Policy and governance to address depression and suicide in Bhutan: the national suicide-prevention strategy

Gampo Dorji1,2, Sonam Choki3, Kinga Jamphel4, Yeshi Wangdi4, Tandin Chogyel5, Chencho Dorji6, Damber Kumar Nirola3,7

1World Health Organization Regional Office for South-East Asia, New Delhi, India, 2University of Newcastle, Australia, 3Jigme Dorji Wangchuck National Referral Hospital, Thimphu, Bhutan, 4Department of Public Health, Ministry of Health, Royal Government of Bhutan, Thimphu, Bhutan, 5Department of Traditional Medicine Services, Ministry of Health, Royal Government of Bhutan, 6Department of Psychiatry, Jigme Dorji Wangchuck National Referral Hospital, Thimphu, Bhutan, 7Khesar Gyalpo University of Medical Sciences of Bhutan, Thimphu, Bhutan

Correspondence to: Dr Gampo Dorji (gampo_73@yahoo.com)

Abstract
Suicide and mental disorders are a growing public health issue in Bhutan, due in part to a rapidly transitioning society. The burden of suicide has been recognized by the Royal Government of Bhutan and, as a result, it introduced the country’s first ever national suicide-prevention plan in 2015. The 3-year action plan takes a holistic approach to making suicide-prevention services a top social priority, through strengthening suicide-prevention policies, promoting socially protective measures, mitigating risk factors and reaching out to individuals who are at risk of suicide or affected by incidents of suicide. This article documents Bhutan’s policy and governance for addressing depression and suicide within the context of its national suicide-prevention strategy, examines progress and highlights lessons for future directions in suicide prevention. Since the endorsement of the 3-year action plan by the prime minister’s cabinet, the implementation of suicide-prevention measures has been accelerated through a high-level national steering committee. Activities include suicide-prevention actions by sectors such as health, education, monastic communities and police; building capacity of gatekeepers; and improving the suicide information system to inform policies and decision-making. Suicide-prevention activities have become the responsibility of local governments, paving the way for suicide prevention as an integral mandate across sectors and at grass-root levels in the Kingdom of Bhutan.

Keywords: Bhutan, depression, mental health, national strategy, prevention, suicide

Mental disorders and suicide in Bhutan
The Kingdom of Bhutan is nested in the eastern Himalayas. The country’s population of 0.78 million,1 traditionally an agrarian society, is experiencing a rapid socioeconomic transformation. The nation is on a fast track towards becoming a market-driven competitive consumeristic society.2 With rapid urbanization, rural–urban migration is a concern, as an increasing proportion of the country’s elderly population is left behind in the villages.3 In urban settings, the systems for extended family support are becoming less affordable, and social norms and traditional values are rapidly evolving towards the nuclear family. Mental health becomes a pertinent subject in the context of a transitioning society struggling to strike a delicate balance between the forces of modernization and tradition.

Mental disorders and suicide constitute a significant disease burden in Bhutan.4 Although population-level data on mental disorders are scant, health-facility morbidity reports indicate that, from 2011 to 2015, there was an increase in the total number of documented cases of mental health disorders, from 2878 cases to 7004, of which 45% and 31% were anxiety and depression respectively.5 Suicide attempts are associated with depression6 and other mental disorders.7 In interviews among the next of kin of people who died by suicide in Bhutan, many reported the deceased’s feelings of hopelessness, a characteristic that, although found in a range of situations, can occur in individuals with depression.8 Although the suicide rate in Bhutan (10 per 100 000 population per year) is consistent with global averages, the figure is likely to be inaccurate and lower than the actual number of cases, owing to widespread stigma and a reluctance of close family and other relatives to undergo police investigation.9 Therefore, additional work is required in order to comprehend the higher rates of suicide seen in rural areas (88%) in Bhutan and among young adults (66%) aged 15–40 years.9

Overview of policies to prevent depression in Bhutan
An effort to provide mental health service as an integrated primary health-care service was initiated in 1997. The National Mental Health Programme was established at the Department of Public Health, to oversee the efforts. Short courses to train primary health-care workers to recognize and treat common mental disorders, including depression and anxiety disorder, at primary health-care level have been conducted over the years. An acute shortage of mental health professionals who are able to provide back-up to primary health-care providers is one of
the critical obstacles facing mental health services in Bhutan. In the country’s history of 60 years of allopathic medicine, Bhutan only has four psychiatrists. In addition, the country lacks any psychiatric social workers or mental health counsellors with comprehensive training. As a result, routine clinical mentoring of primary health-care services in management of mental disorders is compromised. The quality of mental health services is therefore low and relatively basic. Treatment and rehabilitation centres for misuse of drugs and alcohol are provided through joint efforts of government and civil society, and their coverage is very low. In addition, back-up from the health services is not optimum, owing to low capacity of the health-service providers. Myths and lack of awareness about mental disorders abound, as the concept of mental health is relatively new in Bhutan.2 Stigma and discrimination related to mental health are universal challenges,10 and are prevalent in Bhutan, such that most people with mental disorders and depression receive no treatment or delay seeking care.

