ROYAL GOVERNMENT OF BHUTAN

SUICIDE PREVENTION IN BHUTAN - A THREE YEAR ACTION PLAN (July 2015-June 2018)

The document was granted approval in the 74th Session of the Lhengye Zhungtshog held on May 12, 2015

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PRIME MINISTER

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Royal Government of Bhutan

24 July 2015

FOREWORD

It is alarming to note that every month around 7 people die in our country by suicide. Many more are treated in the BHUs and hospitals for suicide attempts and deliberate self harm, and still there must be others not even seeking care and treatment. This is a contradiction to the great emphasis we place on the self preservation and incalculable value on human life. Suicide is a tragic loss of life and cause of extreme suffering both for people living with the loss and to the society as a whole. But we must not forget the fact that to a large extent, suicide is preventable with appropriate interventions provided at a right time. For a nation committed to upholding the values of Gross National Happiness and promoting happiness as a goal of human existence, there is a great sense of urgency to overcome this unhealthy trend in our society.

As a government we are deeply committed to addressing suicide prevention as a top social priority. The Royal Government has, therefore, instructed the important stakeholders to develop the nation's first comprehensive Suicide Prevention Action Plan. Our main goal is to have zero death by suicide; no families, villages, communities, and neighborhood would desire anyone dying of suicide.

As a society, Bhutanese are resilient. We must uphold this character and further strengthen the longstanding social capital. We are enjoying the fruits of socio-economic development. However, due to the rapid socio-economic transition, our social fabric, family values and relationship are fast changing. Economic demands, need for academic and work excellence are getting ever more competitive, putting additional pressure on the society. We must all be aware of these realities and work together to preserving a resilient society truly bounded by the vision and values of a happy society. That can only happen when everybody shares the same vision and works hard towards achieving the same end.

PRIME MINISTER

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Royal Government of Bhutan

Causes of suicide are complex and multi-factorial. Suicide prevention efforts must be multipronged addressing at individual as well as society levels. The government agencies, non-government organizations and civil society organisations have significant roles in suicide prevention. The three year action plan for suicide prevention offers us an opportunity to exercise our roles in suicide prevention and in creating a harmonious society. The plan is comprehensive addressing universal prevention targeting general population through, mass media and social mobilization, to providing specific services for individuals at high risk of suicide and those affected by suicide. The plan offers the most practical ways of addressing suicide prevention in a short time frame and has the potential to save many lives.

This is a goal worth pursuing. I call upon the agencies, individuals and those affected, and bereaved by suicide for a collective action to save lives by preventing further suicidal deaths. One suicide death is too huge a loss to the society. We must act together with a sense of urgency.

(Tshering Tobgay)

ACKNOWLEDGEMENTS

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ABBREVIATIONS

AA	Alcoholic anonymous
BICMA	Bhutan Information and Communication Media Authority
BNCA	Bhutan Narcotic Control Agency
CBOs	Community based organizations
CBSS	Community based support systems
CBT	Cognitive behavioral therapy
CECD	Career Education and Counseling Division
CPA	Chithuen Phendey Association
DEO	District Education Office
DMS	Department of Medical Services
DICs	Drop in centers
DV	Domestic violence
DYS	Department of Youth and Sports
ED	Emergency Department
EMT	Emergency Medical Team
FNPH	Faculty of Nursing and Public Health
GB	Gender based
GNH	Gross National Happiness
GPMS	Government performance monitoring system
HHC	Health Help Center
HISC	Health Information and Service Center
HMIS	Health management and information system
HRD	Human Resource Division
IDU	Injecting drug users
JDWNRH	Jigme Dorji Wangchuck National Referral Hospital
KGUMS	Khesar Gyalpo University of Medical Sciences
LG	Local Government
LGBT	Lesbian Gay Bisexual and Transgender
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MoHCA	Ministry of Home and Cultural Affairs
MI	Motivational interviewing
MSTF	Multisectoral Taskforce
NA	Narcotic anonymous
NCWC	National Commission for Women and Children
NGO	Non-government organization
NSB	National Statistics Bureau
NSPSC	National Suicide Prevention Steering Committee
NSPP	National Suicide Prevention Program

OSCCs	One Stop Crisis Centers
RBP	Royal Bhutan Police
RCSC	Royal Civil Service Commission
RENEW	Respect Educate Nurture Empower Women
RNR	Renewable Natural Resources
RUB	Royal University of Bhutan
SCE	Samtse College of Education
SGCs	School guidance counselors
SPEA	School parenting education and awareness
TRCDAD	Treatment and rehabilitation center for drugs and alcohol
VHWs	Village health workers
WCPDs	Women Child Protection Desks
WCPUs	Women Child Protection Units
YDF	Youth Development Fund
YDRC	Youth Development Rehabilitation Center

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Contents

SUICIDE PREVENTION IN BHUTAN: A THREE YEAR ACTION PLAN (2015-2018)

SECTION I

PROGRAM ASSESSMENT

Introduction

Suicide is defined as an act of killing oneself [1] or death caused by self-directed injurious behavior with any intent to die as a result of the behavior [2]. It is a serious public health issue and generally impacts the most vulnerable and disadvantaged members of the society. Suicide causes extreme pain and suffering for people who are left behind. Also it causes loss of economic productivity as most suicide deaths occur among economic productive age group. Societal stigma towards suicidal behaviors (suicide ideation, attempted suicide, and suicide) poses a formidable barrier to providing care and support to individuals in crisis and to those who have lost a loved one to suicide.

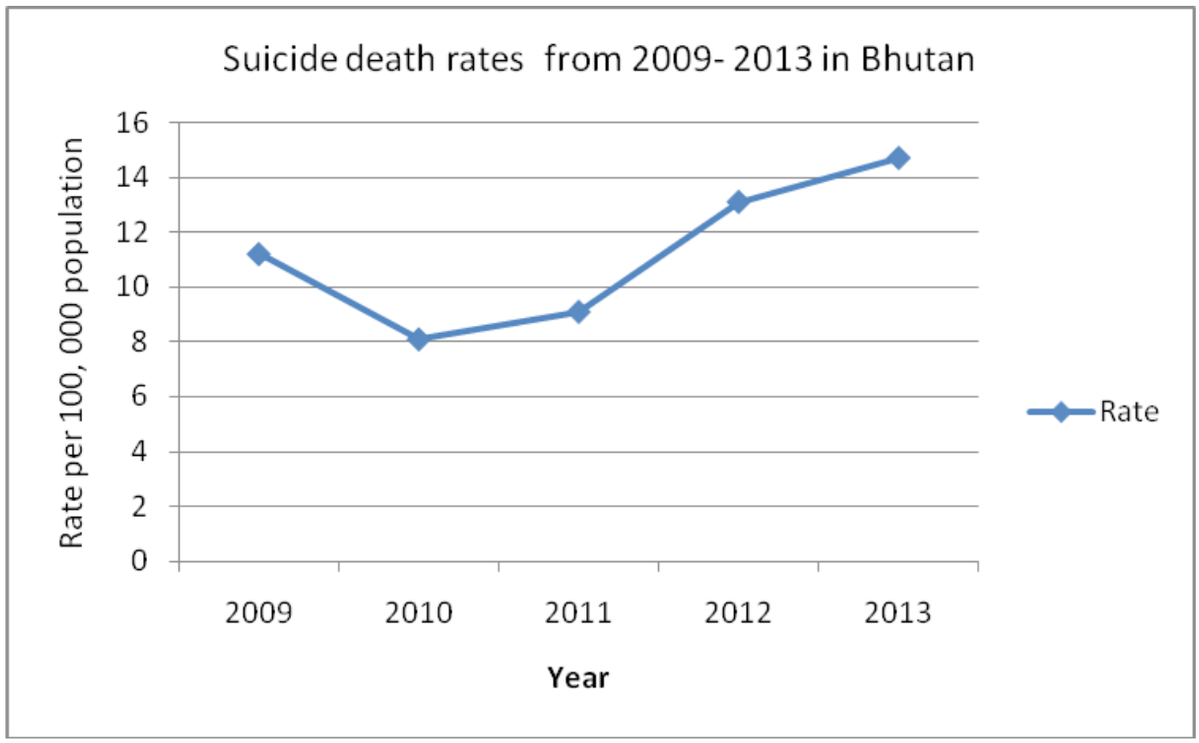
Suicide is a complex human behavior, with no single cause. [2] Psychological, social and cultural factors interact to lead an individual to a suicidal behavior. Links between mental illness and suicide are well established, but there are combinations of other factors that affect an individual's life such as drug or alcohol abuse, social isolation, poor family and personal relationships, lack of social supports and difficult economic conditions that increase the risk of suicidal thoughts and behaviors.

Suicide is preventable to a large extent [1][3] through collaborated efforts of multiple sectors involving both government and non-government sectors. Comprehensive, synergistic approaches are required to address an issue as complex as suicide; no single approach or organization can prevent suicide on its own.

Suicide epidemiology in Bhutan

In Bhutan, suicide deaths ranks among the top six leading causes of deaths after alcoholic liver disease, other circulatory diseases, cancers, respiratory diseases, and transport deaths. Suicide deaths outnumber the combined deaths due to TB, malaria and HIV. [4] In a five year review of suicide cases from 2009 -2013 in Bhutan, a total of 361 suicide deaths were documented by the Royal Bhutan Police.[5] This is an average of 73 suicide cases in a year or six suicide deaths in a month. The completed suicide rate in Bhutan is 10 per 100 000 population[1] slightly lower than the global rate of 11.4 per 100 000 population per year. The proportion of suicide deaths among all deaths is 4.5% higher than the corresponding proportion of 1.4% in the low middle income countries. Suicide occurrs among the most productive age groups; 87% of deaths occurred within the age group of 15-40 years. Although the global suicide rate has seen a drop, [1]suicide rates in Bhutan have remained steady and rather increased particularly in 2012 and 2013.

Globally for every suicide death, many more people attempt suicide. In Bhutan, for every 4.5 suicide deaths there is one suicide attempted case recorded, indicating gross under reporting of the attempted cases. The Health Management Information System (HMIS) of the Ministry of Health has been collecting data on "intentional self harm" since 2010. Cases of intentional self harm reported in the health facilities ranged from 502-682 cases while only 3-5 deaths due to intentional self harm which are likely suicide deaths were recorded in health facilities during 2009-2013. [4] This shows that suicide attempt cases end up in health facility care. Suicide attempts results in enormous cost to the health care, family and individuals due to injury and disability.



Male-to-female ratio of suicide deaths in Bhutan is 2 men to each woman, slightly higher than an average ratio of 1.5 men to each women in low and middle income countries. [1] Suicide deaths have been reported in all parts of Bhutan with a few districts having a higher burden as compared to others. Most suicide deaths (88%) have occurred in rural areas, among married people (66%) and those with less education. About 42% of suicide deaths occurred among uneducated people while 58% of suicide deaths in low income bracket earning less than Nu. 3,000 per month. As is already known, economic factors, relationship problems, domestic violence, and emotional abuse are significant risk factors for suicide in Bhutan.

The majority (80%) of those who died by suicide or attempted suicide had projected some forms of distress.[5] Mental illness is a key suicide risk factor. The most common diagnoses of mental disorders among suicide death are psychosis, depression, anxiety and other mental disorders. However, mental health services are often less sought by individuals at risk of suicide. Only 12% of suicide deaths had

received mental health support. The links between suicide to alcohol and drug abuse is well known in suicide literature and is true in the Bhutanese suicide epidemiology. The majority (58%) of suicide deaths has a history of alcohol addiction, and about 14% were addicted to marijuana or other drugs.

Only about 20% of suicide deaths and 23 % of people who attempted suicide had shown some signs of suicide risks, the majority in the form of verbal or written expression. Bhutan's suicide study showed that the key risk factor for suicide was mental problems (84%), stressful events (68%), addiction (59%) and followed by domestic violence (46%).

The only national survey that sampled for suicidal ideation was the Gross National Happiness Survey 2010. Suicidal ideation in the past 12 months was 3.4% and was more prevalent in rural (4%) as compared to urban (1.7%) areas. [6]This is consistent with 88% of the suicidal deaths from 2009-2013 being from rural areas. It is also to be noted that suicide attempts were reported more from urban areas (65%).[5]

The current situation in suicide prevention

Suicide prevention requires a combination of universal, selective, and indicated strategies to address the wide spectrum suicide risks. [7] Universal strategies target the entire population. Selective strategies are appropriate for subgroups that may be at increased risk for suicidal behaviors. Indicated strategies are designed for individuals identified as having a high risk for suicidal behaviors, including having made a suicide attempt.[2] To date there has been no stand alone comprehensive suicide prevention program in Bhutan, but some forms of integrated services are available through primary care mental health services, domestic violence prevention and de-addiction strategies for alcohol and drugs. Basic Health Units (BHUs) and hospitals can potentially identify patients with suicidal risk factors and behaviors but mental health screening or suicide risk identification is not a routine practice.

Encouragingly, scattered programs or activities are addressing one of more key risk factors of suicide such as curbing domestic violence, substance abuse prevention, and de-addiction and rehabilitation services for alcohol and drugs through NGO initiatives. These have the potential for a positive impact on suicide prevention. Even among these selective strategies, a focus on suicide risk identification and risk minimization is low. However, with the slight adjustment to the current practices, services offered by these organizations can be made more responsive to suicide risk. The universal strategies on suicide prevention using mass media and educational programs are not available yet. Religious and socio-cultural values that can build a positive influence that can discourage suicidal behaviors have not been fully tapped. Despite gaps, there are several ongoing interventions that offer hope for building a comprehensive suicide prevention services in the country. The following sections describe the current state and identify potential opportunities for strengthening suicide prevention programming in Bhutan.

UNIVERSAL STRATEGIES

Mass media and public information

In Bhutan's relatively short history of mass media (print media, radio, television, movie industry, and social media), health promotion through mass media is increasingly becoming a popular medium. Many movies have focused on drugs, substance abuse, HIV prevention, and difficult relationships – all suicide risk factors. Although the mass media was less engaged in suicide prevention, after the commissioning of the government suicide report in 2014, film makers, and media agencies have shown interest in suicide issues. While being enthusiastic about engagement in suicide prevention, inappropriate reporting of suicide by mass media can have a contagion effect. [8] Despite the fact that media reporters are aware of the needs to handle suicide news sensibly,[1] it is crucial that measures are taken to promote responsible media reporting on suicide.

Stigma remains the major barrier for suicide prevention efforts across the world and prevents vulnerable people and their friends, families and individuals from accessing services such as counseling and postvention support.[3] Media can focus on de-stigmatizing mental illness, reducing stigma attached to suicidal behaviors, and enabling help-seeking among those vulnerable to suicide. Public information campaigns to support the understanding that suicides are preventable and mental illnesses are treatable must be established. Public and professional access to information about all aspects of preventing suicidal behaviors should be increased. Social media such as facebook, twitter, youtube and apps-enabled media are fast penetrating the lives of Bhutanese; the capability of social media channels should be used for mass media communications for suicide disseminating suicide prevention messages.

Religious beliefs and cultural practices

Most religious preaching focuses on human value and morality. Buddhists belief in self preservation of human life is a protective factor in suicide prevention. In a highly spiritual Bhutanese society, religion and spirituality may engender social cohesion and supportive community. Buddhism also recognizes suicide risk factors such as alcohol and drug use as the root of misdeeds. Involvement of the central monastic body for health programs goes back far into 1989 when the Religion and Health Project was established. The Central Monastic Body, Rabdeys and Shedras have since then, actively supported diverse social and health programs with the blessings from His Holiness the Je Khenpo. High Ranking Lopens, Lam Netens, Khenpos, from the central monastic body and other prominent religious figures conduct Choshed Lerim through mass sermons, television and radio broadcasts, and visit schools and institutions. Religious preaching highlighting the negative karma that could accumulate from suicide should be further advocated in the general public and targeted groups such as schools and institutions to discourage suicide. Kuzoo FM, a popular radio program in the country is hosting one hour daily religious program from 5-6 pm in which suicide prevention messages can be subtly integrated. Providing support to neighbors during sickness and death is an age old social capital prevalent across communities in Bhutan. Such practices should be promoted and encouraged,

[1]The National Suicide Report 2014 was reported on February 8, 2015 issue of the Bhutanese Newspaper. The editor's note appeared: The writer and the paper have jointly agreed to leave out the various methods of carrying out suicide from this story to prevent any copycat acts. Namgay Zam/ Thimphu http://www.thebhutanese.bt/majority-of-suicide-victims-are-rural-married-depressed-young-and-poor-govt-report/

particularly in fast growing urban communities in Bhutan, where society is caught between the values of modern and traditional lifestyles.

