, in terms of identification and referral. The CHC staff, therefore, may be provided with simple screening checklists (that could be implemented during clinical services as well as house-to-house visits) that enable them to identify developmental, mental health, and protection concerns in children, and refer them to the DMHPs /DCPOs and relevant government schemes.

Additionally, in this regard, an effective coordination mechanism, linking the CHC to critical services, such as the DEIC, DMHP and DRC is imperative to ensure effective provision of mental health, developmental and disability-related services to children in need. This coordination mechanism needs to stipulate the number of scheduled visits to the CHC, types of services to be provided by these governmental agencies, and clear guidelines for referral to tertiary care centres. This will enable a rationalised approach to referrals to tertiary care, and address concerns regarding overburdening of tertiary service providers.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

EXISTING SERVICES AND SYSTEMS

SAMVAD interviewed the following participants from the Federation of Traditional Village Leaders of Khasi and Jaintia Hills- President, the General Secretary and two Rangbah Shnongs from Ri Bhoi District.

Meghalaya has a unique traditional self-governing system as the State is under the provisions of the Sixth Schedule of the Constitution of India. The purpose of the inclusion of the State, in the Sixth Schedule of the Constitution, is to ensure- preservation of its cultures and traditions, protection from exploitation and autonomy in socio-political matters. The traditional system of administration is an established institution which is several generations old and is culturally accepted and relied upon by the clans/ community members.

This traditional system has a three-tier system which includes-

- Dorbar Phyllun is a general body and administrative unit, comprising four or more Dorbar Shnongs, and is constituted by the Dorbar Shnongs to look into the common interest and general welfare of the inhabitants of the villages under its jurisdiction.
- Dorbar Shnongs are the village councils headed by Rangbah Shnongs or the Headman and is under the Dorbar Phyllun. It is the traditional village institution, and is composed of all inhabitants of not less than 18 years of age, where the prevailing age-old customary and traditional governance and adjudication processes are carried out.
- Dorbar Dongs is the lowest-level of this system, headed by the Rangbah Dongs. It is a subordinate part or locality of a village and has a distinct identity within the village.

A Dorbar Phyllun may have a cluster of villages or Shnongs under it. Under this system of governance, each Shnong or a village has its own village headman who is chosen by the community through mutual consensus. On an average, there are about 35-60 households per Shnong/ village.

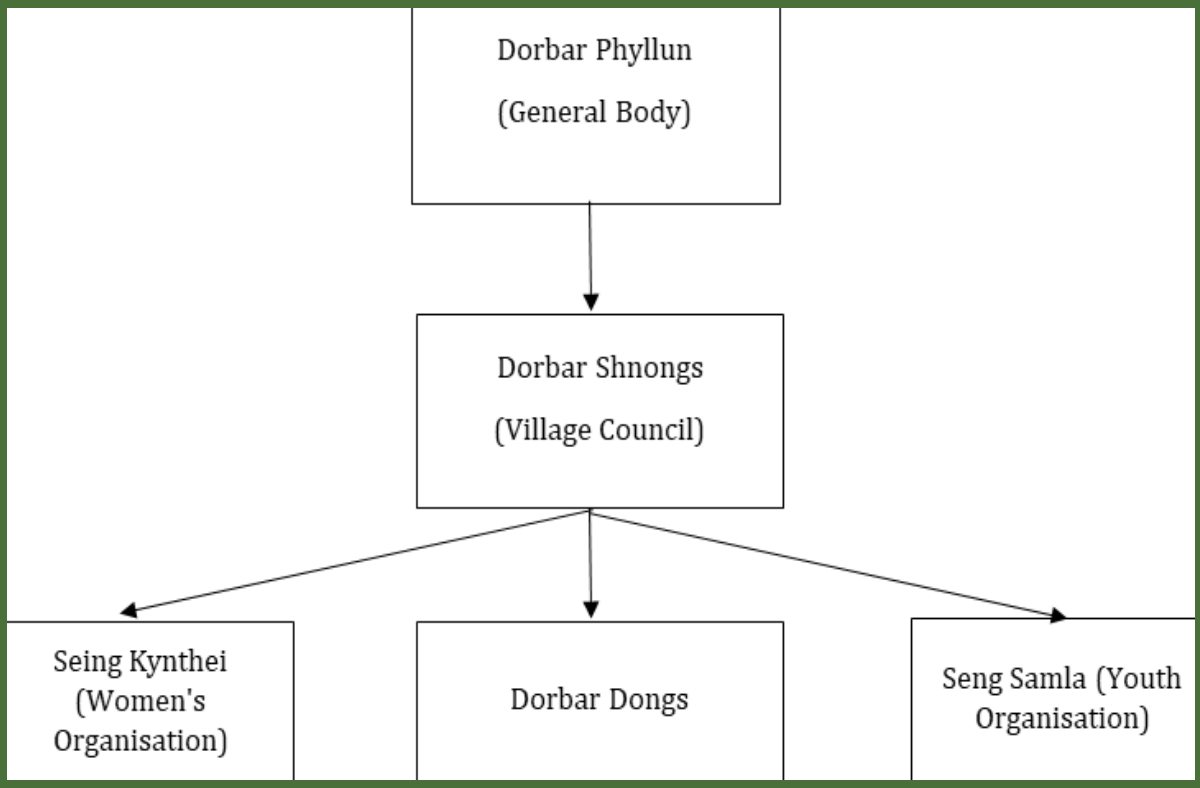
The headman is elected by the community through an election process, but not by the process of a secret ballot, especially in rural areas. The urban areas are now beginning to use the secret ballot for the election of the headman.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

EXISTING SERVICES AND SYSTEMS

It was interesting to note that the Rangbah Shnong or the village headman is not appointed by the government but is a voluntary position (not paid remuneration for their work like in a Panchayat System). They are responsible for the overall administration and wellbeing of the clans/ community. And, therefore, each Rangbah Shnong is well connected with each family in the village.

A particularly unique feature of this system is that each Village/ Shnong includes a Seing Kynthei (women's organization) and Seng Samla (youth organization).



D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

EXISTING SERVICES AND SYSTEMS

The following are key roles of the village headman - a) the primary job of the village headman is to maintain peace and tranquility by resolving any issues/conflicts between the clans; b) to facilitate birth and death registrations; c) to assist the district administration in implementing the government schemes.

The Dorbar Shnong or the village council meets to discuss issues whenever necessary in case of emergencies or on a need basis. The most common issues discussed during these meetings are related to the finances, or planning and implementation of activities in the village-celebrations, implementation of certain schemes, action plans in the course of emergencies etc. The funds to the Dorbar Phyllun are provided through the Dorbar Shnong, as received from donations.

This fund is used to help individuals/ families/ communities in times of emergency. The village council conducts these meetings on a need basis - i.e., weekly/fortnightly or even on a monthly basis based on the requirement. It was quite evident that the issues related to children's protection and well-being are mostly not a part of these discussions held during the meetings of the village council.

In fact, it was found that the village council refrains from engaging with issues such as child marriage, school dropouts etc., as these are considered to be personal and family-related matters. Therefore, they presume that they do not have the authority to engage in these matters.

The Federation of Traditional Village Leaders of Khasi Hills and Jaintia Hills have 3000 Shnongs under its jurisdiction. The Dorbar Phyllun have been decentralised in order to enable autonomous decision-making, attend to various contextual issues faced by Shnongs, and to settle the issues faced by the Dorbar Shnongs or the village councils.

When asked about the most prevalent issues related to children and adolescents, the Rangbah Shnongs listed down the following issues - school dropout, substance abuse, children in conflict with the law, stigma surrounding mental health and disabilities, malnutrition, single mother-led families, broken families, teenage pregnancy.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

EXISTING SERVICES AND SYSTEMS

They mentioned, however, that they would not delve deep into these issues, as these are considered to be personal. However, if the need arises and a case needs to be reported, they may report it - as they believe that the law cannot be violated, and neither the Dorbar Phyllun nor Dorbar Shnong have the authority to take action in these matters.

As the SAMVAD team tried to understand more about the issues and the reporting mechanisms within the villages, particularly with reference to some of the issues that they considered reporting to the police, and cases where assistance was sought to be provided to families, the following issues were highlighted- sexual abuse, in cases where the family is incapable of taking care of a child with disability (intellectual disability) and substance abuse cases.

The SAMVAD team also asked the Rangbah Shnongs, to explain the ways in which the Dorbar Shnong or the Rangbah Shnong responds to each of these issues

ISSUE	KEY FINDINGS
Child Sexual Abuse (CSA)	Stigma and notions of the family's honour are the biggest barriers in reporting. Only in cases of violent and coercive sexual acts, a case of CSA typically gets noticed. In CSA cases, where the family either directly reports, or raises suspicion about sexual abuse, medical help is sought first through the Primary Health Centre (PHC) or the Community Health Centre (CHC). CSA cases are only reported to the police if they are found to be coercive. In case sexual engagement is found to be 'consensual', the reporting of the case is not done.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

EXISTING SERVICES AND SYSTEMS

ISSUE	KEY FINDINGS
Child Sexual Abuse	In CSA cases, where the family either directly reports or raises suspicion about sexual abuse, medical help is sought first through the Primary Health Centre (PHC) or the Community Health Centre (CHC). CSA cases are only reported to the police if they are found to be coercive. In case sexual engagement is found to be consensual, the reporting of the case is not done. Most cases are settled between the perpetrator and the victim's family without any legal action. The Rangbah Shnong does not interfere in these issues as these issues are considered to be personal family matters. In case the victim is being ill-treated, or not being supported by the family, only then the Rangbah Shnongs intervene for support.
Substance Abuse	Identified as the most difficult issue to manage amongst adolescents. Many adolescents either are users or carriers of substances. While the village headman may suspect substance use by an individual or a group, confrontation or any kind of enquiry is not possible as the headman is not authorised to do so, and it would be considered a boundary violation by the person or their family. According to the village headman, substance abuse cases are treated leniently, and no strict action is taken against the person consuming or carrying illegal substances. There is a lack of fear of punishment from the law.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

EXISTING SERVICES AND SYSTEMS

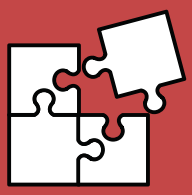
ISSUE	KEY FINDINGS
Children with Disability	Stigma and discrimination towards children with intellectual disability was identified as a critical issue. In this regard, it was reported that children with disabilities are considered as liabilities by their families. The COVID pandemic worsened the situation, as the financial situation of the families deteriorated due to unemployment issues, and children with disabilities became more vulnerable and excluded. In order to address these COVID-related vulnerabilities, families are counselled and assistance is provided financially or by linking families to livelihood schemes.
Emotional and Behavioural Problems in Children	Primary responsibility for ensuring emotional wellbeing, and identification of emotional and behavioural issues, lies with the school and family, and not with the Rangbah Shnongs/ Village Headman. Behavioural issues commonly seen are delinquent behaviour or aggression in adolescents. The main reason for behavioural issues was reported to be the use of substances. Frustration and stress experiences, easy access to substances, normalisation of substance use from a young age (exposure to adults consuming substances), were identified as the main reasons for the consumption of substances by adolescents.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

EXISTING SERVICES AND SYSTEMS

ISSUE	KEY FINDINGS
School Dropouts	The issue of school drop-outs was linked to the poor financial situation of families, and consequently, child labour. Desperate families usually prefer having more children, and subsequently, push them into child labour, at an early age, to improve their financial situation. Most children start working by the age of 12-13 and drop out of school permanently. While both parents go out to work, the older children take up household responsibilities and caretaking roles for their younger siblings.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG



GAPS AND CHALLENGES IN SERVICES

- Lack of linkages between the formal child protection systems and the traditional administrative systems
- Prevailing notions that village council should not intervene in 'private' matters such child sexual abuse and substance use
- Lack of understanding about the prevalent child protection and mental health issues

The Village Council has enormous power in the community. However, their power and influence has not been leveraged by the State and District-Level Institutions. Working with the Village Council, the Women's Wing and the Youth Wing will yield better results as the State Institutions are often perceived to be outsiders.

There exists a common notion amongst the Headmen and the Village Council that sexual abuse cases are personal matters and the village council has no obligation to intervene. The POCSO Act makes reporting of abuse, or any suspicions about CSA perpetration, mandatory. Non-reporting of sexual offences against children, in this regard, is a punishable offence. It was found that there is not just a lack of knowledge about the POCSO Act, but there is also a serious lack of understanding about the dynamics of child sexual abuse, as the Village Headmen kept referring to non-violent acts as "consensual", completely disregarding the vulnerabilities of children and adolescents due to their developmental stages, and most importantly, grooming processes used by perpetrators, resulting in unlawful compromises in most cases.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

POTENTIAL OPPORTUNITIES

Training & Capacity building of the Rangbah Shnongs to enable identification of vulnerable children at risk.

Empower the women councils and youth councils to support Rangbah Shnongs in carrying out activities for protection & well-being of children.

Leverage the influence of Rangbah Shnongs for the enforcement of child protection laws and schemes in the community.

Enable change in attitude towards child & adolescent mental health issues, and reduce stigma, by keeping the Rangbah Shnongs at the forefront of all the mental health awareness programs run by the DMHP.

D.1.3. VILLAGE HEADMAN/THE RANGBAH SHNONG

POTENTIAL OPPORTUNITIES

Training and Capacity building of the Rangbah Shnongs is imperative, specifically on child protection and mental health issues, and indeed, child and adolescent vulnerabilities, given that they would typically be the first to identify protection issues, or are most likely to be approached by the community members for assistance in these matters. Given their familiarity with these families in the community, and their situation, they are in a position to identify high-risk children and families in the villages, thus preventing and addressing protection concerns. They can also play an important role in the prevention of trafficking of children, through keeping a track of those migrating from the village, by actually registering their details and recording their purpose of leaving. If linked with the beat officers, they can also facilitate the reporting of abuse to the law enforcement agencies, if standard operating procedures are developed, and training on the same is provided to them.

It was also suggested that they are provided with IEC material, in the local language, so that they can work with the community to raise awareness on important issues. Awareness building programs can be done with the assistance of the women's councils and youth councils. DMHPs can also collaborate with these institutions to implement awareness programs.

D.1.4. BLOCK DEVELOPMENT OFFICER

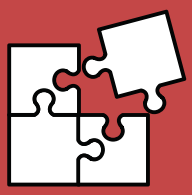
EXISTING SERVICES AND SYSTEMS

The block in question contained 119 villages. With regard to the profile of the schools in the block, around 70% of the schools consisted of missionary and government-aided schools. In terms of grade levels of the schools within the villages, most schools were at the lower primary level. For upper primary and higher grade levels, children typically have to leave their villages. It was reported that efforts were made post the lifting of COVID lockdowns, to bring children back to school, despite the financial challenges reported amongst families. However, there is no consolidated data regarding the number of children out of school at the block level currently.

LINKAGES AND CONVERGENCE

THEME	KEY FINDINGS
Awareness Programs	In terms of awareness programs, programs on teenage pregnancies were conducted at the block level, focusing especially on areas reporting higher numbers of teenage pregnancies. Additionally, programs on substance abuse, particularly with reference to tobacco have been conducted.
Child-related activities in other programs	There are currently components of programs like the National Rural Livelihoods Mission (NRLM), where specific programs on school attendance are conducted for women self-help groups. These programs are facilitated at the village level.

D.1.4. BLOCK DEVELOPMENT OFFICER



GAPS AND CHALLENGES IN SERVICES

- Identification of Children's Vulnerabilities
- Implementation of Samagra Shiksha Abhiyan (SSA)
- Accessing Mental Health Services
- Convergence with other Departments

❖ **Identification of Children's Vulnerabilities**

As reported, there is no database or system in place to facilitate understanding of children's issues at the block level. The implication is that even in the context of COVID, there have been no systematised ways of monitoring enrolment and attendance.

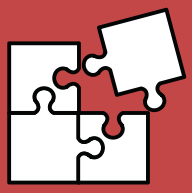
❖ **Implementation of Samagra Shiksha Abhiyan (SSA)**

Related to the above point, the BDO reported that the SSA is not active in the block, which has resulted in a lack of availability of data on school and educational issues, particularly with regard to out-of-school-children.

❖ **Accessing Mental Health Services**

With regard to mental health services, the most important issue reported was a lack of mental health facilities available in the district, with the consequence that families have to travel to Shillong to access these services. This acts as a significant impediment in accessing healthcare.

D.1.4. BLOCK DEVELOPMENT OFFICER



GAPS AND CHALLENGES IN SERVICES

❖ **Convergence with other Departments**

With regard to children's issues, one of the issues reported is lack of convergence of concerned departments (such as Social Welfare, Education, and Health at the block level). However, while efforts are made, at the BDO level, to coordinate with CHCs, PHCs, Sub-Centres, there is a requirement for more systematised coordination.

D.1.4. BLOCK DEVELOPMENT OFFICER

POTENTIAL OPPORTUNITIES

Convergence Guidelines

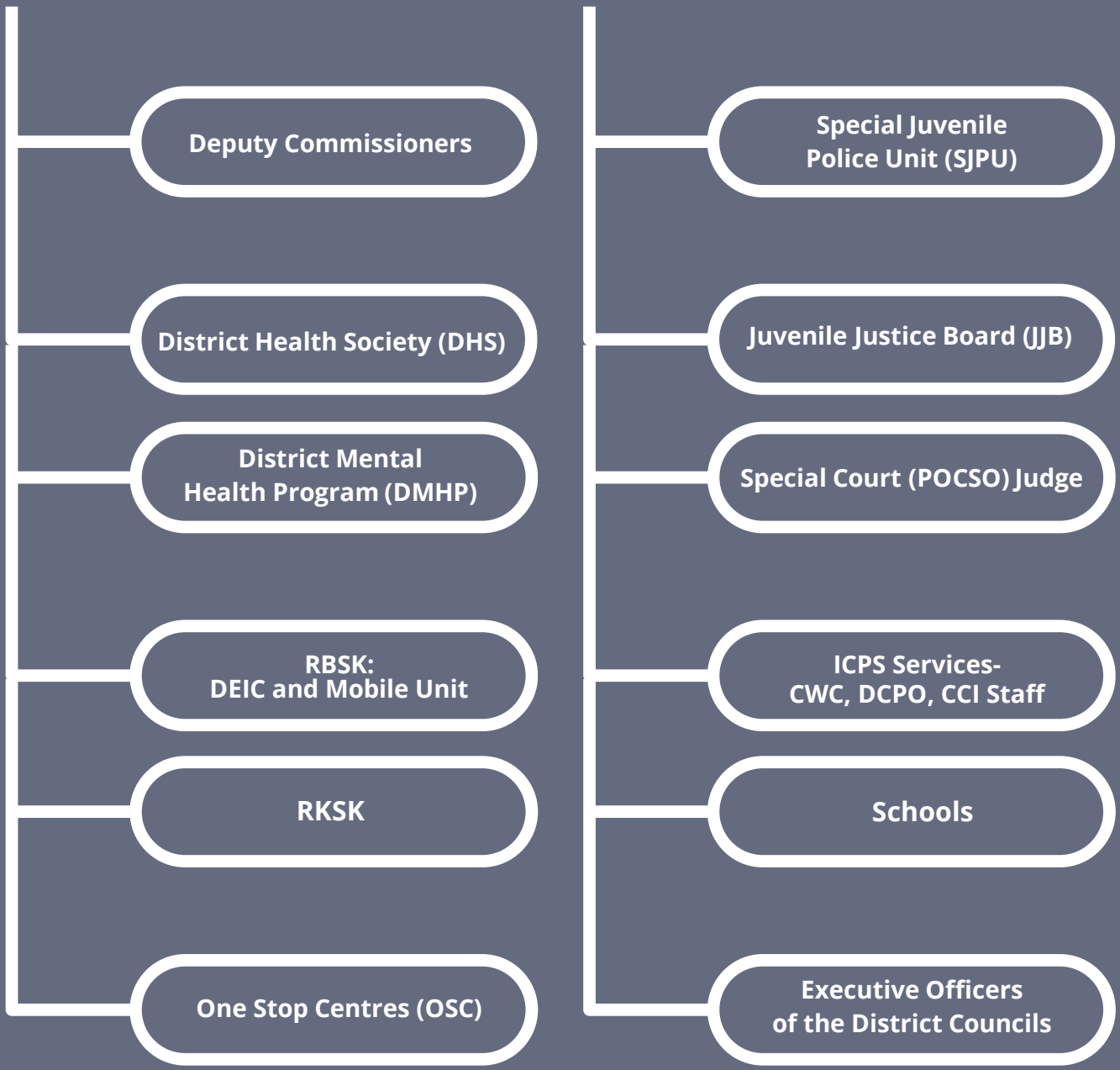
While systemic issues may take longer to resolve, creation of a set of convergence guidelines at the block level, will help clarify role ambiguities and ensure more efficient and regular implementation of nodal schemes like the Samagra Shiksha Abhiyan. Additionally, in light of these role ambiguities, given the central role performed by the BDO at the block level, the convergence guidelines can also specify their role as liaison officers between the CHCs and secondary level authorities such as the DMHP, DEIC and other key district level programs. Given the inaccessibility of district-level services to children in villages across the state, the BDO's role as a nodal officer can contribute towards assisting and streamlining referral services.

Linkages with Other Programs

One of the suggestions to facilitate wider awareness on mental health issues was to train the Community Health and Gender Activists (CHGA), who work at the field level under the aegis of NRLM, to facilitate awareness programs on mental health and disability issues in the community. This was also specifically highlighted given the proximity of the CHGA and ASHA worker.

FINDINGS AND ANALYSIS

D.2. SECONDARY LEVEL



D.2.1. DEPUTY COMMISSIONERS

EXISTING SERVICES, NEEDS AND CONCERNS

The Deputy Commissioner serves as the executive head of district administration in Meghalaya, whose key functions relate to facilitating planning and coordination amongst all district authorities in development, labour, education, health and other key domains. From a child and adolescent perspective, the Deputy Commissioner is the foremost authority at the district level, who performs not just coordination-related functions, but is also mandated to oversee the discharge of statutory duties by all child-related stakeholders and monitor the implementation of relevant schemes. Additionally, the Deputy Commissioners also highlighted efforts made to ensure scheme benefits reach intended beneficiaries. In cases where beneficiaries were not able to avail of scheme benefits, or were not aware of the relevant schemes, the Office of the Deputy Commissioner worked with relevant district authorities to facilitate the same.

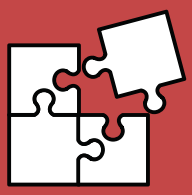
Specifically, given the roles and responsibilities of the Deputy Commissioner vis-à-vis district authorities under the Juvenile Justice Act, such as the Child Welfare Committee, Juvenile Justice Board and District Child Protection Unit, the Deputy Commissioners of East Khasi Hills and Ri Bhoi, in addition to the Additional Deputy Commissioner of Jowai, reported cases wherein their functions included coordination with these district authorities to assist vulnerable children. Instances of such coordination include assistance to child victims in POCSO Cases, for victim compensation claims through the District Legal Services Authority. Additionally, in cases wherein the child in contact with the law is from a different state, the Deputy Commissioners also assist with repatriation. This is a particularly relevant issue for families undertaking migrant labour.

D.2.1. DEPUTY COMMISSIONERS

EXISTING SERVICES, NEEDS AND CONCERNS

THEME	KEY FINDINGS
Monitoring Functions	The monitoring functions of the Deputy Commissioner are primarily executed through district committees overseeing child-related issues such as the District Task Force Committee (dealing with child and adolescent labour), District Inspection Committee (overseeing Child Care Institutions under the Juvenile Justice Act), District Child Protection Committee (overseeing implementation of the Integrated Child Protection Scheme), wherein the Deputy Commissioners serve as chairpersons.
COVID-related measures	In the COVID context, as a high number of infant and maternal deaths were reported, due in large part to widespread fears of contracting COVID in hospitals, the Deputy Commissioners also highlighted action taken through “rescue missions” initiated by the Government of Meghalaya to track and monitor pregnant women and adolescents, and persuade them to opt for institutional deliveries. These efforts were coordinated by the Deputy Commissioners to also ensure that Ante Natal Care is provided. Furthermore, financial assistance was provided in the case of children orphaned (wherein one or both parents died as a result of COVID) or abandoned during COVID, in accordance with funds available under the PM CARES for Children Scheme.

D.2.1. DEPUTY COMMISSIONERS



GAPS AND CHALLENGES IN SERVICES

- Child Sexual Abuse
- Adoption Dynamics
- Child Labour and Abuse
- Attitudes and Beliefs contributing to low health-seeking behaviours

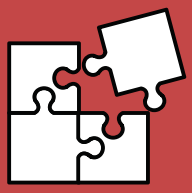
❖ Child and Adolescent Issues in the Districts

Child Sexual Abuse

One of the issues reported across districts was the prevalence and rise in POCSO cases reported, wherein adult perpetrators are typically relatives of the child victim. In this context, single parent families with subsequent remarriage, were identified as risk factors for child sexual abuse by the stepfather. As a Deputy Commissioner from Ri Bhoi noted, child victims in POCSO cases reported in the district, range from 7 to 18 years of age. Additionally, mutually consenting relationships between adolescents that result in teenage pregnancies were also identified as one of the types of POCSO cases reported.

One of the specific issues with teenage pregnancies that poses challenges to Deputy Commissioners is the provision of assistance to young mothers who seek to avail of anganwadi services under the Integrated Child Development Scheme (ICDS). Typically, these cases are required to be registered under the POCSO Act, wherein assistance can only be provided through the Child Welfare Committee. This contributes to non-reporting of teenage pregnancies, due to community-level concerns regarding the registration of a POCSO complaint. This is further complicated by the fact that, in many instances, teenage pregnancies are not viewed as being contrary to community norms, thereby affecting the likelihood of reporting.

D.2.1. DEPUTY COMMISSIONERS



GAPS AND CHALLENGES IN SERVICES

Child Labour and Abuse

One of the commonly reported issues across the state includes children who are sent from predominantly rural areas to perform domestic labour in urban households. These instances are typically kept private as urban households are wary of identification of such children by concerned authorities. Similarly, the children's families are also reluctant to divulge the names of their children working in these households. In many cases, these children are also sent to school, thereby bringing such cases within the ambit of the legal exception to child labour i.e., family-related vocations. As the Deputy Commissioners noted, such cases usually come to light only when these children are victims of abuse.

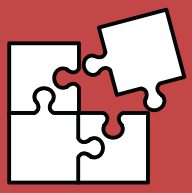
Sporadically, there are also cases of child labour engaged in sand mining and quarrying in some parts of State with significant mining activity.

❖ **Adoption Dynamics**

Given Meghalaya's unique societal composition, and the importance of community norms amongst the various tribal groups, there is a strong reluctance to adoption (as a form of family-based care), as it involves a permanent severing of the legal relationship between the child and biological family. Additionally, potential cases of adoption can also be complicated by vested property interests of the child. Therefore, informal kinship care arrangements through relatives of the child are the preferred alternative. Interestingly, institutionalisation of the child is preferred over adoption in some cases, as it does not alter the child's legal relationship with the family.

Despite these prevailing notions, some adoptions do take place. However, following significant changes to the role of the Deputy Commissioner/District Magistrate in adoption cases under the Juvenile Justice Amendment Act, 2021, trainings have not been conducted to apprise the Deputy Commissioners of their new role i.e., to conduct adoption hearings and pass final orders. Therefore, there is a lack of clarity on the new role of the Deputy Commissioner, and the manner in which adoption proceedings are to be conducted. As was reported, there is also

D.2.1. DEPUTY COMMISSIONERS



GAPS AND CHALLENGES IN SERVICES

a lack of clarity on the basis of decision-making in adoption cases before passing of final orders. Owing to the relatively fewer number of adoptions, there are challenges in the development of the relevant know-how for facilitating pre-adoption counselling as well.