Bhutan’s suicide-prevention strategy 2015–2018

While suicide prevention is receiving increased attention in many high-income countries, suicide-prevention programmes remain largely ignored in low- and middle-income countries, owing to a number of impeding factors and competing priorities.11 In Bhutan, suicide did not feature as a social and public health issue before 2014. Even among health-care providers, the idea that suicide was preventable was not fully understood. When a suicide occurred, health workers merely viewed it from the perspective of a medico-legal task and accompanied police to the scene to complete the medico-legal investigation. No post-event services – i.e. counselling and other social care for those directly affected by a suicide – were provided to the family members and individuals who were bereaved.2

Frequent reports of suicide in health facilities, and news coverage by the media of suicide incidents in the country, captured the government’s attention; the prime minister’s cabinet intervened and issued an executive order in 2014 to conduct an assessment of the suicide situation in the country. An 11-member multisectoral task force led by the secretary of the Ministry of Home and Cultural Affairs was appointed to review suicide in Bhutan. Subsequently, Bhutan’s first study on suicide, commissioned from May to June 2014, revealed 315 deaths in a span of 5 years, covering 2009–2013 – an average of 76 deaths annually.8 Although hanging was the most common means of suicide, consumption of drugs or toxic substances such as pesticides and insecticides was also documented.8 The fact that suicide deaths exceeded the deaths due to tuberculosis, HIV, malaria and road traffic accidents9 heightened the political desire to prioritize suicide prevention in the country. In December 2014, the prime minister’s cabinet directed the task force to develop a suicide-prevention action plan. In February 2015, the Ministry of Health mobilized multisectoral agencies and spearheaded the development of the 3–year action plan (2015–2018).8 Key stakeholders, including the Central Monastic Body, the Ministry of Education, the Ministry of Health, the Women and Children’s Commission, academia, civil society organizations and the Royal Bhutan Police, engaged in a series of consultations. In May, 2015, the 3-year suicide-prevention action plan was endorsed by the country’s highest executive body, in the 74th session of the prime minister’s cabinet, paving way for implementation of the first suicide-prevention plan in Bhutan. Some government funding for suicide-prevention activities has been integrated within the annual sectoral budgets for the health, education, police and other sectors.

The 3-year action plan encompasses approaches to prevention, service delivery, and strengthening institutional and policy responses for suicide prevention.9 The implementation of the plan is designed to mainstream complex determinants of suicide into the multisectoral programme, with the aim to reduce suicide rates by 10% by 2020, in line with the May 2013 declaration of the World Health Assembly.9,12 The plan is fairly comprehensive, with actions targeting the general population through mass media and social mobilization, providing focused prevention and post-event services for individuals at high risk of suicide and those affected by suicide. The plan has clear deliverables, an implementation matrix and a framework of stakeholder accountability. The logic of change of the 3-year action plan is synthesized in Box 1.

Initial achievements in suicide prevention

Progress in implementation of the 3-year action plan for suicide prevention has been notable since its release in 2015.9 Most of the activities are being implemented in accordance with the plan, as described next.

Governance

The structure of governance for suicide prevention is in place. The National Suicide Prevention Plan is implemented under the auspices of the National Suicide Prevention Steering Committee (NSPSC). A 10-member committee chaired by the health minister has met twice to discuss the progress of implementation. The National Suicide Prevention Programme (NSPP) has been instituted at the Department of Public Health, to function as secretariat to the NSPSC and as a technical agency for suicide prevention, with full-time staff and budget allocation. The implementation of activities has been assured by signing a memorandum of understanding between the NSPP and all the implementing partners.

At the local level, coordination of suicide prevention is integrated within the roles of local governments. Eight of the 20 districts have set up a district suicide-prevention rescue team and the remaining districts are expected to establish the mechanism within the remaining period.