Lams and monks can play a direct role in helping individuals exposed to suicidal risks. Amongst suicide victims who availed help for addiction, seeking advices from Rinpoche/religious persons, and elders were common [5] in search for calmness and tranquility of life. Value based psychotherapeutic programs should be piloted by blending age old Buddhist traditions with the modern psychotherapeutic techniques for providing psychological support for individuals at risk of suicide. Lessons from such pilots can be used for designing wide scale programs. Prior to this, focal points from religious institutions should be exposed to the modern counseling programs who can then adapt programs addressing psychosocial problems.

Suicide prevention in schools and institutions

About 69% of completed and 90% of attempted suicide cases were youth and young adults. [5]Students spend significant time in school. Teachers and others who interact with them there daily are in a prime position to recognize the signs of suicide, and to make appropriate referrals. Schools offer an excellent opportunity for prevention of suicide through helping someone at risk of attempting suicide or other students experiencing loss from suicide. The Ministry of Education's existing counseling services and school parenting education and awareness (SPEA) programs[9] are universal interventions in schools in Bhutan that can contribute towards case finding among students.

Since 2011, counseling services have been strengthened by providing full time school guidance counselors (SGCs) in middle and higher secondary schools. Out of 187 secondary schools in the country, 73 government middle and higher schools have one fulltime SGCs. The MoE plans to deploy SGCs in all the secondary schools by 2015. The plan is underway to equip all primary schools with teacher counselors in twenty dzongkhags by 2017. Counselors provide preventive program, development program (psycho education), and peer help program and remedial programs such as one to one counseling, group counseling and critical response programs. School counseling programs are able to reach out to students exposed to drug use, and other life distressing situations. Out of total 2496 cases of student counseling in offered in 52 schools in 2014, 725 were counseled for substance abuse, 301 for family issues, 465 for academic and career issues, 270 for relationship issues and 69 for self harm incidents.

Identification of students in distress, and requiring psychosocial help can be improved through adequate peer network program in schools. Efforts of the MoE to build student peer helpers programs as link to SGCs[10] are a welcome move. A dzongkhag level Peer Helper Conference was started in 2014, where 54 students from selected schools participated in a two day conference. In future, coverage and quality of the peer network program can be improved through training and increasing participation of male and female peers. School counseling service data formerly collected quarterly by the MoE (CECD) will be collected monthly routine from 2015. School SGCs are also required to maintain service records, and a daily log of activities. In order to adapt to the high inflow of information, the CECD urgently needs to upgrade the data system at central and district from the current crude excel sheet

which found to be inefficient and burdensome [2]. Youth Leadership Program of the DYS offers unique opportunity for youth with severe behavioral disorders for reform and serves as a suicide prevention measure; two batches of 56 and 54 students from various schools in the country have graduated the program in 2013 and 2015 respectively.

Bhutan's education policy promotes equal responsibility and ownership of parents in child's education. The SPEA program initiated in 2010 is such policy that aims at raising awareness among parents on parenting [3], understanding child's needs, addressing children's behavioral disorders, understanding mental illnesses.[11][12] This program can potentially identify children at high risk of suicide as well as those among family members. Parents suffering from depression can become anxious and irritable and may be less tolerant of child's normative behaviors and, as a result, may rely on coercive techniques for dealing with child behavior.[13]Cluster community SPEA program initiated by the MoE for families of the armed forces in Paro, Thimphu and Wangduephodrang can be replicated for wider coverage of the program.

School personnel need effective training and support to help them build the skills and confidence to identify and assist vulnerable youth in seeking help. Supportive supervision should be strengthened among schools by training district focal points of school supervisors to improve suicide prevention services. Quality of school counseling services should be monitored taking care that counselors are not tasked as school disciplinarian but facilitators for addressing child's psychosocial needs. In the long term, having full time SGC male and female counselors in schools can enable improving services for gender specific student support.

Mental health services

Poor mental health is a risk factor for suicide.[14] In an effort to integrate mental health in the primary health care services, a mental health curriculum was included in pre-service training of health workforce at the Royal Institute of Health Sciences, and the National Mental Health Program was established in the Department of Public Health in 1997 to coordinate mental health services. Although the capacity of health workers has been strengthened in the field of mental health care and de-addiction, mental health services are still limited and rudimentary. Trained mental health professionals are limited. Most of the six psychiatric nurses and psychiatrists trained have already left the mental health services. There are no clinical psychologists or social workers in the mental health care cadre in the whole of Bhutan. The Royal Government of Bhutan recruits expatriates to address shortage of specialists including psychiatrists. JDWNRH has two psychiatrists a Bhutanese and an expatriate from Myanmar.

Mongar and Gelephu Regional hospitals have one expatriate psychiatrist from Cuba. In the remaining 29 hospitals in the districts, psychiatric consultations are provided by general doctors and assistant clinical officers.

The psychiatric unit at the JDWNRH considered as the nation's referral center for mental illness and psychiatry has only eight hospital beds. Ward infrastructure of the psychiatric unit of the JDWNRH is inadequate for proper patient care. Ideally, wards should be located at a central location to be

[2]Interview with the chief counselor, CECD, MoE.
[3]Shonkoff and Phillips (2000 p226) state that 'parenting' is a term used to "capture the focused and differentiated relationship that a young child has with the adult (or adults) who is (are) most emotionally invested in and consistently available to him or her."

able to monitor the patients; the nurse's duty station is detached from the patient ward. The current infrastructure does not have any room for such redesign. The unit's eight nurses are not trained in psychiatric nursing, de-addiction or detoxification. The situation in JDWNRH demonstrates large gaps in human resources in mental health care. Priority should be given to human resource management and development in psychiatric and mental health services in the country.

Integrating suicide prevention programming in primary health care reduces suicide deaths.[15] The mental health curriculum in the pre-service training at the Faculty of Nursing and Public Health (FNPH) does not address suicide prevention. This partly explains why mental health promotion and illness screening at the BHUs and hospitals are weak in general. At all levels of care, suicide screening and prevention education is largely non-existent or where provided, it is not systematic. Suicide risk identification, providing community led suicide prevention including postvention services should be institutionalized at the FNPH by inclusion in the curriculum for health workers. The high treatment gap in mental illnesses and suicide prevention should be narrowed by providing more emphasis on mental health promotion and suicide prevention in the primary health care service. The network of primary health care centers and health workforce should be advocating for suicide prevention programs within their communities. Specific activities should include enhancing case identification of mentally ill including depression and individuals requiring mental health support, assessing chronic disease patients for mental health and suicide risk, providing suicide prevention services through community outreach, and building partnership with community members in suicide prevention.

Restricting the Means of suicide

Understanding means of suicide is important as it can guide the prevention program of restricting the lethal means for suicide. In Bhutan, hanging is the most common means (91%) contrary to countries where fire arms or pesticides are common means.[1] Consumption of drugs/substance accounted for 64% of the total attempted suicide. Seventeen victims used pesticides and insecticides as mode of suicide. Suicide attempts using pesticide appears to be common from the health facility reports. There are 18 pesticides and one rodenticide (zinc phosphide) used in agriculture sector including the crop and livestock sectors. The Pesticide Act of Bhutan 2000 outlines regulated use and protecting the users from hazards of chemicals. The Rules and Regulations for the implementation of the provisions within the Pesticide Act are yet to be framed. Some pesticide products are also available in the markets and shops. Procurement, supply, and distribution of pesticides should be well regulated to prevent attempt resorting to misuse and self harm. For management of pesticides as per the international code of conduct, pesticide handlers, procurement agencies, dealers, commission agents, extension agents, researchers, regulatory personnel, farmers, growers and producers, transporters and the general public including consumers of food products should be made aware and educated on the pesticide act, and the rules and regulations. Regulatory staff from BAFRA, Agriculture, Livestock and Forestry should trained be trained on use and regulation of pesticide. In the similar way, general public should also be educated on the safe handling of pesticides once the regulations are enforced.

SELECTIVE STRATEGIES

Psychosocial support for vulnerable women and children

The Domestic Violence Prevention Act 2013 provides a supportive legal framework for protecting the rights of victims of domestic violence, generally women and children. The Child Care and Protection Act of Bhutan 2011 provides for care and protection of children in difficult circumstances and children in conflict with the law. The National Commission for Women and Children (NCWC) is the nodal agency for protecting and promoting the rights of women and children and is also designated as the competent authority for implementation of the two Acts. A small number of women and girls who are victims of rape, abuse, violence, prostitutions, child battery and child labor are supported through RENEW by providing counseling, legal assistance, consultation, referrals and shelter services. RENEW provides walk-in counseling services and telephone consultations at its Headquarter in Thimphu. Every week, the center receives 7-8 new walk-in clients, and a total of 20 clients per week including the old cases. The unit also provides daily telephone counseling for former clients. Shelter services are provided at the Gawailing Happy Home.[4] RENEW services cater to people at risk of suicide. In 2014, a counselor at the RENEW walk-in center received a call that a woman was about to jump in Thimpchu near the Weekend Vegetable Market area. The counselor alerted the police and later the client was escorted by the RBP to the RENEW counseling center where she made to a full recovery.

Counselors need more skills to address mental illnesses, identify suicidal thoughts and behaviors in clients. Client assessment is focused on domestic violence and gender based violence (DV, BV forms) includes components on emotional status (whether the client is fearful, depressed or anxious?), and sexual history (rape, sexual assault, extra marital affairs) but lacks screening on suicidal ideation, and thoughts. The revision of the client assessment form is necessary to include suicide screening.

In 2014, dzongdags and RENEW agreed to combine dzongkhag-led MSTF and RENEW activities under community based support systems (CBSS) to build greater synergy and coverage through partnership of the local governments and RENEW. Mental health training initiated by RENEW for volunteers will enhance the ability of volunteers to identify, recognize and improve referrals of mentally ill patients such as severe depression and has the potential to expand district outreach among people exposed to suicide risks.

The NCWC and the RBP has collaborated to institute Women and Child Protection Units and Desks (WCPUs /WCPDs) of the Royal Bhutan Police. The WCPUs/WCPDs provide services for women and children exposed to family, domestic or gender violence which is a critical platform to identify suicide risks. As a legal mandate to provide care and support to victims of domestic violence and child abuse, the National Commission of Women and Children (NCWC) instituted one stop crisis center (OSCC) at the JDWNRH. Although this effort is at an early phase, OSCCs have great potential to directly reach victims in psychosocial crisis and at risk of suicide. The JDWNRH OCSCC, currently, is not able to provide optimum client services due to lack of fulltime counselors. At least fully staffed OSCC should

[4]The center has 40-60 beds and staffing includes two counselors, a nurse, RBP security, and one finance officer. In 2014, the center served 228 clients. Admission of clients to the center are screened by the RENEW, HQ. The stay-in client services are offered as per the Shelter Guideline. Shelter services offered are counseling, Sheltering, basic medical care, legal services including accompanying to court. Livelihood skills provided at the center are: tailoring, gardening, weaving trainings. The duration of stay depending on client needs and have provided shelter for 2-3 years. After graduation from the center, clients are offered job support opportunities.

be established in bigger urban settings such as Phuntsholing and Gelephu in the immediate future. In other hospitals, OSCC teams should be identified; suicide and self harm prevention programs should be integrated to expand the coverage of services.

The YDRC at Tsimasham manages children in conflict with the law who are at potential risk for self harm and suicide. It is not unusual for officers to come across clients with suicidal ideations and intents.[5] Police officers and personnel are not trained to recognize suicidal thoughts and ideation at the WCPUs and YDRC. Police officers also face difficulties in providing referrals due to lack of appropriate centers for handling suicidal clients. Capacity building of personnel through training and workshops to recognize risks for self harm, suicidal intent will be crucial.

In general, social and family therapy and counseling services are not available in the country. The Chithuen Phendey Association (CPA), an NGO based in Thimphu has an initial plan to introduce family therapy programs in alcohol de-addiction program. Couple counseling programs, psychosocial support and assisting couples discuss problems with professions is a significant service gap. The government and NGOs should develop interventions to breach this policy and service chasm.

Addiction and substance abuse

Most (64%) suicide attempts were by consumption of drugs/substance.[5] Addiction and substance abuse programs have direct links to suicide prevention. Seven drop in centers (DICs) supported by Bhutan Narcotic Control Agency, YDF and CPA provide outreach services, counseling, referrals, relapse prevention services, reintroduction program for self help of alcohol anonymous (AA) and narcotic anonymous(NA). DICs are managed by 2-3 counselors who are trained for a week in cognitive behaviors therapy (CBT), and another week in basic counseling. Counselors employ motivational interviewing (MI) technique for clients in denial and for relapse counseling.[7] Peer counselors are important frontline providers of mental health screening and assessment of risk for suicide.

Alcohol and drug users with suicidal intent do contact DIC services. DICs have to be able to recognize, identify and appropriately refer clients with high risk of suicide for services. DICs conduct drugs and substance abuse awareness programs in the communities depending on the availability of funds. DIC services need to be advocated among schools, and young people to increase the service utilization without stigmatizing the centers. The majority of clients visiting the DIC in Bumthang were not Bumthaps; most local clients were reported to seek services out of Bumthang because of a high social stigma attached with use of DIC services. DICs should also be adequately staffed to increase the availability of services to the public. The DIC services in Samdrupjongkhar and Mongar were not always available as the centers have only one counselor. BNCA is working towards establishing a staffing standard for DICs with a manager, 2 peer counselors and 2 outreach workers, which is urgently required. Once implemented, this will strengthen DIC services in drug use prevention and de-addiction services.

[5]Interview with Captain Karma Dema, former officer incharge of the YDRC, Tsimasham.
[6]Four Bhutan Narcotic Control Agency (BNCA) centers managed in Mongar, Samdrup Jongkhar, Gelephu and Phuntsholing, and two Youth Development Fund (YDF) managed drop in centers in Bumthang and Thimphu, and one Chithuen Phendey Association managed drop in center in Paro
[7]A typical competency building training for a DIC counselors is a one week training course in cognitive behaviors therapy (CBT) and one week training on basic counseling. Counselors employ technique of motivational interviewing (MI) for clients in denial and counseling for relapse clients.

Competency of counselors should also be upgraded. Added skills are required in the area of family therapy, IDU counseling, knowledge on medical and legal issues, program development and management of outreach services. The current client assessment at DICs does not routinely include mental health, level of distress, depression and risks for suicide. Proper tools are required to identify suicidal behaviors among clients to prevent clients at serious risk of suicide being missed.

Alcohol and drug detoxification, de-addiction and rehabilitation services

Like in other countries, harmful use of alcohol is linked to suicide in Bhutan.[5] Most patients seeking detoxification services are found to be in harsh economic conditions and often with poor family support. Such situations can lead to mental distress that can trigger suicidal events. Alcohol detoxification[8] and rehabilitation is an important strategy in recovery and relapse prevention. Detoxification services in health facilities are not uniformly implemented. In Lhuentse, the detoxification service is reported to be implemented using a protocol which provides followed up on day three, one week, and one month after the discharge.[9] Where clients are not able to visit the hospital, follow up telephone calls are made to the client. At JDWNR Hospital, clients are left to seek follow up services at their own initiative. About 50% of the clients seek rehabilitation services at Serbithang, Paro Retreat Center, Siliguri, Sikkim, and some travel as far as to Chennai, India. Disparities in alcohol detoxification services are high as alcohol addicted individuals in more remote areas of the country may not even access detoxification, far less access rehabilitation services.

Implementing a follow up schedule or sending reminder personal calls or sms from the service providers are effective strategies to minimize relapse. Providing close follow up of recovering alcoholic addicts is feasible by district hospitals, while bigger health centers like the JDWNRH or other referral hospitals may need to provide specialized staff. At a broader level, linking alcohol policies to reduce harmful use is essential for suicide prevention.[3]

In Thimphu, the Chitheun Phendey Association (CPA) provides peer counseling to recovering addicts undergoing alcohol detoxification at the psychiatric unit of JDWNRH. A three month residency rehabilitation service is provided at Samzang Retreat Center of CPA in Paro and YDF's Nazhoen Pelri Treatment and Rehabilitation Center for Drugs and Alcohol Dependence (TRCDAD)[10] in Thimphu. Since the establishment of the 20 bedded facility in June 2013, Samzang Retreat Center has admitted 170 clients in the program. About 95% of the clients are recovering alcohol addicts with ages ranging from 15 to 66 years hailing from mixed background including rich and broken families. Counselors offer cognitive behavior therapy (CBT). Counselors at the centers encounter individuals at risk of suicide and inflicting self harm. High risk clients are often sent back to families when it becomes too difficult for the center to handle the risk. However, efforts are made to provide counseling services wherever possible. Counselors require additional skills in identification, and tackling high risk clients with suicidal thoughts and potential for inflicting self harm.

[8]The standard alcohol detoxification regime is a tapering doses of diazepam and lorazipam for abnormal liver functions, and combination of thiamine and vitamin B complex.
[9]Interview with Dr. Sonam Jamtsho, Medical Officer , Lhuentse Hospital, February 12, 2015
[10]TRCDAD's three month de-addiction and rehabilitation services at Serbithang was started in 2009 for men and in 2010 for females.