❖ **Attitudes and Beliefs contributing to low health-seeking behaviours**

An issue of concern across health service delivery in different contexts including vaccination, pre-natal/ante natal care, and indeed, mental health services, is the issue of skepticism regarding health services amongst different communities. As a result, state government efforts face significant challenges in ensuring that targeted beneficiaries are able to receive critical health services. As outlined earlier, the 'rescue mission' was initiated to counter widespread fears about COVID transmission, as these fears severely hampered availing of health services for pregnant mothers. The consequences of these perceptions included a marked increase in infant and maternal mortality. This issue was also observed in the context of COVID-affected children, wherein COVID denial created significant barriers in identification of these children and in the provision of financial and other social assistance.

As one of the Deputy Commissioners noted, in one such case, a community renounced their existing way of life (including utilisation of government services) and believed a 15-year-old girl in the community was a saint. Such perceptions severely affect the provision of critical services through the district authorities, including the Deputy Commissioner.

D.2.1. DEPUTY COMMISSIONERS

POTENTIAL OPPORTUNITIES

Coordination

While there are challenges at the district-level, the centrality of the Deputy Commissioner offers significant potential for effective delivery of key services to children and caregivers. As one District Commissioner noted, notification of periodical meetings of key district committees (at least on a monthly basis), such as the District Task Force Committee, District Inspection Committee and District Child Protection Committee, will contribute to streamlining and regularising coordination efforts at the district level for all issues related to children and adolescents. Additionally, an important aspect of coordination also includes human resources. Shortage of staff in child care institutions and limited human resources, in key district authorities like the District Child Protection Unit, also contribute to delayed response time in cases of vulnerable children in need of assistance. In large districts like East Khasi Hills, the availability of sufficient number of District Child Protection Officers would contribute significantly towards quick redressal of vulnerable children's needs.

Capacity-Building & Awareness Programs

In adoption cases, comprehensive training efforts to orient Deputy Commissioners on their new role under the Juvenile Justice Act, can help provide clarity on the statutory framework and duties to be discharged by the Deputy Commissioner. Such capacity building initiatives can also help leverage the Deputy Commissioners' vast experience to conduct adoption proceedings in a standardised manner, with incorporation of key child mental health and psychosocial perspectives in adoption-related decision making. Additionally, awareness programs on socio-emotional well-being can be critical in improving the utilisation of mental health services across the State.

Keeping in mind time constraints of these officials, training materials including booklets and podcasts may be developed on key issues related to children, with specific focus on key frameworks such as the Juvenile Justice and POCSO Acts. These materials will contribute towards orienting the Deputy Commissioners on key mechanisms for assisting children in the district, without requiring a significant time investment.

D.2.2. DISTRICT HEALTH SOCIETY (DHS)

EXISTING SERVICES AND NEEDS

Under the National Health Mission, each District has a District Health Mission and the District Health Society is constituted to support the functioning of the District Health Mission. The District Health Society integrates various programmes, societies, schemes being run at the district level. They are also responsible for facilitating convergence and implementation of health-related activities at the district level.

The SAMVAD team observed that there was a lack of coordination and knowledge about issues related to child protection and children's mental health. Some of the issues that were identified following interviews with the DHS Team are as follows:

ISSUE	FINDINGS
Single Mother-Led Families	The team shared concerns about the exploitation of women at a community-level. On the one hand, it was observed that Meghalaya has a matrilineal system, but the ways in which the society functions were reported to be patriarchal. A number of families are led by single mothers and it is quite common for the father to abandon the mother and the child. Children are commonly observed to be abandoned by the father, particularly in cases involving the death of the mother. It was reported that the onus of child-rearing is placed entirely on the mother, since traditionally the women is the head of the family unit. This results in the male members of the family typically shirking responsibilities of the household, including caregiving responsibilities in respect of the children.

D.2.2. DISTRICT HEALTH SOCIETY (DHS)

EXISTING SERVICES AND NEEDS

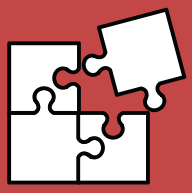
ISSUE	FINDINGS
Drug Abuse and Addiction within Families and Communities	The issue of drug and alcohol addiction within families and communities is reportedly quite prevalent. Due to these issues, there are often unpleasant and unfavourable conditions in households including – domestic violence and marital discord, thereby making children vulnerable and prone to mental health issues. These issues also lead to substance abuse, self-harm and other high-risk behaviours, in children and adolescents, as they struggle to navigate through the difficult circumstances at home. The DHS team also reported that they see cases of "depressed children coming from broken families". It was also shared that, within the communities, children & adolescents have easy access to illegal substances, and as a result of negative peer influence, children are highly susceptible to substance abuse.
School Dropouts	Dropout rates in the community have been quite high, especially after children reach the 6th and 7th grade. The reasons stated by the group were: a) poverty within the families; b) teenage pregnancies; c) substance abuse issues; e) child labour; and f) caregiving responsibilities of younger siblings.

D.2.2. DISTRICT HEALTH SOCIETY (DHS)

EXISTING SERVICES AND NEEDS

ISSUE	FINDINGS
Teenage Pregnancies	The issue of teenage pregnancy was also reported to be quite common. The pregnancies can occur in two contexts – i) romantic relationships between two consenting adolescents; and ii) in cases of abuse (which may or may not be physically coercive). In the first scenario, the pregnancy is a result of romantic attraction and an interest in exploring sexual relationships, as a part of normative adolescent development. The pregnancy is usually a consequence of a lack of knowledge about sex and sexuality, which also raises concerns of life skill deficits. However, in the second scenario, the pregnancy is a result of sexual abuse which may have been violent or seemingly consensual (due to complex grooming processes employed by the perpetrator). One of the team's findings was that families consider these issues of sexual abuse to be personal and private family matters, and hence, settle the issue with the perpetrator through compromise arrangements. These pregnancies, even at a young age, are accepted by the community, wherein termination of pregnancy is not favoured due to religious and socio-cultural reasons. Adolescents are typically not equipped to take up parenting roles this early, given their own developmental stage and the related challenges. Additionally, while clans support the mother and share the responsibility of child-rearing, there is no psychosocial support for the child. The group also shared some examples – they mentioned that it is usually only the mothers who bring children for immunisation; it has been observed that fathers may sometimes even discourage taking children to the CHC, because they feel it disrupts the child's routine.

D.2.2. DISTRICT HEALTH SOCIETY (DHS)



GAPS AND CHALLENGES IN SERVICES

- Lack of initiative to facilitate convergence
- Lack of knowledge about policies and schemes related to children
- Stigma around mental health

Although the intent behind the constitution of the District Health Society is to create a platform for convergence, SAMVAD observed that members of the DHS were not aware of programs like the Rashtriya Bal Swasthya Karyakram (RBSK), Rashtriya Kishore Swasthya Karyakram (RKSK), and even reported that they heard about these programs for the first time during the interview with the SAMVAD team. One of the concerns raised by the DHS members was about the change in the ways of work adopted by the Anganwadis. The members shared that since the initiation of Mission POSHAN, the focus of the Anganwadis has been purely on nutrition and has moved away from the overall development of the child. The anganwadis should be spaces for early stimulation and early intervention work. However, the administrative workload does not allow them to spend enough time with children. They also mentioned that the community usually feels demotivated and hesitates to seek assistance from mental health professionals, or through mental health programs, as the use of the word “mental” itself is stigmatising and not acceptable in the community. Stigma related to mental health issues was observed to be a significant impediment in the utilisation of mental health services.

The DHS also raised concerns about schools not taking initiative to engage with the DMHP, RKSK or RBSK, on their own account, to conduct mental health awareness programs. The DHS also reported that schools, on many occasions, are not very open to mental health programs, including instances wherein they have refused to have mental health professionals onboard to facilitate these programs. It was found that there is, indeed, a need for change in the perspective of the schools towards the mental health issues in children and adolescents in order to reduce the stigma.

D.2.2. DISTRICT HEALTH SOCIETY (DHS)

POTENTIAL OPPORTUNITIES

Facilitating convergence of mental health and protection-related schemes and programs for children.

Operationalize prevention and awareness activities related to mental health and child protection at the community level.

As envisioned under the National Health Mission, the District Health Society can be strengthened to facilitate convergence amongst the various health-related schemes for children & adolescents. During the interview, the DHS team also pointed out that sometimes the term “clinics” can also be scary, and therefore, changing the name to something less discouraging to adolescents, would be useful in reducing the stigma surrounding the availing of services by adolescents. The team also suggested incentivising visits to the Adolescent Health Clinic (AHC). In a similar context, it was also suggested that, on some occasions, sex education is also not accepted by the community, and perhaps, a change of terminology would be helpful in overcoming stigma and breaking social barriers.

The DHS team can mobilize various mental health professionals, across the State, and create a platform for operationalizing preventative and curative activities at the community level.

D.2.3. DISTRICT MENTAL HEALTH PROGRAM (DMHP)

EXISTING SERVICES AND SYSTEMS

The District Mental Health Program operates from the Community Health Centre, District Hospital and MIMHANS. The DMHPs are constituted and functional in all districts of Meghalaya. Although the teams are constituted, there are only three psychiatrists that work with the District Hospitals, Tertiary Centres and the DMHP. Given that there are few trained psychiatrists in the state, the DMHP doctors or medical officers are given a ten-day training program in community health at the Lokpriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Assam. Upon further inquiry, the DMHP medical officers reported that the focus on children and their issues is miniscule in the ten-day training program, and therefore, they do not feel fully equipped to deal with issues of children.

The DMHP staff reported that, on an average, while they see about 4-5 children in a month, the cases do not directly come to them. The children are brought to the DMHPs, mostly by police personnel, for the purpose of assessment. After the assessment, the DMHP sends the children to the Child Welfare Committee (CWC) /District Child Protection Unit (DCPU), in case they are sent by the Social Welfare Department, or if there is a context of abuse. In other cases, children are referred to the Civil Hospital. The SAMVAD team observed that there was a lack of knowledge about therapeutic work, trauma-informed care and other child protection-related laws and processes, especially in the context of trauma and abuse. The DMHP team reported that, since they usually see these children only once or twice, they do not engage in long-term therapeutic work. The cases of children who usually come to them, through the police or Social Welfare Department, are then taken over for counselling by the counsellors in the District Child Protection Unit or the Child Care Institutions (CCIs). In cases where children need ongoing assistance, the DMHP writes to the CWC, DCPU or the CCI informing them of the same, or in case they are seeing the child directly, the child is called on a weekly basis.

D.2.3. DISTRICT MENTAL HEALTH PROGRAM (DMHP)

EXISTING SERVICES AND SYSTEMS

Assessment Protocols

The team reported that there are no particular formats or assessment protocols used by them. It was also reported that the developmental or trauma assessments, are done rather intuitively, through observations of signs and symptoms, and in case a detailed assessment is required, the child is referred to the Civil Hospital in Shillong. Some issues discussed with the DMHPs are mentioned below:

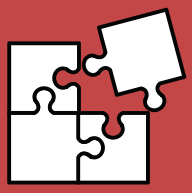
ISSUES	KEY FINDINGS
Teenage Pregnancies	The DMHP staff conducts an assessment and then ensures that the child is sent for therapy. The DMHP staff does not undertake therapeutic work by themselves. They explained, that in such cases, the termination of pregnancy is not common, and in fact, many families insist that the adolescent goes ahead with the pregnancy. Culturally, termination of pregnancy is not acceptable, and consequently, the impact the pregnancy can have on the adolescent is hugely neglected. The health and psychological consequences of giving birth, and parenting at a young age, are also neglected. It is often observed that by the age of 30, the mother has 9-10 children. The older children are engaged in household work/child labour, take up caregiving roles for younger siblings, or are married off early. This leads to early adultification and complete negation of regular childhood experiences.

D.2.3. DISTRICT MENTAL HEALTH PROGRAM (DMHP)

EXISTING SERVICES AND SYSTEMS

ISSUES	KEY FINDINGS
Child Sexual Abuse	Although the cases of child sexual abuse are quite common, there is a culture of silence and denial when it comes to the reporting of these issues. Most families may acknowledge that this is a widespread problem, while simultaneously externalising the problem to "other families", and denying the possibility of abuse occurring in their own homes. These issues of child sexual abuse are typically not reported, and instead, settled within the communities through clan meetings. The child is often subject to significant pressure and coerced to forgive the perpetrator.
Broken families and domestic violence	In their observations, a number of children also come from broken families. The DMHP staff found that, in many cases, once the father abandoned the mother, it was likely that the mother proceeded to have different partners in the future. There are several children in each household, and due to this instability amongst parents, they are often neglected and their education is not given due importance. Oftentimes, in these families, when children experience abuse, or any kind of trauma due to violence, it goes unnoticed. Even in some cases, where children make disclosures, these issues are ignored because the mothers, themselves, are victims of abuse, and therefore, feel helpless.

D.2.3. DISTRICT MENTAL HEALTH PROGRAM (DMHP)



GAPS AND CHALLENGES IN SERVICES

The DMHP Staff highlighted that the biggest challenge for them is the lack of critical infrastructure such as a playroom, counselling space etc. The spaces within the Community Health Centres (CHCs), or other spaces in the community, are not conducive to children and therapeutic work.

The staffs' knowledge about therapeutic methods and interventions was observed to be fundamentally inadequate. On being asked about the work done in cases of child sexual abuse, the staff reported that "they do not prescribe any medicines for CSA". As the DMHP staff is usually stationed in the CHC/ District Hospital, for those travelling significant distances, the poor accessibility becomes an issue and hinders their treatment process. Further, there are financial issues, and issues related to transportation, that often make the operations of the DMHP difficult to implement.

From an awareness generation standpoint, once within the communities, the staff also reported that there are no effective ways of dissemination of IEC materials. They usually invite the community members for a meeting, through the village headman, and talk to them about the issues. However, they are not able to frequently visit these villages or follow-up on these programs. In this regard, use of technology and other mediums, through infrastructure available in the community, that can be accessed even when the staff is not physically present, would be useful in ensuring that the information reaches the community. This is extremely critical for initiating any kind of behavioural change in the community. The DMHP staff also highlighted the lack of counsellors, within schools and hospitals, as a challenge that needs to be addressed. There is also a lack of coordination between the DMHP with the RBSK and RKSK.

D.2.3. DISTRICT MENTAL HEALTH PROGRAM (DMHP)

POTENTIAL OPPORTUNITIES

The DMHP requires detailed orientation and training on the following, in order to strengthen their skills in terms of assessment/ case-history taking and interventions: a) conducting systematic psychiatric assessments of children and adolescents (through the use of appropriate assessment proformas); b) knowledge of child and adolescent psychiatric disorders, including assessment and management techniques; c) Case formulation and analysis for appropriate diagnosis of disorders; and d) first-level responses to children and adolescents.

While the DMHP may not have been intended to provide depth interventions to children with mental health issues, in an LMIC context such as India, with a serious paucity of mental health service providers, it would be imperative for the DMHP to engage in mental health service provision beyond identification, diagnosis and referral. Indeed, if they restricted their functions to referral, the tertiary care services, already few in number, would be heavily over-burdened and unable to cope with the case load.

In light of the above, DMHP service providers must be trained to provide first-level responses to child mental health (and protection) issues with a view to: (a) containing the problem; (b) addressing mild-to-moderate problems at secondary level. First level responses entail: Recognizing and acknowledging (accepting) the child's emotions; providing reassurance and comfort; (Re)framing the problem in such a way as to help the child gain insight/ understanding of the problem and its consequences; suggesting to the child certain steps they can take to reduce the problem (This part depends on the problem—for instance, a child with anxiety may be taught relaxation exercises, or a child with anger issues may be taught anger management techniques); providing relevant psychoeducation to caregivers; measures to ensure child's safety and physical well-being. Referrals may be made where longer term, depth pharmacotherapeutic and other forms of therapeutic assistance are required.

Additionally, the nature and type of public awareness programs that the DMHP conducts, at community-level, requires much re-thinking. These programs need to be strategically planned to suit the context-specific and socio-cultural needs of the community (in Meghalaya

D.2.3. DISTRICT MENTAL HEALTH PROGRAM (DMHP)

POTENTIAL OPPORTUNITIES

these programs, for instance, would require to be predicated on an understanding of the matrilineal societal cultures and some of their adverse impacts on child protection and mental health)—so that vulnerable children requiring assistance are identified and linked to requisite services. Additionally, the link between protection risks and mental health issues needs to be made to allow for the adoption of an integrated approach to child psychosocial care and protection.

D.2.3. DISTRICT MENTAL HEALTH PROGRAM (DMHP)

POTENTIAL OPPORTUNITIES

Recommendations made by the DMHP officers

The SAMVAD team asked the DMHP officers to share areas in which they can be supported through the State Mental Health Policy, in order to optimize their efficiency and functioning. The following suggestions were made:

- Standardized training on child & adolescent mental health issues, assessments and on laws pertaining to children.
- To maximize the outreach, the DMHP staff can also train the PHCs/ CHCs on screening for the 4 Ds- Defects at Birth, Deficiencies, Diseases and developmental delays, thereby ensuring early identification and referrals for children in need of assistance.
- To have access to the standardized tools and protocols for assessment. Currently, unavailability of these standardized tools and assessment protocols hinders their ability to provide assistance and support.
- The first level of counselling can be done by the DMHP counsellors, rather than making quick referrals after the assessment. It would be useful to institute trainings, on facilitating therapeutic sessions, and organizing life skills training for children and adolescents, which will help in providing guidance and insight, and serve both preventative and curative agendas.
- Issues of parenting should also be addressed by the DHMP in the community.
- Organisation of trainings on POCSO, assisting children through court processes and carrying out assessments relevant to child victims and witnesses in POCSO cases.
- The awareness programs and the DMHP activities can be calendared for effective planning and implementation.

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): DISTRICT EARLY INTERVENTION CENTRE (DIEC)

The SAMVAD team interviewed the staff at the District Early Intervention Centre (DEIC), for East Khasi Hills. While the DEICs are established at the district hospital level, in each district, there are currently only three DEICs across Meghalaya. This particular DEIC was set up at the Ganesh Das Hospital and caters to the population from East Khasi Hills, Jaintia Hills and Ri Bhoi Districts.

The DEIC team is a multidisciplinary team, with the staff comprised of the following professionals - Social Worker, Nursing Staff, Audiologist, Psychologist, Paediatrician/ Medical Officer, Special Educator, Data Entry Operator, Lab technician and Dental surgeon.

EXISTING SERVICES AND SYSTEMS

The services of the DEIC are accessed by the population, between 0–18 years, in accordance with the guidelines of the Rashtriya Bal Swasthya Karyakram (RBSK). The infrastructure of the DEIC was colourful and welcoming, run by a team which was deeply caring and enthusiastic. The DEIC staff explained that most children that they see are between 0-5 years old. They are referred to the DEIC by the Mobile Health Team of RBSK or by the Community Health Centres (CHCs) / Primary Health Centres (PHCs) after identification of signs and symptoms of the 4Ds i.e., defects at birth, diseases, deficiencies, and developmental delays, at a primary level. In the experience of the staff of this DEIC, children in this age group usually come to the DEIC with developmental delays, typically when some critical milestones are missed. They shared that the developmental issues, or regression in developmental stages, during the pandemic have also been a challenge. While older children are independent and are able to engage themselves and socialize more easily, the younger children, especially between 0-6 years, had very few opportunities for growth and socialization. When asked about the kinds of issues that they usually treat, the staff mentioned that some issues that frequently occur are perinatal asphyxia, birth defects, speech delays, inattention, hyperactivity, adjustment disorder and learning disability. They have also seen cases with behavioural issues like aggression and oppositional defiant disorder (ODD).

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): DISTRICT EARLY INTERVENTION CENTRE (DIEC)

EXISTING SERVICES AND SYSTEMS

The team also mentioned that they have often observed that emotional and behavioural issues are mostly manifest in children with speech delays, given that they are not able to communicate their needs effectively. Neglect of children within families is also quite common, and more so, with children with disabilities, as they are considered to be a liability. When asked more about the neglect within families, the DEIC staff shared that most children who avail DEIC services come from lower socioeconomic backgrounds, and it is often found that there are on an average 4-5 children per household. Therefore, parents are unable to pay attention to the individual needs of their children. In most of these households, both parents are working, and as children grow older, they also start working and younger children are left at home under the supervision of older siblings.

After a referral is made to the DEIC, a detailed assessment of the 4 Ds - defects at birth, diseases, deficiencies and developmental delays is done by the paediatrician or the medical officer and the psychologist. The assessment usually focuses on neuromotor, cognitive and speech issues, and hardly takes into account the socio- emotional development of the child, as was reported by the medical officer. The psychologist informed, that the M-CHAT scale is used for the assessments. The M-CHAT Scale is only applicable for toddlers between the age groups of 16-30 months of age. The screener is a set of 20 questions to assess the risk of autism. Based on the scoring, if it is found that the child has autistic features, further specialized evaluation is done by a psychiatrist. If the child is found to have any cognitive impairment, or the child is found to be at risk for developmental disorders, like Autism or ADHD, then the DEIC refers the child to the Civil Hospital for detailed assessment and diagnosis. All children, found eligible for a disability certificate, are also referred by DEIC to the Civil Hospital or the District Disability Rehabilitation Centre (DDRC). After the assessments, many children are also referred to special schools.

Thus far, the DEIC has supported children through their services and facilities like physiotherapy, nutrition, audiology and speech pathology, dental services, special education and lab services. The DEIC staff also acknowledged and recognized the importance of involving parents and empowering them with knowledge on management of the four Ds (as mentioned above). Since this DEIC caters to children from different districts, many children

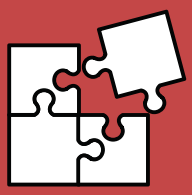
D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): DISTRICT EARLY INTERVENTION CENTRE (DIEC)

EXISTING SERVICES AND SYSTEMS

come from long distances, and in that situation, it becomes difficult for these children to come back for follow-ups repeatedly. In these cases, the parents are provided with written instructions to conduct activities with the children at home. The time in the DEIC is spent preparing and teaching the parent, through demonstration of the early stimulation activities/ interventions with children. In such cases, the DEIC staff follows up with the parents of these children telephonically once in 2-3 weeks to check if the child has been attending school or is continuing therapy with the referred institution.

The DEIC staff also shared that they are soon planning to extend further support to parents and set up a parent support group for the same.

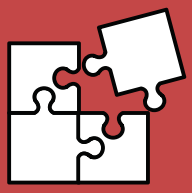
D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): DISTRICT EARLY INTERVENTION CENTRE (DIEC)



GAPS AND CHALLENGES IN SERVICES

- Lack of Knowledge about conducting assessments of mental health issues & developmental disabilities
- Lack of access to standardized tools for assessment of mental health issues and disabilities
- Lack of training on child mental health – identifying emotional and behavioural challenges and related issues such as abuse/ neglect.
- Lack of knowledge about child protection issues and laws – identifying signs & symptoms of sexual/ emotional/ physical abuse

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): DISTRICT EARLY INTERVENTION CENTRE (DIEC)



GAPS AND CHALLENGES IN SERVICES

The DEIC staff reported that one of the biggest challenges that they face is while making a diagnosis. For instance, they very commonly see children with autism, and although they are able to identify the children's signs and symptoms, they do not feel confident in using standardized scales/ tools for psychological testing. They also stated that they do not have access to these standardized scales/ tools, and therefore, they mostly refer children to the Civil Hospital, or a Tertiary Facility, for diagnosis and the confirmation of the provisional diagnosis made by them. They also expressed concerns over not being fully equipped to carry out comprehensive developmental screening, which includes the socio-emotional aspects of child development. Keeping in mind the above, the staff emphasised that training and capacity building programs on child mental health, and the use of psychological tools for testing, would be critical and requested for the same.

One of the challenges raised by the team, unanimously, was the lack of training on issues of child mental health and child protection. When asked if they are able to identify emotional/ behavioural issues or if a child has experienced neglect/abuse, they reported that these cases did not come to them. It must be noted that signs of emotional issues in children can be difficult to identify, and sometimes, the behavioural issues, due to various reasons, can be misunderstood.

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): DISTRICT EARLY INTERVENTION CENTRE (DIEC)

POTENTIAL OPPORTUNITIES

Training of the DEIC Staff on mental health issues related to children & adolescents, particularly in the area of developmental disability. This would include orientations to developmental disability and related mental health (co)morbidities, protection risks in children with disability, as well as developmental screening and the use of psychological testing scales and requisite interventions for specific disabilities.

Scaling up of the DEICs by setting up more DEICs across the State.

Developing linkages of the DEIC with the District Disability Resource Centre (DRC) & the District Mental Health Program (DMHPs) for intensive and holistic support to children.

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): DISTRICT EARLY INTERVENTION CENTRE (DIEC)

POTENTIAL OPPORTUNITIES

The DEIC, with a multidisciplinary team, can be strengthened to provide holistic interventions to children. Other than the knowledge of the four Ds, it is also important that the DEIC broadens its work to provide more depth/ comprehensive tertiary care services. The staff's training needs are beyond disability i.e., the staff require to be trained on the following subjects that are critical to interventions undertaken by them: a) child & adolescent mental health issues – developmental disabilities, intellectual disability, ADHD, autism and other emotional/ behavioural issues; b) childhood adversities & pathways to vulnerabilities; c) child protection laws like the Juvenile Justice Act & POCSO Act; d) systematic methodologies for screening and assessment of mental health issues and disabilities (in accordance with the Diagnostic and Statistical Manual- V (DSM-5)). Further, training also needs to be provided on first level responses to children upon identification of any child protection and mental health concerns i.e., to enable containment of a situation so that the problem does not escalate, thereby causing greater distress to children and their families. The DEIC can also facilitate linkages with the District Disability Resource Centre (DRC) (to provide specialized interventions for children), District Mental Health Programme (DMHP), Tertiary Care Centres etc. Additionally, it would be useful to scale up the DEICs and set up more DEICs across the State, especially in remote places, as many children drop out of the treatment due to the difficulty in accessing services located at long distances.

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): MOBILE TEAM

EXISTING SERVICES, NEEDS AND CONCERNS

The team interacted with the RBSK team from East Khasi Hills. Each Block has two RBSK teams comprising of – one AYUSH doctor, one nurse and one pharmacist. The team is primarily engaged in the screening of children for early detection of concerns in these four areas- defects at birth, disease, developmental delay, deficiencies, as per the RBSK guidelines.

The RBSK team works with children from 0-18 years of age, through anganwadis and schools. The RBSK team informed SAMVAD that they currently have 508 schools and 384 Anganwadis under their supervision. They also reported that, within their block, they have a child population of 1,70,000. They were aware that as per the RBSK mandate, they must visit each school and Anganwadi at least twice, but it becomes impossible for them to do so given the magnitude of work at hand and a lack of human resources. They, however, aim to visit each anganwadi and school at least once a year, or once in two years. Currently, each team manages to visit about 20 Anganwadis and 20 schools per month.

The team primarily screens children and updates their data on the Child Screening Mobile Apps. Unlike most other Institutions, the RBSK has a standardized screening tool, developed by the Ministry of Health and Family Welfare. The tool has the key indicators under each of the 4 Ds for screening of children aged 0-6, 7-14 and 14-18.

