Suicide Prevention in Bhutan - A Five Year Action Plan (2018 - 2023)

Royal Government of Bhutan

FORWARD

There is concern over the growing incidence of suicide, particularly amongst young people in the country. It is a serious public health issues that generally impacts the most vulnerable and disadvantaged members of the society. Every suicide is a tragedy and causes extreme pain and suffering for people who are left behind. It also causes loss of economic productivity as most suicide deaths occur among the economic productive age group. For a nation who is committed to upholding the values of Gross National Happiness and promoting happiness as a goal of human existence, this uphill task must be overcome.

It is estimated that seven to eight people die in Bhutan by suicide every month and there are many more who attempted suicide. To a large extent, suicide is preventable with appropriate interventions provided at the right time. The stigma surrounding suicide persists and often people do not seek help which prevents timely and effective intervention and treatment. The Government is deeply committed to addressing suicide prevention as a top social priority. As a society, Bhutanese are resilient and we must leverage this character and further strengthen our social capital. We must all be aware of these realities and work together to preserving a resilient society truly bounded by the values of happiness for all. Therefore, it is crucial everybody shares the same vision and works hard towards achieving the same goal. No families, villages, communities, and neighbourhoods wish for anyone to die from suicide.

The causes of suicide are complex and multi-factorial. Suicide prevention efforts must be multipronged addressing both individual and society level issues. The burden of suicide does not weigh solely on the health sector; it has multiple impacts on many sectors and on society as a whole. Government agencies, non-government organizations and civil society bodies have important roles in suicide prevention; concerted efforts are required by all sectors to prevent deaths. The action plan offers a roadmap for each level of society to support the prevention of suicide in Bhutan. The plan comprehensively addresses universal prevention strategies targeting the general population through mass media and social mobilization, to individual strategies of providing specific services for those at high risk of suicide and those affected by suicide.

Every single life lost due to suicide is a huge loss to the society. We must act together with urgency. Therefore, I call upon all the agencies, individuals and those affected, and bereaved by suicide for collective action and to make prevention an imperative to save lives by preventing further suicidal deaths.

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HEALTH MINISTER

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ABBREVIATIONS

AA	Alcoholics Anonymous
BBCC	Bhutan Board of Certified Counselors
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
CSO	Civil Society Organisation
DEO	District Education Office
DHO	District Health Office
DHSP	District Health Services Program
DICs	Drop in centers
DMS	Department of Medical Services
DT	Dzongkhag Tshodgu
DV	Domestic violence
DYS	Department of Youth and Sports
ED	Emergency Department
EMT	Emergency Medical Team
FNPH	Faculty of Nursing and Public Health
FYP	Five Year Plan
GB	Gender based
GSHS	Global School Health Survey
GT	Gewog Tshodgu
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
HIV	Human Immunodeficiency Virus
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
MHP	Mental Health Program, Ministry of Health
MI	Motivational interviewing
MSTF	Multisectoral Taskforce
NA	Narcotics Anonymous
mhGAP	Mental Health Gap Action Programme
MI	Motivational Interviewing
NCWC	National Commission for Women and Children
NGO	Non-government organization
NSB	National Statistics Bureau
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
SPU	Suicide Prevention Unit
TRCDAD	Treatment and rehabilitation center for drugs and alcohol
VHWs	Village health workers
WCPDs	Women Child Protection Desks
WCPUs	Women Child Protection Units
WHO	World Health Organization
YDF	Youth Development Fund
YDRC	Youth Development Rehabilitation Center

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SECTION - I

PROGRAM BACKGROUND

Introduction

Suicide is the act of intentionally causing one's own death or death caused by self-directed injurious behavior with intent to die as a result of the behavior. Each death due to suicide is a tragedy and the devastating effects due to suicide reach into the lives of families, friends and communities.