With the completion of the construction of the 60 bedded national rehabilitation center in Chimithangkha (Tshaluna) Thimphu, YDF will soon offer a national rehabilitation service. While awaiting bigger programs, steps should be taken to improve the quality of current services. Client assessment forms in the rehabilitation centers do not have a component on mental health assessment and suicide prevention. Mental health and suicide risks assessment should be incorporated in the forms. Counselors should be trained further in providing suicide prevention services.

Other groups with psychosocial needs

Individuals suffering from chronic diseases, destitutes, socially isolated individuals, individuals in severe financial stress are also at high risk of suicide. Others suffering from social identity such as Lesbian Gay Bisexual &Transgender (LGBT), and pregnancy-related depression require counseling support. Providers of maternal and reproductive program, chronic disease prevention programs, HIV/AIDS program and banking industry should be included as partners in identification and referrals of individuals needing psychosocial care. Mental health promotion and suicide risk assessment should be provided for these groups of population. Organizations such as Lhak-sam, a NGO of peer led HIV group can play an important role in mental health promotion and suicide prevention program among HIV infected and affected individuals and families through networking/outreach or paying home visits, conduct monthly follow up calls to discuss mental health and psychosocial issues for those going through psychosocial problem. However, mental health screening and suicide screening tools are not routinely used in Lhak-Sam's programs. Training on mental health assessment and suicide prevention, and adoption of tools among peer helpers can enhance the capacity of peer helpers for people living with HIV.

Of note is the growing concern for abandonment and social isolation of elderly. The fact that around 7% of suicide victims in the past five years were individuals above 65 years[5], highlights, the need for a deeper understanding of the problem faced by the senior citizens and instituting adequate social welfare for the elderly.

Community resilience building approaches

Community resilience and support programs are important to build broader suicide prevention services. Community linkages and partnerships are vital for reaching individuals and households. Village health workers (VHWs) are a classic success story of community engagement in primary health care services in improving antenatal, family planning and immunization services. Without burdening their current roles, VHWs should be engaged as a health literate community member in raising suicide prevention messages in the communities. Previously, mental health support didn't necessarily come from mental health professionals. Suicide attempters mostly received treatment from a traditional healer.[11] Also local community links should be vitalized through educating local traditional healers, practitioners, and lams in identification of mental and behavioral risks that may pose suicidal outcome. CBSS volunteers and other community linkages should be explored through community

[11]Draft Suicide Survey Report 2014, Royal Government of Bhutan

groups who can identify a member who is socially isolated, elderly people in need of care, individuals in stressful life situation and mentally ill individuals and make referrals to health facilities or a counseling center. Community members should be invited to join the advisory board for health at the district health office and BHUs to build community resilience for suicide prevention. Dzongkhag and gewog administration should be engaged to promote both formal and informal mechanisms for supporting community resilience development programs. Local governments should champion for innovative community-driven social programs and enhance community support mechanisms such as dispute settlements in relationships and marriage issues. Most communities have trusted community members with innate skills and aptitudes who are effective in dispute settlement. Such community confidantes should be identified and local recognition systems should be encouraged to champion community resilience.

Local governments, and academia and social organizations should document community best practices so that similar lessons can be shared or replicated in other community systems.
The growing number of youth organizations with a social service focus should be engaged in suicide prevention programs. Youth Volunteers in Action (Y-VIA), an active network of young people initiated in 2003 under the Bhutan Youth Development Fund, is now established in 8 Dzongkhags: Thimphu, Phuentsholing, Tsirang, Trashigang, Bumthang, Pemagatshel, Gelephu, and Dagana with 1500 members across the country. Suicide prevention and social issues falls within the Y-VIA's wider interest of addressing issues of community and social concern through youth program. Similarly, Go Youth Go (GYG), a youth wing under Youth Media Center, is engaged in social issues including raising responsible service of alcohol among vendors and consumers.[12] More youth based and community groups should be encouraged to assume mental health education and suicide prevention roles.

Counseling and social work capacity building

Counseling is an important psychosocial intervention in mental health and suicide prevention. [16]Counseling services are provided by peer counselor, social counselors, health counselors trained in short term counseling courses. It is important that a group of well trained counselors is established to address the future expansion of services through government, NGOs, and CBO providers. A proposal to establish a Board for Certified Counselors in Bhutan is under review by the Cabinet. If approved, this will strengthen the quality of counseling services in the country.

Bachelors in counseling are trained at the Samtse College of Education (SCE), the Royal University of Bhutan in affiliation with the Naropa University in Colorado, USA. Seventy trainees have graduated from the program, of which 28 candidates were selected by the RCSC and employed primarily in school settings. The SCE is in the process of developing a masters degree program in counseling.

Counseling services are required in diverse fields in clinical and social settings, and for groups vulnerable to drug and alcohol addiction. BNCA is offering a nine module, 45 day in-country

[12]GYG conducted a door to door education requesting 437 alcohol sellers in Thimphu to be responsible and compliant to the rules in January 2015.

certificate course in counseling in coordination with the International Center for Certification and Education of Addiction Professionals. At the time of writing this document, 20 peer counselors from DICs, and other agencies including Health sector, and 30 school counselors were enrolled in the training program. Six Bhutanese master trainers have been trained. BNCA also has a plan to institute Universal Prevention Curriculum from May 2015- a similar nine module program focusing on family-based, school-based, workplace and environmental interventions. Both curricula cover crisis intervention including suicide. As a regulatory agency, the BNCA can often get bogged down with the primary responsibilities of enforcement and implementation. Transferring the training program to the academic institutions such as Khesar Gyalpo University of Medical Sciences (KGUMS) or Samtse College of Education can strengthen the long term program development and capacity building.

Other categories of clinical counselors, clinical psychologists and social workers, although an important health workforce for mental health care and suicide prevention, are not included in the civil service cadre of health professionals. Urgently, MoH should take a lead role to formalize and build these cadres of professionals within the civil service. The RUB and KGUMS have the opportunity to establish and strengthen academic programs for building the cadre of counselors, clinical psychologists and social workers.

INDICATED STRATEGIES

Access to services and care for individuals at heightened risk of suicide

Call centers serving as crisis helplines are useful in providing timely access to care, and they are critically important to individuals in crisis when professional care is unavailable or face to face meeting is not preferred.[2] Currently, telephone advice can be accessed through multiple channels. Health Help Center (HHC)[13] provides a toll free line 112 for patient services for trauma, medical emergencies, and basic medical advice. However, HHC paramedics are not trained to provide crisis helpline services for individuals with suicidal intent despite HHC paramedics having received such crisis calls. In a recent incident, a HHC staff attended to a caller who was under the influence of alcohol and under severe financial stress, and who shared his suicidal intent. The staff provided counseling to the caller but he was unsure whether the counseling worked.

Other toll free lines are available at two sites in Thimphu: Health Information and Service Center (HISC) (toll free 202), and Nazhoen Helpline at Department of Youth and Sports (DYS) which was revived in late 2014 after previously being discontinued. The HISC toll free was established to provide health advice for HIV, sexual reproductive services and to encourage HIV testing and counseling while the Nazhoen helpline provides general youth counseling. The toll free lines only operate during usual office hours. They are not hotline crisis centers as messages are left and there is no dedicated person to attend to calls. While toll free lines offer options for helpline, a separate 24 hour helpline services is also a legal mandate. The Domestic Violence Prevention Act 2013 mandates the Ministry of Health to provide 24 hour emergency and treatment services for the victims of Domestic Violence. Further the Domestic Violence Prevention Rules and Regulations 2015 mandates any national Civil Society Organization registered as health service provider to provide 24 hours service to the victims of domestic violence.[17]

A helpline, online crisis chat, and self-help tools should be available through the helpline services. This will require space, staff, hotline IT system and overhead costs. The HHC presents an opportunity to host the crisis helpline. However the service set up would require well trained crisis counselors and adequate space for privacy both of which are unavailable at the current facility. With slight re-modification of the HHC by creating a crisis counter and upgrading the skills of a select group of staff in crisis counseling and management, 112 can be piloted as a national crisis helpline. Locating the crisis helpline at the HHC could congest and hamper the current HHC services. Prompt administrative decisions are required to either relocate the hotline or to strengthen the capacity of the HHC if the volume of service for crisis callers becomes unmanageably high. The NCWC also has an immediate plan to establish a 24

[13]HHC is a national helpline center located in the compound of the JDWNR Hospital providing 24 hour service. Four call lines are open at the same time and have the capacity of 6-8 lines. HHC communicates to a nearby GPS monitored ambulance for patient pick up. Twenty eight health workers trained to manage calls and provide services. The basic training for HHC staff include a three day logistic training and a five day training on computer and call management.

hour national toll free line dedicated to victims of women and children.[14] When NCWC toll free line and HHC crisis helpline are operated, the toll free services should collaborate closely to ensure effective complementarities and referrals of clients.

Survivors and postvention services

Offering timely services to survivors (those who have lost someone to suicide such as immediate family members, close friends and class mates) are important to support in bereavement as well as being a method of suicide prevention itself, as they can be prone to depression and suicidal behaviors. Institutional services to provide postvention[15] services to the bereaved are not available and cultural and religious practices for the deceased may provide positive support during the bereavement. The goal of the postvention services include: reducing further risk of suicidal behavior, prevent suicide contagion by identifying other members at high risk for suicidal behavior, and connecting high risk members to psychosocial services.[18]

As first hand emergency responders, health workers, emergency medical team (EMT), police personnels and school counselors need competence to handle postvention situations. Unfortunately, there is no postvention protocol and procedures for health workers, police personnel and school counselors. As early responders they are inadequately trained in Bhutan. The disastrous handling of suicide events in Bumthang in 2014 which led to the dismissal of an EMT staff for irresponsibly spreading suicide photos in social media indicates systemic weakness and very poor postvention service provision. Postvention training should become an integral competency for these category of first hand responders to enable them to provide a comprehensive integrated community response, including ways to reduce risk of suicide contagion with other key service providers after a suicide death. Trauma training module for EMT should incorporate additional module on postvention services.

In schools, postvention programs are still at the early phase of development. Programs should be designed to deal with the aftermath of a youth suicide in school. School management should be advocated to institute response team to organize open discussion, encourage communication and expression of feelings and to diffuse the crisis situation surrounding a youth suicide. Students who are in need of individual counselling or referral should be given assistance. School personnel need effective training and support to help them build the skills and confidence to identify and assist vulnerable youth in seeking help.

Also as the first responders, police, health personnels, EMT and school counselors can themselves be affected dealing with suicide victims and events. They should also have access to mental health support services, including access to key information on mental wellbeing.

[14]Interview with the director general, NCWC.
[15]Postvention is a term used to describe providing crisis intervention, support and assistance to those affected by a completed suicide. The term was first used by Edwin Shneidman (1972), coined the word to describe “appropriate and helpful acts that come after a dire event.”

Promote continuity of care for suicide risk clients in health care settings

Making a suicide attempt is a known risk factor for later death by suicide, particularly in the following weeks and months after suicide attempt. Twenty percent of completed suicide had history of having attempted suicide earlier.[5] It is therefore critical to have follow-up services for individuals with suicide history. Physical treatment should be followed up with appropriate psychotherapy in the health facility. Patients presenting at health services with suicide risk factors require appropriate mental health assessment and proactive follow up after the discharge. The current health services in Bhutan do not have such practices as standard, and individuals with suicide attempts and suicidal behaviors are not followed up.[16] Providing telephone reminders of appointments, or providing patients with suicide risk with emergency phone numbers should produce positive health outcomes. Clear clinical follow up protocols should be instituted for health facilities for the follow up of individuals with suicidal attempts. Once the hospital management is complete, care should be taken to refer them for appropriate social and psychological support after discharge from the hospital or a health facility.

Referral and service linkages

Due to overlapping of service needs in dealing with drug addiction, domestic violence, sexual assault, rape and child abuse, multiple stakeholders need to refer clients for other services. Referral linkages are often based on personal relationships and lack an institutional system for referral linkages. A memorandum of understanding or referral guidelines is necessary to improve referral mechanisms and linkages. Constant dialogue and interaction among health facilities, RENEW, DICs, HISC, schools, WCPUs and other providers should be encouraged through annual conferences and meetings of stakeholders. Standardized screening tools for suicidal behaviors and mental health assessment are required among service providers. Referrals of clients between health facilities and other providers such as to school counselors, peer counselors and rehabilitation services, and from one provider to another should be promoted. At the hospital level, cross referrals of patients within hospital units and traditional medicines units are also inadequate. Referrals mechanisms should be strengthened within the hospital by encouraging proactive cross referral and consultation for better identification and management of mental illnesses and suicide risks among hospital units.

Medico legal and forensic investigation

Effective forensic services enable delivery of fair justice and conversely poor forensic services can cripple the criminal justice system. In general, forensic services are not accorded a top priority in Bhutan. The medico-legal investigations of health and police forensic investigations are slightly different in intent, approach and scope. However, both health and RBP officials need to cooperate during medico-legal events including suicide investigations. Health and RBP personnel are spending increasing amount of time resources on the investigation of

[16]During the drafting of this document, Dr. Gampo Dorji visited Samdhingkha BHU, Punakha where he noticed that the BHU staff successfully conducted gastric wash on a 28 year old divorced female who consumed pesticide following an argument with her mother just the other night on February 23, 2015 and referred to Punakha Hospital. The patient referral sheet misclassified the diagnosis as “poisoning case”, and the staff had no follow up plans with the patient. This practice is quite common in health facilities when managing cases of suicidal attempts.

suicide attempts and completed suicide cases. Still there are no proper policy guidelines for investigation, which mostly occurs through an informal arrangement.

In general, Bhutan has very limited forensic service capacity. A proposal to set up an independent forensic service was approved during the 2006 Annual Conference of the Ministry of Health but it remained unimplemented due to resource issues.[17] The nation's leading forensic unit at the JDWNRH is the only center with a forensic specialist. Although small numbers of primary health workers have been trained in the investigation of gender based violence, sexual violence and deaths, it has not strengthened institutional capacity for medico-legal services. Most of the investigations are conducted by untrained health workers or personnel.[18] Doctors rely on basic undergraduate training in medico legal investigation which is insufficient to handle the real field forensic needs.

Generally procedures for suicide investigations involve external examination and verbal autopsies. No standard operating procedures and standard protocols of investigation are followed. Multi-year data on self harm, domestic violence and injury collected by the forensic unit at the JDWNRH remains unanalyzed. Mongar and Gelephu Regional Hospitals have established a documentation unit for medico-legal and forensic cases, but the staff managing the unit has other responsibilities.

The KGUMS and the MoH could take joint ownership for capacity building of forensic services. The KGUMS has the potential for developing forensic and medico-legal training program, while the MoH could support training of the health workforce. In view of the resource constraints, a multi-skilled health worker should be engaged in medico-legal services. However, a core forensic health workforce is also necessary. The MoH should take a lead role in formalizing and building the workforce within the Royal Civil Service of Bhutan. Autopsy services with appropriate infrastructure, mortuary standards and human resources are urgently needed in the country.

Suicide investigation by the Royal Bhutan Police

Investment in forensic services and criminology has become urgent in the fast changing Bhutanese society with rising rates of crime and suicide. The RBP has four officers trained in DNA Technology, Forensic Biology and Serology, Fingerprints, and Physical Evidence.

Approximately 30 police personnel trained in basic forensic investigations have been deployed in key police stations. However, the RBP capacity for forensic and suicide investigation services is still limited largely due to inadequate skills upgradation. Also police are multitasked such that in reality investigations are not necessarily conducted by forensic or crime scene investigation trained personnel. Although the Evidence Act of Bhutan is an enabling law, court forensic

[17]Interview with Dr. Pakila Dukpa, the registrar, Khesar Gyalpo University of Medical Sciences and the first Bhutanese forensic specialist on February 3, 2015.

[18]A chief nurse in Lhuentse thrice attended attempt to suicide and suicide investigation. He did not receive any training either during the in-service training or during the service. He expressed that he was clueless on what he was looking for during the examination but still had to discharge his official call. Similarly, the doctor in Lhuentse attended three attempted suicide and two suicide investigations. Doctor expressed that the basic training on wound identification, nature of injury covered in the undergraduate medical education was inadequate to provide a clear inference during field investigations and expressed that medico legal investigations may be wrongly concluded as a result. (Tele interview, 2015 by Dr. Gampo Dorji)

procedures are necessary to cover forensic requirements and protocols. Forensic and criminal investigation procedure guidelines for suicide cases should be developed as a priority.