On being asked about the kind of cases they usually identify and refer, the team reported that they have referred cases of Intellectual Disability, Down Syndrome, ADHD, Autism, Speech Delay and Learning Disorders. Following the conclusion of the screening process, the team refers children with disability or developmental disorders to the District Early Intervention Centre. If the child is found to have a physiological condition, dental issues, skin-related problems, the child is referred to the Community Health Centre (CHC) or the Primary Health Centre (PHC).

If the team identifies issues related to substance abuse, reproductive health, teenage pregnancies, with reference to adolescents, they make a referral to the Adolescent Health Clinic. However, they also reported that most of the cases referred to the centres, especially

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): MOBILE TEAM

EXISTING SERVICES, NEEDS AND CONCERNS

to the adolescent health clinic, actually dropout and do not engage in follow-up processes. They were unclear about the reasons for the same, but they mentioned that people usually prefer private services over government services, as beneficiaries have previously reported that they found the doctors to be unresponsive in government facilities.

To understand some of the emotional and behavioural concerns that they commonly see amongst children, the SAMVAD team asked the RBSK team to share some of their concerns and illustrate them with some examples. The RBSK team was requested to share their experiences and observations during the COVID pandemic. In context of the pandemic, the RBSK team shared that they were mostly involved and occupied with vaccinations in communities. The team's knowledge about emotional and behavioural issues, or child mental health issues, was not adequate. In response to the questions asked about these issues, the team reported that children were observed to have "poor manners", and they do not respond when someone talks to them in the school. In this regard, the mobile health unit was observed to have a fundamentally physiological perspective of children's challenges. However, it is important that the team also understands the various psychosocial determinants that affect the health of children and adolescents in the communities. For example, the developmental issues that they see in a child could be a result of abuse or trauma. In such a case, it becomes even more important for them to elicit contextual details in order to make the right referral and provide assistance. As the SAMVAD team probed more and tried to understand the reasons for the behavioural changes after COVID, the team explained that children now feel scared to speak up and may have anxiety as the schools have opened up. They also mentioned that serious learning gaps have emerged, in many rural areas in Meghalaya, due to the lack of internet and network facilities.

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): MOBILE TEAM

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Issue of Teenage Pregnancy	The team said that they have only come across one case of teenage pregnancy in the last few years. The girl was identified by the ANM and was brought to the Anganwadi. The RBSK team was asked to counsel the girl in this case. The SAMVAD team enquired about the process through which they intervened and the details of the girl's context. The team reported that they did not enquire about the case and simply referred the girl to the DEIC. This approach can be problematic as the child/ adolescent is made to wait for assistance, as a result of which, they are usually filled with anxious and self-defeating thoughts; with the uncertainty of the process that lies ahead only making matters worse. It is important the RBSK team extends its role and is equipped to provide first level responses in such cases, reassuring the adolescent of their safety and agency, acknowledging their emotions and providing some knowledge about the legal and medical processes.

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): MOBILE TEAM

EXISTING SERVICES, NEEDS AND CONCERNS

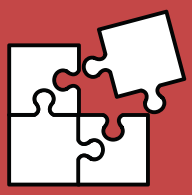
ISSUE	KEY FINDINGS
Child Sexual Abuse	Although Child sexual abuse was identified to be one the most concerning issues by all stakeholders, the RBSK team reported that they had not come across any cases of child sexual abuse in their block. It was only one case, wherein the girl was about 9 years old, where the RBSK counsellor suspected CSA, as a result of emotional and behaviour changes observed in the girl by the teacher. However, when asked about the interventions implemented in this case, the counsellor informed the SAMVAD team that they don't interact with the parents. Reportedly, the teacher tried to contact the mother, but the mother never attended their call, and therefore, the matter was not followed up. The SAMVAD team observed that it is due to a lack of knowledge about legal processes and clarity about how such matters can be approached, which culminates in inaction/lack of motivation to pursue these cases. The counsellors require skills in communicating with children in order to gently elicit their experiences or narratives. In most cases, when the disclosure is not made by the child directly, counsellors are apprehensive to file a complaint, due to the fear that a person may be wrongly accused. And therefore, the knowledge of the POCSO law, which stipulates that even suspected abuse of a child can be reported, and that non-reporting of abuse against a child is a punishable offence, is critical for this group of child duty-bearers.

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): MOBILE TEAM

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Substance Abuse Issues	Substance abuse issues are quite prevalent amongst adolescents between 14-18 years. Mostly, in their observations, the RBSK counsellors have observed children smoking cigarettes and marijuana. According to the counsellors, a commonly cited reason for their indulgence in these substances was peer pressure. They were unsure about the context of these children, and stated that they usually refer these children to the Adolescent Health Clinic. Some children are also reportedly sent to the New Life Foundation's De-Addiction Centre.
Adolescent Issues	The RBSK team informed SAMVAD that adolescents' issues of menstrual health and hygiene are discussed in schools. However, these issues are not discussed in groups, but instead, during one-on-one consultations. When asked about the specific concerns that adolescents bring to the team, they said there were no specific concerns, and issues of sexuality were not discussed in the schools. These gaps arise mainly due to the discomfort at both ends i.e., of the counsellor, doctor, school team, on one hand, and the adolescents, on the other. Adults do not usually know how to approach these issues and adolescents feel a sense of shame and reluctance in initiating conversations and asking questions on subjects of sexuality, relationships and substance use. Facilitating discussions on some of these issues, by creating a comfortable space, and normalizing these discussions in schools, through the implementation of life skills education, is critical from a prevention standpoint.
Protection Concerns	While the counsellors reported that there were absolutely no cases of child marriage or child labour in Meghalaya, this position can only be attributed to their lack of knowledge about the prevalent child protection issues, as the information shared by them is not corroborated with the information shared by other stakeholders interviewed.

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): MOBILE TEAM



GAPS AND CHALLENGES IN SERVICES

- No routine enquiry about child abuse during assessments
- Lack of knowledge on child & adolescent mental health concerns
- Lack of human resources
- Lack of training on child mental health issues
- Lack of linkages with the DMHP

The current gaps that SAMVAD could identify in the functioning of the Mobile Health Units were as follows:

a) lack of human resources to cater to a huge population;
b) lack of training on child mental health issues; and
c) lack of knowledge about child protection issues.

Although the team currently uses a screening tool developed by the Ministry of Health and Family Welfare, the tool focuses on the 4 Ds - defects at birth, developmental delays, deficiencies and diseases; it does not include questions about child abuse and mental health issues (emotional/ behavioural problems).

D.2.4. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK): MOBILE TEAM

POTENTIAL OPPORTUNITIES

- Training on primary level screening and assessments.
- Making referrals to mental health services.

The RBSK is a powerful workforce and can play a huge role in conducting primary level screening of mental health issues, developmental problems and protection concerns. They must be duly trained, not just on basic child mental health and developmental problems, but also on the assessment of protection concerns and the criteria for referral of the same. A list of mental health services available in the state also needs to be provided to the mobile units.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

EXISTING SERVICES, NEEDS AND CONCERNS

There are two spaces in which the RKSK counsellors sit, in Shillong, East Khasi District—in Ganesh Das Hospital, which works primarily in the area of maternal and child health, and in the Civil Hospital, which is the largest hospital in the state, serving patients from different parts of the state. In Shillong, there appears to be an informal arrangement between the two counsellors on the division of cases with adolescents having sexual and reproductive issues, such as teen pregnancy, assisted by the RKSK counsellor in Ganesh Das Hospital and those with substance use assisted by the RKSK counsellor in the Civil Hospital. However, in other districts, RKSK counsellors deal with both issues. RKSK is also attempting currently, to set up centres within the community, rather than hospitals, to be more accessible to adolescents. For instance, Mawprem, a locality within the East Khasi Hills district, has established one such centre called the ‘Adolescent Health Resource Centre’. Staffed by a doctor, nurse and counsellors, who visit thrice a week, on rotation, the centre carries out various RKSK activities.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Sexual and Reproductive Health Issues	Referrals are received either directly, with walk-ins from adolescents (and their families) or from doctors of (Ganesh Das) Hospital, for counselling. Adolescents present with various sexual and reproductive health concerns, such as menstrual problems, sexually transmitted diseases and teenage pregnancy, as well as child sexual abuse. The counsellor reported that recently, a school in Shillong had 90 school drop-outs of which 36 were adolescents who were pregnant. She reported that the incidence of teenage pregnancy is attributable to: (a) lack of knowledge amongst adolescents, on safe sex practices; (b) a perception that they would not be at risk of pregnancy— 'I did not think I would get pregnant'; (c) the desire to 'please the boyfriend' or belief in their promises to marry them, especially in case of first-time sexual experiences.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Sexual and Reproductive Health Issues	If an adolescent comes directly to the RKSK counselling centre, and if required, pregnancy tests are administered by the RKSK counsellor (following which the adolescent is referred for medical assistance to the main hospital). Other interventions provided by the RKSK counsellor, particularly to adolescents who are pregnant, comprise of counselling for nutrition, encouragement to continue with schooling and education, family planning and contraception, and referral for antenatal care. The RKSK also encourages the partner and parents of the adolescent girl to avail of counselling on these issues. In cases of medical termination of pregnancy, parental consent is required. The RKSK counsellor reported that a majority of girls continue with the pregnancy as parents frequently do not allow for abortion, and are accepting of both the pregnancy and its consequences of dropping out of school. In cases where there are differences of opinion between the adolescent and her parents with regard to continuing with the pregnancy, the RKSK leaves it to them to decide— 'you decide—it is between your parents and you'. Additionally, the counsellor reported that adolescents in urban areas, tend more to attempt MTP through the use of the 'unwanted pregnancy pills'. These pills (to be taken as a course of 5 pills), available in many pharmacies, is priced at Rs. 300 to 400, but is sold to adolescents at exorbitant rates of Rs.3000 to 4000.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Sexual and Reproductive Health Issues	In child sexual abuse cases i.e., sexual assault and 'non-consenting' sexual engagement of adolescents, the RKSK refers them to the One Stop Centres for legal assistance and reporting. They also provide some first level psychosocial responses to adolescents, by 'making them feel calm, asking what happened, how they are feeling…helping them understand that it is not your fault and so no need to feel bad…' and acknowledging the adolescents' 'courage and motivation'. The RKSK also conducts outreach programs in schools, communities, shelter homes and churches, on emotional and sexual and reproductive health. These are of a duration of 1 and 3 hours, to full day programs. Information is shared with adolescents through power point presentations and videos, followed by discussions in which participants are encouraged to ask questions. The content for emotional programs is focused on life skills issues, such as anger management, self-image, creativity, empathy and interpersonal skills. Programs on sexual and reproductive issues are focused on body changes (during adolescence), normalization of feelings of attraction and sexual desire, the consequences of sexual relationships, namely pregnancy, body parts and how pregnancy occurs, the ABC method i.e., abstinence as a primary method to prevent pregnancy, and in case of engagement in sexual relationships, being faithful to one partner and using condoms. Awareness programs on child sexual abuse (for 10- to 19-year-olds) focus on information regarding the POCSO Act and 'good touch-bad touch'. The counsellor suggested that more efforts need to be made by the RKSK to mobilize community leaders and parents i.e., that adolescents cannot be the sole targets of the RKSK initiative as much of adolescent work also necessitates building adolescents' relationships with parents and families.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Substance use	Having worked with adolescents since 2007, previously on the government Adolescent Reproductive and Sexual Health (ARSH) program, the RKSK counsellor at the Civil Hospital had considerable experience, in adolescent work. Indeed, the RKSK, under the National Health Mission, which started in Meghalaya in 2014, was previously the ARSH program under the National Rural Health Mission (NRHM). The counsellor reported that some of the common cases of substances pertain to tobacco, alcohol and heroin; the ages of children received by the RKSK, in the context of substance use, are 9 years and upwards. Tobacco and alcohol use are found to be more prevalent in boys than in girls. Associated mental health issues pertain to depression and suicidal tendencies (consuming of pesticides, hanging, over-dose of pharmaceuticals and stabbing of self) in the context of exam failure, mother-daughter relationship problems, and romantic relationship issues. She also reported cases of 'neurosis' due to exam stress, domestic violence within families and child sexual abuse. She reports that she has observed several mental health issues in cases of teen pregnancy, wherein adolescents suffer from stress reactions, depression and suicidal tendencies (because they do not wish to go forward with the pregnancy).

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Substance use	The causes of substance use range from curiosity and experimentation (such as if older siblings use substances, younger ones are exposed to these practices and wish to try them out) to family dysfunction. In the latter situation, parents may be substance dependent with the family also in serious financial crisis; children then start to use substances, both due to stress, but also due to dropping out of school. Indeed, school dropout issues and substance use are very much linked, as observed by the counsellor. Girls as young as 13 to 14 years start to use substances often due to the influence of their partners in romantic relationships; they then develop addiction problems, also resorting to prostitution to procure money for drugs. Their male partners enable the girls in these prostitution activities, in order to also benefit from the money and drugs obtained thereof. Such high-risk sexual engagement leads to girls contracting sexually transmitted diseases such as HIV and hepatitis C, as well as skin diseases and abscess (due to use/ sharing of needles). The counsellor uses 'Adolescent Job Aid', a WHO publication, as a guide to implementing assessments and counselling with adolescents. This book contains information for primary healthcare providers on: (a) clinical interactions between the adolescent and the health worker; (b) algorithms, communication tips and frequently asked questions on 25 presentations related to developmental conditions, pregnancy-related conditions, genital conditions including sexually transmitted infections, HIV and other common presentations; (c) information for adolescents and their parents or other accompanying adults on important health and development issues.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

EXISTING SERVICES, NEEDS AND CONCERNS

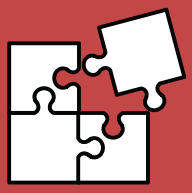
ISSUE	KEY FINDINGS
Substance use	While no systematic assessment protocols or proforma are used to evaluate adolescents' substance use and mental health issues, the HEADS format contained in the book is used: (Home, Education/Employment/Eating, Activity for daily living, Drugs, Sexuality, safety-related concerns). However, RKSK counsellors from other districts do not necessarily use this book or these approaches in their work—this information, therefore, is not generalizable to the ways of work of the RKSK across the state. Once substance use and mental health issues are assessed and identified, in individual adolescents, the RKSK then send them on for treatment and rehabilitation to centres that specialize in this. In other words, no treatment interventions are provided by the RKSK for substance use. Such adolescents are also referred for requisite medical tests (namely haemoglobin, skin infections, liver function, HIV, Hepatitis C testing), after obtaining their consent. Counselling is provided on the risks of not cooperating with testing (including spread of infections/ risks to family etc), in case adolescents refuse medical tests—and, finally, are persuaded to agree to testing through counselling.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Substance use	With regard to associated mental health co-morbidities, such as depression and suicide, the RKSK counsellor stated that 'if the adolescent is stable' then 'we monitor the verbal and non-verbal communication of the client' and provide stress management techniques such as deep breathing/ relaxation and advise on sleep habits. In case the mental health issues remained unresolved, then the concerned adolescent is referred to the psychiatrist (in the Civil Hospital). 'We are just a counselling centre', the counsellor said, 'advising on reading books, sleep hygiene, personal hygiene, exercise…what is a bad thing and what is a good thing…we say you are young; you can take up studies, you can choose'. Outreach programs on substance use, through schools, colleges, youth groups, NGOs and churches are held. The RKSK also collaborates extensively with NGOs and community-based organizations working on adolescent health issues (such as Voluntary Health Association of Meghalaya, Kripa Foundation, Khasi Students Union and others). The themes and content of the awareness program include: nutrition, substance use, emotional adjustment, learning difficulties, and violence and abuse issues. Substance use awareness programs, like others, use power point presentations, videos and charts as well as methods such as group discussions, games, quiz; they include assertiveness and refusal issues, and information on impact of substance use on mental health. Awareness programs have helped remove the stigma associated with mental health and substance use—unlike in previous years, many young people now seek assistance at clinics and RKSK centres.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM



GAPS AND CHALLENGES IN SERVICES

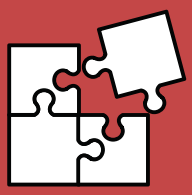
- Dilemmas and Challenges in Mandatory Reporting
- Lack of legal awareness (Juvenile Justice and CICL)
- Lack of comprehensive role clarity and knowledge on standardised assessment and intervention protocols

One of the challenges highlighted by the RKSK counsellor is that of navigating the dilemmas of mandatory reporting in cases of child sexual abuse/ assault versus maintaining the confidentiality as required by counselling processes—how the counsellor should respond when a child pleads not to report abuse. In such cases, currently, the counsellors report abuse to the CWC, allowing them to take the processes forward and thus try to circumvent 'direct reporting' so that the counsellors are able to maintain their 'relationship' with the child or adolescent.

In addition to difficulties with implementing mandatory reporting issues under POCSO, SAMVAD observed that the counsellors were not aware of specific provisions under the Juvenile Justice Act, nor those pertaining to children in conflict with the law—this understanding would be important to assisting vulnerable adolescents with protection and mental health issues, particularly with regard to rehabilitation and juvenile transfer issues.

SAMVAD also observed that the lack of standardized assessment protocols and content for awareness programs, as well as methodologies for intervention are likely to hinder effective assistance to the complex problems of adolescence. The use of power point presentations and videos, largely to impart information is important but limited in its impact—this is because the mere possession of information does not, especially in adolescence, necessarily lead to

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM



GAPS AND CHALLENGES IN SERVICES

appropriate decision-making. Life skills methods require to be used in ways that more strongly inculcate position-taking and decision-making skills in adolescents. Furthermore, in a state that does not, as yet, have a robust system of child and adolescent mental health services, counsellor perceptions of being 'just a counselling centre' and providing generic relaxation techniques, with little contextualization of intervention according to issues, followed with referral is not a tenable position vis-à-vis adolescent mental health.

D.2.5. RASHTRIYA KISHOR SWASTHYA KARYAKRAM

POTENTIAL OPPORTUNITIES

The RKSK program, with its deeply passionate counsellors, who have both experience in working with adolescents, as well as a knowledge of societal systems and how they place adolescents at risk, has tremendous potential for development into a specialized and effective service for adolescent mental health. The counsellors need to be equipped with:

(a) stronger conceptual understanding of adolescent development and mental health;

(b) child laws such as POCSO and Juvenile Justice Act, particularly the psychosocial and mental health implications of these legal provisions;

(c) intensive and systematic approaches to counselling in all areas pertaining to adolescent counselling, through the use of creative and participatory methods and the use of life skills training in ways that not only impart information but guide adolescents on perspective-taking and decision-making on high-risk behaviours.

D.2.6. ONE STOP CENTRES (OSC)

EXISTING SITUATIONS AND SERVICES

With a primary mandate to support women affected by violence, the OSC at Ganesh Das Hospital was, at the beginning, run by the North East Network (NEN), because of this NGO's experience in the area (at which time it was called 'Support Centre'). However, currently NEN no longer has a role to play in this OSC, whose services are implemented as per the government OSC guidelines under the Nirbhaya scheme. The rationale for locating this OSC within a hospital (as opposed to the community), is based on Centre for Enquiry into Health and Allied Themes (CEHAT)'s Dilaasa Model which views domestic violence as an issue within the larger societal context of gendered inequalities and violence and promotes recognition of domestic violence as a public health concern within the medical context that is largely unresponsive to issues of domestic violence. Dilaasa was established as a public hospital-based crisis centre to address the psychosocial needs of women facing domestic violence. While this OSC was started in 2016, others across the state followed in 2019, with Meghalaya now having 1 per district, and so 11 OSCs in total. Each OSC is staffed by a centre manager, a case worker, a counsellor, a paralegal worker, 2 medical workers, a police officer and other helpers/ support staff. A temporary shelter is currently under construction and the OSC is expected to shift buildings then—in the interim, women requiring shelter are referred to the Swadhar Grih, the government home for women.

The OSC mainly receives women survivors in the context of domestic violence. Several of the women seeking assistance are single mothers and/or abandoned by their partners. In such cases, the OSC enables them to access support from extended family members through home visits; in case of women who have no family, they attempt to ensure these women's safety by informing the local police and headmen. They also liaison with community-based networks, through women's groups and sub-committees of women and youth (village bodies constituted under headmen), to support such women. The OSC connects with community-based networks through the Block Development Officers at district level.

The OSC receives child cases through referrals from police, doctors, private clinics and health centres, NGOs and schools. Cases of child abuse, particularly child sexual abuse (CSA) i.e., persons below the age of 18 years, when received, are referred to Child Welfare Committees under the Integrated Child Protection Scheme (ICPS). However, as reported by the OSC, when they receive child cases, they perform the following functions, at a first level:

D.2.6. ONE STOP CENTRES (OSC)

EXISTING SERVICES AND SYSTEMS

provision of psychosocial support (mainly comfort and reassurance) to the child, information on the POCSO Act to the family, mandatory reporting of CSA cases to the police, referral for medical assistance (if not already received), following which they intimate the child welfare committee (CWC) regarding the case. In a week, the OSC states that they may receive up to 4 to 5 cases of child sexual abuse—referring to cases of assault.

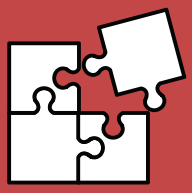
OSCs also receive cases of under age or teen pregnancy, most of which are a result of 'consenting' sexual relationships between adolescents. Given the provisions of POCSO, the latter cases are also mandatorily reported to the police, and provided with medical assistance as required. Teen pregnancies that are beyond the medical termination of pregnancy (MTP) period, require not only the assistance of the CWC, but also of the Medical Board in making decisions regarding the pregnancy. The OSC also provides adolescents with some counselling on the health consequences relating to MTPs.

When women affected by domestic violence seek assistance at the OSC, many are accompanied by children. As per the Ministry guidelines, the OSC allows children below 10 years of age to stay in the shelter (with the mother), while those above 10 years of age are referred to the CWC. The OSC acknowledged that children from contexts of domestic abuse are traumatized, with some of them having to work (to assist with the family income) and drop out of school; they have also observed that such children tend to either become fearful and isolated, frequently experiencing 'black-outs and fainting fits'*. No interventions as such are provided to these children and OSC staff are also not trained to provide responses to such children.

Additionally, the OSC conducts awareness programs in schools and colleges on child sexual abuse and domestic violence, using World Health Organization videos and other materials to facilitate discussions on these issues. They also talk to women and children about domestic violence and help seeking at OSCs, creating community-level awareness, through women and youth sub-committees. Generally, in these awareness programs (lasting about 2 to 3 hours), discussions are held, with no structured program that is based on a curriculum or plan.

*Note: These are symptoms of anxiety and post-traumatic stress disorder, occurring in children experiencing trauma and extremely stressful life events.

D.2.6. ONE STOP CENTRES (OSC)



GAPS AND CHALLENGES IN SERVICES

- Challenges in assisting child sexual abuse victims with intellectual disability
- Challenges in providing first-level psychosocial responses to children
- Lack of role clarity regarding services to be provided to children

One challenge expressed by the OSC staff was their difficulty in handling sexually abused children with intellectual disabilities—as they struggle to communicate with such children and take action accordingly. The staff therefore requested training on sexual abuse and children with special needs.

SAMVAD's understanding of the possible gaps and challenges in the OSC services pertains to the lack of skills in providing psychosocial responses to child victims of sexual abuse and adolescents who are pregnant. For instance, the challenges of mandatory reporting, especially when children and families do not wish to report to the police, entail psychosocial skills in working with them to enable reporting processes.

A larger level challenge is the lack of clarity in the Ministry's guideline for OSCs vis-à-vis their specific role in case of child sexual abuse, whether in the context of sexual abuse or domestic violence. This might be a possible reason why OSCs around the country do not function in standardized ways, except perhaps for their referral to CWCs—and they have 'chosen' what their function in child sexual abuse cases may be*. In Meghalaya, it pertains to mandatory reporting and medical assistance. What is common to most OSCs, however, is a concern that Meghalaya also reflects—negligible psychosocial responses provided to children, who are often the less visible, but deeply affected victims in such situations, particularly given the long-term consequences of childhood exposure to domestic violence.

D.2.6. ONE STOP CENTRES (OSC)

POTENTIAL OPPORTUNITIES

While the role of OSCs vis-à-vis child abuse cases is somewhat nebulous, the mandate for women affected by violence is clear. The OSC therefore has great potential for provision of psychosocial and mental-health related responses to children in contexts of domestic violence. Given that concerns of domestic violence, abandoned and single mothers and their impact on child psychosocial well-being, the OSCs may be trained to respond to children in these contexts—their understanding of women in violence could be capitalized upon, and linked to the accompanying children, so that the mother and children are assisted as a unit.

*Note: In Uttar Pradesh, for instance, they also attempt to do child counselling and sometimes provide assistance to the child for legal reporting. In Telangana, OSCs simply refer children to the Bharosa Centres explicitly set up by the Telangana Women Safety wing, to address CSA issues.

D.2.7. SPECIAL JUVENILE POLICE UNIT

EXISTING SERVICES AND NEEDS

As was reported by a Superintendent, in-charge of an SJPU, typically, with regard to children, there are few categories of common cases received by the police. In the context of children in need of care and protection (CNCP), POCSO cases are most frequently reported. This includes cases of child sexual abuse by an adult perpetrator, and mutually consenting adolescent relationships (which have resulted in teenage pregnancies). Additionally, cases of cruelty and abuse, where children are employed as domestic labour, are an additional category of cases involving child victims.

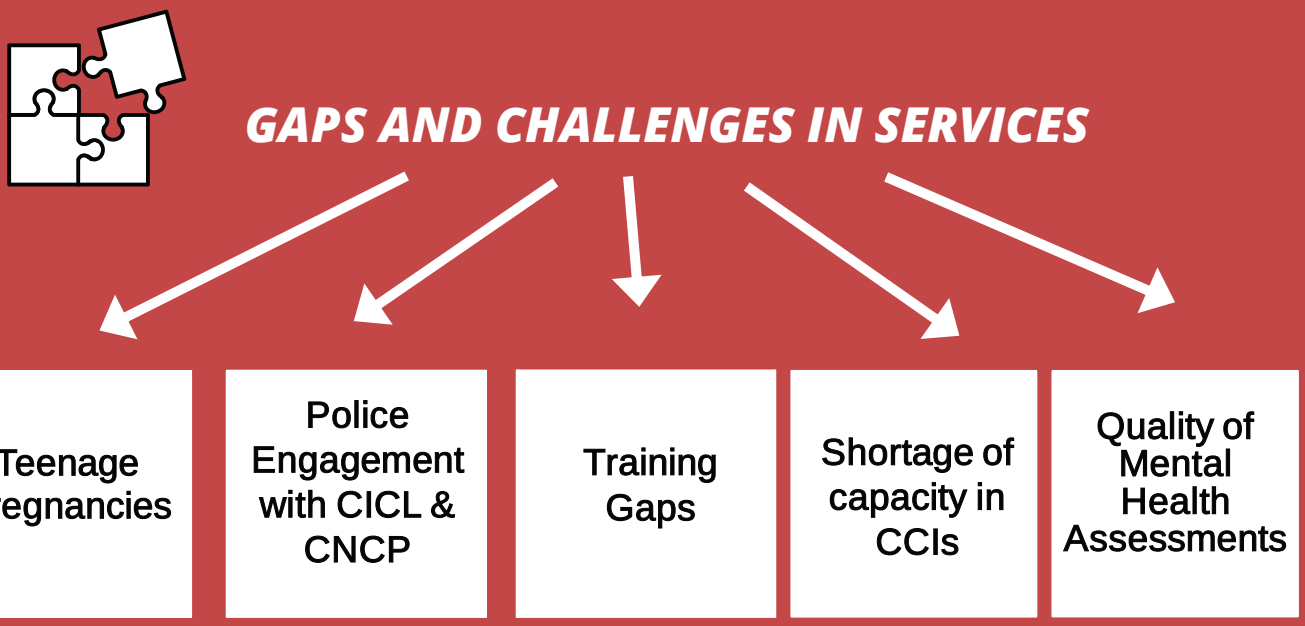
In the context of children in conflict with the law (CICL), adolescent offenders under POCSO, theft, and substance abuse, are most commonly reported. In substance abuse cases, typically, non-punitive diversionary measures are adopted, wherein the child is referred to NGOs working on substance abuse and de-addiction facilities. In some cases, the offence for which the child entered the system is theft. So, the offence of theft is the focal point of the case, with the child receiving rehabilitation assistance for substance abuse. In cases involving heinous offences by CICL aged 16-18, where Section 15 of the Juvenile Justice Act (Juvenile Transfer) is applicable, the child is immediately referred to the JJB for preliminary assessment to be conducted.