The causes of suicide are multi-factorial. Links between mental illness and suicide are well established, but there are combinations of other factors that affect an individual's ability to cope such as drug or alcohol dependence, social issues, poor emotional literacy and coping, poor family and personal relationships, lack of social supports, economic hardships, all of which increase the risk of suicidal thoughts and behaviors. Suicides may also occur impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness.

With effective and collaborative efforts, most suicides are preventable through assessing and addressing risk factors among vulnerable groups and by providing timely, evidence-based and often low-cost interventions. Suicide prevention requires a concerted effort from the community, governmental and non-governmental organizations in building efficient primary health care, mental health care services, post-vention supports and community-based support services. A single organization cannot prevent suicide and breaking service boundaries is a must to provide timely intervention to prevent suicides. The community also plays a vital role in suicide prevention, by noticing, asking and supporting its most vulnerable members to access help and support if they are going through a tough time.

With the objective to reduce suicide and provide preventive services, the National Suicide Prevention Program (NSPP) was launched in 2015 under Non-communicable Disease Division, Department of Public Health. The Program works with all relevant agencies as suicide prevention demands collective efforts from multiple agencies.

Global and National Suicide Epidemiology

The World Health Organisation (WHO) reports close to 800,000 people die by suicide every year and it is the second leading cause of death among 15-29-year-olds [1]. About 78% of global suicides occur in low- and middle-income countries. Worldwide, common modes of suicide are ingestion of pesticide, hanging and use of firearms. Every 40 seconds a person dies by suicide somewhere in the world. According to WHO, for every completed suicide there are many more unrecorded suicidal attempts and the number of attempts may be as high as 25 times the number of completed suicides.

In Bhutan, for every 1.5 deaths by suicide there is one suicide attempt recorded. It is possible suicide attempts are under reported due to factors such as stigma, shame, guilt, regret and concerns about claiming/accessing insurance; attempts are one of the known major risk factors for future death by suicide. Early intervention and providing support to those who have attempted to take their life provides an excellent opportunity to prevent suicide and thus reduce the suicide rate. In Bhutan, suicide deaths rank among the top six leading causes of death. In 2016 -2017, a total of 191 suicide deaths and 132 attempted suicide cases were recorded in the National Suicide Registry maintained by NSPP. The focus of this suicide prevention action plan is on strategies to increase the detection of suicidal ideation and responding to ideation and suicide attempts.

The Ministry of Health has been recording deaths by suicide since 2013 and has recorded an average of 73 suicide cases per year or six suicide deaths a month. The completed suicide rate in Bhutan is 12 per 100 000 population [2] slightly higher than the global rate of 11.4 per 100 000 population per year. The majority (57%) of suicide occurs among 18 – 35-year old's, the most productive age group. Although the overall global suicide rate has decreased, suicide rates in Bhutan have increased.

Suicide prevention requires a combination of universal, selective, and indicated strategies to address the wide spectrum of suicide risks. Universal strategies target the entire population; Selective strategies are appropriate for subgroups that may be at increased risk for suicidal behaviors and Indicated strategies are designed for individuals identified as having a high risk for suicidal behaviors, including those who have previously attempted suicide. Implementation of the previous Three-Year Action Plan for Preventing Suicide (2016 – 2018) has helped in building services and response systems for preventing suicide and crisis management after suicide events. However, there are opportunities and areas to strengthen to make programs more responsive.

National Suicide Prevention Program (NSPP)

The NSPP was created under the Department of Public Health, Ministry of Health in 2015 with an officer designated for the Program. The overarching purpose of the national suicide prevention program is to act as the national coordinating point for suicide prevention in Bhutan and 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.

Guiding Principles

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

1. 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.
2. Suicide prevention will address wide range of factors related to suicidal behavior, including social support, mental illness, substance misuse, economic factors, and community and personal risk and resiliency.

3. Suicide prevention will be comprehensive and include population-level interventions to build supportive community systems with a focus on individual risks for suicide.
4. Suicide prevention will employ combination of public health and individual clinical approaches focusing on identification of risk and provision of individually tailored services.