High-level advocacy support

Suicide prevention is championed by some of the highest social figures in the country. His Holiness the Je Khenpo, the Chief Buddhist Abode of the country, has addressed youths, promoting human values and dissuading suicidal attempts. Similarly, Her Majesty the Queen Mother has adopted school-based programmes focusing on depression and suicide prevention as a priority, as part of school youth programmes.14 The World Suicide Day on 11 September has been routinely observed since 2015, and remains a platform for advocacy and engagement of parliamentarians and partners on suicide prevention.15
**Box 1. Outcomes to be achieved by 2018 for suicide prevention in Bhutan**

**Inputs**
- National Suicide Prevention Steering Committee (NSPSC)
- Governor’s suicide-response team at district level
- Suicide-prevention unit of the Royal Bhutan Police at the police headquarters
- Local governments’ (dzongdags’) suicide-prevention response teams
- National Suicide Prevention Programme (NSPP)
- Budget allocation from government funding

**Outputs/activities**
- Establish a certified board of counsellors in Bhutan
- Set up training courses for counselling and medico-legal investigation
- Set up forensic units at the three referral hospitals
- Conduct school-based programmes
- Conduct public campaigns, public events and media advocacy
- Orient media houses on responsible media reporting
- Set up a 24-hour national helpline and toll-free youth lines
- Introduce interactive social media
- Frame rules and regulations for the Pesticide Act of Bhutan
- Build capacity for police, women and child protection units, and peer counsellors for misuse of alcohol and drugs
- Integrate mental health, depression and suicide for paramedics at the Faculty of Nursing and Public Health
- Set up a national suicide registry
- Brief community traditional healers, local shamans, tsips, and local lamas on suicide prevention
- Identify community confidantes in villages and communities
- Conduct annual parliamentary briefing on suicide prevention
- Revise ICD* coding to include suicide and mental health disorders in the health management and information system

**Short-term outcomes to be achieved by 2018**
- Counselling services and mental health assessment are integrated as a standard of care for primary health-care service
- 100% of the health facilities in the country have integrated mental health screening tools in the patient examination checklist
- Annually, 100% of secondary schools and 90% of the school students receive at least one religious discourse (choeshed lerim) with a Buddhist lama
- 100% of school guidance counsellors are trained on mental health and recognition of depression and signs of potential suicide
- Annually, 100% of the district and block councils (dzongkhags and gewog tshogdues) include an agenda on mental health promotion and suicide prevention
- 90% of the suicide stories reported in the media observe responsible media reporting
- 100% of suicide attempters and of those with addiction to substance presenting in a health facility receive a mental health assessment as a standard of care
- 50% of suicide survivors receive crisis counselling and suicide risk assessment by a trained professional (health worker, school counsellor or peer counsellor)
- 80% of families bereaved by suicide receive support from their neighbours and communities
- Real-time data on suicide are available

**General outcomes**

![Diagram showing the relationship between decreased depression and mental disorder, improved mental health, decreased in suicide, improved gross national happiness index and well-being.]

*International Statistical Classification of Diseases and Related Health Problems.*13
Institutional capacity development
The National Certified Counselling Board has been established, to promote the certification of professional counsellors in the country. In 2016, a Bachelors of Science in clinical counselling was established in Khesar Gyalpo University of Medical Sciences of Bhutan, with the first batch of six students. The Royal University of Bhutan has integrated suicide and mental health in the curriculum in its postgraduate counselling training programmes, where trainees are mostly the future employees of school systems.

Prevention services
A national hotline service has been set up as a part of medical emergency response and provides 24-hour support to crisis calls, including free ambulance services. Additional toll-free services for youth offered by the Ministry of Education have been oriented on the management of crisis calls. A Facebook forum “Mind Over Matter Bhutan”,16 moderated by a group of professionals, is becoming a popular online platform for people in Bhutan with depression and suicidal intent. All medical technicians have been trained as the first responders for suicide. Similarly, a suicide component has been included as part of training for primary health-care workers. The school system, which traditionally focused on career guidance, is now including psychosocial areas as a component of interventions, using a network of peer counsellors and sensitization of teachers. The level of engagement of nongovernmental organizations providing rehabilitation for women, children and youth has increased, and the services are being aligned to address depression and risks for suicide.

Data and information system for suicide
A national suicide registry has been set up at the NSPP and health workers have been trained to report suicide and attempted suicide. Information from police and the health sector is triangulated to complete the national suicide registry; the data collected are shown in Table 1. These data are too preliminary for detailed interpretation. However, it is notable that Samtse and Thimphu districts have reported higher numbers of suicides to date than other districts. Among other reasons, this may be because these districts have relatively large populations. Data on suicide are available in real time with the NSPP, to inform programme developers and policymakers. In addition, ICD (International Statistical Classification of Diseases and Related Health Problems) coding13 has been revised in the health information system, to include disaggregated data on suicide and self-harm.

Suicide-prevention strategy complements other policies and governance
Suicide-prevention strategy is complemented by numerous government policies. The overarching framework of gross national happiness, Bhutan’s developmental model, includes psychosocial health as an important dimension of progress.17 This includes building social resilience and cohesion – a protective factor for suicide.18 Using Buddhist precepts to address deeper psychological issues, attempts are made to reach schools and the general population, through curricular and mass education on the positive value of human life and discouraging suicide and self-harm.