D.2.7. SPECIAL JUVENILE POLICE UNIT

EXISTING SERVICES AND NEEDS

THEMES/ISSUES	FINDINGS
Recording of Child's statement	In cases where there are issues with recording the child's statement, the SJPU typically contacts the CWC. As reported, the CWC is the child-related body most closely acquainted with the police in their engagement with children. For instance, if a child is unable to speak to the Investigating Officer (IO), the CWC is contacted to provide for a support person, special educator/interpreter to assist the child with statement recording. Children's statements are usually recorded in writing. However, if there is a necessity in cases involving persons with disabilities, the statement is recorded through audio-visual mode.
Procedure in POCSO Cases	Following reporting of an offence, the child is first taken for medical examination, as many children come from rural areas and have to travel a significant distance. Following the examination, the child is produced before the CWC. In some instances, this procedure can take 2-3 days.
Awareness Programs	A range of awareness programs, in tandem with other agencies such as the District Legal Services Authority and Child Welfare Committee are conducted at the community level. Police personnel also facilitate awareness programs at the school level. Prior to COVID, there were also monthly 'Community Liaison Meetings' organised with village heads on issues relating to child abuse and substance use, and ways forward in terms of coordination.

D.2.7. SPECIAL JUVENILE POLICE UNIT



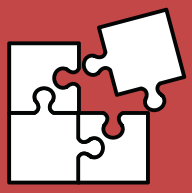
❖ Teenage Pregnancies

In POCSO cases involving consenting relationships between adolescents, there tends to be a reluctance amongst parents in reporting the case and seeking registration of the FIR, despite the legal mandate to do so. As the Superintendent reported, police personnel also face challenges in these cases, as there is no element of abuse involved, creating anguish amongst families, and indeed, making it difficult for the police to report. The police themselves find it difficult to register an FIR in such cases, keeping in mind the nature of the circumstances. Additionally, children in these cases also do not usually consent to medical examinations.
Information in these cases comes from child-related professionals, such as the Community Health Centre, ASHA, anganwadi workers; and at the village level, from the Village Health, Sanitation, and Nutrition Committee.

❖ Police engagement with CICL and CNCP

As per procedure, it is the Child Welfare Police Officer (CWPO) who interviews children in contact with the law. The children are typically interviewed in the designated ‘child’s corner’ of the police station. However, not all police stations reportedly contain separate areas for interviewing children. Children are also required to accompany the concerned police personnel during spot visits, as procedurally required to confirm important details of the abuse incident.

D.2.7. SPECIAL JUVENILE POLICE UNIT



GAPS AND CHALLENGES IN SERVICES

❖ Training Gaps

One of the critical challenges is the lack of training on mental health issues for children in contact with the law i.e., CNCP and CICL. While regular trainings are conducted with a cross-section of stakeholders, particularly the Meghalaya Judicial Academy and the Meghalaya Police Training School, on a range of subjects (including legal awareness programs on POCSO, child trafficking, juvenile justice), specific training programs have not been conducted on mental health issues concerning children.

The only mental health-related training program was conducted by SAN-KER Hospital on suicide-related issues.

❖ Shortage of capacity in Child Care Institutions (CCIs)

Typically, in cases involving CICL, due to shortage of capacity in the CCIs, children may have to be released on bail, or otherwise sent home. This reportedly does cause further stress to the child in some cases. However, due to shortage of institutional capacity, there are limitations. Additionally, in cases where the JJB is not available for first production of the child, the child is required to stay at their own residence, further creating issues pertaining to the child's safety and subsequent behaviour.

❖ Quality of Mental Health Assessments

The quality of mental health assessments received is ambiguous or unsubstantiated sometimes. As a result, these assessment reports do not provide clarity on capacity of the child, thereby requiring assessments to be requested multiple times. This issue delays provision of assistance to the child due to lack of clarity on the child's specific issues, including with courtroom engagements.

D.2.7. SPECIAL JUVENILE POLICE UNIT

POTENTIAL OPPORTUNITIES

The most significant intervention, keeping in mind the needs of the police, are capacity-building interventions to build skills on how to engage with children in contact with the law. This would include trainings on a range of issues, including forensic interviewing and communication skills for vulnerable children in contact with the law.

D.2.8. JUVENILE JUSTICE BOARD (JJB)

EXISTING SERVICES, NEEDS AND CONCERNS

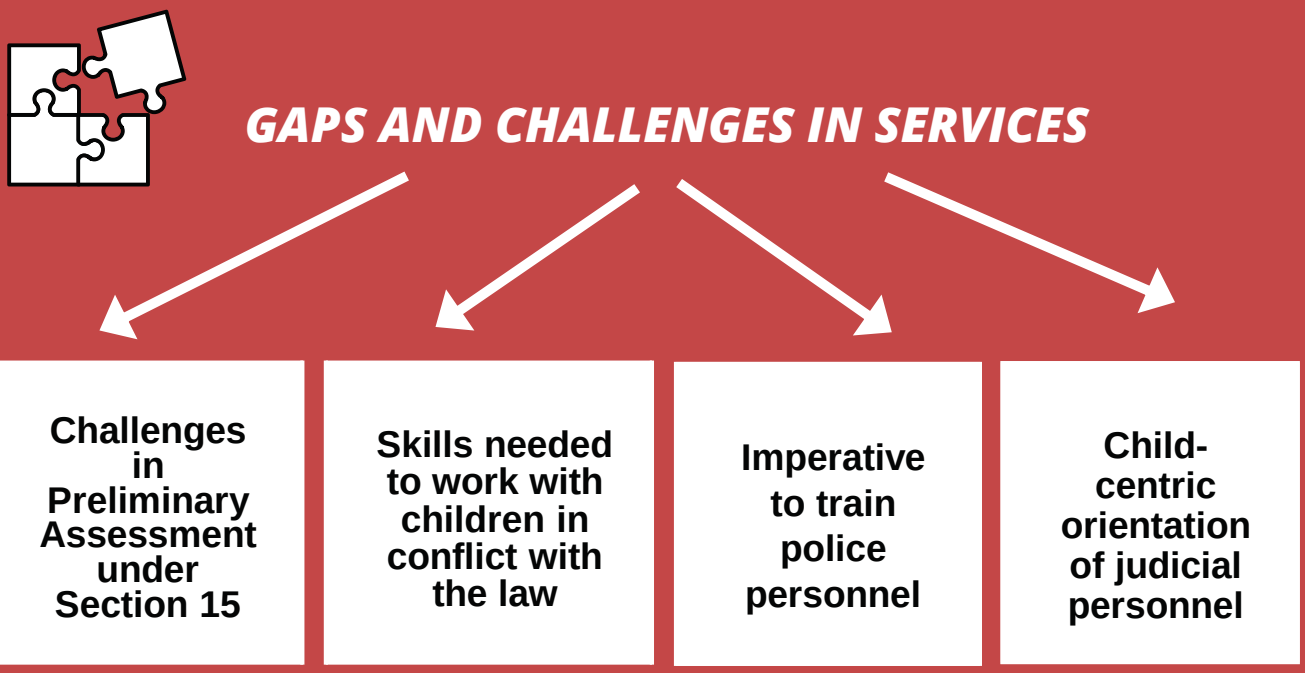
ISSUE	KEY FINDINGS
Adolescent Offenders in POCSO Cases	The JJB reports that in recent times there has been a tremendous increase in POCSO cases, among children in conflict with the law, because adolescents lack knowledge on sexuality, consequently leading to issues of teen pregnancy. While families are accepting of teen pregnancy situations, the mandatory reporting provision under POCSO, which is followed when cases come to hospitals, brings the adolescent boy to the JJB. The JJB arranges for the Observation Home counsellors to provide psychosocial and counselling services to the boy concerned, and his family. Recently, cases of younger children engaging in CSA are also being brought to the JJB—for instance, there was a case of a group of boys and girls between ages 5 and 9 years.
Juvenile Transfer (1): Types of Cases	The JJB magistrate mentioned that a majority of boys (between 16 and 18 years) apprehended in POCSO cases, as per the provisions of Section 15 of the Juvenile Justice Act, are transferred to the adult criminal justice system. She however mentioned that transfer decisions were made on the basis of the facts and circumstances of a given case—for example, 'a boy who knowingly kept a girl in the house, threatened her and then abused her…while he did feel remorse later on, he knowingly and intentionally did it' and so he was transferred. Similarly, in cases of adolescents being involved in improvised explosive device (IED) attacks, they are transferred because 'there is knowledge and intention'.

D.2.8. JUVENILE JUSTICE BOARD (JJB)

EXISTING SERVICES, NEEDS AND CONCERNS

ISSUE	KEY FINDINGS
Juvenile Transfer (2): Procedure for preliminary assessment	Upon inquiry, the JJB stated that they refer adolescents for Section 15 assessments to NEIGRIHMS. There, the Superintendent is asked to form a Medical Board with child specialists, for assessment of mental and physical capacity as per the preliminary assessment requirements under the Juvenile Justice Act. The JJB then records statement of the medical board to understand how they came to conclusions about the child's capacities. The JJB reported that they were heavily reliant on the Social Investigation Reports (SIRs) provided by the DCPO and Observation Home counsellors, and that they had found these reports adequate for understanding the child's circumstances and vulnerabilities. The Board does not make many referrals for treatment of mental health issues and psychosocial care of children in conflict with the law, except in case of substance use—for this, the Board refers children for assistance through the DCPOs and Legal-Cum Probation Officers and/or to the Kripa Foundation Rehabilitation Centre for Children (located in the children's complex in Shillong).

D.2.8. JUVENILE JUSTICE BOARD (JJB)



❖ **Challenges in Preliminary Assessment under Section 15**

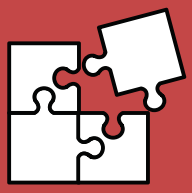
The implementation of Section 15 (juvenile transfer) was discussed, by the JJB magistrate, as a major 'grey area' with many challenges as follows:

- The difficulty of navigating situations wherein the offence was committed a few years ago and the need to assess mental capacity now.
- Whether Section 15 should be considered if the child was 13 years old at the time of commission of offence, but was 17 years old when the incident came to light.
- How different doctors use different psychological tests, and the confusion thereof for the JJB regarding which tests would be appropriate to determine children's capacities.

❖ **Skills needed to work with children in conflict with the law**

Furthermore, the JJB reported that medical and psychiatric personnel did not seem to know 'how to treat' children in conflict with the law—and that this situation was worse in remote districts farther from Shillong. The JJB magistrate also expressed a need for detailed training of all board members, as well as lawyers (through the Bar Association), on working with children in conflict with the law, with special attention to the implementation of Section 15; the need to approach the implementation of the Juvenile Justice Act from a psychosocial perspective, rather than a merely legal one was emphasized. Given that there are not many decisions from higher courts with regard to children in conflict with the law, JJBs do not also have a precedent to guide their work.

D.2.8. JUVENILE JUSTICE BOARD (JJB)



GAPS AND CHALLENGES IN SERVICES

Furthermore, JJBs would benefit if the training focussed on the ways in which the Board could communicate with children, when evidence needs to elicited— 'if a child does not wish to talk or says he does not remember, how much to push and force them to say something?' According to the Board, this is particularly a problem when conversations with the child are being had in the presence of lawyers. This is because a child may have admitted to committing the offence when talking to the counsellor in the Observation Home (given that they feel more reassured and less fearful than in the presence of lawyers), but does not know how to respond when the lawyer is present—since the child has been told by the lawyer not to admit to the offence. This complexity, of mental health and rehabilitation agendas being at odds with the defense lawyers' agendas of assisting the child by making him/her 'innocent', raises another question: that of the relevance of the previous statements of the child as contained in the counselling report, versus what the child then says during the JJB hearing (and whether, then, the counselling reports have any relevance at all).

❖ **Imperative to train police personnel**

The importance of training police personnel on working with this group of vulnerable children was also highlighted—that while police (due to their fear of courts) tend not to be violent towards children, they focus on apprehension, rather than the need for counselling and other assistance to children in conflict with the law. In a recent instance, a young child was apprehended by police for 'playing with medicines in a hospital', also indicating that police do not consider the age of the child at the time of apprehension, almost blindly following the law. Such difficulties also become apparent in children apprehended due to violations in border crossing issues i.e., since Meghalaya shares a long and porous border with Bangladesh, and in many places the two countries are connected by a simple rope bridge, children cross over to enter into the other country (with no knowledge of laws governing border crossings).
Child-centric orientation of judicial personnel

Finally, the Magistrate also raised the concern that other judicial personnel around the country, who interface with children have raised: that the 'mind set to talk to children is different' and consequently, it is hard for a magistrate, who deals with various (adult) civil and criminal matters, to make a 'sudden' and temporary 'switch' while working in the JJB.

D.2.8. JUVENILE JUSTICE BOARD (JJB)

POTENTIAL OPPORTUNITIES

The JJB members, including the magistrates, are major stakeholders, particularly in adolescent mental health. Their decisions with regard to juvenile transfer, referral for mental health and substance use issues, would do much in the way of rehabilitation and behaviour transformation. While, on the one hand, their proactive interventions with regard to this vulnerable group of children in conflict with the law could enable a crime-free society, if children and adolescents received appropriate and timely psychosocial and mental health assistance, other related psychosocial issues such as substance use and teen pregnancy would also be addressed.

That said, the potential of the JJB could be used only if the existing secondary and tertiary health systems could be enabled to be responsive and effective, in terms of providing mental health support to children and adolescents referred by the JJB, both for capacity assessments as well as for treatment and rehabilitation.

D.2.9. SPECIAL COURT (POCSO) JUDGE

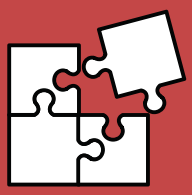
EXISTING PROCESSES AND NEEDS

The Special Courts, statutorily mandated under the POCSO Act, 2012 to conduct judicial proceedings in child sexual abuse cases, marked a significant milestone in the justice system's engagement with an exceedingly complex issue i.e., child sexual abuse. The Special Court, unlike other District and Sessions Courts, is mandated to follow child-friendly procedures while dealing with a child victim-witness. This includes allowing for the presence of a support person in court, prohibiting direct examination by the defence counsel, permitting frequent breaks, and even requiring children to not have to make multiple court appearances. However, as children are developmentally immature, questions of witness competency and testimony credibility can be exceedingly difficult to answer.

As the Special Court Judge noted, in the 262 cases that have come before the court since his posting there, he has framed charges in 100 cases. Therefore, the evidence eliciting process could proceed in these cases. However, despite the framing of charges, the Judge noted that on average, taking the child's evidence requires at least 4 – 5 hours, naturally reducing the number of cases that can be heard on a daily or weekly basis.

From a mental health standpoint, the Judge reported that the jurisdictional Child Welfare Committee is contacted to link the child witness with a counsellor, in the event the child is distressed and requires mental health assistance.

D.2.9. SPECIAL COURT (POCSO) JUDGE

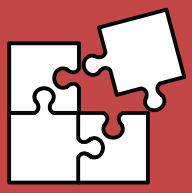


While the Special Courts were statutorily established in accordance with the POCSO Act, 2012, with deliberately distinct procedures to create a child friendly courtroom atmosphere, there are several systemic and case-specific challenges to contend with:

❖ **Competency of Counsellors and Support Persons**

One of the key difficulties discussed was the lack of skilled and competent counsellors and support persons in many cases. An example of this was shared by the Judge, wherein the husband of the superintendent managing the shelter home, appeared as the child's support person. Furthermore, this person claimed to have counselled the child as well. In other instances, where counsellors have provided therapeutic interventions to the child, the Judge

D.2.9. SPECIAL COURT (POCSO) JUDGE



CHALLENGES AND GAPS IN JUDICIAL PROCESSES

also reported counsellors whose qualifications were limited to online courses. These limited qualifications were observed to contribute to lower perceived credibility of the nature of counselling services received by children in POCSO Cases.

❖ **Evaluating Competency and Credibility of Child Witnesses**

Typically, in cases of child witnesses, a common practise is to conduct the 'voir dire' test, which comprise of a set of generic questions about the child and their life, bearing no relation to the facts of the case. The objective of these simple questions is to test the child's ability to understand and respond to questions. However, such an approach does not consider mental health issues of trauma and anxiety, which may not result in cognitive impairment i.e., do not affect the ability to understand and respond to a set of questions. Additionally, the voir dire test does not consider the role of the courtroom environment in the child's proceedings, and its potentially distressing impact on the child.

Additionally, with reference to the role of the counsellor and potential concerns of 'contamination' or suggestibility, the Judge observed that suggestibility, as a risk factor, is fundamentally dependent to the method of questioning (leading vis-à-vis non-leading questions). It does not disentitle a child from receiving critical mental health services.

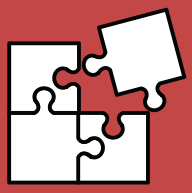
❖ **Safety Risks for child witnesses**

In some cases, even after the child is placed in a shelter home during the pendency of the case, the accused perpetrator (typically someone known to the child), communicates with the child, thereby posing a significant trauma risk to a child who is already traumatised. These instances, particularly when the perpetrator is a relative of the child, are difficult to monitor and put a stop to.

❖ **Challenges with Interim Compensation**

Due to the Scheme Guidelines for provision of victim compensation, one of the challenges highlighted, was the difficulty in assessing the circumstantial and consequential factors, that

D.2.9. SPECIAL COURT (POCSO) JUDGE



CHALLENGES AND GAPS IN JUDICIAL PROCESSES

are the stipulated parameters to decide interim compensation. In this regard, the Judge drew an interesting analogy to his own experiences as a Principal Magistrate of the Juvenile Justice Board, wherein he had access to the children's Social Investigation Reports (SIRs). In terms of securing financial assistance to child victims of sexual abuse, the absence of context-based documentation like the SIRs, contributes to actively lowering the chances of child victims receiving interim compensation.

❖ **Administrative challenges in securing witness' presence during bail hearings**

While child victims are typically required to be present during bail hearings, due to limited time within which the Judge is to pass orders on bail (i.e., typically a week), and the vast distances that children and their families have to travel on many occasions, there are administrative difficulties in notifying them, prompting counsel to forego the requirement altogether.

D.2.9. SPECIAL COURT (POCSO) JUDGE

POTENTIAL OPPORTUNITIES

Evaluating Child's Testimonial Capacity

While there are currently limitations, in terms of access to mental health professionals in POCSO Cases, an area that could benefit greatly from the involvement of mental health professionals is the evaluation of children's testimonial capacity in POCSO Cases. Mental Health Professionals, who currently assist the Court in providing therapeutic services to children, can be provided the requisite training to comprehensively evaluate children's testimonial capacity. Such a comprehensive evaluation will not just assess the child's cognitive capacity, but will also analyse the impact of trauma on the child's ability to provide testimony, and the propensity for secondary traumatisation. In cases where children are unable to provide testimony, legal alternatives can be explored to limit the child's court attendance as well.

Forensically Interviewing the Child Witness

In addition to evaluating the child's capacity for providing evidence, forensic interviewing techniques are also critical to evidence eliciting in many cases. Typically, at the stage of investigation itself, owing to mental distress and trauma, children may be unable to provide a credible police statement, or indeed, a statement to the Magistrate. In such cases, the assistance of a Mental Health Professional, trained in child forensic interviewing, can go a long way towards ensuring that the child is able to provide forensically accurate information. This could prove to be crucial in many cases, given the evidentiary value of the Magistrate statement.

D.2.9. SPECIAL COURT (POCSO) JUDGE

POTENTIAL OPPORTUNITIES

Providing Support in Court

While the POCSO Act contains provisions for the appointment of a support person, to provide pre-trial and trial assistance to the child and their family, this intervention is oftentimes insufficient in addressing children's difficulties with providing evidence in Court. In this context, mental health professionals, trained in providing forensically sound court preparation interventions, will be in a position to adequately assist the child during, and indeed, before the trial as well. These court preparation interventions are critical to addressing challenges regarding the child witnesses' credibility in a non-leading manner.

Facilitating Coordination and Convergence

As the Judge outlined issues in the provision of interim compensation and safety of child victims in many cases, one of the critical interventions, is to facilitate better coordination and convergence. As the Judge mentioned, in one instance, the possession of the SIR, would assist the Court in making decisions regarding the provision of interim compensation. In such cases, the Child Welfare Committee can be provided some basic operating guidelines to assist the Special Court Judges in taking decisions on interim compensation, by facilitating the submission of the SIR to the Special Court in a time-bound manner. This will ensure that Special Court Judges do not have to independently verify the circumstances and consequences of the offence on the child.

Similarly, in the context of the child's safety, regular coordination between the Special Court and the Child Welfare Committee can ensure that the child's placement and bail conditions for the accused are comprehensive enough to secure the child's safety during the trial, and indeed, protect the child from adverse interference from the accused.

D.2.10. INTEGRATED CHILD PROTECTION SERVICES - CHILD WELFARE COMMITTEE (CWC), DISTRICT CHILD PROTECTION OFFICER (DCPO), CHILD CARE INSTITUTION (CCI) STAFF

EXISTING SERVICES AND SYSTEMS

The Child Welfare Committees (CWC) work very closely with District Child Protection Officers (DCPO) (they are also members of the CWC in some districts). It was reported that the CWC receives children from across neighbouring districts and far-flung areas as well. These children come from vulnerable contexts of being orphaned or abandoned, run away kids (typically elopement in cases of girls and runaways in cases of boys). It was reported that children who run away from home, especially boys, eventually get lost and are brought to the CWC as runaway children.

The CWCs consist of a chairperson, 3 members, the DCPO and a support person/counsellor (as required) and are in session along with the DCPU every day. They see over 15-20 cases per month, with up to 6-7 cases a day.

The process followed by the CWC then is to order for a Social Investigation Report (SIR) to understand the circumstances of the child along with deciding the placement of the child. Another immediate step, once the child is presented to the CWC, is to provide the child with counselling services. If required, the child is also referred to the civil hospital- for sexual abuse cases as well as other trauma and violence-related cases. The CWC does not assess the immediate emotional and mental status of the child; it is the counsellor he/she is referred to that conducts an assessment. The assessments conducted by the counsellors are done through proformas that they develop themselves, or the ones provided by the state department (District Health Society).

The CWC identifies and assesses the safety and protection risks from the SIR and the counselling report. The counsellors working with the CWCs majorly assist in POCSO cases where their role is to act as a support person to the child and prepare him/her for court, provide reassurance and support during the trial. The CWCs work very closely with the DCPO as well as the Child Care Institutions (CCI), in the district, on cases before them. There are periodic meetings of the CWC with the counsellors and probation officers of CCIs (every 2-3 weeks,) and special meetings, on an urgent basis, when there is an emergency. The CWCs and DCPOs reported not having received training on child mental health and protection. However, they received a brief of their roles and responsibilities in their orientation sessions.

D.2.10. INTEGRATED CHILD PROTECTION SERVICES - CHILD WELFARE COMMITTEE (CWC), DISTRICT CHILD PROTECTION OFFICER (DCPO), CHILD CARE INSTITUTION (CCI) STAFF

EXISTING SERVICES AND SYSTEMS

Children presented to the CWC, and brought by the DCPO, come from a variety of contexts, as was reported. They are tribal, non-tribal, orphaned, abandoned and sick children, children who have undergone sexual and physical abuse, who have been traumatized and rescued from child labour, violent households and trafficking.

Some of the common concerns that the child welfare committee reported having identified in children were depression, anxiety, violent and aggressive behaviours, withdrawal, refusing to engage or talk to anyone, remaining isolated, self-harm and substance use. They also reported being cognizant of the fact that many traumatised children seem quiet, withdrawn and may not seem to display any explicit signs of distress, but may be at risk of mental health issues. Teenage pregnancy was reported as a recurring concern amongst youth and adolescents in Meghalaya. The highest cases reported were of adolescent girls aged 16 years and above.

The CWCs also engage with the CCI counsellors and the DCPU to work on the rehabilitation plans for children. Their interventions include dividing children in the categories of 11-14 and 15-18 years, and directing the CCIs to develop an individualised care plan for each child, with a focus on preparing children for life outside of the CCI.

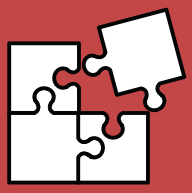
Some of the available vocational training services include baking, pickle-making, craft bags, etc. that they can sell – they are taught the basics of accounting and running a business. They are also taught life skills with regards to communication, skills for everyday living like budgeting, interactions with different members of the community, basics of cooking and cleaning and self-care.

D.2.10. INTEGRATED CHILD PROTECTION SERVICES - CHILD WELFARE COMMITTEE (CWC), DISTRICT CHILD PROTECTION OFFICER (DCPO), CHILD CARE INSTITUTION (CCI) STAFF

EXISTING SERVICES AND SYSTEMS

ISSUE	FINDINGS
Children with Disabilities	With regards to children with disabilities, the CWC reported being unaware of many resources to link children with. There are government homes in certain districts like Shillong where there are special homes for children with disability. However, after COVID, they have been less active. A challenge, in this regard, is also shifting a child with disability to another district for placement in a special home.
Adoption and Foster Care	With regard to adoption, it was reported that most children who are presented to the CWC are children who have lost their mothers. Considering that a majority of the society is matrilineal in nature, many children find themselves abandoned after the death of their mother, as it is common for fathers to then marry elsewhere. However, since it is also a society where community and larger families are prevalent, children are raised by immediate family members or next of kin, informally, without any adoption or kinship care process. In fact, it was reported that adoption is not encouraged. They find it challenging to report a child fit for adoption as the family members do not give approval. Children are therefore institutionalised, and leave the CCIs as adults, in many instances. The DCPO reported that they have worked on only 1 case of foster care in the last 12 years in the East Khasi hills district.
POCSO Cases	It was reported that there has been an increase in the number of POCSO cases that are being reported to the CWC by the DCPO. It was, however, also reported that 30-40% of the POCSO cases are elopement cases, with mutually consenting adolescents who elope being brought back by rescue teams.

D.2.10. INTEGRATED CHILD PROTECTION SERVICES - CHILD WELFARE COMMITTEE (CWC), DISTRICT CHILD PROTECTION OFFICER (DCPO), CHILD CARE INSTITUTION (CCI) STAFF



GAPS AND CHALLENGES IN SERVICES

The CWCs reported facing difficulties in referring children with disabilities to shelter homes or resource agencies for children with disabilities. A need is felt for there to be linkages among the CCIs, CWC and agencies/resource centres where children with disabilities may be screened and early intervention can be facilitated.