Key Roles

1. Drive and promote Action Plan activities and support their incorporation into annual work plans for implementation.
2. Collect and compile progress reports from the stakeholders including the Dzongkhags and produce an annual report on the progress of the action plan implementation.
3. Conduct awareness programs on suicide prevention in the country.
4. Build the capacity across the continuum of care to assess for and intervene on suicidal ideation as well as provide post-vention support services to those affected by suicide.

Current Services in Place

Since the inception of the National Suicide Prevention Program in 2015 and implementing a National Suicide Prevention Action Plan, several services and mechanism were made systematic through synergetic efforts from all relevant stakeholders.

Some of the major achievements are:

- Highlighting suicide and mental health as a public health issue with multiple causal dimensions and garnering support from national, district and community level organizations to address these issues through a multi-agency response;
- Securing support for suicide prevention and promotion of mental health from the religious leaders from 16 districts of Bhutan, as a result of annual advocacy during the conferences for Netens and Shedra Uzins;
- The sensitization of local government (LG) leaders (*Dzongdags, Thrompons, Gups and Mangmis*) in 16 districts on suicide prevention, identification of vulnerable people and the role of local government administration in suicide prevention during the Dzongkhag and Gewog Tshogdues;
- The training of Health Help Centre workers in basic mental health, suicide intervention and counseling skills and the subsequent use of the 112 Health Help Centre number as a 24-hour crisis helpline to respond to individuals experiencing psychological crisis;
- The initiation of counselling services at health centers and schools including the provision of post-vention services in school by trained school counselors;
- Capacity enhancement training to improve practitioner's skill sets;
- The strengthening of data systems to promote evidence-based decision making and programming;
- The development and validation of counseling courses by nationally recognized academic institutes;

- The development and implementation of standard protocols (SOPs) for investigating deaths due to suicide by police and health services;
- The development and implementation of a database of school guidance counselors and
- The implementation of a National Suicide Registry maintained by the NSPP.

Challenges and Barriers

Building an approach to suicide reduction and prevention is a multi-sectoral responsibility however getting it right and doing it poses a challenge to public health professionals, the drug and alcohol sector, teachers and schools, law enforcement, monastic bodies and society at large.