The government policy for reducing harmful use of alcohol adopted community-based programmes to address the high burden of alcohol-related problems, in addition to marketing, economic and enforcement policies.19 Access to means such as pesticide and insecticide, which heightens the risk for suicide,20 will be regulated with the review of regulations. The mental health strategy of Bhutan2 complements health-service delivery at the primary health-care level,11 alongside commitments to enhance the professional mental health workforce in the country. Overall, increased government support for engagement of community-based and nongovernmental organizations dealing directly with misuse of alcohol and drugs in the country contributes to coverage of services among individuals with a higher risk of suicide.

Table 1. Distribution of complete suicide cases in districts from 1 January to 30 October 2016 in Bhutan (national suicide registry)

<table>
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<tr>
<th>District</th>
<th>10–20</th>
<th>21–30</th>
<th>31–40</th>
<th>41–50</th>
<th>51–60</th>
<th>61–70</th>
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Lessons learnt and future directions

This section summarizes the lessons learnt from the implementation of suicide prevention in Bhutan. Mental health is a fundamental component of the concept of holistic health, and its omission, a concept sometimes expressed as “no health without mental health”,21 is a serious policy gap. The greatest influence on mental health is achieved through prioritization of relevant policies and programmes by national governments. Suicide is an acute event and it is often easier to gain policy and political attention of governments in this area, provided the right approaches are taken. Suicide prevention can be used as an entry point to address depression, alcohol misuse and drug addiction, and to set the public health agenda for mental health as a whole.

Clear information on the epidemiological burden, groups affected, socioeconomic implications and rationale for action should be documented, to inform and influence the decision of policy-makers, such as heads of governments. In Bhutan’s case, findings from the 5-year retrospective assessment on suicide5 convinced the prime minister’s cabinet to undertake prompt policy endorsement and resource allocation for suicide prevention.

Suicide prevention requires effective collaboration among government and nongovernment agencies. Forming a policy coalition with agencies and civil society groups is necessary to bring a combined perspective on a highly sensitive subject. It is useful to engage stakeholders early on rather than later, during the stage of policy dialogue, while planning to build ownership during implementation of the programme. When the implementation plan was presented to the cabinet, a single voice was created among stakeholders, and clear areas of response for key stakeholders were identified and agreed upon.

Mental health programming and execution requires a coordinating agency endorsed by all sectors. A well-thought-out coordination mechanism for multisectoral response is crucial for the success of policy governance. The health sector appears to be an acceptable coordinating agency, as most agencies view suicide and depression as severe health outcomes. Once a national coordination mechanism is established, proactive and constant communication is required to keep stakeholders connected. It is vital to expand educational and communication activities beyond identifying suicide and depression as adverse health outcomes and towards raising awareness of the different ways that mental disorders can present – such as depression in a child presenting as low school grades, or in an adult presenting as an alcohol-use disorder.

Where possible, government support, in terms of funds and resources, is needed to boost the initial work. Suicide prevention requires commitment and innovation. As a governance approach, suicide prevention receives a higher priority if it is included as one of the performance indicators of government agencies, particularly local governments. Making suicide prevention a local responsibility builds ownership of the issue.

Suicide is a sensitive issue, as suicidal behaviours can be highly stigmatized. Health workers and service providers must maintain full confidentiality, to gain the trust and confidence of clients and their relatives. The importance of upgrading the skills of the health workforce in mental health services and suicide prevention should not be underestimated. Clinical mentoring and supportive supervision in addressing mental disorders appears to be a good approach to increase coverage of services.

Despite good progress, Bhutan’s work in suicide prevention is only a beginning. While it is too early to comment on the outcomes of interventions, processes are going in the right direction. Institutional capacity-enhancement programmes, such as introduction of medico-legal courses to determine the cause of death, forensic investigation for police, and human resources to train professionals, are challenging and should be given priority. Planning, development and retention of mental health professionals should be well focused, as investment is required to ensure adequate time for producing a mental health workforce. Health services should be improved, to detect, treat and follow up cases of depression and provide post-event services for people at risk of suicide. Community outreach and education on depression are still weak and restricted to case-finding when people seek health services. More capacity is required among community-based organizations to conduct outreach and gate-keeping services. Lessons learnt from implementing the first suicide plan need to be well documented and incorporated in planning the post-2018 phase of the suicide plan in Bhutan.

Source of support: Nil.

Conflict of interest: None declared.

Authorship: GD conceived the concept of the manuscript, wrote the first draft with CD and SC and wrote the final paper. SC and KJ contributed to development and preparation of the initial draft and review of the subsequent draft. YW conducted a review of information in the manuscript. TC provided information on historical development of mental health and suicide services in Bhutan. DKN reviewed the second draft.


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