The RBP is constructing a Forensic Laboratory which is expected to enhance the capacity development in the area of forensic services. Officers need further specialized trainings to sharpen the skills and qualified forensic scientists are required to launch the operation of the new laboratory services. There is scope for the RBP, MoH and the KGUMS to formalize the existing cordial relationship for sharing human resources and personnel to develop autopsy, toxicology, forensic and medico legal services. As an immediate step, accredited courses in suicide prevention, forensic, crime and medico legal investigations can be developed at the KGUMS.

Data, research and information on suicide

Suicide data should be available in timely manner for policy and program decisions. Currently, the data collection method for crime and forensic investigations is not standardized. Data on self harm, domestic violence, and suicide is not universally collected in a standard way. The Crime and Criminal Information System of the RBP does not provide detailed data on suicide cases; it can be improved by developing a standard format, acquiring adequate data devices, and upgrading data software.

Similarly, the Health Management and Information System (HMIS), an integrated repository of health facility data of the MoH, does not efficiently capture information on suicide deaths and suicidal attempts. Although a category of "intentional self harm" was included in the HMIS in 2010, all intentional self harm is not of suicidal intent. HMIS has too high a rate of misclassification of information to provide reliable information. Common sources of misclassification of suicide and suicidal behavior in HMIS include 'burns', 'drowning', 'poisoning' and 'other causes of injuries'. Scope for framing of enabling law/policy to register and investigate all suicide cases including death due to drowning/accidents should be given high priority in order to avoid under-reporting. The HMIS should review the validity of the current information on suicide and revise the forms to include additional ICD for suicides.

The cause of deaths data in the civil registration system of the Department of Immigration collected through the annual census is also non-specific.[19] RBP investigation records are currently the best available source of suicide data. However, data on suicide attempts are scanty even in the police records, indicating under reporting. In order to improve case registration of suicide and suicidal behavior data and information, a national repository which can collate data from police, health facilities and census is required. A national data registry for self harm, suicide and violent deaths should be established at the National Suicide Prevention Program (NSPP) of the Ministry of Health. The registry will generate updated national triangulated information for suicide programming and policy making.

Research and evidence are critical in suicide prevention to build evidence-based programs. A prioritization workshop of health research unit of the Ministry of Health held in December 2014 included suicide prevention on the research priority agenda. Except for the national

suicide assessment conducted in 2014, there are hardly any publication on suicide and suicidal behaviors in Bhutan. Data on suicide prevention and post suicide attempts are necessary for suicide programming. Publication of well-researched papers and position papers on suicide prevention should be encouraged. Prevalence of population level suicide behaviors, suicidal ideation and intent, and level of awareness on suicide risk factors are important baselines against which to assess the state and impact of suicide prevention programs. Information should also be collected at regular intervals through surveys or by including questions on suicidal behaviors in other national representative surveys conducted by Health Sector and other agencies. Potential surveys for capturing suicidal behaviors include Youth Behavioral Surveys, the national HIV Behavioral Surveys, GNH surveys, and the National Population and Housing Census.

Opportunities for suicide prevention

The motivation for suicide prevention policy guidance lies in the His Majesty's hope for youth as the future "wealth of the country". Suicide prevention is a priority public policy directly contributing to the nation's vision of Gross National Happiness. The suicide national prevention initiative was conceived with the instruction of the Hon'ble Prime Minister of Bhutan, which is an exemplary testimony of deep political commitment to address suicide prevention as a social priority.

Stakeholders are deeply motivated to participate in suicide prevention services. Existing government and non-government interventions contribute to suicide prevention. A slight elevation of suicide programming priority is necessary through stakeholders' consultation and advocacy to generate effective stakeholders' responses. Media organizations help in raising awareness on suicide prevention and reducing stigma on mental health and promote suicide help-seeking behaviors. More community groups and NGOs can offer choices for strategic engagement of community gatekeepers in suicide prevention programs.

More effective collaboration between RENEW, YDF, DICs and HISCs can be developed to prevent suicide among Bhutanese. DICs and HISCs collaborate in providing services together under the same roof in Thimphu and Phuntsholing. The action plan provides opportunity to strengthen services and integrate suicide risk identification, counseling and follow up of individuals at risk of suicide.

The police and health sector involvement in violence and death investigation offers better collaboration for partnership. The partnership between religious institutions, health facilities and schools should be further developed for integrating suicide prevention services. Comprehensive school health and counseling programs already have linkages with the Ministry of Health and joint planning, implementation and evaluation of school based programs can be conducted.

Academia such as KGUMS and SCE have the opportunity to strengthen the capacity development of service providers by tailoring courses in counseling, medico-legal investigations and other training packages in suicide interventions.

The rural community needs can be better addressed by integrating suicide advocating the leadership roles of the gewogs and districts. Deep family bonds, religious beliefs and positive cultural values in the communities should be realized as a positive social capital to boost suicide prevention services in the communities. Local leaders and community members should be included in suicide prevention and investigations.

Barriers and challenges

Overall, the fast pace of country's development and societal transition poses major stress on the society. Such stressors include economic and livelihood opportunities, academic competition for excellence in schools and institutions, and job stresses. The increasing tension between relaxed traditional lives with fast and stressful modern lifestyles in the context of rapid urbanization impact the social fabric, family and interpersonal relations and social dynamics affecting all age groups including the old which has direct bearing on mental health and suicidal behaviors.

In addition, many barriers make it difficult to know exactly how common suicidal behaviors are in the population. Suicides are often underreported, in part because it may be difficult to determine intent. The data collection instruments used by HMIS, police and other service providers fail to include questions that would help determine the prevalence of suicidal behaviors. The quality of death investigations needs to improve. Data on the national prevalence of suicide are unavailable and it is difficult to make policy and programmatic decisions in the absence of valid information.

In Bhutan, suicide is not a cognizable offence but aiding in suicide is. However, suicide is a sensitive issue and suicidal behaviors are highly stigmatized. Breaking the social barrier and stigma is formidable and requires constant effort and long term strategic programming. Similarly, deep seated socio-cultural beliefs and values that may facilitate suicidal behaviors cannot be broken overnight.

Most of the rehabilitation services are concentrated in few districts of Thimphu and Paro. It will require both money and competent staff to increase the coverage of prevention services. As more suicides are also occurring in rural communities, it is a challenge to quickly put in place accessible suicide prevention services in the remote communities. More work is required to understand how to address suicide prevention particularly in rural communities. A national suicide prevention program is fairly novel; capacity for implementing technically sound and effective interventions remains to be tested.

SWOT ANALYSIS

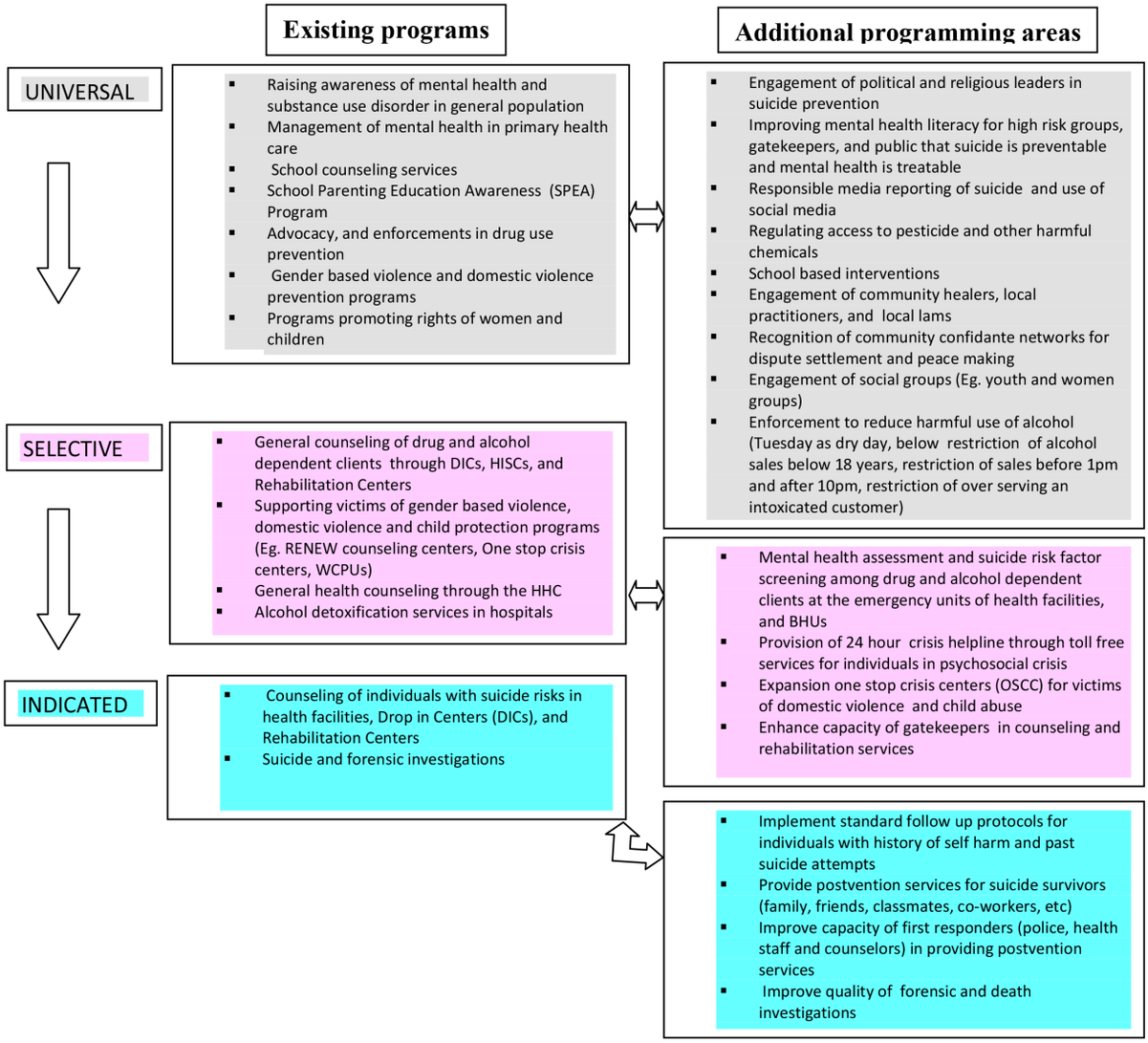
Table 1. SWOT analysis for suicide prevention

Strength	Weakness	Opportunities	Threats
Strong political commitment with the Hon'ble Prime minister's champion to establish suicide prevention program in the country	Lack of a national suicide prevention strategic plan	Realistic action plans can initiate a swift national suicide prevention response	Funding limitations If plans are too ambitious
Stakeholders already engaged in addressing key risk factors of suicide: alcohol addiction, drugs and substance use, and violence prevention	Lack of coordinated action among stakeholders resulting in piece meal programming without recognizing suicide prevention goal	Greater synergies for suicide prevention can be drawn through having a common framework	Competing priorities and multiple interests among stakeholders can put suicide prevention focus on a low priority
Religious beliefs strongly discourages suicidal act	Inadequate engagement of religious figures on suicide prevention advocacy	Prominent religious personalities are supportive of suicide prevention program. Better mileage can be achieved from the goodwill of the religious leaders	Emphasis on suicide from moral and religious reasons can generate stigma which could reducde help-seeking in suicide prevention services
Strong family bonding, shared family values as a social fabric of Bhutanese society	Sometimes too intrusive in personal affairs	Greater engagement of parents in parenting education, and building of community initiatives to enhance social capital	Due to increasing demands for materialism in urban lifestyles, and competitive socio-economic environment, family bonding can fade away
Existing gate keeping programs (drop in centers, HISCs, Rehabilitation services, Outreach Services , community based outreach)	Weak focus on identification, management and referral of individuals with suicidal behaviors	Integration of suicidal risk assessment feasible and stakeholders willing to make adjustments to the existing client assessment forms	Activities can be fund driven, and funds are unavailable services may get stalled
Good access and equitable distribution of general health services	Poor identification of suicidal behaviors due to poor mental health services in general in all level of health services Inactive case finding and health services are demand oriented and absence of community mobilization	Integration of suicide screening and mental health easy	Poor implementation of suicide and mental health screening within the health system due to inadequate supportive supervision

Summary of Bhutan's Suicide Prevention Interventions

Several types of programs contribute to suicide prevention. Figure below presents a summary of programs existing programs and potential programming areas under levels of universal, selective and indicated strategies for suicide prevention in Bhutan.

Figure 1. Summary of the existing levels of interventions and potential programming areas in suicide prevention in Bhutan



SECTION II

STRATEGIES AND ACTIONS

The overarching purpose of the national suicide prevention action plan is to promote, coordinate and support appropriate inter-sectoral action plans and programs for the prevention of suicidal behaviors at national, dzongkhags, gewogs and community levels.

Goal

To prevent premature deaths across lifespan due to suicide among the Bhutanese population

Objectives

Objective 1: Improve leadership, multisectoral engagement and partnerships for suicide prevention in the communities

Objective 2: Strengthen governance and institutional arrangements to effectively implement comprehensive suicide prevention plans

Objective 3: Improve access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide (including those with suicidal ideation, history of self harm or non-fatal suicide attempt)

Objective 4: Improve the capacity of health services and gate keepers to provide suicide prevention services

Objective 5: Improve community resilience and societal support for suicide prevention in communities including schools and institutions

Objective 6: Improve data, evidence and information for suicide prevention planning, and programming

Guiding Principles

The following guiding principles will underpin the suicide prevention program in Bhutan:

i. Suicide prevention will be broad and coordinated system working with a wide range of partners, organizations and sectors including people who have been affected by the suicide.
ii. Suicide prevention will address wide range of factors related to suicidal behavior, including social support, mental illness, substance abuse, economic factors, and community and personal risk and resiliency
iii. Suicide prevention will be comprehensive targeting population, building supportive community systems and focusing on individual level risks for suicide
iv. Suicide prevention will employ combination of public health and individual clinical approach focusing on risk identification and provision of individually tailored services

Prioritization and implementation of the action plan

In order for a suicide prevention strategy to be coordinated and comprehensive, it should have specified finance, time and human resources. [3] Given the fiscal realities and governmental resource constraints, action plan needs to be realistic and implemented through a financially sustainable model in order to accomplish the goals. This has been attempted by designing the interventions through a consultative process (Refer Appendix 3) of the stakeholders bearing ground realities in mind. Existing structure of services have been reviewed and opportunities for suicide prevention interventions have been identified. Easily adaptable services that have the potential to bear immediate suicide prevention outcomes have been listed and proposed for prioritization by stakeholders. Twenty nine participants representing various organizations participated in the prioritization workshop on February 18, 2015. Each activity was graded on a 10 pointer scale in five domains effectiveness, cost, feasibility, public health benefits and cultural acceptability of the activities. Activities scoring an aggregate of above 60% were considered in the priority list and the other activities were left out. The action plan is not an aspirational document, but an actionable deliverable national work plan. The document emphasizes on action. The activities will be implemented by the listed agencies, integrating within their sectoral plan using the available funding.

A relatively short term plan can drive actions as compared to a long term plan which often leads to loss of momentum and suffer from loss of accountability on the way. The action plan is purposely designed for a short term implementation of three years beginning from July 2015 through June 2018. The progress and the fidelity to the plan will be assessed yearly. The full plan evaluation will be conducted towards the later half of 2018. Based on the experience of this implementation, the next phase of the action in suicide prevention will be launched.

National Suicide Prevention Steering Committee

Suicide prevention is a multi dimension program involving various key stakeholders. In order to include an effective cross sectoral implementation and governance, Suicide Prevention Steering Committee (NSPSC) will be constituted at the Ministry of Health from the stakeholders to advise the national suicide prevention response. The Committee will comprise of the following members chaired by the Minister of Health:

i) Secretary, Ministry of Health;
ii) Secretary, Dratshang Lhentshog;
iii) Chief of Police, RBP;
iv) Director/DG, Department of Local Governance;
v) Director, GNH Commission Secretariat;
vi) DG, Department of Youth and Sports, MoE;
vii) DG, Bhutan Narcotic Control Agency;
viii) Director, RENEW; and
ix) Member Secretary, Choedhey Lhentshog

The Committee will meet once in six months. The members of the Committee will serve a term of three-five years and will be subject to renewal for the subsequent terms. The main function of the board will be to provide thrust to the multisectoral response in suicide prevention. The Committee will keep the Government informed on the challenges, issues and progress of suicide prevention response in the country. The organogram for implementing the national action plan for suicide prevention program is shown in Figure 1. The Committee will present a yearly detailed implementation report to the Lhengye Zhungtsog. The report will be posted on website of the National Suicide Prevention Program of the MoH.

National Suicide Prevention Program (NSPP)

NSPP will be based in the Department of Public Health, Ministry of Health. The NSPP under the direction of the Department of Public Health of the Ministry of Health will serve as the secretariat to the NSPSC, coordinate the meetings and follow up on the directions of the NSPSC. The NSPP will also be the national coordinating point for suicide prevention program and engage stakeholders in delivering suicide prevention services.