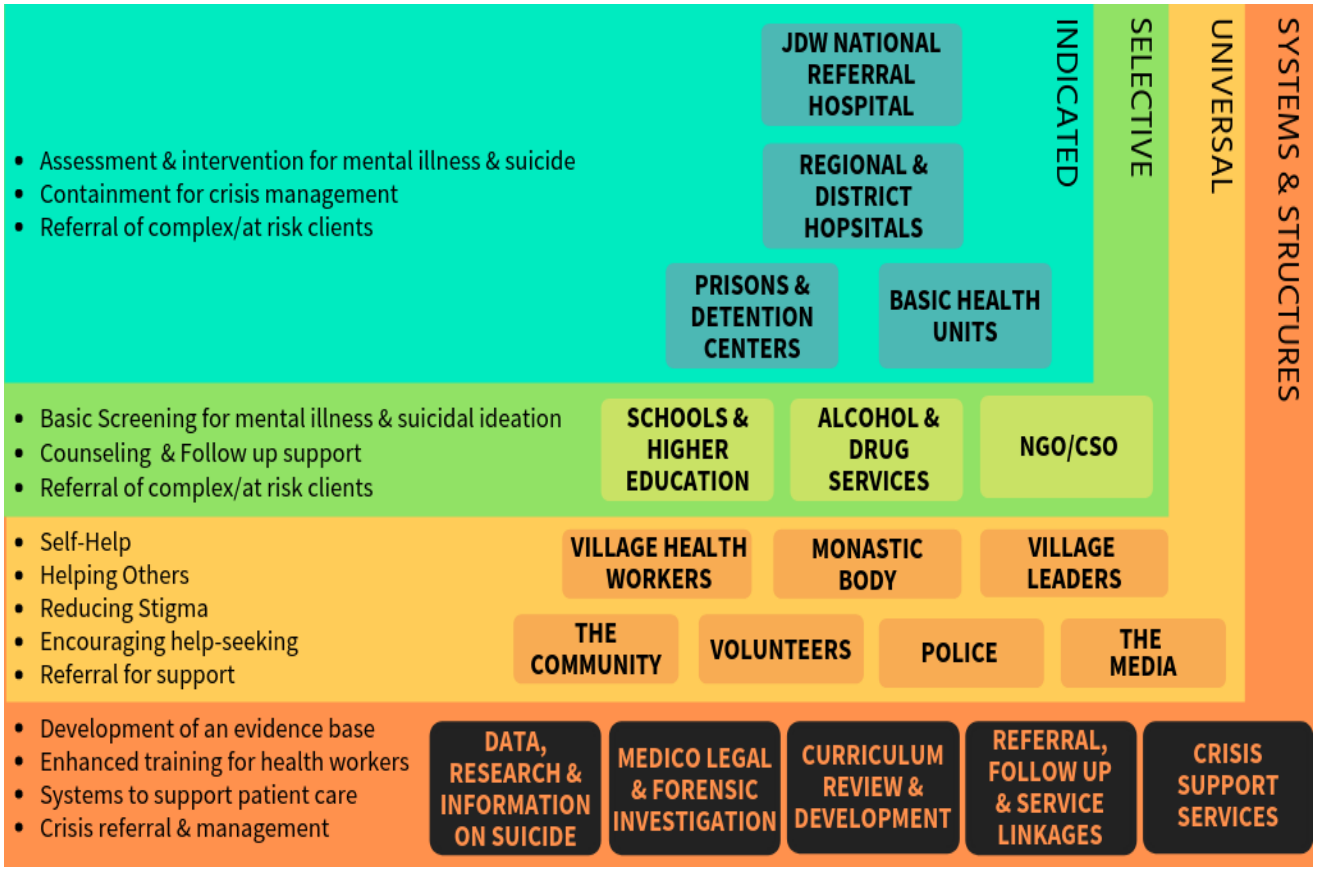
Some of the dominant challenges are:

- Stigma surrounding mental disorders and suicide is barring people from seeking help and community members are therefore not getting the help they need in a timely manner. Raising community awareness and breaking down the taboo is an important task in preventing suicide;
- Resource constraints (financial and human resource) and capacity issues in the districts where officials from non-health sectors need to advocate and intervene on mental health and suicide prevention;
- Coordination challenges in ensuring the implementation of multiagency action plans at national, district and community levels;
- Engaged participation from heads of relevant agencies and robust monitoring and supervision by identified focal persons;
- Lack of clarity in the roles and structure of the "Dzongdag's Suicide Response Team" making monitoring and implementation of action plans difficult;
- The reporting of completed/attempted suicide cases including secrecy from community members, lack of disclosure around deaths by suicide, stigma associated with suicide attempts and lack of clear follow-up procedures and post-vention services for those affected by suicide;
- Need for increased training and support to ensure accurate reporting of suicide cases in the country by investigators and thus ensure quality data.

SECTION – II

STRATEGIES FOR SUICIDE PREVENTION

Suicide Prevention Framework



The framework outlines the role each individual plays in the prevention of suicide, from a community to a specialist level. Different strategies are used to target groups and individuals at different levels of risk and monitor their progress over time. Some strategies are things everyone can do, some require specialist training. Tailoring strategies ensures people have access to professional services when they need them most.

The model is intended to be a step-up/step-down model; that is as the level of risk and therefore expertise required increases, the individual is referred up through the tiers of support. With intervention, risk reduces, and the individual can be referred back down through the tiers for ongoing support and monitoring. By acting as a support network, intervention, treatment and responsibility does not fall on one organization and the scarce resources currently available can be utilized to their best effect, to save lives. The framework is further enabled by systems and structures which support the effective and efficient use of resources, as outlined below.