It was also reported that in districts such as East Khasi hills, only one member forms the CWC in that district. The DCPO and the Chairperson of the CWC take all decisions and pass orders for children presented to them. This results in a lot of burn out for the CWC members as well as the DCPO. They also reported that due to the increased workload, they are unable to cater to all children in a manner that is efficient, and some aspects of helping the child get compromised.

The CWC and DCPO expressed that being equipped with quick screening tools to assess children for mental health and protection concerns would be beneficial to them. They also expressed the need for capacity building on child sexual abuse, trauma and first level responses for CWCs as well as the DCPO.

D.2.10. INTEGRATED CHILD PROTECTION SERVICES - CHILD WELFARE COMMITTEE (CWC), DISTRICT CHILD PROTECTION OFFICER (DCPO), CHILD CARE INSTITUTION (CCI) STAFF

POTENTIAL OPPORTUNITIES

The potential is tremendous as ICPS functionaries engage most with vulnerable children in the State. Since they most frequently encounter at risk children (and provide a safety net), there is an opportunity to provide mental health and family interventions i.e., to address the risk factors that made these children vulnerable in the first place. These interventions could range from first level responses to life skills training, trauma-focused mental health interventions, behavioural therapy, parental psychoeducation amongst others. It is imperative for these functionaries to assume a pivotal role as ICPS services are fulcrum of the JJ Act, and the very vehicle of the implementation of the JJ Act. Every function of the JJ Act is routed through CP functionaries (i.e., functions relating to care, protection, rehabilitation). Therefore, training would have to be provided, along these lines, for these key ICPS functionaries.

Additionally, strengthening of linkages between the CCIs, CWC and the District Resource Centres (DRC) located in district hospitals, is required. Children with disabilities can be referred there through CCI counsellors and the CWC for further assessments and interventions to assist the child. The DRC can also conduct periodic visits to the CCIs of their districts for screening as well as interventions for children with disabilities within the institution.

The staffing and recruitment of CWC members is also required to be regulated in a manner that ensures there is no understaffing within the committees.

D.2.11. SCHOOLS

EXISTING SITUATIONS AND SERVICES

Schools that were visited during the SAMVAD Team's visit were of 4 categories: Government school, Government aided school, Ad-hoc school and a private school. All schools in the city area have children who come from both urban as well as rural contexts. The majority, however, are from the neighbouring urban areas. Most schools have children from the nursery level to the 12th standard.

The most common concerns reported by the schools were children having anxiety, depressive tendencies and conduct issues. Especially after the COVID pandemic, teachers across all schools reported that they observed a lot of adjustment related concerns in children. During the lockdown, considering the difficult terrain and network issues, coupled with financial constraints and lack of resources for online learning, all teachers reported that children could not access education during this time. This led to many different concerns regarding their mental health and education.

With regard to their education, children who did have access to a stable internet connection and a smartphone or laptop, found it difficult to adjust to this new method of learning. Teachers across schools also reported that they found themselves grappling for ways to engage children online through interesting methodologies. There was a serious gap in learning, which was very evident to them after schools re-opened. They reported that along with not having gained a lot of new knowledge, children had also forgotten what they had learnt before the pandemic. They have had to now revise and make the curriculum easier and more adaptable for children so they can re-learn these skills.

Teachers across all schools also reported that children displayed a variety of mental health and behavioural concerns after schools reopened. They reported that children found it very difficult to adjust to long learning hours in schools, behaviours that were expected from them in a school setting, as well as conduct issues. There was a heavy impact of online education on their attention span as well. Children also displayed signs of anxiety, depression and stress. All schools also reported that there is a serious issue of substance use and abuse among young children and adolescents. Use of tobacco in different forms and marijuana is prevalent in children as well as adolescents. It was also reported that some children come from contexts of domestic violence and physical abuse.

D.2.11. SCHOOLS

EXISTING SITUATIONS AND SERVICES

Upon enquiry on the different interventions that schools use to assist such children, they reported that they do intervene with the family, to discuss how the issue is impacting the child. However, this is not done in all schools. The government school, specifically, reported that they do not intervene in these matters with the family, as it is a personal matter, but do speak to the child and offer a space to hear them out. In other schools, it was reported that the school counsellor takes up these cases. Most schools do not have a counsellor, and the ones that do are faith-based schools, which derive their interventions with children through prayer and the religious books.

Some private schools have counsellors that are responsible for conducting not just in-person therapy, but also awareness workshops on the different issues that children experience. The awareness programs are conducted on issues of substance use, sexual decision-making (where they preach abstinence), positive mental health, etc.

D.2.11. SCHOOLS

EXISTING SITUATIONS AND SERVICES

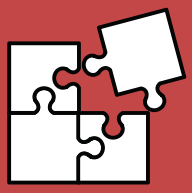
ISSUE	KEY FINDINGS
Child Labour and School Dropouts	Considering that schools have children from all socio-economic backgrounds and contexts, most children from lower socio-economic backgrounds were reported to have dropped out of school (especially during the COVID lockdown). Many children who dropped out were also children who were engaged in different forms of child labour. Most common vocations of such children, as reported by the school staff, were assisting in a dhaba, pan shop, mining (in districts where mining takes place) and agriculture. A private school reported that adolescent girls dropped out of school after the lockdown lifted and got married. They stated that the reasons were financial, as well as 'love affairs' that led to early marriage. They stated that the school found it very difficult to intervene to stop these marriages from happening.
Child Sexual Abuse	With regards to child sexual abuse, all schools were aware of the POCSO Act, but only one school (that ran by international standards) had a safety and protection policy in their school. Most schools reported that they are aware that a law exists and that it is called the POCSO Act. They are also aware that there is a provision for mandatory reporting in this law. However, they stated that there was a lack of knowledge or understanding of child sexual abuse: its identification, responses to provide to children who report or in the operationalising of the law in the context of schools. Some schools that have counsellors, however, reported that they do take some sessions of awareness on "good touch and bad touch", with the children (class 5 onwards), but it is not done in depth. The syllabus in these schools covers sex education for children in the 9th grade under the topic of "Health Education".

D.2.11. SCHOOLS

EXISTING SITUATIONS AND SERVICES

ISSUE	KEY FINDINGS
Children with Disabilities	With regard to children with disabilities, most schools reported that they do not have the level of information on this area required for early detection of disabilities, especially those that cannot be explicitly noticed. Schools that do have cases of moderate intellectual disability, refer the children to organisations that work with children with disabilities like Bethany Society and Mary Rice. Some schools admit children with certain locomotor disabilities, but there is a paucity of inclusive education services within the schools.
School Management Committees	The schools do have management committees, which convene 4-5 times a year to discuss managerial and administrative concerns. They do have parent representation, but do not have child participation. It comprises teachers, board members of the school, the principal and parent representatives.

D.2.11. SCHOOLS



GAPS AND CHALLENGES IN SERVICES

Mental health issues	Child Protection Concerns

❖ **Mental health issues**

As was reported by teachers themselves and also observed by the SAMVAD team, there is limited understanding amongst teachers in schools of mental health issues in children. Further, the paucity of trained counsellors within schools is an added factor in children's mental health and well-being not being addressed adequately. As reported by the Education department of the state, some schools have adapted by appointing certain teachers to play the role of an interim counsellor. This addresses the concern to a limited degree, considering that child mental health-related training is important for efficient support to children.

❖ **Child Protection concerns**

A gap in the knowledge of the POCSO Act, its implementation and a general understanding of child sexual abuse dynamics and responses, has been observed and reported by all schools during the interviews.

D.2.11. SCHOOLS

POTENTIAL OPPORTUNITIES

In a country where school counsellors are more the exception than the norm, teachers, given their intensive daily interactions with children, are critical frontline workers in the area of child mental health and protection. Therefore, although it is acknowledged that they carry the burden of teaching and syllabus completion, they are the best positioned service providers for identifying vulnerability and risk in children, providing first level responses, and ensuring they are linked with the relevant mental health and protection services.

In this regard, capacity-building programs are necessary for key child-related stakeholders, including teachers and school counsellors, to orient these stakeholders on issues related to child mental health, child developmental disorders, and psychosocial well-being. Additionally, training efforts can also focus on orienting teachers and school staff on the POCSO Act, to facilitate the operationalization of their roles and responsibilities under the Act, through training, as well as assisting them in drafting a child safety and protection policy for their schools.

Linkages between the District Mental Health Program (DMHP), District Early Intervention Centre (DEIC) and the District Resource Centre (DRC) are crucial, especially with regards to children with disabilities to enable them to get the assistance and stimulation they require.

D.2.12. EXECUTIVE OFFICERS OF THE DISTRICT COUNCILS

EXISTING SERVICES AND SYSTEMS

As the Executive Officers from the Autonomous District Councils of Jaintia Hills and Khasi Hills discussed, the orientation and functions of the District Councils are limited in terms of their relationship with the jurisdictional Village Heads. Typically, the District Councils are meant to serve as an appointing authority for village heads, but do not perform active supervisory functions over the respective heads.

Additionally, even where District Councils are in receipt of issues requiring assistance or referral, their task is typically limited to coordination with respective State Departments, or other concerned child-related stakeholders, such ASHA workers, CHC/PHC staff. One of the issues highlighted in this regard, is with reference to teenage pregnancies, wherein the ASHA workers are typically contacted.

It was also discussed, however, that the village headmen play a much more active role in the community, therefore requiring policy interventions to be focused more closely on the role of these heads in improving the quality-of-service delivery at the community level.

D.2.12. EXECUTIVE OFFICERS OF THE DISTRICT COUNCILS

POTENTIAL FOR REFORM

Keeping in mind the District Council's limited functions and engagement with the Village Heads, an area that could benefit from assistance, would be orientation programs for District Council members, on the different authorities and bodies responsible for assisting children in various contexts. Such an orientation may improve the referrals made by the District Council and improve overall coordination as well. This will not require detailed capacity-building programs, but rather specific orientations to improve the quality of coordination, particularly in challenging cases. An example of such cases would include teenage pregnancies, wherein the referral process would necessarily have to extend beyond the ASHA worker, keeping in mind the POCSO implications as well.

FINDINGS AND ANALYSIS

D.3. TERTIARY LEVEL

- Meghalaya Institute of Mental Health and Neurosciences (MIMHANS)
- North Eastern Indira Gandhi Regional Institute of Medical Sciences (NEIGRIHMS)

D.3.1. MEGHALAYA INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES (MIMHANS)

EXISTING SERVICES AND NEEDS

SAMVAD interviewed the MIMHANS team and the DMHP team of East Khasi Hills, stationed at MIMHANS. The following duty-bearers were interviewed in a group – Clinical Psychologist, Community Nurse, Psychiatric Social Workers, Psychiatrist, Additional Superintendent (MIMHANS), Nursing Staff, Social Officer, DMHP Nodal Officer, and Psychiatric Social Worker, DMHP.

The MIMHANS team first gave an overview of the profile of the patients usually seen at MIMHANS. For instance, in the month of April, they had seen about 39 patients out of which 31 were male and 8 were female. They have also seen 13 cases of child sexual abuse in the last one year and 2 cases of teenage pregnancy. There are no dedicated services for children and adolescents in the hospital currently. Children and adolescents are admitted in the women's ward with an attender, if admission is required. They see 50 cases per day, on an average, and about 1000 cases per month. Out of the 1000 cases per month, they see about 4-5 children. Upon inquiry by the SAMVAD Team regarding the low number of cases relating to children, they shared that many children also go to SAN-KER, Children's Hospital and NEIGRIHMS.

The children who come to MIMHANS typically access the Hospital's services for issues like conversion disorder, distress due to difficult family circumstances, adjustment disorder and attention-related issues.

They also see children with disabilities, who are usually referred to Bethany society (a non-profit organisation catering to children with disabilities), following an assessment. They reported that they do not have specialised and trained staff to deal with the issues of children with disabilities. Furthermore, the staff reported entrenched stigma surrounding disability, that contributes to unwillingness within families, with respect to acknowledging disability, and consequently, a delay in accessing disability-related support services. In addition to delays in accessing disability services, parents also drop out as they do not wish for their children to be labelled. Disabilities like intellectual disability may get identified more easily, but there is very little awareness about 'hidden' disabilities like learning disorders, autism, and ADHD, further contributing to their invisibility.

D.3.1. MEGHALAYA INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES (MIMHANS)

EXISTING SERVICES AND NEEDS

The MIMHANS team shared that they wish to expand their work and provide more services for persons with disability, and that they have also submitted a proposal for day care to the District Health Society, for people with disability, but they have not received a response to their proposal yet. It was also suggested that mental health professionals from MIMHANS can come to NIMHANS, Bengaluru, for a 3-month/ 6-month fellowship. The MIMHANS team also shared their concerns about having to attend 150 in-patients and about 1000 out-patients on a monthly basis with a small team, which significantly hinders effective provision of specialised disability services.

While identification and treatment of child mental health disorders takes place through the use of clinical and standardised psychological assessments, there seems to be a lack of skill and understanding in providing treatment and interventions in the context of psychosocial concerns. The team reported that they do not make use of assessment methods, including proformas to systematically evaluate and understand children's protection/mental health issues and psychosocial concerns. Consequently, they focus on clinical assessments, which typically exclude critical information on the psychosocial context, and in turn result in ineffective interventions. The staff indicated that they have not been asked by the JJB to carry out any preliminary assessments thus far, which also indicates insufficient integration of child protection and mental health services. In this regard, it was reported that the team only conducts IQ assessments, if requests for preliminary assessment are received by MIMHANS.

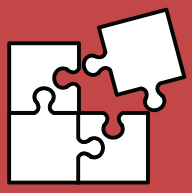
This is an area of concern as preliminary assessments must provide information about the child's physical capacity (i.e., presence of any disability); mental capacity, with specific reference to the ability to make social decisions and judgements (any life skills deficits, experiences of trauma/ abuse/ neglect, substance abuse problems etc.); in addition to the details of the circumstances of the offence; and finally, the child's understanding of the legal and interpersonal consequences of his/ her actions.

D.3.1. MEGHALAYA INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES (MIMHANS)

EXISTING SERVICES AND SYSTEMS

ISSUES	KEY FINDINGS
Substance Abuse Issues	In the last one month, they had also seen 8 cases of substance abuse – those who come are first assessed in the Out-Patient Department, and the history of the patient is recorded using a proforma. After the initial detoxification, the patients are called for a weekly follow-up. There are no de-addiction services, with some clients being sent to private rehabilitation centres like SAN-KER, where the adolescents and their parents are counselled. When asked about what usually happens in these centres, they said that the de-addiction/ rehabilitation centres follow a 12-step model. There are about six to seven such rehabilitation centres in Meghalaya. However, the details of these centres were not available with MIMHANS.
Child Sexual Abuse	Child Sexual Abuse cases are brought by the police or by CHILDLINE for the assessment of the mental state of the child. The doctor makes the diagnosis and sends the child back to the Child Welfare Committee. They also reported that, through their work with children who have experienced CSA, they have noticed that there are often signs of Post-Traumatic Stress Disorder (PTSD).

D.3.1. MEGHALAYA INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES (MIMHANS)



GAPS AND CHALLENGES IN SERVICES

- Lack of human resources
- Lack of specialized child psychiatry services
- Lack of knowledge and training on child mental health and protection issues
- Disconnect with child protection services
- Lack of standard assessment protocols
- Lack of knowledge on systematic therapeutic interventions

The MIMHANS team highlighted that the shortages in human resources was their biggest challenge and often the biggest hindrance in providing effective services. There is currently no specialized Child Psychiatry Department at MIMHANS. The medical doctors are not trained in child psychiatry, and furthermore, due to the lack of mental health professionals, they have been trained, in a 10-day course on community mental health, from Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Assam. The focus of work is largely on mental health treatment without adequately addressing the contexts which places these children at risk.

Additionally, it was observed that the MIMHANS staff is not sufficiently oriented to preventive and promotive child and adolescent mental health care. Consequently, they are unable to make the linkages between child mental health and protection issues. There were also gaps in knowledge about the provisions related to various laws for children (such as the POCSO and JJ Act). Additionally, it was observed that there was uncertainty amongst staff, with regard to their role in carrying out preliminary assessments, under Section -15 of the Juvenile Justice Act, 2015. The lack of any standard assessment protocols and therapeutic interventions was also identified as a challenge in providing support.

D.3.2. NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH & MEDICAL SCIENCES (NEIGRIHMS)

EXISTING SERVICES AND NEEDS

NEIGRIHMS was the first postgraduate medical college set up in the North-East Region. It was established in 1987 and was sought to be developed like the All-India Institute of Medical Sciences or PGIMER, Chandigarh. The SAMVAD team visited NEIGRIHMS and interviewed the team from the Department of Psychiatry.

The Department of Psychiatry, at NEIGRIHMS, was established in 2010, and since 2013 has been functioning as an independent Department. Currently their team comprises 1 Associate Professor, 2 Senior Residents, 1 Clinical Psychologist and 1 Junior Resident. While the Department does not have an inpatient facility, the faculty reported that they have already submitted a proposal for a 30-bedded inpatient ward, and are expecting to get the approvals and initiate work for the same by the end of this year.

The NEIGRIHMS outpatient facility runs every day. They see about 25 patients on an average per day, and out of these cases, about 4-5 patients are children. The patients that come to the Outpatient Department are referred to the Psychiatry Department by Paediatrics, Neurology, ENT and other Departments (in addition to Medico Legal Cases as well). About 37% of the cases are reported to the Department of Psychiatry itself. In terms of institutional capacity, the Department has a De-addiction Clinic, a Child Guidance Clinic, and provides Community Mental Health Services as well.

The kind of cases that are dealt with by the Department range from dissociative disorder, Intellectual Disability, Autism, ADHD, Substance Abuse, Depression, Developmental Delays, Neurosis and Seizures. The staff reported that, in their experience, they have seen more male patients with developmental disorders and ‘temperamental issues’. However, they reported seeing more psychiatric issues in female patients. Based on their own analysis, with respect to children, they also shared that most boys come for assistance at a younger age and most girls come for assistance much later during their adolescent years.

D.3.2. NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH & MEDICAL SCIENCES (NEIGRIHMS)

EXISTING SERVICES AND SYSTEMS

In further discussions, when asked about the kind of therapeutic interventions used with children, the psychologist mentioned that they did pharmacological and non-pharmacological interventions. The psychologist also reported using applied behaviour analysis, behavioural therapy with reinforcement, and also worked with parents as co-therapists in the therapeutic work.

From the point of access, once a patient comes to the hospital, an assessment proforma that has been developed by the team is implemented. Interviews are also carried out with the patients to find out about the causes or reasons for psychological distress. It was mentioned that, typically, distress is experienced due to family-related issues, peer relationships and conflicts, marital discord, difficulties due to single mother-led families, gender and sexuality issues.

One of the concerns that the team raised was the stigma within the community and parents on disability. Disability certification is not usually encouraged. Additionally, all of the cases are then referred to the Civil Hospital in Shillong. As a result, given the distance and the long queues at the hospital, most people do not go ahead with the certification process. The ASHA worker usually identifies children and refers them for assessment of disability to NEIGRIHMS. Other referrals are made by the RBSK Mobile Teams.

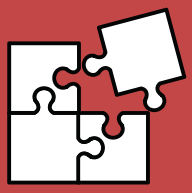
Currently the Department does not engage at any community level. However, if they are called as resource persons for awareness programs by schools, government departments or by religious institutions, they visit and engage with children.

D.3.2. NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH & MEDICAL SCIENCES (NEIGRIHMS)

EXISTING SERVICES AND SYSTEMS

ISSUES	KEY FINDINGS
Teenage Pregnancies & Child Sexual Abuse	The team reported that they have not dealt with cases of teenage pregnancy. Even in cases of child sexual abuse, only if considered necessary, the child is sent to the psychiatry department. Otherwise, the case is handled by the Paediatrics Department in coordination with the relevant child-related functionaries under the Social Welfare Department. While the mandatory reporting processes are handled by the Medical Social Worker, CSA cases typically come through the police or CHILDLINE, after completion of the reporting process. Therefore, the hospital is not involved in the reporting process. In medico legal cases, children are usually sent for assessments of intellectual capacity or for medical check-ups. These assessments are requested by the CWC and JJB, in cases of sexually abused children, and in cases of children in conflict with the law. In terms of frequency, the staff mentioned that these cases are referred only once or twice in a year.

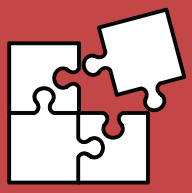
D.3.2. NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH & MEDICAL SCIENCES (NEIGRIHMS)



GAPS AND CHALLENGES IN SERVICES

Lack of knowledge on child protection issues especially in context of child sexual abuse and children in conflict with the law.	Lack of standardised screening and assessment protocols
Lack of knowledge about systematic therapeutic interventions.	Poor coordination and linkages with other mental health systems
Poor coordination and linkages with other mental health systems	Lack of clarity about their role in supporting child protection systems

D.3.2. NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF MEDICAL SCIENCES (NEIGRIMS)



GAPS AND CHALLENGES IN SERVICES

A major challenge shared by the stakeholders was the lack of human resources in the Department of Psychiatry at NEIGRIHMS. The SAMVAD team observed that there was a lack of knowledge and training on issues of child protection- especially in context of child sexual abuse and children in conflict with the law. The role of mental health professionals, in institutions like NEIGRIHMS, play a very important role in assisting the juvenile justice system with preliminary assessments. This is significant keeping in mind that the preliminary assessments, received from mental health professionals, form the basis of transfer of a child in conflict with the law from the juvenile justice system to the adult criminal justice system. This kind of assessment cannot be restricted to the testing of intellectual levels of the child, but needs to be more comprehensive – taking into account the psychosocial factors, vulnerabilities and the child's pathways to the offence.

It was shared that the team finds it hard to manage the cases of CSA, due to the issues of mandatory reporting, as most often, the families are known to them and the families plead with staff members to not proceed with reporting processes. Significantly, there is also a lack of knowledge and skills to carry out trauma-focussed therapeutic work in cases of CSA. The primary focus of all interventions, in this regard, is the cognitive and behavioural work with the victims. Therefore, it is imperative that mental health professionals extend their role to providing information about the law, and preparing the child for legal processes, considering that the uncertainty and fear about these processes also become a source of fear and anxiety in the victims.

There is no specialized Child Psychiatry Department in NEIGRIHMS. While identification and treatment of child mental health disorders takes place in tertiary facilities, through use of clinical and standardized psychological assessments, there appears to be gaps in knowledge and skills required for treatment and intervention in various types of child mental health issues.

D.3.2. NEIGRIMS & MIMHANS

POTENTIAL OPPORTUNITIES FOR MIMHANS & NEIGRIHMS

MIMHANS and NEIGRIHMS are practically the only two specialized tertiary mental healthcare services available in the state. It is therefore critical to equip them with skills and capacities in child and adolescent mental health. Broadly, this would entail: (a) stronger conceptual understanding of child and adolescent mental health issues from a clinical as well as a public health perspective; (b) intensive skill training in therapeutic interventions for various child and adolescent disorders; (c) specialized skills in child forensic work, namely in dealing with child sexual abuse and children in conflict with law cases i.e., the interface of mental health with child law issues, and the role of the mental health professional in facilitating assistance to children in medico-legal contexts. These tertiary care institutions may avail of training opportunities at the Dept. of Child & Adolescent Psychiatry, NIMHANS, which offers various fellowships/internships to enable mental health professionals ranging from 1 month to 6 months; the MIMHANS/NEIGRAMS team may also attend SAMVAD's specialized child forensic training programs.

However, the capacity enhancement initiative and the scaling up of child and adolescent mental health work in these institutions relates considerably to human resources. Coordination with the DHS to ensure adequate human resources and infrastructure would be critical for the development of child and adolescent mental health services in the state.

FINDINGS AND ANALYSIS

D.4. ADMINISTRATIVE STAKEHOLDERS

- Department of Education
- Department of Social Welfare
- State Commissioner for Persons with Disabilities & UDID Resource Persons
- State Mental Health Authority (SMHA)

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA

EXISTING SERVICES AND SYSTEMS

The Department of Education, Government of Meghalaya, operates through 3 Directorates i.e., the Directorate of Higher and Technical Education (DHTE), Directorate of School Education and Literacy (DSEL) and the Directorate of Education and Research Training (DERT). In the context of children and adolescents, the DSEL is critical in improving access to school education at the neighbourhood level, in accordance with the Right to Free and Compulsory Education Act, 2012 (RTE). Therefore, the DSEL is mandated to address educational needs of children across 12 years of schooling (10+2). In addition to ensuring the establishment of neighbourhood schools, the DSEL is also responsible for identifying Out-of-School Children (OoSC) and enrolling such children in schools through the nodal district and block officials. Other critical responsibilities, especially during COVID, have included monitoring learning outcomes in children (fundamental numeracy and literacy); monitoring curriculum development (with special focus on integrating inclusive education in government-owned and aided schools; addressing in-service capacitation needs of school teachers; and development of a framework for the involvement of parents and communities in the management of schools.

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA

EXISTING SERVICES AND SYSTEMS

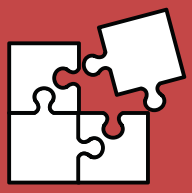
THEMES	KEY FINDINGS
Linkages for the provision of Mental Health Services	The primary mechanism for implementation of the RTE requirements is the Samagra Shiksha Abhiyan Scheme (which now consolidates the erstwhile Sarva Shiksha Abhiyan, Rashtriya Madhyamik Shiksha Abhiyan & Teacher Education Schemes). In the context of mental health and disability services in schools, it was highlighted that the DSEL currently works in convergence, with the Department of Health & Family Welfare, to facilitate implementation of the School Health and Wellness Program, under the aegis of the Ayushman Bharat Scheme. Specific areas of focus include health promotion activities, screening services through the RBSK mobile health teams, and provision of critical health services (like vaccination and menstrual kits). Health promotion activities include age-appropriate health education activities, through teachers (serving as health and wellness ambassadors) on personal safety (for primary school levels), bullying prevention, internet safety and media literacy, substance abuse, mental health awareness, sexual and reproductive health and violence prevention.
Teacher Education	With respect to existing capacity-building programs for teachers, training programs for teachers, are conducted based on teaching materials developed by NCERT. The most significant programs currently are the trainings conducted through the NCERT's National Initiative for School Heads' and Teachers' Holistic Advancement (NISHTHA). Focusing on the elementary and secondary level respectively, NISHTHA 1.0 (Classes I-VIII) and NISHTHA 2.0 (Classes VIII-XIV) cover key aspects of school mental health and wellness. Training programs are currently facilitated with key components on the provision of counselling services. With respect to protection and safety concerns in schools, teachers and school administrators are also specifically provided training on the Protection of Children from Sexual Offences Act, 2012 (POCSO), particularly with respect to legal requirements on mandatory reporting of sexual abuse, screening procedures for schools (incl. police verification of school staff).

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA

EXISTING SERVICES AND SYSTEMS

THEMES	KEY FINDINGS
Children with Disability	The DSEL currently works closely with the State Resource Centre on Disability Affairs to provide linkages between schools and Block/District Resource Centres for identification, assessment and referral services for children with different kinds of disabilities including developmental disabilities and multiple disabilities. The DSEL also collaborates on a school readiness program through Block Resource Centres (BRCs) for children with disabilities. As a part of this program, home visits are conducted by the BRCs, in addition to the assignment of special educators for children with 'high support needs', as defined under the Rights of Persons with Disabilities Act, 2016 (RPWD Act). Furthermore, there are also school remedial programs conducted through BRCs to address the additional learning needs of children with disabilities, particularly for those children with high learning deficits. Additionally, on a case-to-case basis, schools receive support from the BRCs as well.