NSPP will coordinate quarterly review meetings of the key stakeholder focal points and related agencies to discuss, identify implementation challenges and seek joint solutions from the stakeholders. The challenges that are beyond the capacity of the stakeholders should be submitted to the Chair of the Suicide Prevention Steering Committee when immediate guidance is required or should be included in the forth coming NSPSC Meeting. The quarterly review meetings will be a critical platform of the coordination which will determine the implementation of the plan. NSPP should have adequate leadership and drive to ensure that the timely quarterly reviews are conducted. NSPP will also hold annual workshop for work planning for the subsequent year. A similar mechanism is required at the local government level for coordination of the plans. (Discussed below under the section Dzongkhag/Local Government Mechanism).

Suicide Prevention Unit, Crime Prevention Division, RBP, HQs, Thimphu

The Royal Bhutan Police has enormous role in crime prevention, investigation and also providing immediate services as first responder in suicide prevention. It is necessary for the RBP to provide a dedicated unit for suicide prevention with the increase number of suicides, and suicidal attempts. A Suicide Prevention Unit will be established within the Crime Prevention Division of the RBP, Headquarters. The unit will coordinate suicide prevention programs of the RBP.

Agency Focal Points

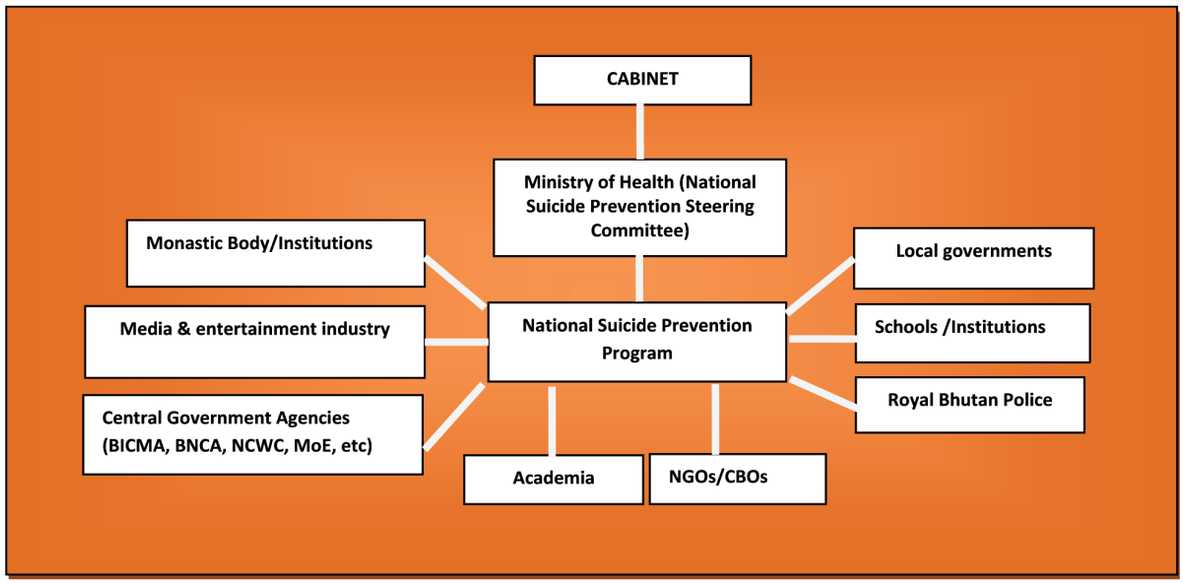
The head of the agency will through an executive order appoint a focal unit of the agency. The chair of the Suicide Prevention Steering Committee will be informed by the head of the agency in writing about the appointment. In order that the focal unit's roles are known to other units within the organization, the head of the agency will also notify the remaining organization about the appointment. The agency focal points will network various units with the organizations responsible for implementation of the activities of the action plan. The focal

point will use his/her decisions to identify challenges, recognize progress and conduct reviews whenever necessary within the organization. The focal point will attend quarterly review meetings at the invitation of the NSPP. In the inevitable situations when the focal point is not able to conduct the functions for the suicide prevention, he/she should approach the organization and propose for a substitute. Identification of the next focal point should be communicated to Chair of the NSPSC with parallel information to the NSPP. This process will ensure greater better coordination in implementing the suicide prevention work plans.

Dzongkhag/Local Government Mechanism

Actual implementation of the suicide prevention work plans should occur in the dzongkhags and local governments. Therefore, dzongdags, thrompons, and gups have the major responsibility to ensure appropriate implementation of suicide prevention work plans. The following key steps should be taken to ensure appropriate implementation of the plan. First, it is important to ensure that suicide prevention activities are embedded within the Government Performance Management System (GPMS). Second, the suicide prevention and rescue efforts must be operated under the direct notice of Dzongdags. The best approach for a coordinated response is to establish Dzongdag's Suicide Prevention Response Team (DSPRT). The key function of the DSPRT is to ensure effective response to rescue suicide attempts and deliberate self harm incidents occurring in the communities. The team will constitute of an appropriate representation of agencies with RBP and Health as mandatory members. The plan also recognizes the complementary effects of the existing multisectoral mechanisms such as CBSS for implementation of the action plan. Since each dzongkhag /thromdemay differ in need and style of functioning, it is best left for the dzongkhags/thromde to form the local mechanism for suicide prevention response. However, the District Health Office/thromde health office will be the secretariat and the coordinating body for implementing the action plan under the direction of the Dzongdag/thrompon. The Secretariat will advise dzongkhag/ thromde (including gewogs) on the action plan. The secretariat will ensure that implementation review is integrated during the quarterly review of the overall dzongkhag plan. District Health Office will also organize joint yearly planning among stakeholders for suicide prevention. The key agencies to be closely coordinated are the dzongkhag Education sector, gewog activities, postvention services and medico-legal investigations of RBP, and Health sector.

Figure 2. Organogram for coordination for implementation of the national action plan for suicide prevention plan



The multistakeholder approach is the cornerstone for the implementation of the action plan. The overall effectiveness of the multisectoral mechanism in implementing the suicide prevention will be measured by the performance measures:

- Suicide prevention included in the GPMS
- Number of meetings of NSPSC with required quorum
- Police and health investigations of suicide conducted by trained officer
- Integration of suicide prevention in the continuous quality assessment indicators in health
- School children (students) reached with psychosocial counseling
- Adults counseled for suicidal ideation through gate keepers programs at the DICs, HISCs and Rehabilitation Center

Once the plan is endorsed by the *Lhengye Zhungtshog*, the chair of the NSPSC will seek an executive order from the Hon'ble Prime Minister and circulate to Dzongdags, LGs, and other government agencies and non-government agencies to launch the action plan.

Objective 1: Improve leadership, multisectoral engagement and partnerships for suicide prevention in the communities

Rationale: Multiple stakeholders can deliver a range of comprehensive suicide interventions in the population. The leadership, support including commitment for resources in suicide prevention efforts is required to make suicide prevention efforts effective.

Key Actions

- Advocate greater engagement of the religious leaders on suicide prevention to promote self preservation and value of human life
- Advocate suicide prevention among law makers, law enforcers and policy makers for greater political and policy support
- Sensitize the local government leaders (dzongdags, thrompons and gups) on the role of governments in suicide prevention, reporting, and identification of vulnerable individuals
- Engage schools and institutions to implement mental health promotion and suicide prevention education for identification, screening and referrals of mentally ill and those with high risk of suicide
- Encourage responsible media reporting in suicidal deaths and attempts by advocating on responsible media reporting to prevent suicide contagion(copycats)
- Implement mass media campaigns and IT enabled health promotion such as through use of emails , social media, twitter and social events to spread suicide prevention messages

Table 2. Activities, milestones, indicators, agencies and timing for objective 1

Activity	Milestones/Tasks	Indicators	Responsible agency/ies	Other linkages	Timing
OBJECTIVE 1: Improve leadership, multisectoral engagement and partnerships for suicide prevention in the communities					
1.1 Advocate religious leaders on suicide prevention and promotion of mental wellbeing during the annual conferences for Netens and Shedra Uzins	Request Dratshang Lhengtshog to include agenda on mental health and suicide during annual conference Conduct a session on mental wellbeing, and suicide during the annual Lam Neten Conference Propose annual visits of Lams in schools/institutions	Annually, 100% of Lam Netens and Uzins from 20 districts discuss on mental health and suicide prevention	NSPP (MoH), Religion and health program(Dratsang Lhengtshog)	Central Monastic Body	Coincide with the annual meeting
1.2 Host annual Choeshed Leyrim of Netens and Uzins and other prominent religious figures in schools and key institutions to conduct on discourses on mental health, and value of self preservation of human lives as an annual plan	DEOs, Principals and head of the institutions seek Lam's endorsement on the visit schedule Lam conducts a 2-3 hour session per institution/school on religion and health including the religious messages on suicide Report Choshed Lerim as a key performance indicator of schools/ institutions	Annually, 80% of lower, middle and higher secondary schools, and institutions visited by Netens/Uzins/ prominent religious figures for Choeshed Lerim	Principals, Head of the Institutions, District Education Office(Dzongkhag Administration), Institutions(colleges)	Central Monastic Body/	School visitation of Lams started from October 2016
1.3 Host TV and radio programs on value based social education programs for Lams	Send request letters for participation to Dratsang Lhengtshog Organize TV and radio talk sessions	Minimum of once a month TV and radio sessions	BBS TV, BBS Radio, Kuzoo FM and other media agencies	Dratsang Lhentshog (Religion and Health Project)	From July 2015
1.4 Conduct suicide prevention advocacy among law makers, law enforcers and policy makers	Prepare brief of the annual suicide report Host 2-3 hour meeting	Annually, 85% of the parliamentarians participated in 2-3 hr meeting on suicide prevention and advocacy	NSPP, MoH	Secretariat of the National Assembly and the National Council	Conducted by December 2016

Activity	Milestones/Tasks	Indicators	Responsible agency/ ies	Other linkages	Timing
1.5 Sensitize the local government (LG) leaders (dzongdags, thrompons, gups and mangmis) on suicide prevention, identification of vulnerable people and the role of local government administration in suicide prevention in Dzongkhag and Gewog Tshogdues	A session on suicide prevention and the role of LG in dzongkhag/ gewog tsogdues Gups disseminate the Tshogdue recommendations on promotion of mental health and suicide prevention to people in the gewog	Annually 100% of the dzongkhag and gewog tshogdues include agenda on mental health promotion and suicide prevention	District Health Office, Dzongkhag Administration	NSPP, MoH CBSS (Dzongkhags)	Conducted by December every year
1.6 Advocate among those engaged in mass media such as media reporters, film makers, Motion Picture Association (MPA) of Bhutan on responsible media reporting of suicide	Develop media toolkit on responsible media reporting on suicide (NSPP and BICMA) BICMA sends annual notification to all media agencies on responsible media reporting Conduct half day meeting with media agencies and reporters	Annually, 100% of the mass media agents receives BICMA notification on responsible media reporting of suicide 90% of the media stories on suicide is reported responsibly	BICMA, NSPP	Motion Picture Association of Bhutan	Completed by December of every year
1.7 Raise awareness on mental health, identification of severe mental illnesses, behavioral problems and suicide risk factors through mass media	Develop (field test and production) mass media messages and materials for TV, Radio, print media, and social media Prepare a yearly media dissemination plan Conduct media campaigns	Three monthly primetime airing of messages on seeking help for suicide prevention and psychosocial needs	HPD, NMHP, NSPP	Media agencies	Complete production of media materials by December 2016, and conduct media campaigns by February 2017

Activity	Milestones/Tasks	Indicators	Responsible agency/ ies	Other linkages	Timing
1.8 Promote print advocacy materials for mental health promotion and identification of suicide risk factors in strategic locations and during public events	Prepare a yearly distribution plan for print materials in work places, strategic public places and public gatherings Distribute print education materials as per the plan	Number of key workplaces including private agencies and public reached with print materials in a year	Head of organizations, and workplaces, HPD (MoH)	Organizations	Every year from 2017 and 18
1.9 Maximize use of IT-enabled mass media campaigns through social media channels (emails, facebook, twitter, telephone, and sms)	Develop mental health promotion and suicide prevention messages for facebook, twitter, emails and sms Disseminate messages on mental health and suicide prevention through emails, facebook, twitter and sms	Mass media messages delivered through phone sms on a three monthly period	IT Unit (MoH), HPD, Mental Health Program, NSPP	Bhutan Telecom	Initiated by December 2015 and conducted every year
1.10 Integrate mental health promotion and suicide prevention activities as a priority social indicator of LGs and include within the Local Government Reporting Framework	Seek a circular from the Office of the Prime Minister/ Cabinet and circulate to LG s (Dzongdags, Gups and Thrompons) to initiate suicide prevention advocacy in community gatherings	All local governments (dzongdags, Gups, and Thrompons received the circular	GNHC, MoH	NSPP(MoH), HMIS(MoH) MoF, MoH	By September 2015

Objective 2: Strengthen governance and institutional arrangements to effectively implement comprehensive suicide prevention plans

Rationale: Functional institutional arrangements and governance framework are required for policy planning and implementation of suicide prevention services. Institutionalizing suicide prevention services requires a systems approach for providing supportive administrative functions.

Key actions

- Establish National Suicide Prevention Steering Committee(NSPSC) to steer multiagency national response for implementing a comprehensive suicide prevention program
- Establish the National Suicide Prevention Program (NSPP) in the Ministry of Health as a national focal point for suicide prevention, and secretariat to the SPB
- Establish Suicide Prevention Unit (SPU) at the Royal Bhutan Police, Head Quarters to provide effective response to suicide prevention, postvention services and investigation of suicide cases.
- Establish Dzongdag's suicide response teams and focal points to respond to individuals, families and communities in crisis

Table 3. Activities, milestones, indicators, agencies and timing for objective 2

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
OBJECTIVE 2: Strengthen governance and institutional arrangements to effectively implement comprehensive suicide prevention plans					
2.1 Establish National Suicide Prevention Steering Committee (NSPSC) to steer multi-agency national response for suicide prevention	Formalize members of the Committee through an executive order of the Hon'ble Prime Minister Conduct two Committee meetings in a year and follow up on the recommendations of the board Publish NSPSC's national suicide prevention report by hiring a local consultant (one month contract)	Annually, two NSPSC meetings conducted with the required quorum Annual report on national suicide prevention response publicly available online	NSPP	Secretariat, Lhengye Zhungtshog	One Committee meeting in 2015 and thereafter two meetings a year National suicide prevention report published for 2016, 2017 and 2018
2.2 Establish national suicide prevention program (NSPP) as a national coordinating agency and the Secretariat to the SPB	Seek the approval of the RCSC for two full time officers Notification and recruitment of a full time staff Discuss the NSPP functions with the RCSC and formalize the unit within the MoH	At least two full time officers assigned to the NSPP within the plan period The MoH organogram revised to include the NSPP	HRD (MoH), DoPH	RCSC	First officer recruited by June 2015, and the second officer by June 2016
2.3 Establish RBP Suicide Prevention Unit under the Crime Prevention Division of the RBP, HQs, Thimphu to provide effective response to suicide prevention and investigations of suicide cases	Hold discussions on the formation of the RBP Suicide Prevention Unit Consultative meeting to develop SOPs for the Units Appoint a suicide prevention unit office bearers and office equipments in 13 divisions plus headquarters	Suicide prevention unit established with full office bearers Functions of the suicide prevention unit included within the RBP organogram	RBP, HQ	MoHCA	RBP Suicide Prevention Unit established by December 2016

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
2.4 Set up forensic units (FUs) in all the regional referral hospitals	Recruitment announcement and interview for the FU Drafting the service standards of FUs and seek endorsement from the MoH Allotment of proper office space	At least one full time health worker assigned for FU in Gelephu and Mongar Regional Hospitals with approved service standards	Mongar RRH and Gelephu RR Hospital, NSPP	HRD (MoH), KGUMS, Forensic Unit, JDWNRH	
2.5 Establish Dzongdag's Suicide Prevention Response Teams with the focal points from the RBP, Health and community members (eg: gewog representatives) and integrate suicide prevention services as social indicator under the dzongkhag's Government Performance Monitoring System (GPMS)	Conduct stakeholder meetings led by Dzongdag and appoint suicide prevention response teams with the official appointment order of Dzongdag Draw terms of reference for the local suicide response team Conduct quarterly meetings of the team to share the lessons Report suicide prevention services as dzongkhag's performance social indicator of the GPMS	85 % of the attempted suicide cases attended by the local suicide prevention response team within the plan period	Dzongkhag administration	NSPP, RBP, HQ	

Objective 3: Improve access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide (including those with suicidal ideation, history of self harm or non-fatal suicide attempt)

Rationale: Most at risks for suicide include individuals with severe mental illnesses, relationship problems, alcohol and substance abuse, history of self harm and suicide attempts, individuals in severe situational distress such as financial and economic conditions. Identification and reaching the individuals at high risk of suicide with prevention services can prevent suicidal deaths.