SYSTEMS AND STRUCTURES

A framework incorporating universal, selective and indicated strategies requires effective and efficient systemic supports in order to be successful. Systems and Structures enables appropriate and timely services provided to people who need them, when they need them.

The Systems

Data, Research & Information on Suicide

Suicide data must be available in a timely manner for effective policy and program decisions. Currently, data on self-harm and suicide is not universally collected in a standard way. Collection of suicide information requires coordination among agencies, a central repository or uniformity in data collection parameters. It involves horizontal and vertical coordination between sectors and sound organizational mechanisms to ensure effective collection and management of suicide data.

The Health Management and Information System (HMIS), an integrated repository of health facility data of the MoH, does not efficiently capture information on intentional self-harm and suicide attempts. The NSPP in collaboration with HMIS will review the current information collected on suicide and revise the forms to include additional collection points for intentional self-harm and suicide attempts.

Except for the national Study on Reported Suicide Cases in Bhutan conducted in 2014 and the Global School Health Survey, there are hardly any publications on suicide and suicidal behaviors in Bhutan. Data on suicide prevention and intervention post suicide attempts are necessary for suicide programming. The publication of well-researched papers and position papers on suicide prevention is encouraged. The collation of information could be improved by including questions on suicidal behaviors in other national representative surveys conducted by Health Sector and other agencies including Youth Behavioral Surveys, the national HIV Behavioral Surveys, GNH surveys, and the National Population and Housing Census.

National Suicide Registry

The National Suicide Registry (NSR) was established as part of the 2015 – 2018 National Suicide Prevention Action Plan to improve reporting and recording of suicide and suicide attempts in Bhutan. The NSR is a paper-based system which relies on health services and police to investigate suicide attempts and deaths by suicide to provide data which is individually entered into a spreadsheet held within the NSPP. This current system, while a useful measurement tool does not incorporate prevention activities and is not responsive to emerging need, trends or to inform service requirements. The NSR can be improved through reviewing the data collection forms and improving the efficiency of the mechanism. Further, 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.

Medico Legal & Forensic Investigation

Currently, there are no comprehensive policy guidelines for the investigation of completed suicides and current investigations occur through an informal arrangement between the Ministry of Health and RBP. In general, Bhutan has very limited forensic service capacity. A proposal for independent forensic service was approved during the 2006 Annual Conference of the Ministry of Health, but it has remained unimplemented due to resource issues. The nation's forensic unit at the JDWNRH is currently the only center with a forensic specialist.

Investment in forensic services and criminology has become a priority in the fast-changing Bhutanese society with rising rates of crime and suicide. However, the RBP capacity for forensic and suicide investigation services is still limited largely due to inadequate skills. The RBP is constructing a Forensic Laboratory which is expected to enhance the capacity development in the area of forensic 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 KGUMSB. By improving investigation procedures, more accurate information can be gathered which in turn can improve prevention and intervention services.

Curriculum Review & Development

Counselling is an important psychosocial intervention in supporting mental health and suicide prevention. Currently, counselling services are provided by peer counsellors, addiction counsellors and health workers trained in short term counselling courses. It is important that a group of well-trained counsellors is established to address the future expansion of services through government, NGOs, and CBO providers.

The Bhutan Board for Certified Counsellors (BBCC) is established, and an undergraduate Bachelor of Science (Clinical Counselling) course was launched in 2016 at the FNPH. BNCA offers a nine module, 45 day in-country certificate course in counselling in conjunction with the International Center for Certification and Education of Addiction Professionals. Other categories of clinical counsellors, clinical psychologists and social workers, although an important health workforce for mental health care and suicide prevention, are not currently included in the civil service cadre of health professionals. The MoH urgently needs to take a lead role to build these cadres of professionals within the civil service. While this cadre is being built, the BBCC must be supported to provide clinical supervision to existing counsellors to further develop assessment, intervention and prevention services.