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA



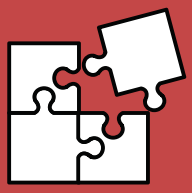
GAPS AND CHALLENGES IN SERVICES

- Common Vulnerabilities in School-Age Children
- Protection, Safety and Life Skills Deficits
- Issues related to Children with Disability
- Challenges faced by schools in providing counselling interventions
- Teacher Training and Capacity-Building

❖ Common Vulnerabilities in School-Age Children

Keeping in mind the common issues reported from schools across the State, it was highlighted that children come from different contexts of vulnerability resulting in truancy and drop-outs, particularly in cases of teenage pregnancies, children with learning difficulties, and children with substance use issues. Additionally, as is commonly reported across schools, there are issues of bullying, isolation, emotional dysregulation and displacement of anger amongst students. There are also issues of inclusion in schools with socio-economic disparities amongst students, wherein financial status is observed to act as a mechanism of exclusion.

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA



GAPS AND CHALLENGES IN SERVICES

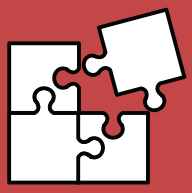
In the context of children with learning difficulties, children from lower socio-economic backgrounds typically have lesser opportunities for growth and stimulation at home. Parents of these children are usually engaged in low-remuneration wage labour, with little time to devote to supporting their children's education needs. As a result, despite possessing average developmental abilities, children from these contexts contend with learning difficulties. Additionally, with specific reference to learning issues, Department officials noted, significantly, that many children are first generational learners. It was also reported that many children come from difficult family contexts, particularly in the case of single mothers and mixed families (including the presence of a step-parent), wherein attachment issues and neglect result in low opportunities for growth and stimulation, further contributing to poor academic performance.

As a consequence of these difficult family circumstances, children also develop challenging behaviours, creating issues in the school space. The influence of social media is reported as an aggravating factor in children with challenging behaviours. Substance Abuse is also a commonly reported issue amongst children from difficult family contexts and circumstances. It was reiterated that there are linkages between different issues, with substance abuse and other behavioural challenges contributing to children's involvement in petty crimes.

❖ Protection, Safety and Life Skills Deficits

With respect to protection and safety concerns in schools, department officials reiterated that cases of child abuse (including sexual abuse) are typically considered family matters, thereby resulting in a refusal to discuss these issues with teachers and school staff. As one official recalled, "we see everyday cases of child rape and abuse, but it is still a taboo in the classroom". In addition, as teenage pregnancies have been identified as a significant concern and a drop-out risk for adolescent girls, there is also a dearth of sufficient engagement, with adolescents, on the centrality of life skills in the context of intimate relationships and sexual decision-making. While the school health program provides a valuable opportunity to engage with children and adolescents on key issues related to their socio-emotional well-being, life skills interventions typically require reiteration and recurrence to be effective and impactful.

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA



GAPS AND CHALLENGES IN SERVICES

Most significantly, perhaps, is the imperative for a state-wide child safeguarding/protection policy for schools. While the training programs, as outlined above, provide a deeply important capacity-building intervention on protection responses such as screening and reporting, the codification and standardisation of these protection mechanisms is currently absent in schools.

❖ Children with Disability

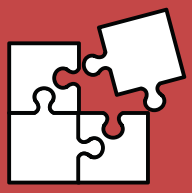
With reference to children with Specific Learning Disability (SLD), it was reported that teachers currently do not possess the requisite skills to assess the extent of learning challenges. While the more severe cases are more visible, and typically, referred to the nearest District Resource Centre, cases that are less evident are not identified or assessed, and furthermore, stigmatized.

Department Officials reported that there is also an imperative to facilitate training for teachers on inclusive education approaches, in terms of curriculum design, delivery and management of the classroom, as there continues to be a lack of capacitation in terms of properly identifying and making reasonable accommodations for children with disability. In this context, it was reported that few teachers and school officials have the requisite qualifications and skills required to facilitate special education services for children with disability. A relevant statistic reported, in this regard, was that there are only 15 Special Educators in Meghalaya, at the moment.

❖ Challenges faced by schools in providing counselling interventions

As discussed previously, substance abuse has been identified as an important concern in schools. Yet, due to a lack of capacitated professionals at the school level with respect to counselling services, these services are typically not accessible across primary, secondary and higher secondary school levels. Subject-specific teaching staff, who typically deal with emotional and behavioural challenges in students, do not have the requisite capacity to address such challenges at the school level.

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA



GAPS AND CHALLENGES IN SERVICES

While some private schools are reported to have dedicated counselling services in schools, government schools do not have the requisite manpower or financial capacity to appoint separate counsellors for this purpose.

Additionally, while some teachers are trained as guidance counsellors through key institutions like the North East Regional Institute of Education (NERIE), and are skilled in the provision of basic counselling services to students, additional academic and administrative duties act as barriers and restrict the time available for teachers to engage in the provision of counselling services.

- **Teacher Training and Capacity-Building**

One of the reported challenges faced by school teachers also related to identifying and understanding children's learning difficulties, particularly in light of the fact that learning difficulties can result from multiple factors in the child's environment. It was also reported that challenges in identifying the causes behind learning difficulties in school, inevitably lead to children dropping out of school as well.

Furthermore, with reference to access to teacher training facilities, on average, it was reported that only 2 teachers from Meghalaya are able to secure admission in NERIE. In this regard, the Directorate of School Education and Literacy has recommended to the State Government that further efforts are required to train teachers as counsellors, particularly to facilitate the provision of basic mental health services in schools.

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA

POTENTIAL OPPORTUNITIES

Children with Disability

The State Resource Centre on Disability Affairs is currently one of best practises adopted in the State of Meghalaya with respect to children with disabilities, given its centrality in decentralising services to assist children with disabilities. While the State Resource Centre (and its sub-divisions) was established in 2000 to implement the National Programme for the Implementation of Rehabilitation for Persons with Disability (NPRPWD), it has been continued by the Government of Meghalaya even under the RPWD, 2016 framework.

The Education Department, particularly through Samagra Shiksha Abhiyan (SSA), converges efforts with the Department of Health & Family Welfare, to identify and assess children with disabilities in schools. This is facilitated through coordination with the State Resource Centre on Disability Affairs, with individual cases referred to the District Resource Centres by School authorities. Upon identification and assessment, children with disability are legally assisted in availing benefits under the Rights of Persons with Disability Act and relevant schemes, through the Department of Social Welfare as well. The State Resource Centre, along with the District and Block Resource Centres are an effective institutional apparatus in terms of providing assessment, referral and intervention services for children, and can be strengthened further to facilitate closer linkages with the RBSK and SSA for better implementation.

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA

POTENTIAL OPPORTUNITIES

First level Mental Health Interventions in School

While one of the Department Officials, who is a member of an SDMC, reported securing funds through the SDMC to appoint a separate teacher as a counsellor, there are currently financial constraints that restrict the feasibility of government schools attempts to appoint separate teacher counsellors. However, this approach provides an opportunity to examine the current challenges faced by teacher counsellors, and possible ways of addressing the same. In this regard, given the significant workload of subject teachers (engaged in academic and administrative work), separate posts for trained teacher counsellors could help provide the required mental health assistance in schools.

Teaching and Capacity Building

Keeping in mind the linkages between schools, RBSK Mobile Teams, and District Resource Centres across the state, school teachers may be capacitated in identifying potential cases of children with disabilities for assessment and referral. Through these training initiatives, teachers may also be provided information, on the requisite nodal officers, for assisting parents and families in securing benefits under the various legal entitlements for children with disabilities. In addition to reducing stigmatisation of children with disabilities, an understanding of children's learning needs will also assist teachers and educational administrators in preparation of inclusive curriculums, and management of students with different learning capacities in classrooms.

D.4.1. DEPARTMENT OF EDUCATION, GOVERNMENT OF MEGHALAYA

POTENTIAL OPPORTUNITIES

[redacted]

Protection and Safety of Children in Schools

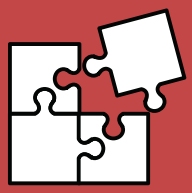
While there are challenges in identifying protection risks and facilitating reporting processes in cases of abuse like child physical or sexual abuse, consolidation of clear policy guidelines can help provide a standardised roadmap for all schools to follow, thereby reducing discretionary measures for child protection and safety at the school level. A clear child protection policy, in this regard, will also be implementable, seeing as teachers are already trained on basic reporting processes (such as mandatory reporting under the POCSO Act). Similarly, the presence of screening processes, for staff recruitments in schools, will enable such a policy to consolidate practises that are already in existence, while introducing other critical internal protection measures for schools, and boosting the overall effectiveness of school safety and protection mechanisms.

D.4.2. DEPARTMENT OF SOCIAL WELFARE

EXISTING SERVICES AND SYSTEMS

THEME	KEY FINDINGS
Departmental Schemes	The Department of Social Welfare, Government of Meghalaya, is the nodal department with respect to child and adolescent concerns. The scope of the Department's functions, with reference to children, relate broadly to the key care, protection, and development schemes under the Ministry of Women and Child Development, Government of India and disability-related schemes and programs under the Ministry of Social Justice and Empowerment, Government of India. The key care, protection and development schemes include the Integrated Child Protection Scheme (ICPS), Integrated Child Development Scheme (ICDS), National Creches Scheme and One Stop Centre Scheme (OSC).
Capacity-building, awareness generation and other initiatives	In addition to the Department's functions under these critical schemes, a major part of the Department's work includes awareness generation, capacity building, treatment and rehabilitation services under the National Action Plan for Drug Demand Reduction (NAPDDR), which also covers children and adolescents affected by substance abuse. With regard to initiatives for children with disability, it was reported that the scholarship awards, vocational training facilities, and benefits under the Rights of Persons with Disabilities Act, 2016 (book grants, uniform grants, conveyance allowance etc.) are some of the key department initiatives.

D.4.2. DEPARTMENT OF SOCIAL WELFARE



GAPS AND CHALLENGES IN SERVICES

Teenage Pregnancies and Child Sexual Abuse under POCSO

Skills and Capacities of Counsellors in cases of Children in contact with the law

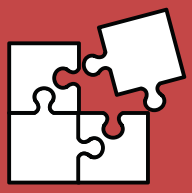
Issues in convergence efforts with other Departments in the State

❖ **Teenage Pregnancies and Child Sexual Abuse under POCSO**

One of the state-wide priorities identified by the Department is the issue of teenage pregnancies and co-habitation, which in some cases leads to early marriages as well. Teenage pregnancies and early marriage were also discussed as factors likely to result in the dissolution of the relationship. As was discussed previously, a significant number of reported child sexual abuse cases include the stepfather as a perpetrator, in cases of mixed family arrangements. In light of this background, the State Child Protection Society, Department of Social Welfare in collaboration with the Centre for Social Research, Action, and Development, Martin Luther Christian University, released a report on 'Teenage Pregnancy with a Special Focus on Familial, Legal, and Socio-Cultural Context in Meghalaya, India (Sample Study)', wherein it was reported that there is a significantly higher prevalence of teenage pregnancies in rural areas of the State. Additionally, school drop outs, health issues, and poverty are reported as commonly occurring concerns in cases of teenage pregnancies.

In this regard, while the Department has a range of schemes for pregnant women and young mothers in addition to the ICDS scheme, such as the Chief Minister's Social Assistance Scheme for Single Mothers, teenage pregnancies fall under the purview of the POCSO Act, thereby bringing these adolescents under the ambit of ICPS authorities such as the DCPU and CWC. Typically, when such cases come to the attention of district

D.4.2. DEPARTMENT OF SOCIAL WELFARE



GAPS AND CHALLENGES IN SERVICES

authorities, a complaint is registered under the POCSO Act. Therefore, in cases of teenage pregnancies, there is a reluctance to avail of government benefits, owing to concerns about a POCSO complaint. Additionally, as these relationships are not perceived to be contrary to community norms, parents and families typically do not bring these cases forward except when constrained to do so.

❖ **Skills and Capacities of Counsellors in cases of Children in contact with the law**

One of the key issues highlighted by the Department Officials is the lack of skills amongst counsellors in the state, particularly in regards to their work with children in contact with the law. Counsellors currently are reported to possess limited skills and abilities required to assess adverse childhood experiences, and provide necessary first level responses and interventions. The Department Officials seemed to recall one such instance, wherein the Juvenile Justice Board expressed great displeasure at the counsellor in a case where the accused CICL attempted suicide. Additionally, this issue is also compounded by a shortage of counsellors in the state.

❖ **Issues in convergence efforts with other Departments in the State**

A recurrent concern raised relates to the difficulties in making convergence goals actionable due to an ambiguity in roles and responsibilities of various officials, and duplication of efforts in some cases. Department Officials discussed the impact of these convergence challenges at the district level, with irregularity of meetings, and lack of sustained coordinated efforts to address issues such as child labour and out of school children.

D.4.2. DEPARTMENT OF SOCIAL WELFARE

POTENTIAL OPPORTUNITIES

Life Skills Training on Sexuality and Decision-Making

While life skills are already part of school health and wellness programs, it is critical to ensure the provision of life skills interventions on a periodical basis, through the use of interactive methodologies, in schools and at the community level. The Village Headman, in this regard, can be consulted to organise regular life skills awareness programs at the village level, in addition to schools.

Capacity-Building Programs for Counsellors

In light of issues highlighted with counselling services, particularly for children who have been subject to adverse childhood experiences, capacity-building efforts that focus on skill development, must necessarily develop an understanding of the transdisciplinary nature of any work with children in contact with the law. Furthermore, the nature of mental health and psychosocial interventions required to be provided to these children, is dependent on a contextual understanding of vulnerability. This necessitates the use of different methods of assessment as well, in order to effectively assess the child and provide necessary recommendations for their rehabilitation and care.

D.4.2. DEPARTMENT OF SOCIAL WELFARE

POTENTIAL OPPORTUNITIES

Facilitating Convergence

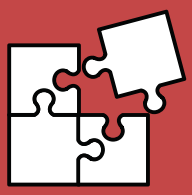
The challenges highlighted in inter-departmental coordination contributing to delays in providing assistance to children can be significantly improved if ambiguities in role performance are addressed. Therefore, on any given initiative, such as the 'Rescue Mission', which involves coordination between the Health and Social Welfare State Departments, clearly documented roles and responsibilities, for each stakeholder, will contribute the reducing these ambiguities and assigning accountability. Additionally, in order to improve overall accountability in the implementation of such initiatives, robust provisions for reporting and evaluation should be seriously considered.

D.4.3. STATE COMMISSIONER FOR PERSONS WITH DISABILITIES & UNIQUE DISABILITY ID (UDID) RESOURCE PERSONS

EXISTING SERVICES AND SYSTEMS

THEME	KEY FINDINGS
State and District Resource Centres on Disability Affairs	The primary infrastructure for disability services throughout the state of Meghalaya is facilitated through the State Resource Centre on Disability Affairs. While the Centre was originally established under the National Programme for the Implementation of Rehabilitation for Persons with Disabilities in 2000, the State Resource Centre continues to act as the nodal institution for disability related services across the State. This continues to be the case under the Unique Disability ID initiative of the Ministry of Social Justice and Empowerment, Government of India. Under the aegis of the State Resource Centre, are 4 District Resource Centres (DRCs) including in the Civil Hospital, Shillong, Jowai and upcoming facilities in Ri-bhoi. Through the DRCs, early screening, certification and early intervention services are provided.
Seminars and other disability-related awareness programs	While there a host of initiatives conducted through the Centre and Commissioner's office, one of the important initiatives includes seminars and other programs on child sexual abuse in the context of children with disability. As was reported by the UDID staff, child sexual abuse has become an increasingly common phenomenon for children with disability, with the incidents usually taking place at the behest of known perpetrators.
Consolidation of Departmental Databases under UDID	Currently, to streamline data available on persons with disabilities across the State, the State Resource Centre has located different departmental databases concerning persons with disabilities, and is consolidating these different databases to produce convergence data under the aegis of UDID.

D.4.3. STATE COMMISSIONER FOR PERSONS WITH DISABILITIES & UNIQUE DISABILITY ID (UDID) RESOURCE PERSONS



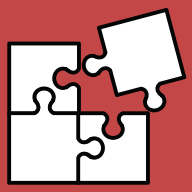
GAPS AND CHALLENGES IN SERVICES

- **Stigmatisation of Children with Disability & School Dropouts**
- **Shortage of Personnel**
- **Mental Health Assessments**
- **Capacities of Field Workers**
- **Registration of Crimes**

❖ **Stigmatisation of Children with Disability & School Dropouts**

Due to a lack of mental health and disability awareness, children are subjected to very harmful practices (particularly in rural areas) that can have a debilitating effect on their well-being and health. For instance, there was a report from a remote area in Garo Hills, wherein a child was severely abused due to a lack of knowledge on issues that affect disability in children. Traditional Healers are often relied upon, especially in areas with low awareness of disability issues, to address the child's issues.

D.4.3. STATE COMMISSIONER FOR PERSONS WITH DISABILITIES & UNIQUE DISABILITY ID (UDID) RESOURCE PERSONS



GAPS AND CHALLENGES IN SERVICES

❖ Shortage of Personnel

While there are efforts to expand disability services in the state (like the new facility being developed in Ri-Bhoi), shortage of mental health professionals and other key professionals (like special educators) has limited the feasibility of establishing more facilities. A related point is that the Jowai DRC is the only facility with special educators.

❖ Mental Health Assessments

While there are cluster-level camps functioning on a weekly basis to assess children and refer cases to the DRC for certification and interventions, these assessments do not evaluate mental illness, thereby resulting in lacunae in the assessment process. This is significant given the mandate of the Rights of Persons with Disabilities Act, 2016, which recognises mental illness as a category of disability.

❖ Capacities of Field Workers

There have been reports from a multitude of stakeholders regarding inaccuracy and inefficiency in assessing disability by field workers. The first important concern is misidentification of disability and overdiagnosis of intellectual disability. This has the effect of masking other disabilities like Specific Learning Disability which require a different set of interventions.

Additionally, keeping in mind the nature of the assessment camps, there are also concerns regarding the limited availability of time, resulting in inaccuracy in the identification of disabilities amongst children.

❖ Registration of Crimes

One of the other concerns highlighted was with regard to the registration of cases involving children, wherein chargesheets in POCSO cases, and indeed, cases under the Juvenile Justice Act, do not provide information regarding the children's disabilities. This significantly hampers efforts to identify and assist children through the DRCs, where necessary, including in providing assistance for evidence eliciting processes.

D.4.3. STATE COMMISSIONER FOR PERSONS WITH DISABILITIES & UNIQUE DISABILITY ID (UDID) RESOURCE PERSONS

POTENTIAL OPPORTUNITIES

Guidelines for Child Care Institutions on Children with Disability

One of the specific suggestions was with regard to the development of clear guidelines for the treatment of children with disability in child care institutions, given the general ambiguity that affects caregiving for children with disability. A similar suggestion was made for parents to address the stigmatisation of children's disabilities, through clear and helpful guidelines for parents.

Training of Field Workers and Provision of Mental Health Assessments

One of the critical interventions, in light of the above, is to train field workers in conducting comprehensive and accurate disability assessments (including assessments with regard to mental health issues). These assessments can be simple and comprehensive to ensure easy utilisation and time-bound assessments.

Guidelines to Police Personnel

In terms of facilitating better coordination between the police and DRCs, guidelines requiring the police to mention details of children's disabilities in their documentation (including in the FIR and final report) will help improve identification of these children. Additionally, similar to the model adopted in Delhi for coordination between the Police and State Legal Services Authority, FIRs (involving children with disability) can be forwarded to the State Resource Centre, and subsequently, devolved to the concerned jurisdictional DRC for further action.

D.4.4. STATE MENTAL HEALTH AUTHORITY (SMHA)

EXISTING SERVICES AND SYSTEMS

The State Mental Health Authority, constituted in accordance with the Mental Healthcare Act (MHCA), 2017, has been assigned the responsibility of regulation and coordination of mental health services; implementation of the mental health legislation, and the operationalizing of the mental health services in the State.

The SMHA, Meghalaya currently has 13 official members and 8 non-official members. The Chief Executive Officer (CEO) of SMHA was interviewed by SAMVAD to understand the Mental Health Structure in the State and the role SMHA plays in operationalizing various mental health activities in the State. The CEO was recently deputed in April 2022 and has taken charge temporarily till June 2022. Along with the CEO, a psychiatrist from the Civil Hospital was also present for the interview.

Describing some of their key responsibilities, the SMHA reported that they are involved in the registration of disability cases across the state and the registration of mental health professionals and organizations in the state. Their work also involves training and capacity building of the mental health professionals working under different schemes and programs. This includes the District Mental Health Program (DMHP). Currently, all the 11 districts in Meghalaya are running the DMHP program. However, in 8 out of the 11 district programs, there are currently no psychiatrists. Doctors, with MBBS qualifications, are provided a ten-day course at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Assam, on Community Mental Health, in order to fill the present gap due to the lack of trained psychiatrists in the districts.

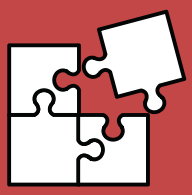
The SMHA reported that the cases related to mental health are first identified at the level of the community health centre, where a primary level screening is conducted. Upon the completion of the screening at the Community Health Centre (CHC) level, the cases are referred to the DMHP. Further, if specialized treatment is required, the DMHP refers cases to the Civil Hospital, Shillong. While the DMHPs make several referrals to the Civil Hospital, there are hardly any referrals to the tertiary centres, like the North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIMS). The Authority is also in the process of constituting Mental Health Review Boards in the Districts to facilitate registration of all NGOs in the State.

D.4.4. STATE MENTAL HEALTH AUTHORITY (SMHA)

EXISTING SERVICES AND SYSTEMS

The SMHA is not involved in the organization and implementation of any awareness programs. The programs are conducted through the NHM, by the DMHPs, at the school and community level. The SMHA also reported that in cases of children from vulnerable circumstances, the cases are mostly handled by the social welfare department functionaries, and only if any kind of assessment is to be conducted, the children are referred to MIMHANS or the Civil Hospital.

D.4.4. STATE MENTAL HEALTH AUTHORITY (SMHA)



GAPS AND CHALLENGES IN SERVICES

Inactive engagement in operationalizing mental health activities in the State

Infrequent meetings for planning & discussion of the mental health work in the state

Lack of strategy for the delivery of mental health awareness programmes

Activities limited to registration of mental health organizations and disability certification

There were no significant gaps identified by the SMHA, other than the lack of human resources. It was evident that the SMHA's involvement was limited in operationalizing mental health activities - facilitating linkages between various mental health programs run in the State; planning and implementation of activities such as awareness generation programs; training and capacity building of the mental health professionals; support to the tertiary centres and the district mental health program; review and monitoring of the work of mental health programs and institutions in the State. The SMHA's role is currently limited to registering the Mental Health Institutions and facilitating disability certification.

D.4.4. STATE MENTAL HEALTH AUTHORITY (SMHA)

POTENTIAL OPPORTUNITIES

- Strategic planning and implementation of the Community Mental Health Awareness Programs.
- Strengthening of the District Mental Health Program (DMHP) and the tertiary care centres through training and capacity building programs on child & adolescent mental health issues and child protection concerns.
- Monitoring and process-based evaluation of mental health programs and institutions at primary, secondary and tertiary levels through use of technology.

It would be useful for the SMHA to meet at least once every quarter to develop an action plan for mental health, and specifically, for the review of the progress made at the end of each quarter, in accordance with the Section 56 (1) of the MHCA, 2017. SAMVAD observed that although work is being done at various levels to raise mental health awareness, the delivery of these programs is done in a random fashion- unstructured content implemented without proper planning and scheduling. There is a critical need to, therefore, pay attention to the contextual mental health needs of the communities and development of a strategic plan for the delivery of these programs. At present there is no calendar developed for such activities or follow-up schedules.

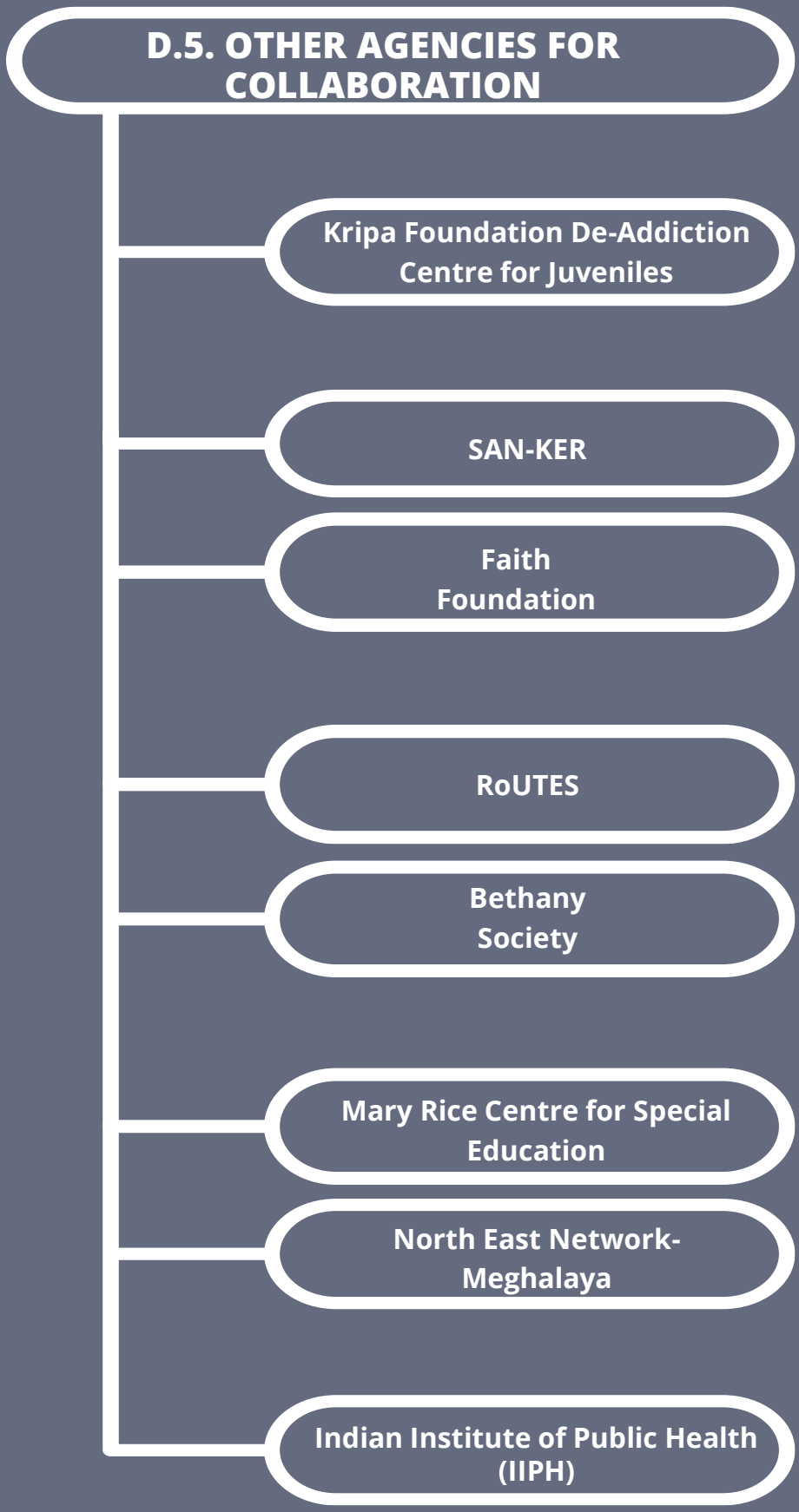
D.4.4. STATE MENTAL HEALTH AUTHORITY (SMHA)

POTENTIAL OPPORTUNITIES

The SMHA in consultation with the DMHP can assist in developing strategic calendars catering to the contextual needs of different groups. The SMHA can also play a crucial role in raising awareness within the communities and can facilitate the use of new and creative methods for this purpose.