Key Actions

- Increase access counseling and prevention services to individuals in psychosocial crisis including victims of violence needing immediate attention or those who do not prefer face to face services, a 24 hour helpline services
- Increase access to suicide information and support on social media and toll free telephones for individuals in crisis
- Audit current processes of treatment/ follow up of people who present to ED with suicidal ideation or self-harm
- Set up a standard service protocol to improve care for individuals who have attempted suicide or inflicted self harm, and those affected by suicide
- Provide information and support for service providers (Eg; health workers, and RBP) of people who have attempted suicide to deal with the distressing events at work
- Strengthen postvention services among EMTs, police health workers, school staff and others with immediate contact with completed suicide cases
- Encourage culturally appropriate community bereavement support for families and others impacted by suicide

Table 4. Activities, milestones, indicators, agencies and timing for objective 3

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
OBJECTIVE 3: Improve access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide (including those with suicidal ideation, history of self harm or non-fatal suicidal attempt					
3.1 Establish a 24 hour crisis helpline including webpage, and social media channel, and live chat	Developing standard of care and interplay protocol between crisis helpline and emergency services Ex-country exposure visit of the HHC staff Setting IT, documentation and data base Quarterly review of the hotline service	Helpline services available 24 hours throughout the week and the year	NSPP, HHC	Bhutan Tele Com Corp. Druknet	To be set up by December 2015
3.2 Training of staff for crisis helpline and toll free providers (HHC, DICs, Nazhoen Helpline, HISC and others)	Development of training package for crisis helpline management Training of crisis helpline counselors		NSPP, HHC	JDWNRH	To be set up by September 2015
3.3 Yearly evaluation of helpline services on crisis counseling and referral services	Hire a local consultant to conduct the evaluation (4 week contract) Field work and dissemination meeting of the evaluation Implement the recommendations	Evaluation report endorsed and printed within 6 weeks after the dissemination meeting	NSPP,HHC	JDWNRH	
3.4 Increase access to suicide information by continuing services through toll free telephone services in HISC, Nazhoen Helpline, and expand services of other toll free lines	Assign a trained counselor to provide constant toll free services during the office hours Conduct quarterly review meeting of toll free services to share experiences among counselors		YDF, CPA, HISC, RENEW, CECD (MoE)	NSPP	

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
3.5 Audit current processes of treatment/ follow up of people who present to health facilities with suicidal ideation or self-harm and develop clinical protocol for care	Recruit a local consultant to conduct the audit (Four week contract) Meeting to disseminate the audit findings and recommendations Develop the clinical protocol for follow up	Final report available within 6 weeks after the dissemination meeting	NSPP	DMS (MoH	
3.6 Set up a standard protocol to improve care for individuals who have attempted suicide or inflicted self harm	Hire an international expert to develop the standard (15 day contract) Meeting of providers to develop a service protocol containing adequate follow up visits Printing of protocol Integrate protocol in mental health trainings for primary care, and other specialized groups	100% of people who attempted suicide, or having addiction to substance presenting in the health facility receive a mental health assessment as a standard of care	NSPP, DMS(MoH)		
3.7 Provide postvention support for survivors (family members, friends, classmates, co-workers of people who have attempted suicide).	Develop postvention protocol for health workers, police, school counselors and district response teams Train staff on postvention services	50% of suicide survivors receive crisis counseling and suicide risk assessment by a trained professional (health worker, school counselor or peer counselors)	NGOs, Health Facilities, Schools	All stakeholders	Postvention protocol develop by March 2016, and training initiated by July 2016
3.8 Strengthen capacity for suicide prevention and postvention services among EMTs	Review the trauma training protocol and integrate medico-legal, suicide and crisis management module	100% of EMT trained on trauma module with crisis and postvention services	DMS	NSPP	Module revised by December 2015 and training initiated by March 2016

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
3.9 Recognize culturally appropriate community bereavement support for families and others impacted by suicide (Community-based postvention services)	Encourage and promote local practices supportive of bereaved family in villages and communities Hold community advocacy meetings to recognize community social capital and preserving them Document best practices of community support and social capital in suicide prevention (local consultancy)	80% of the bereaved families receiving support from the neighbors and communities	LG, (Gewogs and Chiwogs)	Center for Bhutan Studies, National Statistics Bureau	Document one case study of social capital in suicide prevention by December 2017
3.10 Reduce access to pesticides by strengthening implementation of the Pesticide Act of Bhutan	Frame rules and regulations for the Pesticide Act of Bhutan and assign a strong implementation framework Orient regulatory staff and staff of RNR to monitor and advocate for safe use of pesticides	80% BAFRA and RNR staff informed on the rules and regulations of the Pesticide Act of Bhutan	NPPC/MoAF, BAFRA		Pesticide control rules and regulations endorsed by December 2016

Objective 4: Improve the capacity of health services and gate keepers to provide suicide prevention services

Rationale: It is important to take advantage of existing programs and efforts that address risk and protective factors for suicidal behaviors, including programs that may not yet include suicide prevention as an area of focus. Improving health services provided by gatekeepers will enhance delivery of suicide prevention services.

Key actions

- Establish Certified Board of Counselors in Bhutan to promote adoption of core education and training counseling guidelines by credentialing and accreditation
- Institute certified counseling training courses for gatekeepers (1-2 months duration)
- Conduct in-service training on suicide prevention for RBP (1-2 weeks)
- Institute accredited courses in forensic, crime and medico legal investigations through collaboration of University of Medical Sciences and Royal Bhutan Police
- Establish forensic procedure of court to cover forensic requirements and protocols
- Improve the capacity of the health workforce to integrate mental health assessment and suicide risk assessment in the health services by adopting core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education
- Improve detoxification and de-addiction services in health facilities and create center of excellence in detoxification services
- Improve referral mechanism among health facilities and between/among gate keepers and health service providers by instituting a clear protocol and understanding for referrals cases
- Provide training of de-addition and universal prevention counselors
- Standardize the staffing capacity of the DICs operated by all agencies to minimum of five staff: one manager, two peer counselors, and two outreach workers to improve the quality, scale and scope of DIC services

Table 5. Activities, milestones, indicators, agencies and timing for objective 4

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
OBJECTIVE 4: Improve the capacity of health services and gate keepers to provide suicide prevention					
4.1 Initiate certification of counseling profession through Bhutan Board of Certified Counselors (BBCC)	Seek government approval for the BBCC Establish fulltime office and office bearers of the board Implement functions of the board for validation and accreditation of the counseling academic trainings and counseling services Develop certification guideline and protocol	100% of the office bearers as planned are recruited by the end of the plan period	RENEW	RUB, KGUMS, Bhutan Health and Medical Council	Government endorsement sought by June 2015 Full office bearers appointed by March 2016
4.2 Develop accredited certificate courses* in forensic, crime and medico legal investigations *duration of 1-2 months	Appoint faculty for the course Hire a curriculum expert Consultations with key experts from RBP, and forensic specialists Print the curriculum	Curriculum and faculty ready	KGUMS, RBP	MoH, RUB	Faculty appointed by December 2015 and curriculum ready by October 2016
4.3 Training of forensic and crime focal points in certificate courses in forensic, crime and medico-legal investigations for 20 focal persons in Health and RBP	Selection of the candidates of 20 candidates (10 police personnel and 10 Health workers) Offer training courses Deployment of the trainees	First batch of 20 trainees graduated	KIGUMS, RBP		First batch of graduation by March 2017
4.4 Develop accredited certified courses in counseling training courses for gatekeepers	Appointment of the faculty Hire a curriculum expert and develop the course Validation of the course	Course validated by the BBCC Faculty recruited	Samtse College of Education (RUB), KGUMS	RCSC, MoH, MoE	Faculty recruited by December 2015Course validation completed by September 2016

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
4.5 Conduct training of counselors (30 counselors) from DICs, HISCs, Rehabilitation Centers, and health workers including HHC counselors , WCPU (RBP), selected focal points from Dratshang and Lhak-Sam peer volunteers on mental health and suicide screening	Develop suicide and mental health screening tools Offer training program	Atleast one certified counselor in each DICs, HISCs, rehab, and WCPUs, four HHC counselors and 3 dratshang counselors, and 3 from Lhak-Sam	KGUMS, SCE, RENEW, CPA, YDF, NACP, NSPP, Religion and Health Project (Dratshang Lhentshog)	BBCC, KGUMS, SCE	Trained certified counselors deployed by June 2016 and screening tools implemented
4.6 Develop in-service training program and train personnel including WCPU office bearers on suicide prevention for RBP * *(duration of 1-2 weeks)	Hire an expert to develop the training package Conduct the training of trainers for officers and personnel Conduct cascade trainings for personnel	Atleast one trained personnel trained in all 40 Police stations	RBP, KGUMS, SCE		
4.7 Conduct training courses in forensic, crime and medico legal investigations	Develop the training curriculum Conduct training		KGUMS, RBP		
4.8 Develop forensic procedure of court to cover forensic requirements and protocols.	Form a drafting committee Hire an expert (40 day contract) Develop and print suicide investigation procedure		NSPP,RBP,Forensic Unit (JDWNRH),	JDWNRH, RCSC	Criminal investigation procedure by December 2017
4.9 Capacity building of health workforce on mental health assessment and suicide risk assessment	Develop mental health assessment and suicide risk assessment tools Conduct orientation of the health workforce to integrate mental health and suicide assessment tools in patient examination checklist	100% of the health facilities in the country has integrated the tools in the patient examination check list	Mental Health, NSPP	Psychiatric Unit (JDWNRH), KGUMS	Tool developed by March 2016, and integrated in all health examination checklist by December 2017

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
4.10 Improve in-service curriculum teachings for health workforce by including topics on suicide prevention, suicide screening, suicide investigation and postvention services at the FNPH	Review the current contents of the curriculum by all subject teachers in nursing, and health assistants program Integrate the revised topics in the curriculum	The revised curriculum taught to 100% of nursing, and health assistants graduates by 2016	FNPH	Psychiatric Unit, JDWNRH	Curriculum revised by December 2015 and courses taught by early 2016
4.11 Strengthen referral linkages for services among rehabilitations and counseling services of YDF, CPA, RENEW, HISCs and health facilities for individuals with psychosocial needs to prevent suicide or self harm	Meeting of YDF, RENEW, CPA, HISCs, JDWNRH, and other related health facilities Sign a memorandum of understanding on referrals Develop a referral protocol	MoU endorsed by all parties Referral protocol printed and delivered to all parties	NSPP, DMS (MoH), JDWNRH, YDF, CPA, RENEW		MoU by September 2015 Referral protocol distributed by November 2015
4.12 Improve de-addiction and detoxification programs in hospitals and create four health facilities an excellence centers	Hire a consultant to conduct a service and training needs assessment for detoxification services (4 week contract) Develop revised training curriculum for detoxification and de-addiction services Identify two hospitals in the east, one in the center and the JDWNRH as a center of excellence for detoxification services		Mental Health Program		
4.13 Training of health workers on detoxification and deaddiction services	Identify atleast 2 staff for excellence centers for detoxification and de-addiction centers and other hospitals Conduct the training		Mental Health Program, NSPP	Psychiatric Unit (JDWNRH)	Three center of excellence launched by December 2016

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
4.14 Develop curriculum and train health workers and the Royal Bhutan Police on suicide investigation and documentation	Module on suicide investigation and forms for data forms Training	80% of suicide and violence investigation conducted by RBP and Health officials trained in suicide investigation	RBP and UMS	MoH, National Legal Institute	
4.15 Provide training of de-addition and universal prevention counselors	Admission and selection of candidates Training	60 counselors	BNCA	KGUMS	30 counselors trained in 2016 and remaining counselors in 2017
4.16 Standardize the staffing capacity of the DICs operated by all agencies to minimum of five staff: one manager, two peer counselors, and two outreach workers to improve the quality, scale and scope of DIC services	Revise service conditions for the DICs and agree with the key organizations operating DICs Staffing exercise (notification, recruitment and appointment)	All DICs operating with minimum of five staff	BNCA	YDF, CPA, RENEW	Service conditions review and endorsed by December 2016 All DICs operating with five staff minimum by June 2017
4.17 Strengthen OSCCs in JDWNRH, Gelephu and Mongar Regional Referral Hospitals for providing one stop services including medical, psychosocial support, investigation and legal support	Develop the SOPs for OSCC Assign trained counselors, and identify	24 hour OSCC service provided as per the protocol	JDWNRH, DMS, Mongar and Gelephu Hospitals , RBP, HQ	NCWC	Counselors posted by December 2016

Objective 5: Improve community resilience and societal support for suicide prevention in communities including schools and institutions

Rationale: Promoting opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities is a positive factor for suicide prevention

Key actions

- Strengthen implementation of policies of promoting mental health by making schools/ institutions mandatory by greater involvement of teachers on mental health promotion, identification of behavioral disorders, prevention of alcohol and drug use, and identification of suicide risks among students
- Encourage schools to adopt local school policies for counseling, and referral of children with mental illnesses and risks for suicide and integrate within the school performance framework at the dzongkhags
- Strengthen outreach to parents on parenting through school parenting education awareness programs
- Strengthen supportive supervision and monitoring for school guidance and counseling program
- Support community based (outreach) advocacy on suicide prevention through community groups (Village Health Workers, Women Association, RENEW Volunteers, traditional healers and local healers)
- Expand training of trainers program on mental health using Mental Health Facilitators Training Manual for Community Based Support System (CBSS) volunteers
- Support engagement of youth groups to advocate suicide prevention services in schools and communities

Table 6. Activities, milestones, indicators, agencies and timing for objective 5

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
OBJECTIVE 5: Improve community resilience and societal support for suicide prevention in communities including schools and institutions					
5.1 Strengthen implementation of policies promoting mental health by making schools/ institutions[19] mandatory to orient teachers on mental health, and identification of behavioral problems, prevention of drug use and alcohol, and suicidal behaviors on an annual basis [20]	Issue a circular from the Secretary, MoE/ and Vice Chancellor RUB requiring schools to conduct mandatory orientation of all teachers on mental health promotion, identification of behavioral problems, strategies for anti-bullying, prevention of drug use and alcohol, and identification of suicidal behavior Send printed brief on mental health promotion ,and identification of behavioral and drug use problems in schools and identification of suicide risk factors to be used during the mandatory reorientation of the school teachers		School Principals and the Head of the Institutions	District Education Office	Circular and the materials to be sent by February 2016
5.2 Encourage schools to adopt local school policies for counseling, and referral of children with mental illnesses and risks for suicide and integrate within the school performance framework	Teachers meetings Adoption of school local policies Documentation of services provided Three monthly review of the services provided		School Principals	District Education Office	

[19] Institutions include colleges under the RUB

[20] Promoting safe and healthy environment in schools is reflected in Guidance and counseling framework for Schools in Bhutan, MoE, 2010

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
5.3 Require districts to integrate mental health promotion, and suicide prevention activities focusing on screening and identification, and supportive services provided to students as school and district education sector performance indicator	Dasho Dzongdags/ Head of the institutions informed on the policy decision through a letter from the Education Secretary DEO/Head of the Institutions include the indicators within their performance framework Indicators monitored routinely		Dzongkhag administration, (DEOs), Principals and Head of the Institutions	MoE, RUB, MoH	Start school reporting from March 2016
5.4 Enhance the capacity of school guidance counselors in mental health screening and suicide assessment	Review and adapt the training module on substance use and co-occurring mental disorders offered through BNCA to include suicide prevention topics Training of school guidance counselors	100% of school guidance counselors trained on adapted training module	DYS	NSPP, NMHP (MoH)	Adaptation completed by December 2015, and 50% of SGC trained by December 2016 and remaining 50% by December 2017
5.5 Strengthen peer support program in schools for identification, and providing support and referrals among students in need of services	Continue annual peer helpers conference and school guidance counselors and increase number of participants to the conference Expand the membership of the peer helpers in schools making it gender sensitive by engagement of male and female peer counselors Conduct one annual national review of the peer support program		CECD (MoH), DEO, Principals, Head of Institutions		

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
5.6 Strengthen supportive supervision and monitoring for school guidance and counseling program in schools and institutions	Prepare a supportive monitoring tools for SGC program Train core monitors among the teachers in each district Facilitate movement of teachers for SGC monitoring visits Prepare an annual district report on SGC program, or include a section in the Annual District Education Report Publish annual national report on SGC program services		CECD (MoE), DEO	School principals	
5.7 Strengthen School Parent Education Awareness Program (SPEA) in schools to improve parental skills to identify mental, emotional and behavioral needs of children	Institute SPEA program for all schools (including primary and preprimary schools) Schools make it mandatory for atleast one of the parents to attend the annual SPEA meeting	Atleast one of the parents attend SPEA program annually	CECD, Schools		
5.8 Improve the capacity of the Community Based Support System (CBSS) volunteers of RENEW and MSTFs to advocate for identification of mental illnesses including suicidal risk factors by expanding advocacy and training on mental health using Mental Health Facilitators Training Manual	Conduct training of CBSS volunteers in all districts	All core volunteers trained using the document	RENEW, Dzongkhag Administration	Mental Health Program (MoH), Psychiatric Unit, JDWNRH	