As already laid out in the MHCA, 2017, the SMHA has a critical role to play in the reviewing of mental health services. It would be necessary to ensure that the mental health services are strengthened and monitored by the SMHA at all levels - primary, secondary and tertiary. The SMHA can play a more active role in monitoring the outcomes of the mental health programs. It is important to note that the monitoring must not be limited to result-oriented outcomes, as monitoring of the process is equally important. A tracking system has to be developed; technology can be leveraged for this purpose. The SMHA can also work towards training and capacity building of tertiary care centres and DMHP on child and adolescent mental health issues - psychiatric disorders, disabilities, developmental issues. It is also critical that orientation on child protection issues, child protection systems and child laws such as the Juvenile Justice Act, POCSO Act are integrated with the mental health training curriculum. It is observed that the mental health systems at the secondary and tertiary levels are highly adult-oriented, and therefore, it is through continuous in-depth training that they will be equipped to assist children fully.

FINDINGS AND ANALYSIS



D.5.1. KRIPA FOUNDATION DE-ADDICTION CENTRE FOR JUVENILES

EXISTING SERVICES AND SYSTEMS

According to Kripa Foundation, children as young as 7 years of age engage in substance use. Children from broken and dysfunctional families, also from contexts of deprivation, feel the need for money and set out to work. When they do so, and given their vulnerability, they are often targeted by drug peddlers—who get them to buy and sell drugs, for which children are paid in kind i.e., in drugs. This is one of the major ways in children get into substance use, particularly younger ones. Family contexts, wherein parents are drug users and engage in domestic violence, including child abuse, place children at risk of mental health disorders such as anxiety and depression, to which they respond by using substances. Others enter drug use through the route of curiosity and experimentation, trafficking and prostitution, which are also facilitated by the easy availability of drugs, through cross-border smuggling from Silchar, Myanmar and Bangladesh. Nomensong, Jhalupara, Moprem, Polo, Happy Valley, Nongpo and Nongstoi form some of the 'hot spots' in the state, with an increased number of dealers and pedlars, and consequently more users.

Although Kripa Foundation has been working actively in Meghalaya, on substance use issues, for several years, it initiated a centre exclusively for children only recently—and this KF centre is currently the only such centre for children. It is located within the premises of government child care institutions in Mawkasiang, Shillong, and run through a public-private partnership mode, in collaboration with the Dept. of Social Welfare, Government of Meghalaya. Housing only boys (girls requiring assistance are referred to other agencies such as the New Hope NGO), it has a 20-bed capacity. It is staffed by an administrator, a visiting psychiatrist (thrice per week), a counselling psychologist, 3 counsellors (social workers), a teacher, 2 twenty-four-hour nurses, and other support staff including a ward boy, security guards, cook, and cleaners/helpers.

When the Kripa Foundation Centre (KFC) receives an enquiry for assistance, the child is first referred for detoxification treatment to Super Care Hospital, a private facility. After about a week of treatment there, a counsellor from KFC picks up the child and brings him to the juvenile de-addiction centre. Assessments and mental status examination are conducted gradually (to include drug use as well as other psychosocial and mental health issues), over a period of a month i.e., the child is interviewed and information is elicited, over a course of time, so that the child does not feel overwhelmed or threatened. This time is also used to make some agreements with the family, whom KFC meets and consults.

D.5.1. KRIPA FOUNDATION DE-ADDICTION CENTRE FOR JUVENILES

EXISTING SERVICES AND SYSTEMS

A child is permitted to meet with his family, after the first few weeks (to allow him time to settle in the centre) and then regularly, once every fortnight. KFC counsellors report that children frequently become upset and angry when family visitations occur—since much of their problems stem from family relationships and contexts.

Here a 90-day rehabilitation program, following the 12-step program as set out in the Alcoholics Anonymous model, is implemented. The program is modified to suit the needs of children and adolescents, mainly through group sessions in which there are games, role plays and life skills activities. In these sessions, topics pertaining to human values, such as honesty, kindness, forgiveness and acceptance are discussed. Life skills methodologies are used, by presenting videos for learning and discussion. These sessions are part of a daily routine which also comprise of literacy classes, library time and vocational training. Additionally, every child also undergoes individual sessions for treatment—in which cognitive behaviour therapy (using the ABC analysis on substance use as a behaviour) and art therapy are used to work with children. Family systems therapy is also conducted—in which parents and caregivers are educated on how to engage with children upon discharge, the challenges to expect thereafter, and the need for intensive care and supervision.

The visiting psychiatrist deals with mental health co-morbidities in children, namely attention deficit hyperactive disorder, anxiety, depression and other mood-related issues. The staff report that the psychiatrist generally works on her own, with the children, with sessions ranging from 15 to 30 minutes, and does not provide the staff/counsellors with inputs on these disorders or how to deal with children in such cases. They were only aware that the psychiatrist engaged in assessment and follow-up but had no idea of any therapeutic work being done to assist children with specific mental health concerns.

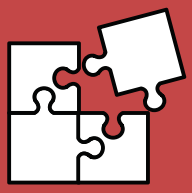
After the 90-day period, some children who remain aggressive, or need more time for recovery, continue to stay at the centre, while others go home to their families. The counsellors report that many children do not wish to leave the centre—an indication of the stability and peace that this space provides them with perhaps, in contrast to their often-fraught homes. Regular follow ups are conducted by the staff, of children who leave the centre, via phone and home visits.

D.5.1. KRIPA FOUNDATION DE-ADDICTION CENTRE FOR JUVENILES

EXISTING SERVICES AND SYSTEMS

Thus far, 60 children have undergone the program. As this centre has been in existence for less than a year, there is as yet no data available on medium-to-long term outcomes and impact of the program i.e., in terms of recovery and relapse. So far, it is only known that out of 20 cases, 1 has shifted drug use, from heroin to cannabis.

D.5.1. KRIPA FOUNDATION DE-ADDICTION CENTRE FOR JUVENILES



GAPS AND CHALLENGES IN SERVICES

Management of children during initial stages of the program (aggressiveness/destructiveness, anxiety/withdrawal)

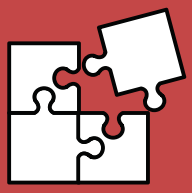
Working with children's families (families' inability to disable children's substance use, parental substance abuse)

Lack of robust vocational training for reintegration

Training/Capacity Building on child-specific interventions for substance use

The challenges described by the KFC staff pertain to (a) management of children i.e., their aggression and destructiveness, or anxiety and withdrawal, especially at the initial stages of the program, when the staff have to make tremendous efforts to calm them and understand their worries; (b) dealing with children's families, who are frequently uncooperative and more readily than not, provide children with substances, when they plead or have cravings for it. A related challenge in working with families, to elicit support for children, is addiction issues amongst family members themselves—in which case they also require to be referred for treatment.

D.5.1. KRIPA FOUNDATION DE-ADDICTION CENTRE FOR JUVENILES



GAPS AND CHALLENGES IN SERVICES

They also feel the gap as far as vocational training is concerned, stating that unless the state plans for a robust vocational training program for such children, to help them re-integrate into society, they are likely after discharge, to return home and relapse.

Thus far, the KFC staff have not received any specific training on interventions for children with substance use. They feel that they greatly require more inputs, specifically on conceptual issues pertaining to substance use, such as harm reduction, cue reduction, and relapse prevention, as well as motivational interviewing and other therapeutic methods. Also, it is important to note that the 12-step Alcoholics Anonymous program was not developed for children and adolescents i.e., it was meant for adults. Consequently, SAMVAD is of the view that it is not an appropriate model for use with children with substance use issues. Training would therefore need to address more child-appropriate interventions, focussing on life skills methodologies, to effectively assist children in this context.

D.5.1. KRIPA FOUNDATION DE-ADDICTION CENTRE FOR JUVENILES

POTENTIAL OPPORTUNITIES

- Replication and Scale-up of the Model developed by the Kripa Foundation Centre across Meghalaya.
- Facilitation of Training Programs for KFC staff to facilitate more child-appropriate interventions models.

There is no doubt about the deep caring, passion and motivation with which the staff of the KFC run the centre. The children's reluctance to leave the centre at the end of the program is a testament to this. The design of the centre, allowing for large, bright and airy spaces, wherein children have sufficient room for physical play and activities, and the structure and content of the program are child-friendly and well-suited to the needs of this very vulnerable group. Given KFC's apparent success (although more research is required on an on-going basis to evaluate the impact of the program), the state of Meghalaya has a model that could be scaled up i.e., through creation of more such rehabilitation centres for children and adolescents and with requisite changes and shifts to more child-appropriate intervention models. Given the enormity of the substance use problem in the state, and its roots in childhood adversity and adolescent risk, it is imperative for the state to invest its resources in rehabilitation of children and adolescents—this would serve as a secondary prevention measure, to curtail the substance abuse problem in adults, in the future.

D.5.2. SAN-KER

EXISTING SERVICES AND SYSTEMS

SAN-KER is a non-governmental organization that aims to provide affordable psychiatric services and de-addiction services for the residents of Meghalaya. The Institution is set up amidst forest land and runs an Out-Patient Department and a 100 bedded in-person facility. Initially, when the services were initiated, the organisation primarily provided child and adolescent mental health services, but currently do not run exclusive child psychiatry services.

Due to the lack of trained psychiatrists and psychologists, SAN-KER has also struggled to recruit psychologists and psychiatrists on a full-time basis. SAN-KER also runs an outpatient service and does outreach work in 4 districts in Meghalaya. Out of the total number of cases seen at SAN-KER, 2-5% cases are of children. In the cases where children and adolescents require admission for treatment, they are admitted in the female ward with an attendant. It was also reported that children usually come for treatment concerns related to neurology, intellectual disability and substance abuse. Children also come through the CWC, JJB and the police, or from the CCIs, however, these cases are very low in number i.e., about 3-4 in the last few years. It was also reported that community-based organisations help bring patients to SAN-KER.

D.5.2. SAN-KER

EXISTING SERVICES AND SYSTEMS

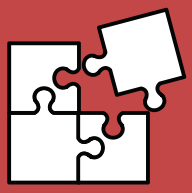
ISSUE	KEY FINDINGS
Teenage Pregnancies	Pregnancies are common amongst girls between ages 10- 17 years. The girls are usually brought to SAN-KER by the Police. In most cases of pregnancy, the victim is also found to have mild to moderate intellectual disability. The SAN-KER team provides medical support to the girl, while the social worker and the psychologist provide psychological support. In Meghalaya, teenage pregnancy is not considered a taboo. On the other hand, given socio-cultural beliefs - termination of pregnancy is not supported. Even in the context of pregnancies, due to child sexual abuse, the victim is expected to accept and forgive. This is detrimental for children's socio-emotional health, and disrupts their education. While the family may be aware of the pregnancy, they usually remain silent about the pregnancy until the signs become too evident. By the time the issue comes to light, the termination of the pregnancy is not a suitable option, as it is not considered to be medically safe.
Child sexual abuse	Child Sexual abuse was highlighted as one of the most prevalent issues in the State of Meghalaya. Interestingly, during the discussions it was also mentioned there is a strong linkage between the issue of women seeking multiple partners and child sexual abuse. It was discussed that some of these behavioural trends could also be an impact of the experiences of sexual abuse in the early years of childhood. Sexualisation is often observed in cases of child sexual abuse, particularly in the context of extensive grooming processes, which contribute to the persistence of high-risk sexual behaviours.

D.5.2. SAN-KER

EXISTING SERVICES AND SYSTEMS

ISSUE	KEY FINDINGS
Single-Parent families	Within single parent families, due to the difficult circumstances, drug abuse problems and mental health issues (like depression within children and adolescents) are also quite common. Children are also abandoned by their fathers in many cases of marital discord. The mothers, in many cases, also find other partners. Children, therefore, are sometimes abandoned by either one or both parents.
Intellectual Disability	There was no particular assessment proforma cited in the context of these children. The assessment is reportedly done by the clinical psychologist, in some cases, while others are referred to a special school. The children are also sent to the day care centre run by SAN-KER.
Substance abuse	There are detoxification services offered through the out-patient department. There are also Saturday group sessions organised for relapse prevention. If beds are available, children are also admitted to the 12-step program. However, there are no adolescent-specific models used in cases of substance use.

D.5.2. SAN-KER



GAPS AND CHALLENGES IN SERVICES

The lack of human resources was highlighted as the biggest challenge by the staff at SAN-KER. There is also a lack of specialized child and adolescent in-patient facilities, and a dearth of standardised assessment protocols.

D.5.2. SAN-KER

POTENTIAL OPPORTUNITIES

Given that there is a paucity of tertiary level services, SAN-KER can support the services of tertiary care facilities. If SAN-KER builds its own capacities, it has the potential to provide training and capacity building support to other mental health programs run by the State administration.

D.5.3. FAITH FOUNDATION

EXISTING SERVICES AND SYSTEMS

A non-governmental organization based in Shillong, Meghalaya, Faith Foundation was established in 2013, to work towards ensuring the safety of children and adolescents. It is staffed by a team of 8, including counsellors and program associates, to work in communities, with families, children and school teachers, delivering personal safety education programs (including sexual and reproductive information for adolescents), using life skills approaches. Currently, they work in 26 (government-aided and church-run schools) in East Khasi and Ri Bhoi districts, and plan to expand this initiative to reach out to more schools.

Their awareness programs' content pertains to themes such as knowledge of the body, menstrual hygiene, early warning signs of lack of safety, grooming and manipulation in child sexual abuse, the POCSO law and the need to share information with trusted adults. The agency works with children of two age groups: from grade 3 to 6 and grade 7 and above, primarily with girls. Faith Foundation also mentions increased incidents of child sexual abuse ('non-consenting sexual engagement of minors) in communities, for which they provide psychosocial assistance to affected children. The staff also serve as CWC Support Persons in case of CSA cases, and are, therefore, called upon to provide assistance to children through court processes.

The agency has conducted a study on teenage pregnancy in Ri Bhoi district, in which their findings have pertained to: taboos around discussions on sex and sexuality (reluctance of parents and teachers to engage in such discussions); the unavailability of appropriate information on health and sexuality to adolescents; mothers' concerns about their adolescent girls becoming pregnant versus their aspirations for their children to complete their education—this is also in conflict with their hesitancy to engage adolescents in requisite discussions on health and safety in the context of sexuality (i.e., not providing information on contraception etc), as well as their being against medical termination of pregnancy (MTP) when a situation occurs (due to religious reasons). The study also revealed hesitancies on the part of adolescents to ask for MTP services, and gaps in the MTP services themselves, within health facilities i.e., they are not freely or systematically offered in case of teen pregnancies. It has also established a link between how when (young) parents, and single mothers, are extremely stressed, it has adverse impacts on adolescents—who then want to leave home

D.5.3. FAITH FOUNDATION

EXISTING SERVICES AND SYSTEMS

and find a partner, thereby increasing the risk of becoming pregnant, and perpetuating a similar cycle of family dysfunction and teen pregnancy. An interesting study finding is also that adolescent male partners do not allow contraception use as they fear that their adolescent female partners will then engage in sexual relationships with other males i.e., non-use of contraception and consequent pregnancy is also used by men and adolescent boys to ensure that women and girls 'remain' in relationships with them. Thus, Faith Foundation is of the view that despite the matrilineal societal systems, patriarchy is widely prevalent, in many ways, within communities, with adverse impacts on the health and lives of girls and women.

As a passionate group of young professionals, providing community-based programs and services, Faith Foundation has a great deal of potential for growth. The counselling and psychosocial skills of the staff with regard to both teen pregnancy and CSA cases, and their knowledge of assisting children through court processes appear to be hindrances for the services provided by the agency. In-depth training and capacity building with more technical know-how on CSA and sexuality-related interventions would enable them to provide more systematic services. Their research and dissemination activities, including translation of the same into policy and practice would benefit from partnerships with agencies such as IIPH—the latter may assist Faith Foundation to capitalize on their strong community presence and networks, to generate knowledge, and implement programs in a stronger and more evidence-based manner. Indeed, given the agency's research interests and community presence, there is an increased potential for integrated evidence-based programming, on child sexual abuse, adolescent sexuality concerns and mental health.

D.5.4. RoUTES

EXISTING SERVICES AND SYSTEMS

RoUTES was established in September 2020, in the midst of the COVID pandemic as a non-government organisation. It comprises a team of mental health professionals who work with children in different contexts. RoUTES works in many capacities with regards to direct work with children as well as capacity building of child care workers.

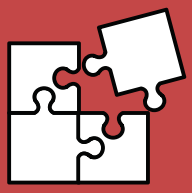
The most common child and adolescent mental health problems they encounter in their work with children are anxiety, depression, self-harm and eating disorders. Eating disorders and associated body image issues are a recurring issue in adolescents in the state, according to the staff at RoUTES. Early pregnancies and teenage pregnancies are also a very common concern among youth. Some reasons for early pregnancies in their experience, has been adolescents engaging in sexual behaviours for experimentation, emotional support, and falling prey to peer pressure.

D.5.4. RoUTES

EXISTING SERVICES AND SYSTEMS

THEME	KEY FINDINGS
Awareness & Capacity Building	➢ They build the capacity of mental health professionals on Professional Continuing Education, Mental Health Training for Teachers and Mentoring programs for young mental health students and professionals. ➢ They also conduct 'training of trainer' programs on disaster management, personality development, children and adolescent development, parenting skills, life skills and behaviours, as well as training of community-based rehabilitation centre volunteers on mental health services.
Direct work with children	➢ Engage in therapeutic work for children with disabilities and other emotional and behavioural concerns. ➢ They also perform assessments for disability certification of children with disabilities.
Linkages with government and non-government facilities for children & Government child duty bearers	➢ They work closely with the Civil Hospital, Mary Rice, Bethany Society and within neighbourhood schools. ➢ They train teachers in the schools to sensitise them to children's mental health and well-being. ➢ They work with child protection functionaries like the District Child Protection Officers (DCPO) and Child Welfare Committee (CWC) Members on trauma and its impact on children's mental health, well-being and behaviours. ➢ They also support the CWCs for assessments of children who are presented to the CWC. ➢ They also work with Sarva Shiksha Abhiyaan schools to train teachers and also assist them with cases of children with mental health concerns, disability or parental counselling.

D.5.4. RoUTES



GAPS AND CHALLENGES IN SERVICES

The RoUTES team believes that the disconnect among all child related stakeholders is a cause for concern. It is through a transdisciplinary approach that the gaps in services and effective interventions for the best interest of children can be ensured. According to them, there is also a serious need for all child-related spaces (CWC, DCPU, Courts, police) to be child inclusive and child friendly.

D.5.4. RoUTES

POTENTIAL OPPORTUNITIES

Standardised assessment proformas for their work with children with disabilities as well as capacity building of other child protection and mental health duty bearers is observed to be a significant consideration.

Resources and training material for standardised training on child protection, mental health and psychosocial care encompassing child development, mental health concerns in children, communication skills, basis of emotional and behavioural concerns of children, common child mental health disorders, life skills, assessments and information on child related laws, may be beneficial for their training and capacity building programs.

D.5.5. BETHANY SOCIETY

EXISTING SERVICES AND SYSTEMS

Bethany Society is a non-governmental organisation that works with persons with disabilities, including children and adolescents, with a specific focus on children residing in rural areas. The main initiatives of Bethany Society include developing and organising programs on disability which are inclusive, barrier-free and rights based, in line with the imperatives of the Community Based Rehabilitation (CBR) model.

In order to perform a range of functions for persons with disability, Bethany Society operates through its subsidiary units which include the Jyoti Sroat Inclusive School, Mainstreaming Disability Unit and the Divine Flame Hostels for Children, as key units working with children with disabilities. The Jyoti Sroat Inclusive School provides an inclusive educational space for children with and without disabilities, with a specific focus on children from disadvantaged socio-economic backgrounds. The school collaborates with 15 NGOs and the Samagra Shiksha Abhiyan across 5 states in Northeast India to promote inclusive education through the Universal Design of Learning (UDL) framework. Furthermore, early intervention services (i.e., therapeutic and support services) are provided to children from (0-8 years), in addition to counselling services for their parents and families. Early education services provided through the school also aim at assessing the child's needs at an early stage and developing a roadmap for the child's learning and social skill requirements. The school itself provides educational services till the higher secondary level (Class XII).

The Mainstreaming Disability Unit further strengthens the availability of community-based services, including therapy for children with various types of disabilities, and significantly, home-based rehabilitation services (specifically for children with high support needs). Additionally, the Divine Flame Hostels also provide children with comprehensive therapeutic services (including life skills training and career counselling services) in addition to rehabilitation services for children residing in these hostels.

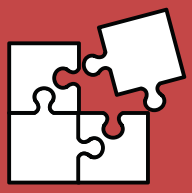
As a part of its community work, Bethany Society has also trained field workers to identify children with disabilities within the target catchment area (for e.g., 30 villages with 6 field workers), and subsequently link their families with relevant government programs and schemes.

D.5.5. BETHANY SOCIETY

EXISTING SERVICES AND SYSTEMS

THEME	KEY FINDINGS
Protection framework for Children with Disabilities	In order to address protection risks for children with disabilities, Bethany Society instituted a Child Protection Policy (CPP) in 2000, and designated a nodal Child Protection Officer. The policy outlines staff responsibilities, standards for appropriate behaviour and reporting protocols to be followed in cases of abuse allegations. In accordance with the CPP framework, Bethany Society also conducts risk assessments affiliated units and organisations, to periodically review the implementation of the overarching protection framework.

D.5.5. BETHANY SOCIETY



GAPS AND CHALLENGES IN SERVICES

Lack of awareness on Mental Health

Gaps in Assessment and Intervention Services for Children with Disability

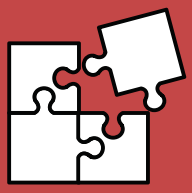
❖ **Lack of awareness on Mental Health**

One of the critical issues with mental health service delivery is the lack of awareness regarding mental health and disability issues, and concomitantly, a reliance on traditional healers. Typically, families and caregivers, particularly in rural contexts, seek assistance from traditional healers when confronted with unexplained emotional and behavioural challenges, or disability concerns. These cases are not reported to mental health, or disability facilities, because of a lack of awareness of the causal factors for the genesis of these issues. In some cases, reliance on traditional healers has also reportedly had fatal consequences for children.

❖ **Gaps in Assessment and Intervention Services for Children with Disability**

Despite the presence of assessment camps organised by the State Resource Centre for Disability Affairs, through the District Resource Centres, Bethany Society resource persons identified significant issues with the assessment process. Specifically, there is reportedly a lack of technical capacity in the relevant stakeholders conducting these assessment camps, resulting in multiple instances of misdiagnosis of the type of disability. Examples of such instances include cases of Specific Learning Disability (SLD) and Mental Illness, which when not assessed accurately, have been misdiagnosed as Intellectual Disability (ID).

D.5.5. BETHANY SOCIETY



GAPS AND CHALLENGES IN SERVICES

Such overdiagnosis of ID also contributes to masking other disabilities, thereby compromising access to critical interventions for these children.

Additionally, for children with disabilities, lack of availability of interpreters itself can affect the caregivers' ability to avail of mental health services through professionals who may require the assistance of an interpreter. These issues also compound the process for acquiring disability certification and the UDID, due to misdiagnosis of the child's disability.

D.5.5. BETHANY SOCIETY

POTENTIAL OPPORTUNITIES

Replication of Bethany's Child Protection Policy and Risk Assessment Framework

Keeping in mind that there currently isn't a Child Protection Policy at the State level, Bethany Society's Child Protection framework, which stipulates a code of conduct, behavioural standards, and reporting protocols, could be replicated in other critical child care settings such as schools in Meghalaya to mitigate protection risks for children. In addition, their risk assessment frameworks, can be implemented on a periodical basis to monitor child safety standards in schools and other child care settings across the state.

Capacity-Building for disability service providers

One of the critical requirements in disability services is improvement in assessment of children with disabilities. While the District Resource Centres provide crucial infrastructure for disability services in the State, the assessment camps can be improved to ensure that assessment, identification and certification of disability is conducted in a comprehensive and accurate manner. All nodal officers and personnel concerned with the assessment camps can be trained, in this regard, to accurately identify different types of disabilities and provide the necessary linkages to assist the child.

D.5.6. MARY RICE CENTRE FOR SPECIAL EDUCATION

EXISTING SERVICES AND SYSTEMS

The Mary Rice Centre for Special Education, initiated in 1989, is an NGO that provides direct services for children with disability, in addition to conducting awareness and advocacy programs on disability issues. The direct services provided by the Centre include assessment and early intervention services, special education, physical and speech therapy, vocational training and counselling with the aim of facilitating integration in the community, in accordance with the Independent Living approach to disability interventions. The Centre works with all children (0-18 years), particularly those children with cognitive disabilities, such as Intellectual Disability, Autism Spectrum Disorder, Specific Learning Disability. The Centre also works with children with cerebral palsy and locomotor disability.

Currently, the Centre works more closely with children with neurological disabilities. Children who come to the Centre are typically from urban areas, given that the Centre largely receives cases due to word of mouth, and referrals from schools and hospitals. As the Centre has conducted awareness programs in Schools, there has reportedly been an increase in referrals from schools. These awareness programs typically provide an orientation to the different types of disability and strategies for identification at the school level. Few cases are also received from child care institutions.

As a part of the RAISE NORTHEAST project, covering 15 NGOs in collaboration with the Samagra Shiksha Abhiyan, the Centre along with the Jyoti Sroat School, conducted a series of capacity-building and awareness programs across 5 model schools, in 5 states, to implement inclusive education through the Universal Design of Learning principles. As a part of this project, a series of teacher trainings were conducted, in addition to awareness programs for students. Awareness programs were also conducted for community health workers to address children with disabilities who were not enrolled or had dropped out from school. In order to give children a platform in their school, a unique activity called the ‘children’s parliament’ was initiated in schools, wherein children were given an opportunity to discuss their issues and challenges in the school. This initiative also facilitated peer learning, with the model schools subsequently noting improvements in students’ engagement with classroom learning.

D.5.6. MARY RICE CENTRE FOR SPECIAL EDUCATION

EXISTING SERVICES AND SYSTEMS

With respect to facilitating inclusive education in these model schools, the first step was teacher capacitation to develop an understanding of different types of disability, and crucially, methods to initially identify possible cases of disability that may require referral to the Mary Rice Centre for assessment and depth interventions. Following these trainings, the Centre provided knowledge support on making reasonable accommodations to mainstream curriculums, and furthermore, facilitated model classes on how to accommodate different children's learning needs and implement lesson plans. These model schools were also provided training and support to develop individual education plans at the beginning of the year, following the yearly assessments of children. In line with the principles of inclusive education, these model schools do not place a disproportionate number of children with disabilities in each classroom, to ensure that the curriculum and lesson plan can be reasonably implemented. The RAISE NORTHEAST project has been concluded, with the model schools receiving handholding support from the Centre, in addition to sending children for assessment and intervention to the Centre.

D.5.6. MARY RICE CENTRE FOR SPECIAL EDUCATION

POTENTIAL OPPORTUNITIES

The RAISE NORTHEAST project, which was initially setup in 5 model schools across 5 states has immense potential to realise the imperatives of the Rights of Persons with Disabilities Act, 2016, with reference to inclusive education. The project has resulted in building school capacity for the identification of children with disabilities, in addition to creating educational institutions that are welcoming of children with disabilities. The unique activities such as the Children's Parliament also provide an opportunity for children to voice their challenges and engage on some of these concerns with the school. Furthermore, institutions like the Mary Rice Centre for Special Education and the Jyoti Sroat Inclusive School provide much needed support for assessment, referral and interventions, in more severe cases that cannot be dealt with at the school level. Therefore, such initiatives should be considered for scaling up and replicating in more schools across Meghalaya. This would gradually ensure that the objectives of inclusive education are instrumentalised across the State.

D.5.7. NORTH EAST NETWORK - MEGHALAYA

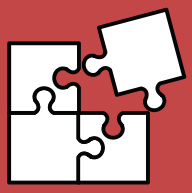
EXISTING SERVICES AND SYSTEMS

The North East Network (NEN) is a women's rights organisation, with links to urban and rural women, given the reach of its advocacy and awareness generation programs. While the NEN primarily works on women's issues, its key areas of focus, as they relate to children, are gender-based violence (GBV), reproductive health and governance reforms. The organisation's work on GBV began with a desire to explore the links between reproductive health and violence, as a result of the issues brought to the organisation's notice through its awareness and outreach programs.

Subsequently, it was the identification of the links between GBV and reproductive health, that led to an organisational approach to GBV as a predominantly public health issue, as opposed to just a law-and-order concern. This approach to GBV prompted efforts to establish a multidisciplinary support centre for women within hospitals, as opposed to police stations and key law enforcement agencies. The State's first support centre was thereafter piloted in 2010 at the Ganesh Das Hospital, to provide key violence-related interventions. Following the implementation of the One Stop Centre Scheme, the management of this centre has been handed over to the Government of Meghalaya.

In addition to the intervention services provided through the support centre, NEN is also systematically engaged in training and capacity-building programs with the State's police authorities. The key program organised by NEN is the Gender Sensitisation Program at the Northeast Police Academy, for newly inducted police officials. These programs are currently conducted on a yearly basis, for each successive batch of police officials. The key areas of focus of this comprehensive training program for the police includes various components such as legal awareness (on women and child-related laws such as the Domestic Violence Act, POCSO and Criminal Amendment Act, 2013); gender and power dynamics, types of violence against women (VAW); and basic counselling interventions.

D.5.7. NORTH EAST NETWORK - MEGHALAYA



GAPS AND CHALLENGES IN SERVICES

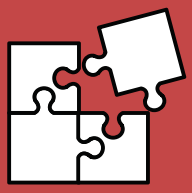
Co-habitation and Protection Concerns	Implementation of the POCSO Act, 2012	Challenges in Training Programs

❖ **Co-habitation and Protection Concerns**

Co-habitation was identified as a concern, given that children as young as 13 years of age were engaged in such relationships. The related concern, from a reproductive health perspective, were the strong cultural preferences against contraception, and instead, in favour of child rearing. These perspectives were identified as significant in the initiation and maintenance of co-habitation arrangements.

Additionally, with regard to the children borne out of these relationships, one of the common instances of child sexual abuse cited were cases of abuse by a step-parent. The organisation discussed that there are families consisting of children from different partners. This was identified as a protection concern in some instances, wherein proximity to a child, in the context of the role of the step-parent, contributes to easier targeting of child victims of abuse. These relationship dynamics were also observed to affect the reporting of sexual offences under the POCSO Act.

D.5.7. NORTH EAST NETWORK - MEGHALAYA



GAPS AND CHALLENGES IN SERVICES

❖ Implementation of the POCSO Act, 2012

With regard to the POCSO Act, one of the key challenges raised was the protection of children during the course of legal proceedings, particularly when the accused is granted bail. Due to lack of sufficient oversight and follow up, one instance was shared wherein the accused perpetrator was allowed to reside at the family residence with the child, following receipt of bail. Additionally, at a preliminary level, due to prevailing socio-cultural beliefs on co-habitation and adolescent sexual relationships, there is also a dearth of reporting in cases concerning child sexual abuse.

❖ Challenges in Training Programs

With regard to the training programs conducted by NEN, particularly in the context of police officials, one of the structural challenges identified was with role demarcation and role awareness amongst the police personnel.

D.5.7. NORTH EAST NETWORK - MEGHALAYA

POTENTIAL OPPORTUNITIES

Given the critical role of NEN's training programs for police personnel, there is scope for learnings from their training experiences to be incorporated in training programs for the police, specifically for child-related issues. Additionally, these training interventions could be supplemented with specific modules on child-related concerns, including on the provision of first-level responses to children in distress who may come in contact with the law.

D.5.8. INDIAN INSTITUTE OF PUBLIC HEALTH (IIPH)

EXISTING SERVICES AND SYSTEMS

IIPH, Shillong was established by the Public Health Foundation of India (PHFI) in collaboration with the Government of Meghalaya. It aims to address the institutional and systemic challenges in public health in the north east region of the country. It runs several graduate and post-graduate programs on public health, with the view to capacity strengthening and to improving health outcomes, through research, training and advocacy initiatives.

In the light of its mandates and resources, IIPH could be specifically engaged to conduct research and training in specific areas of community mental health, such as with the Anganwadi workers and their role in early childhood development and identification of disability; they would also be well-positioned to conduct research on sensitive issues such as child abuse within families and communities—an area wherein very little is known in Meghalaya, largely due to the hesitancies of people to talk about such concerns (due to the belief that such issues are ‘private’ and not be discussed outside of the family). The Director of IIPH offered for such studies and community-based interventions to be undertaken by graduate students and faculty of IIPH, with relevant funding and support from the state and other sources.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

Based on the above-described situational analysis and needs assessment, a Conceptual Framework for understanding Child and Adolescent Mental Health Needs is conceptualised, as below: (Fig. 2)

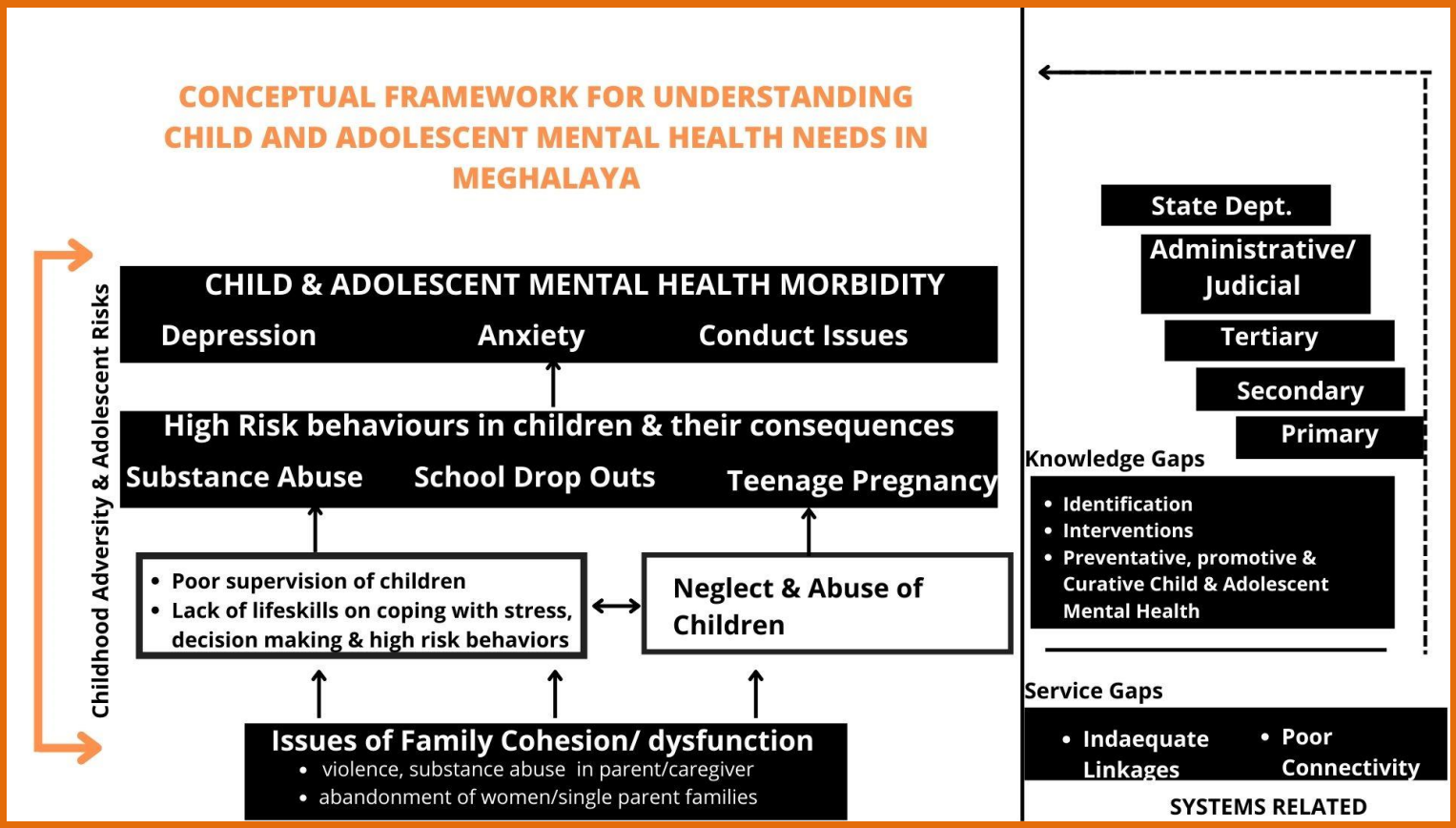


Figure 2: Conceptual Framework for understanding Child and Adolescent Mental Health Needs in Meghalaya

This framework outlines critical vulnerabilities of children in the state, along with knowledge and service gaps affecting the provision of requisite mental health services needed to address these vulnerabilities, as outlined in the situational analysis provided above.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

Drawing from the conceptual framework, the following tables (i.e., Table 2 and 3) provide a summary of recommendations for policy and practice, in pursuance of the mandate to advance child and adolescent mental health services in Meghalaya:

Table 2: Summary of Recommendations for Childcare Service Providers & Stakeholders directly engaged with children

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Primary/ Community Level	Anganwadi	➢ Staff to be equipped with skills and screening checklists for protection concerns in children as well as mental health and developmental issues. ➢ Skills to include an understanding of child development, assessments, emotional and behavioural concerns of children, communication skills, mental health issues and life skills interventions, along with a role-specific understanding of child related laws. ➢ Development of skills to identify protection risks and refer children/families to schemes and other health institutions for further interventions.	Training Programs to develop an understanding of critical areas of work with young children: ❖ Child development, (incl. activities to promote age-appropriate child development of young children); ❖ Identification of common emotional and behavioural problems among children ❖ Basic communication skills and creative methodologies for children ❖ Personal Safety Modules, First-level responses to child victims of abuse, and referrals

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Primary/ Community Level	Community Health Centre (CHC)	➢ Staff to utilise simple screening checklists (to be implemented during clinical services as well as house-to-house visits) for identification of developmental, mental health, and protection concerns in children; ➢ Linkages with DMHP, DCPU & DEIC, for periodic visits and referral of children for psychosocial interventions (incl. linking children to relevant govt. schemes.	Training for key village-level functionaries to cover the following domains for effective delivery of services: ❖ Understanding Child Development ❖ Pathways to Vulnerability and Children for Children ❖ Assessment checklists for Child Protection and Development Issues ❖ Orientation to key Child Protection, Laws and Schemes ❖ Role of the Panchayat in Child Protection and Development (Village Child Protection Committees) ❖ Development of a Child Development Plan at the village level.
	Village Headman	➢ Need to be oriented to child protection and development issues. ➢ Use screening check-list for referral of children to block and district-level services like the CHC, DMHP and DCPU. ➢ Maintaining a record of migration from the village, and utilisation of these records for screening possible cases of trafficking. ➢ Utilisation of IEC materials, in the local language, to raise awareness on important child-related issues.	

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Primary/ Community Level	**Block Development Officer**	➢ Development of convergence guidelines to specify BDO's role as liaison officers between the CHCs and secondary level authorities such as the DMHP, DEIC and other key district level programs. ➢ Utilising the convergence framework to link the community to key stakeholders such as the CHC, DMHP, DRC and other key block/district level service providers. ➢ Providing awareness and linking vulnerable children and families to child-related benefits and schemes at the block level.	Training for key village-level functionaries to cover the following domains for effective delivery of services: ❖ Understanding Child Development ❖ Pathways to Vulnerability and Children for Children ❖ Assessment checklists for Child Protection and Development Issues ❖ Orientation to key Child Protection, Laws and Schemes ❖ Role of the Panchayat in Child Protection and Development (Village Child Protection Committees) ❖ Development of a Child Development Plan at the village level.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	District Mental Health Program (DMHP)	➢ DMHP staff to provide first-level responses to child mental health (and protection) issues with a view to: a. containing the problem; b. addressing mild-to-moderate problems at a secondary level. ➢ Referrals to be made to tertiary mental healthcare services where longer-term, depth-pharmacotherapeutic and other forms of therapeutic assistance are required. ➢ Implementation of awareness programs that are rooted in the context-specific and socio-cultural needs of the community.	❖ Imperative for standardized training on child & adolescent mental health issues, including signs and symptoms and management of child and adolescent mental health disorders, as per the Diagnostic Statistical Manual. ❖ Use of systematic assessment protocols and interventions (including preventive and curative interventions that incorporate life skills approaches). ❖ Orientation to child laws and their application in child protection and mental health work. ❖ Skilling on special issues such as child sexual abuse and children in conflict with the law.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	**District Early Intervention Centre (DEIC)**	➢ Scaling up of the DEICs by setting up more DEICs across the State. ➢ Treatment and intervention responses to children referred to DEIC. ➢ Developing linkages of DEIC with the District Disability Resource Centres (DDRC) & the District Mental Health Program (DMHPs) for intensive and holistic support to children.	❖ Training of the DEIC Staff on mental health issues related to children & adolescents, particularly in the area of developmental disability. ❖ Knowledge and skills focused on different types of developmental disability, and related mental health (co)morbidities, protection risks in children with disability, developmental screening and use of psychological testing scales and requisite interventions for specific disabilities. ❖ Training on laws related to disability issues and inclusion, incl. processes relating to disability certification.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	**Rashtriya Bal Swasthya Karyakram (RBSK) Mobile Team**	Mobile Teams to develop requisite skills for conducting primary level screening of mental health issues, developmental problems and protection concerns. Development of Guidelines for RBSK referrals to the DEIC and DMHP, to be instituted.	❖ Training required on basic child mental health and developmental problems, in addition to assessment of protection concerns and the criteria for referral for the same. ❖ Orientation to school mental health issues, is also imperative, namely emotional, behavioural and learning issues, and development disabilities. ❖ While some areas of training are similar to school teachers, more emphasis is required on screening and assessment. .

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	Rashtriya Kishor Swasthya Karyakram (RKSK)	➢ Intensive and systematic approaches to counselling in all areas pertaining to adolescents, through the use of creative and participatory methods and the use of life skills training in ways that not only impart information but guide adolescents on perspective-taking and decision-making on high-risk behaviours. ➢ Participate in implementation of child laws such as the POCSO and Juvenile Justice Act, particularly the psychosocial and mental health implications of these legal provisions.	❖ Depth capacity building programs on (normative) adolescent development, key issues in adolescent neurodevelopment, and its impact on adolescent functioning and behaviour, use of effective communication skills with adolescents, conceptual knowledge and understanding of adolescent risk behaviours, context specific interventions on adolescent sexuality, substance use, self-harm, and other relevant adolescent mental health issues. ❖ Knowledge of POCSO and Juvenile Justice Acts incl. how these laws pertain to CICL, with specific focus on issues related to preliminary assessments undersection 15 of the Juvenile Justice Act. .

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	**One Stop Centre (OSC)**	➢ One Stop Centre Counsellors to extend their role to provision of: a. first-level psychosocial responses to children in Domestic Violence cases; b. first-level responses to sexually abused children; c. Dealing with sexuality, abuse and pregnancy issues in adolescents approaching the OSCs.	❖ In cases of child sexual abuse (CSA), the training would need to cover the following: a. Dynamics of child sexual abuse and the implications for disclosure and mental health issues; b. Identifying developmental and mental impacts of CSA and providing appropriate referrals to specialized mental health services; c. Communication skills for counselling of child victims of CSA d. Administering psychosocial and mental health assessments in CSA e. Provision of first-level responses to child victims f. Provision of immediate family and systemic interventions ❖ For domestic violence cases, a similar training for children in the context of these cases would be beneficial.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	**Special Juvenile Police Unit (SJPU)**	➢ Child-inclusive and child-sensitive ways of engagement with children in contact with the law i.e., children in need of care and protection and children in conflict with the law. ➢ Utilisation of forensically-accurate interviewing techniques for recording of child's statement.	❖ Capacity-Building interventions to build communication skills for enquiry with children. ❖ Training on POCSO-specific issues (incl. orientation to trauma in children; forensic interviewing; support to child victims and witnesses) amongst others. ❖ Training on CICL-specific issues (orientation to procedural norms in accordance with the Juvenile Justice Act; developing a child-inclusive approach towards CICL (focused on diversion (in cases of petty offences) & rehabilitation and restoration more generally)

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	**Juvenile Justice Board (JJB)**	➢ JJB's role to emphasise treatment and rehabilitation. The Board's role must be envisaged more broadly than assessment and understanding of offence circumstances, to include facilitating rehabilitation and treatment. ➢ The significant potential of the JJB could be realised only if the existing secondary and tertiary health systems are enabled to be responsive and effective, in terms of providing mental health support to children and adolescents referred by the JJB (both for capacity assessments as well as for treatment and rehabilitation).	Training on understanding CICL pathways to vulnerability; communication skills; available avenues of treatment and rehabilitation; developing robust social investigation reports; implementing psychosocial and mental health assessments to understand root causes of challenging and offensive behaviour; and navigating preliminary assessment issues in ways that secure the child's best interest and safety.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	**Integrated Child Protection Services (Child Welfare Committee, District Child Protection Officer, Child Care Institution Staff)**	➢ ICPS functionaries must be re-oriented to understand the link between protection risks and mental health issues so as to allow for the adoption of an integrated approach to child psychosocial care and protection. ➢ ICPS functionaries, as key child care service providers, must develop skills for comprehensive evaluation of children's circumstances to facilitate decision-making on placement and repatriation. ➢ Links between CCIs and CWC with the District Resource Centres (DRC) located in district hospitals and DMHPs, is required to be strengthened.	❖ Training on integrated approaches to child protection and mental health issues, to take cognizance of children's vulnerabilities, mental health and psychosocial needs (including child interviewing and systematic assessments of children's contextual needs) ❖ An orientation to law-related training content, as relevant to placement issues, decision-making on rehabilitation of children, and application of child laws in the country.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	Schools	Linkages between the District Mental Health Program (DMHP), District Early Intervention Centre (DEIC) and the District Resource Centre (DRC) are crucial, especially with regard to children with disabilities to enable them to get the assistance and stimulation-based activities and interventions they require.	Training efforts for school staff must be directed at developing an understanding of common emotional and behavioural issues in children, identification of signs and symptoms, management of such issues at the school level (where possible), first level responses and life skills training interventions.
Tertiary Level	Meghalaya Institute of Mental Health and Neurosciences (NIMHANS) North Eastern Indira Gandhi Regional Institute of Health & Medical Sciences (NEIGRIHMS)	Mental health services in tertiary care institutions must be scaled up to improve and expand child and adolescent mental health service provision across the state. Training and enhancement of human resources is critical in this regard.	Mental Health Professionals in tertiary care institutions must be trained on the following: a. Knowledge of child and adolescent mental health issues from a clinical as well as a public health perspective, including standardized assessments, child interviewing and case management skills; b. Intensive skill training on therapeutic interventions for various child and adolescent disorders; c. specialized skills in child forensic work, namely in dealing with child sexual abuse and children in conflict with law cases i.e., the interface of mental health with child law issues, and the role of the mental health professional in facilitating assistance to children in medico-legal contexts.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Other Agencies for Collaboration	Non-governmental/ community-based/ service/ academic and research organisation	➢ Replication of effective models of care (as outlined earlier) with requisite scaling up, and adoption of approaches and techniques beneficial to children. ➢ Collaboration between governmental and non-governmental agencies for referral of children for critical child services. ➢ Implementation of public awareness/ community-based campaigns. ➢ Collaboration for research and knowledge creation and management.	Appropriate subject-related/ technical knowledge and skill training (based on the agency and its technical area of work)

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

Table 3: Summary of Recommendations for Judicial and Administrative Authorities/Officers

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	Deputy Commissioners	Notification of periodical meetings of key district committees (at least on a monthly basis), such as the District Task Force Committee, District Inspection Committee and District Child Protection Committee, to streamline and regularise coordination efforts at the district level.	❖ In adoption cases, comprehensive training efforts to orient Deputy Commissioners on their new role under the Juvenile Justice Act, to develop clarity on the statutory framework and duties to be discharged by the Deputy Commissioner. ❖ Training materials including booklets and podcasts may be developed on key issues related to children, with specific focus on key frameworks such as the Juvenile Justice Act and POCSO.
	District Health Society (DHS)	➢ Facilitate convergence of mental health and protection-related schemes and programs for children. ➢ Operationalize prevention and awareness activities related to mental health and child protection at the community level	❖ Orientation on child and adolescent mental health and protection needs. ❖ An overview of requisite training and human resource development for key mental health-related agencies across the State

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Secondary Level	**Executive Officers of the District Councils**	District Council administration must develop an understanding of vulnerability and risk issues in children, and different authorities and bodies responsible for assisting children in various contexts.	Risk Pathways for children in contact with the law; and linkages/referrals with govt. agencies, schemes etc.,
Judicial Stakeholders	**Special Court (POCSO) Judge**	Imperatives to facilitate child-friendly adjudication and mitigate secondary traumatisation include: a. Integrating Mental Health Professionals in court processes necessitating expert assistance (capacity assessments, forensic interviews for recording of magistrate's statement) b. Facilitating support services in court (through Mental Health assessment and court preparation interventions that provide child victims necessary skills in contending with an adversarial courtroom). c. Ensuring child's safety and non-interference of the accused through coordination with CWC for placement of the child in best interest of the law; d. Documentation sharing arrangements (for judicial consideration of Social Investigative Reports to facilitate judicial decisions on compensation)	Training on forensic interviewing techniques for evidence eliciting processes in court, understanding dynamics of child sexual abuse, evaluation of child witness competency, facilitation of procedurally just court proceedings, imperative for court preparation interventions, and interpretation/appreciation of medical evidence.

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Administrative Stakeholders	Department of Education	➢ The State Resource Centre, along with the District and Block Resource Centres are an effective institutional apparatus in terms of providing assessment, referral and intervention services for children with disabilities, and can be strengthened further to facilitate closer linkages with the RBSK and Samagra Shiksha Aabhiyan for better implementation. ➢ Given the significant workload of subject teachers in schools (engaged in academic and administrative work), separate posts for trained teacher counsellors could help provide the required mental health assistance in schools. ➢ Consolidation of clear policy guidelines, through creation of a state-wide child protection policy can help provide a standardised roadmap for all schools to follow, thereby reducing discretionary measures for child protection and safety at the school level.	Orientation to the capacity building needs and initiatives for other stakeholders providing child-related services—in order to enable requisite monitoring and supervision mechanisms.
	Department of Social Welfare	The challenges highlighted in inter-departmental coordination, contributing to delays in providing assistance to children can be significantly improved, if ambiguities in role performance are addressed. Therefore, for child-related initiatives under the Dept., clearly documented roles and responsibilities, for each stakeholder, is imperative.	

E. CONCEPTUAL FRAMEWORK & RECOMMENDATIONS FOR 'CARE, PROTECTION AND SOCIO-EMOTIONAL WELL-BEING POLICY FOR CHILDREN AND ADOLESCENTS'

TIERS OF SERVICE PROVISION	STAKEHOLDERS	RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH POLICY	
		(EXTENSION OF) ROLE & FUNCTION	REQUISITE TRAINING & CAPACITY BUILDING
Administrative Stakeholders	State Commissioner for Persons with Disabilities & Unique Disability ID (UDID) Re-source Persons	➢ Development of clear guidelines for the treatment of children with disability in child care institutions. ➢ Training to be provided for field workers in conducting comprehensive and accurate disability assessments (including assessments with regard to mental health issues). ➢ Guidelines requiring the police to mention details of children's disabilities in case documentation (including in the FIR and final report) will help improve identification of these children and coordination efforts with the Disability Resource Centres.	Orientation to the capacity building needs and initiatives for other stakeholders providing child-related services—in order to enable requisite monitoring and supervision mechanisms.
	State Mental Health Authority (SMHA)	➢ Strategic planning and implementation of the Community Mental Health Awareness Programs. ➢ Strengthening of the District Mental Health Program (DMHP) and the tertiary care centres through training and capacity building programs on child & adolescent mental health issues and child protection concerns. ➢ Monitoring and process-based evaluation of mental health programs and institutions at the primary, secondary and tertiary levels through use of technology	

REFERENCES

1. Dhawan, A., Pattanayak, R. D., Chopra, A., Tikoo, V. K., & Kumar, R. (2017). Pattern and profile of children using substances in India: Insights and recommendations. *The National Medical Journal of India*, *30* (4), 224–229. https://doi.org/10.4103/0970-258X.218679

2. Fox, B. H., Perez, N., Cass, E., Baglivio, M. T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child Abuse & Neglect*, *46*, 163–173. https://doi.org/10.1016/j.chiabu.2015.01.011

3. Government of Meghalaya. (2017). *Statistics Handbook Meghalaya 2017*. Directorate of Economics & Statistics, Government of Meghalaya. http://megplanning.gov.in/handbook/2017.pdf

4. Hasan, A., & Tawfeeq Alee, N. (2018). *Mental Health and Psychological problems in North East India*.

5. International Institute for Population Sciences (IIPS) and ICF. (2021). *National Family Health Survey (NFHS-5), India, 2019-20: Meghalaya.* IIPS, mumbai. http://rchiips.org/nfhs/NFHS-5Reports/Meghalaya.pdf

6. Sheffler, J. L., Stanley, I., & Sachs-Ericsson, N. (2020). Chapter 4—ACEs and mental health outcomes. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse Childhood Experiences* (pp. 47–69). Academic Press. https://doi.org/10.1016/B978-0-12-816065-7.00004-5

7. Slong, D., & Ropmay, A. D. (2011). Domestic violence: A hidden problem. *Journal of Forensic Medicine and Toxicology*, *28* (2), 32–34.

SAMVAD

(SUPPORT, ADVOCACY AND MENTAL HEALTH INTERVENTIONS FOR CHILDREN IN VULNERABLE CIRCUMSTANCES AND DISTRESS)

A NATIONAL INITIATIVE & INTEGRATED RESOURCE
FOR CHILD PROTECTION, MENTAL HEALTH & PSYCHOSOCIAL CARE

DEPT. OF CHILD AND ADOLESCENT PSYCHIATRY
NATIONAL INSTITUTE OF MENTAL HEALTH & NEUROSCIENCES (NIMHANS), BANGALORE

SUPPORTED BY MINISTRY OF WOMEN & CHILD DEVELOPMENT,
GOVERNMENT OF INDIA

IN COLLABORATION WITH

DEPARTMENT OF HEALTH & FAMILY WELFARE,
GOVERNMENT OF MEGHALAYA

Design and layout by Aishaanyaa Tewari, Media Officer, SAMVAD