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
5.9 Support formation of male and women groups for prevention of domestic violence and suicide prevention and timely referrals	Expand the membership of the core CBSS volunteers Create a system for maintaining an activity log of all the volunteers to document the services provided Document an annual activity report of the core CBSS volunteers Conduct annual conference of the core CBSS volunteers activities	Every gewog has atleast one active CBSS volunteer reporting the activities	RENEW, Dzongkhag Administration	MoH	Activity log maintenance system launched by December 2015
5.10 Engage youth groups and youth organization in suicide prevention advocacy to reach messages in the communities	Support project proposals on suicide prevention by formal and informal youth groups such as Y-VIA, and Go Youth Go (GYG) Youth groups conduct mental health awareness and suicide prevention activities in the communities	Atleast six CBO led suicide prevention and mental health promotion projects are supported with grants during the plan period	CBOs	All stakeholders	Atleast the first grant to be awarded within 2015
5.11 Advocate community members including VHWs to identify and support individuals at risk of suicide and refer to health facility and agencies who can help them	Append a section on suicide prevention and mental health in VHWs module Integrate the revised module in the VHW training		VHW Program (MoH)	NSPP, District Health Sector	Conducted annually
5.12 Advocate among community gate keepers (traditional healers and local shamans, tsips, and local lams) on the role of mental health and suicide prevention	DHOs circulate brief guidelines on mental health and suicide prevention to BHUs Allot 2-3 hour advocacy time by integrating with other local health advocacy events	Annually, 80% of community traditional healers, local shamans, tsips, and local Lams attended health worker briefing session atleast once in 2016, and 2017	BHUs, DHOs	NSPP, District health sector	Completed by December 2016 and 2017

Activity	Milestones/Tasks	Indicators	Lead agency/ies	Other linkages	By When
5.13 Pilot interventions in two sites: JDWNRH psychiatric unit, and Trashigang hospital for blending Buddhist approaches and modern psychotherapeutic techniques in counseling alcoholic and addiction problems	Develop a brief protocol for intervention by Religion and Health Project and detoxification sites in JDWNRH and Trashigang Train/orient the staff monk and unit staff Implement the protocol		Religion and Health Project (Dratshang Lhengtshog), Psychiatric Unit, JDWNRH, and Trashgang Hospital	NSPP, DMS	To develop the protocol by December 2015 and implement the pilot by January 2016
5.14 Encourage networking of informal community members for peace making and dispute settlements in remote rural areas in relationship problems and social disputes to enhance community resilience	Identify community confidantes in villages and communities Promote their participation in dispute settlements	Gewogs have atleast 3 community confidante identified in each gewog	Gewogs	Dzongkhags	Initiated by Decemebr 2015

Objective 6: Improve data, evidence and information for suicide prevention planning, and programming

Rationale: Improving the knowledge base through timely analysis of data and dissemination of information concerning suicide and suicide attempts facilitates prevention planning and implementation. Also generation of new evidences and evaluation of the program interventions are crucial for future program iteration.

Key actions

- Introduce the National Registry of Deliberate Self Harm and Violent Deaths to include attempted suicide and suicide deaths
- Include suicidal behaviors in the health behavioral surveys for adolescents and adults to identify suicide risk factors to strengthen behavioral surveillance
- Strengthen data system of the school counseling services through CECD
- Strengthen reporting systems of the gatekeepers on suicide, suicide attempts and self harm
- Conduct annual review and assessment of the implementation of the national suicide action plan
- Review and revise HMIS to include specific ICD information on suicide and attempted suicide, and self harm

Table 7. Activities, milestones, indicators, agencies and timing for objective 6

Activity	Milestones/Tasks	Indicators	Responsible agency/ies	Other linkages	By when
OBJECTIVE 6: Improve data, evidence and information for suicide prevention planning, and programming					
6.1 Introduce a National Registry of Deliberate Self Harm and Violent Deaths to improve timely availability of a national data on suicide , triangulating data from RBP, Health Facilities and other relevant sources	Hire of a registry expert to develop the registryConsultation meetings of RBP, Health , CECD, RENEW, YDF, CPA and NCWC Orientation of health staff, RBP and other agencies on the registry Publish annual suicide report from the registry	All health facilities and RBP stations submit data to the registry	NSPP, RBP	CECD (MoE), Census (MoCA)	Consultant hired by December 2015 and registry launched from June 2016 Orientation of RBP and Health Centers on the registry by March-April 2016
6.2 Develop SOP/protocol for suicide investigation including the roles of RBP, Health Officials and community representatives	Revise forms for suicide investigation and verbal autopsy forms Develop SOP	One SOP	MoH/RBP		
6.3 Introduce standardized mental health assessment and suicide risk assessment in all health facilities	Development of forms through consultations Conduct orientation on data collection	One standardized tool	National Mental Health Program, NSPP	District health services	
6.4 Introduce a standardized mental health and suicide risk assessment tools in DICs, HISCs, Counseling Units, and Rehabilitation Centers	Revise the existing forms by including a section on mental health and suicide risk assessment	One standardized tool	NSPP		

Activity	Milestones/Tasks	Indicators	Responsible agency/ ies	Other linkages	By when
6.5 Compile an yearly review and implementation report of the National Suicide Action Plan	Hire a local consultant Conduct the review and compile the report	One report	NSPP		To be implemented by December of the year
6.6 Upgrade School Guidance and Counseling database for school counseling service information including self harm, suicidal intent and suicidal ideation	Hire a database developer Form a key advisory group with members from schools, NSPP, Psychiatric Unit, JDWNRH, and Forensic Unit of JDWNRH, National Statistics Bureau and other agencies Revise the SGC form and orient the SGC through self explanatory instructions on forms Set up the database Produce national annual report on SGC services	100% of lower and middle secondary schools report SGC services using the updated forms CECD generates a quarterly summary report of SGC services	CECD (MoE)	NSB, NSPP, Psychiatric Unit, JDWNRH, and Forensic Unit of JDWNRH,	Upgraded system ready by December 2015 and information collected from March 2016
6.7 Include suicidal behaviors in the relevant health behavioral surveys for adolescents and adults to strengthen behavioral surveillance	Include in Youth and adolescent surveys and other nationally representative surveys (Eg, GNH Survey)	At least 3 national surveys include information on suicidal behaviors	National Statistics Bureau, NSPP	MoE, MoH, and other agencies	Spread over the plan period
6.8 Review of HMIS ICD Coding to include suicide, self harm revision	Form a review committee to assess information gap on suicide and suicidal behaviors in the HMIS Revise the ICD Coding and integrate in the HMIS Orient Health workers on the new inclusion of information		HMIS (MoH)		

Activity	Milestones/Tasks	Indicators	Responsible agency/ ies	Other linkages	By when
6.9 Document Best Practice in Suicide Prevention in Bhutan	Hire a local consultant to identify success and best practices in suicide prevention including community resilience programs(30 day contract) Program assessment and documentation of best review Publication of the best practices	One document on best practices in suicide prevention	NSPP	All stakeholders	Contract awarded by February 2018, and document published by June 2017

SECTION III

FINANCING AND BUDGET

This is a comprehensive multi-year national suicide prevention action plan which addresses a range of interventions through multi agency partnership. Activities in the action plan can be categorized into three subgroups of funding needs: i) integrated funding, where activities are implemented as a part of ongoing approved plans, and do not require separate funds, ii) minimal funding, activities require minimal budget to implement the activities, and iii) full funding are new activities requiring total fund support. As shown in Table 8, the action plan has a good mix of activities with no funding, minimal funding and full funding requirement. Given the fiscal realities, caution has been taken to devise ways to optimally use the available resources including human resources and infrastructures and minimize cost where possible.

Table 8. Category of activities by funding needs

Integrated funding	Minimal funding	Full funding
• Hosting visit of Lam Netens/Uzins to institutions and schools for Choshed Lerim • Hosting TV/radio programs by BBS • Sensitizing LG through dzongkhag and gewog tshogdues • Appointment of agency focal points • Appointment of Dzongdags Suicide Prevention Response Team • Improving toll free line services • Suicide prevention in EMTs, VHWs, community healers • Curriculum for in-service at FNPH • School policies • Review HMIS ICD –Coding • Training of school guidance counselors • Mental health assessment and suicide screening in health facilities • Strengthening peer support programs in schools • In-school orientation of school teachers by school management • Conducting SPEA programs • Expansion of the CBSS program	• Promoting responsible media reporting • National Suicide Prevention Steering Committee • Setting up forensic unit in two regional hospitals • Introducing two pilot intervention sites for Buddhist approaches in detoxification centers • Gate keeping trainings on mental health and suicide screening for DICs, HISCs, Rehabilitation Centers • Introducing three OSCCs	• Mass media production and dissemination including sms and other social media • Staff for NSPP • Setting up 24 hour crisis helpine • Assessments (clinical practices for follow up of self harm and suicide attempts) • Postvention and service protocols and trainings • Instituting Bhutan Board of Certified Counselors • Hiring technical experts (curriculum, and assessments) • Training programs in KGUMS and others • RBP Suicide Prevention Unit • Create National Registry for Suicide and Self Harm • Develop SOPs for suicide investigations for health and RBP • Document Best Practices in Suicide Prevention • Standardizing DIC services to five staff • Engage community and youth groups for advocacy

Cost description

The plan addresses overall systems strengthening in schools, health services, communities through realistic programs. Capacity improvement for service delivery in suicide prevention by key gatekeepers addressing drug use, addiction, and violence are included as the core approach. Forensic and medico-legal services which are necessary but inadequate will be addressed by this plan. Similarly, data and information system, and evidence generation will be strengthened. Overall, additional professionals required for suicide prevention services will be trained by the academic institutions in the country. Obviously, launching the plan will require resources, man, money and organizational system.

The tentative cost to implement the three year comprehensive action plan is Nu.29 million or a yearly budget of Nu 9.6 million. The activities will be implemented by various sectors such as Education, Health, RBP, KGUMS, BNCA, Local Governments and NGOs through three levels of strategies Universal, Selective and Indicated interventions reaching grass root communities and individuals exposed to suicidal risk factors. On an average, yearly budget per agency will be approximately Nu 800,000 to Nu.900,000. This is a modest spending in addressing a national social priority to prevent many deaths and potential suicide attempts and will improve the capability of health sector, education sector, community based organizations, and police and legal systems for long term suicide prevention and response.

Funding sources

It is expected that most of the funding will rely on the government grants and budgetary support. However, stakeholders will also compete for mobilizing from other sources such as UN agencies and other developmental partners to meet the funding requirements. Other international grant application and philanthropic sources will be considered for securing additional funds for implementing the action plan.

Economic evaluation

This is the first comprehensive suicide prevention national plan. At the end of three year implementation of the plan, appropriate economic analysis should be conducted to assess the cost-benefit and cost effectiveness of the plan by monetizing the effects of the interventions. The information from the economic analysis will be useful for future directions of financing for suicide programming.

SECTION IV

MONITORING AND EVALUATION

The National Suicide Action Plan will aim at reduction of suicide rates by 10% in 2020 in line with the May 2013 declaration of the World Health Assembly.(Ref) The M & E framework will follow a set of indicators as in Table 8. Due to the short time period of implementation, the focus will be to monitor the inputs and outputs. Overall trend of the suicide reduction will be monitored through the national data on suicide collected through the national registry for suicide and deliberate self harm.

NSPP will assume overall in-charge monitoring of the action plan under the guidance of the SPB. The implementing partners will submit a six monthly implementation reports to the NSPP using a standard reporting forms. An annual progress report will be published; the report will be disseminated widely through media coverage. This report also will feed into the annual performance review to be conducted by an independent consultant. The following are the targets to be accomplished during the plan period and by June 2018.

Action Plan Evaluation

Suicide services assessment will be conducted to review the service delivery of all agencies including health services, RBP, school programs, and gatekeepers programs in DICs, HISCs, Detoxification Services, CBSS Services. The evaluation will be conducted under the direction of the Suicide Prevention Steering Committee (NSPSC). The NSPP, MoH will be responsible for the evaluation management including hiring of the team and coordination during the field work. The action plan evaluation will be conducted through a three month contract from July through September, 2018.

Priority indicators

Table 9. Indicators by objective areas

Area	Level of indicator	Baseline in 2015	What is likely to be in the next 36 months?	Means of verification
Improve leadership, multi-sectoral engagement and partnerships for suicide prevention				
1.Secondary Schools covered with atleast one choshed leyrim visit by Lam Neten/khenpo per year that included suicide prevention	Output	Very few school visits	100 schools per year with one choshed lerim for 90% of the students	District Education Office Activity Report
2.Stakeholder yearly activity plan outlined in the Action Plan supported with funding from government or other sources	Input	0	85%	Annual agency work plan
3.Dzongkhags that included suicide prevention agenda in the Dzongkhag Tshogdue atleast once in a year	Output	0	20	Minutes of the Dzongkhag Tshogdue
4.Dzongkhags reporting suicide prevention implementation indicators within the GPMS	Output	0	20	Dzongkhag GPMS Report
OBJECTIVE 2: Strengthen governance and institutional arrangements to effectively implement comprehensive suicide prevention plans				
1. Meetings conducted by National SPSC atleast twice in a year with the required quorum	Output	0	2 meetings with required quorum per year from 2016 through 2018	Minutes of the NSPSC meetings
2. National Suicide Prevention Program with a full time staff	Input	0	One full time staff by June 2015 and second full time staff by June 2017	Appointment order of the MoH
5.Incidents attended by Dzongdag's Suicide Prevention Response Team to rescue suicide attempters and deliberate self harm	Output	0	200	Incident Report of Deliberate Self Harm and Suicide Report
OBJECTIVE 3: Improve access to suicide prevention services and support for individuals in psychosocial crisis or those at most risk for suicide				
1.One 24 hour national crisis helpline for suicide prevention operational	Input	0	One center functional by December 2015	HHC Activity Report

Area	Level of indicator	Baseline in 2015	What is likely to be in the next 36 months?	Means of verification
2.Number of crisis callers counseled through the helpline crisis center	Output	-	600	HHC Activity Report
3.Number of suicide attempts including intentional self harm provided counseling in the health facilities	Output	-	200	Health Facility Activity Report/ HMIS
4.Patients presented with suicidal ideation/ intentional self harm followed up after discharge through one of the following modes: i) telephone call, ii) sms and iii) email as per the protocol	Output	0	70%	Health Facility Activity Report
OBJECTIVE 4: Improve the capacity of health services and gate keepers to provide suicide prevention services				
1.Number of peer counselors certified by the Bhutan Board of Certified Counselors (BBCC) including school counselors	Output	0	100	BBCC Report
2.Number of health workers, police personnel and other staff certified in crime, forensic and medico-legal investigations (1-2 months course duration)	Output	0	30	KGUMS Training Report
3.Develop forensic court procedures for criminal and suicide investigations		None	Two procedures	Documents
4.Completed and attempted suicide investigations conducted by health workers and police personnel trained in medico legal investigations	Output	NA	75%	Health Facility Suicide Investigation Report and Police Suicide Investigation Report

Area	Level of indicator	Baseline in 2015	What is likely to be in the next 36 months?	Means of verification
5.Number of health facilities with atleast one health workers trained on mental health and suicide risk assessment	Output	NA	150	NSPP training Report
6.Patients screened for mental health and suicide risk factors using the assessment tools at the i) OPD, ii) indoor and iii) ANC settings for postnatal depressions	Output	NA	60%	Health Facility Service Assessment Report
7.Number of DICs, rehabilitation centers and HISCs using the revised form that include mental health and suicide risk assessment	Input	0	16	DICs, rehabilitation centers and HISCs Assessment Report
8.Number of detoxification units in hospitals providing timely follow up in atleast 60% of detoxified clients per protocol	Output	0	15	Hospital Assessment Report
9.Number of health facilities that adopted mental health assessment and suicide risk assessment tools for general patient examination as a checklist	Outcome	0	80	Health Facility Assessment Report
10.Number of clients with suicidal thoughts, ideation, and severe self harm cross referred to services from gatekeepers: school, CBSS volunteers, DICs, HISCs, Rehabilitation Centers for after establishing the memorandum of understanding of referral using client referral protocol	Outcome	0	200	Reports of DICs, HISCs, Rehabilitation Centers, CBSS Reports

Area	Level of indicator	Baseline in 2015	What is likely to be in the next 36 months?	Means of verification
11.Number of clients attending detoxification services in the four Detoxification Excellence Health Centers	Output	0	150	Hospital service assessment report
12.Number of health facilities with atleast one health worker trained in detoxification and de-addiction providing services	Output	0	120	Health facility service assessment report
OBJECTIVE 5: Improve community resilience and societal support for suicide prevention in communities including schools and institutions				
1.Number of schools (all levels of schools) undertaking yearly in-school mandatory 2 hour orientation session for teachers within the schools on mental health, identification of behavioral disorders and suicidal behaviors among students and teachers	Output	0	400	School Activity Reports
2.Districts reporting school guidance and counseling services within the Government Performance Monitoring System (GPMS) of the dzongkhag	Output	0	20	Dzongkhag GPMS document
3.Number of school children in distress and life triggering events counseled by school guidance counselors	Output		1000 per year	School Guidance Counseling Report
3.Number of school children in distress and life triggering events counseled by school guidance counselors	Output		1000 per year	School Guidance Counseling Report

Area	Level of indicator	Baseline in 2015	What is likely to be in the next 36 months?	Means of verification
4.Number of lower, middle, and higher secondary schools with atleast 25 students trained and engaged in peer helpers program in schools	Output		75%	District/Thromde Education Sector Report
5.Middle and Higher Secondary Schools including private schools with full time SG counselors reporting monthly counseling service report to the CECD	Input	0	90	CECD/ MoE Report
6.Schools receiving atleast one supportive supervision visits per year for School Guidance and Counseling by trained SGC supervisors	Output	0	1 visit per school per year by trained supervisors	District/Thromde Education Sector Report
7.Parents attending atleast one session per year on School Parenting Education Awareness (SPEA) Program in lower, middle and higher secondary schools	Output	NA	Coverage of 50% of the parents in 60% of the schools per year	District/Thromde Education Sector Report
8.Number of clients in psychosocial distress including victims of domestic violence requiring psychosocial support identified and provided on-site support by the CBSS volunteers disaggregated by rural and urban areas	Output	NA	2500	CBSS Activity Report
9.Number of male clients in psychosocial distress requiring psychosocial support identified and provided on-site support by the CBSS volunteers disaggregated by rural and urban areas	Output	NA	500	CBSS Activity Report

Area	Level of indicator	Baseline in 2015	What is likely to be in the next 36 months?	Means of verification
10.Number of alcohol and drug users reached through self help and peer network groups in the communities	Output	100	300	YDF, BNCA, CPA and other NGO Reports
11.Number of community confidantes identified in gewogs and providing informal community services for solving relationship problems and other social disputes	Output	???	600	Gewog reports
12.Number of community events conducted by youth groups and community based groups to advocate self help seeking behaviors or suicidal thoughts and promoting mental health	Output	NA	3 per year	CBO Reports
OBJECTIVE 6: Improve data, evidence and information for suicide prevention, and programming				
1.National Registry of Deliberate Self Harm and Violent Deaths established and in use for data collection	Output	0	1	Registry of the NSPP
2.Key focal person of the RBP, health workers, and counselors trained in the national registry	Output	0	200	Training Report
3.Yearly assessment report of the National Suicide Action Plan printed and distributed	Output	0	400	Assessment Report
4.School Guidance and Counseling data base which includes deliberate self harm and suicidal intent and ideation developed and in use for monthly report collection	Output	0	1	

Area	Level of indicator	Baseline in 2015	What is likely to be in the next 36 months?	Means of verification
5.Number of national surveys and studies conducted that included questions on suicidal thoughts, ideation and other suicidal behaviors included in surveys such as BLSS, PHC, and Children Study	Output	0	2-3	Survey Reports
6.HMIS reporting suicidal behaviors and intent with the revised ICD Coding	Output		By December 2016	HMIS Forms of the MoH

Broad roles of the key stakeholders

Government/Cabinet/Parliament

Ensure that the National Suicide Prevention Action Plan is included in the Government Performance Management System; and allocate financial and human resources for implementation of the plan.

NGOs

Offer counseling and psychosocial support for individuals/families with addiction problem, victims of violence; provide shelter and protection, provide forum for developing professional capacity development for better livelihood; and advocate for prevention of alcohol and drug use, rights.

Community Based Groups

Organize events to advocate prevention of suicide among youth population, women, and community groups, participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level, develop and implement communication strategies that convey messages of help, hope, and resiliency, and provide opportunities for social participation and inclusion for those who may be isolated or at risk. PLHA, LGBT

Suicide survivors

Participate in suicide prevention and services policy reforms, advocate on reducing accessing to means of suicide, drug and alcohol campaigns, and involve in community activities and mentor youth, community members to reach out to older adults in the community, and form community based support groups for bereaved people.

Religious Bodies

Promote religious messages promoting self preservation of human life and discourage suicidal behaviors by stressing on negative karma of suicide among general population and key population groups such as young people; and provide support to individuals in psychosocial needs and depression while seeking religious services

Academia/KGUMS/ SCE

Lead in capacity building through training mental health professionals and health workers, counselors, offer short term and long term training courses in counseling, medico-legal and forensic investigations; and conduct studies in suicide prevention to build evidence based interventions in the country.

Media organizations, film and entertainment industry

Engage in de-stigmatizing mental illnesses and promoting help seeking behaviors for suicide prevention services; and prevent suicide contagion by engaging in a responsible media reporting.

Education sector

Build universal suicide prevention education programs for students and teachers, and expand school counseling services to effectively identify students in need of psychosocial support and provide counseling, referrals, implement programs and policies to prevent abuse, bullying, violence, and social exclusion, implement programs and policies to build social connectedness and promote positive mental and emotional health among parents, and integrate information about the responsible depiction of suicide and suicide-related behaviors into the curricula of schools.

Health sector

Provide mental health services, detoxification and de-addiction services for alcohol and drugs, provide postvention services, and conduct medico-legal and forensic investigations, offer 24 hour hotline services; set up suicide surveillance system, and communicate messages of resilience, hope, and recovery to patients, clients, and their families with mental and substance use disorders. Counseling services and crisis intervention

Royal Bhutan Police

Provide suicide prevention services for individuals in conflict with law, women and children in police custody, intervene during suicidal attempts, and conduct forensic and death investigations.

Local Governments

Mobilize grassroot communities in generating greater awareness on suicide prevention and build network of community champions among local leaders, healers, religious figures and influential individuals, network with and enhance existing community networks created by other organizations such as women's self-help groups, CBSS, which are effective and influential in many developing countries, could be encouraged to participate in suicide prevention efforts, and form suicide intervention squads to respond to save suicidal attempt events.

Other Government and Regulatory Agencies (NCWC, BNCA, BICMA)

Enforce regulations to reduce domestic violence, interpersonal violence, drug use, and improve compliance with alcohol service policies and responsible media reporting of suicide; provide support to NGOs implementing activities

Key assumptions for the suicide prevention action plan

There are several factors that will determine the success of implementing the action plan.

The key assumptions for the success of the Suicide Prevention Action plan include:

- The political commitment of the government to address suicide prevention remain unchanged and suicide prevention indicators are included in the GPMS
- Proposed NSPP unit is staffed and the SPB is diligently able to meet and function
- The other stakeholders including the NGOs and CBOs effectively participate in implementing the plan

- Financial resources are increased for implementing the program
- WHO and other donors provide continued partnership, support and guidance at the country level

Post 2018 Suicide Prevention Program

The continuity of robust suicide prevention is imperative. The lessons learnt from this phase of implementation of the suicide prevention action plan should be appropriately documented and incorporated in the post 2018 phase of suicide prevention programming. The second phase of Suicide Prevention Action Plan should be developed towards the second half of 2018 initiate the implementation by 2019.

Possible areas of post 2018 interventions will be deepening interventions initiated in this plan. Focus may include building professional cadre of human resources such as counselors social workers and mental health professionals, strengthening legal framework for addressing suicide risk factors, greater engagement of civil society and NGOs for addressing suicide prevention in communities and schools, expanding family therapy and counseling services, violence prevention programs. Strengthening health system for prevention and postvention services, improving medico-legal investigations are likely to be priority. Focus on building a value based communities and strengthening social capital will be important. In sum, current efforts and responses will determine much of the future direction in suicide prevention as Bhutan continues to increasingly face the challenges of social, cultural and economic risk factors that impact individual's environment.

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APPENDICES

Appendix 1: Glossary[21]

- **Affected by suicide.** All those who may feel the effect of suicidal behaviors, including those bereaved by suicide, community members, and others.
- **Behavioral health.** A state of mental and emotional being and/or choices and actions that affect wellness. Behavioral health problems include mental and substance use disorders and suicide.
- **Bereaved by suicide.** Family members, friends, and others affected by the suicide of a loved one (also referred to as survivors of suicide loss).
- **Means.** The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).
- **Methods.** Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).
- **Suicidal behaviour** refers to a range of behaviours that include thinking about suicide (or ideation), planning suicide, attempting suicide and suicide itself
- **Suicidal ideation.** Thoughts of engaging in suicide-related behavior.
- Suicide. Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
- **Suicide attempt.** A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
- **Nonsuicidal self-injury**—Self-injury with no suicidal intent. Same as nonsuicidal self-directed violence.

Behavioral disorders: Behavioral disorders is an umbrella term that includes more specific disorders, such as hyperkinetic disorder or attention deficit hyperactivity disorder (ADHD) or other behavioral disorders. Behavioral symptoms of varying levels of severity are very common in the population. Only children and adolescents with a moderate to severe degree of psychological, social, educational or occupational impairment in multiple settings should be diagnosed as having behavioral disorders. For some children with behavioral disorders, the problem persists into adulthood.

Cognitive Behavioral Therapy (CBT): Cognitive behavioral therapy (CBT) is based on the idea that feelings are affected by thinking and behavior. People with mental disorder tend to have unrealistic distorted thoughts, which if unchecked can lead to unhelpful behavior. CBT typically has a cognitive component (helping the person develop the ability to identify and challenge unrealistic negative thoughts) and a behavioral component. It is recommended for behavioral disorders, alcohol use disorders or drug use disorders, and also recommends it as a treatment option for psychosis just after the acute phase.

[21]CDC definitions

Family counselling or therapy: Family counselling or therapy should include the person if feasible. It entails multiple (usually more than six) planned sessions over a period of months. It should be delivered to individual families or groups of families. It has supportive and educational or treatment functions. It often includes negotiated problem-solving or crisis management work. It is recommended therapy for people with psychosis, alcohol use disorders or drug use disorders.

Motivational enhancement therapy: Motivational enhancement therapy is a structured therapy, typically lasting four sessions or less, to help people who are dependent on substances. It involves an approach to motivate change by using the motivational interviewing techniques described in the section on brief interventions. it is recommended as therapy for people with alcohol use disorders or drug use disorders.

Suicidal behavior: Suicidal behaviors can be conceptualized as a complex process that can range from suicidal ideation, which can be communicated through verbal or non-verbal means, to planning of suicide, attempting suicide, and in the worst case, suicide. Suicidal behaviours are influenced by interacting biological, genetic, psychological, social, environmental and situational factors (Wasserman, 2001).

Suicide risk factors: Risk factors for suicide include mental and physical illness, alcohol or drug abuse, chronic illness, acute emotional distress, violence, a sudden and major change in an individual's life, such as loss of employment, separation from a partner, or other adverse events, or, in many cases, a combination of these factors. While mental health problems play a role which varies across different contexts, other factors, such as cultural and socio-economic status, are also particularly influential (Public Health Action For the Prevention of Suicide, A Framework- WHO)

Appendix 2: Evaluation criteria for deciding on priorities in suicide prevention

A. Effectiveness	Not effective to very effective
B. Cost (from lowest to highest)	Very expensive to Inexpensive
C. Feasibility	Feasible to not Feasible at all
D. Public health benefit	No benefit to Highly beneficial
E. Cultural acceptability	Not acceptable to Highly acceptable

Appendix 3: Workshop and meetings

February 18, 2016: Stakeholder prioritization workshop
March 11, 2015: Technical Committee Meeting
March 16, 2015: Presentation to the Ministry of Health
March 25, 2015: National Taskforce Meeting
May 12, 2015: Submission of the action plan to the 74th Lhengye Zhungtshog

Appendix 4: List of stakeholders and persons consulted

Sl.No.	Organization	Date	Person(s)
1	Khesar Gyalpo University of Medical Sciences	February 3,11, March 17, 2015	Dr. K.P. Tsehring, President Dr. Pakila Drukpa , Registrar Dr. Tashi Tobgay, Director Dr. Neyzang Wangmo, Deputy Dean Mr. Tashi Norbu, Lecturer
2	RENEW , RENEW Walk In Center, and RENEW Gawaling Happy Home	February 4, 13, 14, 2015	Ms. Tshering Dolkar Dolkar, Director Ms. Karma Choden, Counselor Ms. Lhadon Wangmo, Manager
3	Samtse College of Education (Tele discussion)	February 6, 2015	Ms. Dechen Dolma, Lecturer
4	Department of Youth and Sports, MoE, Thimphu, (Tele discussion)	February 6, 9, March 9, 2015	Ms. Tashi Pem , Chief Program Officer Ms. Tshering Lham , Program Officer Mr. Needup Gyeltshen , Program Officer Mr. Kunzang Chophel, Program Officer
5	Psychiatric Department, JDWNRH	February 7, 2105	Ms. Sonam Chuki and nursing team
6	VCT Center, JDWNRH	February 7, 2015	Ms. Jyoti Gurung , Counselor
7	Drop-in-Center, Thimphu	February 7, 2015	Jigme, Counselor
8	HISC, Thimphu	February 7, 2015	Ngawang Choida, Chief Counselor Jambay Dorji, Counselor
9	Youth Development Fund	February 9, 2015	Kinley Tenzin Ms. RomaPradhan
10	Chithuen Phendey Association (CPA), Samzang Retreat Center	February 9, 2015	Tshewang Tenzin , CEO Dawa, Administrative Officer Kinley Tenzin, Manager
11	Royal Bhutan Police: Narcotic Division , Forensic and Crime Prevention and WCU, Thimphu	February 9, 10, 11, 2015	Lt. Col Sonam Genzin , Lt Col Namgay DorjiMajor Lobzang Phuntsho Major Norbu Zangpo Captian Karma Dema
12	Central Monastic Body, Zhung Dratsang, Religion and Health Program (Tele discussion)	February 10, March18, 2015	Lopen Passa, Focal person , Religion and Health Project Lopen Gembo Dorji, Secretary General

Sl.No.	Organization	Date	Person(s)
13	District Health Service , Pema Gastel (Tele discussion)	February 10, 2015	Kinley Dorji, District Health Officer
14	District health services, Lhuentse (Tele discussion)	February 10, 2015	Ugyen Dorji DHO, Kezang Rinzin, Chief nurse Dr. Sonam Jamtsho , Medical Officer
15	Drop –in-Center (Bumthang) (Tele discussion)	February 12, 2015	Chador, Counselor
16	HHC, Thimphu	February 7, 13, 2015	Dr. Karma Sangay, CEO Mr. Sangay Karpo , IT Officer Mr. Jigme Wangchuk, HHC Staff
17	Suicide Survivor Interview	February 14, 2015	Name not revealed
18	Forensic Unit/One Stop Crisis Center DV and child abuse, JDWNRH	March 6	Dr. Norbu, Forensic Specialist Ms. Kencho Peldon
19	Meeting suicide survivor	March 14, 2014	Unnamed
20	Visiting a suicide victim at the ICU,JDWNRH, and interview with wife	March 16, 2015	Unnamed
21	Bhutan Narcotic Control Agency (BNCA)	March 17, 18, 2015	Mr. Phuntsho Wangdi, Director General Mr. Sonam Jamtsho, Deputy Chief Program Officer Dorji Tshering, Deputy Chief Program Officer
22	Department of Medical Services, MoH Meeting with EMT Unit, DMS	March 17, 2015	Dr. Ugen Dophu, Director General Mr. Jamtsho, Offtng. Chief Chador and Sangay Program Officers
23	Lhak-sam (Email)	March 18, 2015	Wangda Dorji
24	Ministry of Agriculture , National Soil and Plant Protection Agency	March 25, April 1, 2015	Ms. Yeshey Dema, Program Director Mr. Doe Doe, Specialist
25	National Commission for Women and Children	March 25, 2015	Ms. Phintsho Choden, Director General Ms. Tshewang Lhamo, Program Officer
26	Bhutan Information and Communication	April 17, 2015	Mr. Lakshuman Chettri, Chief Media Officer
27	Presentation of the action plan to the 74th Lhengye Zhungtshog	May 12, 2015	National Taskforce for Suicide Prevention

The purple and turquoise suicide prevention ribbon symbolizes Suicide Prevention and Awareness and serves as a reminder that suicide is an issue we need to talk about.

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