Referral, Follow up & Service Linkages

Due to the overlapping presenting needs of clients accessing support services, there is often the need to refer. Current referral linkages are based on personal relationships and there is a lack of clear referral pathways which impede a systemic response to mental illness, suicidal and self-harming behaviour. A comprehensive referral guideline would improve such linkages and provide follow up support for people following discharge from hospital or rehabilitation

centers. These pathways could be further strengthened through annual conferences, case review and stakeholder meetings.

The current health services in Bhutan do not have referral and follow-up practices as standard, and individuals who have attempted suicide or who demonstrate suicidal behaviours are not effectively monitored. Providing telephone reminders of appointments or providing patients with suicide risk with emergency phone numbers have been demonstrated to produce positive health outcomes. Clear clinical follow up protocols must be instituted in health facilities and CSOs for the follow up of individuals with suicidal ideation and previous suicide attempts. Once hospital treatment is complete, care should be taken to refer clients to NGO/CSO bodies or school counsellors, for example or maintain their care through outpatient services through hospitals and BHUs for appropriate social and psychological support after discharge.

Crisis Support Services

A crisis is a very individual reaction to an event or experience. One person may be extremely affected by an event, while someone else experiencing the same event may experience little or no negative effects. If a crisis is not dealt with in a healthy way, it can lead to longer lasting mental health issues, as well as social and physical problems. Crisis support is short term, and phone counselling provides people with assistance, non-judgemental support and resources in their time of need.

The main aim of crisis support is to reduce stress and improve the person's ability to cope with their current situation, as well as with future crises. Crisis support saves lives, prevents unsafe and damaging reactions to difficulties and creates opportunities for personal growth and change. Crisis services are currently available through the Health Help Center (112) 24 hours a day, 7 days a week to support suicide prevention and poor mental health during times of difficulty by offering supportive counselling. The extension of this service to also provide support online, through messenger services ensures a broader reach of support which in turn increases availability in times of need.

THE STAKEHOLDERS

Government/ Cabinet/ Parliament

All implementing partners ensure the National Suicide Prevention Action Plan is included in the Government Performance Management System (GPMS); and allocate financial and human resources for implementation of the plan. A further, quarterly reporting expectation on program implementation ensures timely and complete services for the community we serve.

Other Government & Regulatory Agencies

Enforce regulations to reduce domestic violence, interpersonal violence, drug misuse, and access to the means to suicide as well as improve compliance with alcohol service policies and responsible media reporting of suicide. Where department resources are scarce, support will be provided

to NGOs implementing activities.

Local Government

Mobilize communities and build a network of champions among local leaders, healers, religious figures and influential individuals; network with and enhance existing community networks created by other organizations; participate in suicide prevention efforts, and form suicide intervention squads to respond to suicide attempts.

Academia - KGUMS, SCE

Academia play a leadership role in capacity building through training mental health professionals and health workers, counsellors, offering short term and long-term training courses in counselling, medico-legal and forensic investigations; and conducting studies in suicide prevention and intervention to build evidence-based interventions in the country.

UNVERSAL STRATEGIES

Universal strategies target the entire population and provide information on mental health, suicide, intentional self-harm as well as encouraging help seeking and where to go for support. Universal strategies encourage community members to play an active role in their wellbeing as well as supporting the wellbeing of others. These strategies are most effective when they incorporate cultural/religious beliefs and are thus further supported by monastic bodies.

The Strategies

Reducing Stigma

Stigma is when someone views you in a negative way because you have a distinguishing characteristic or personal trait that's thought to be, or actually is, a disadvantage (a negative stereotype) [3]. Stigma is a reality for many people with a mental illness, and they report that how others judge them is one of their greatest barriers to a complete and satisfying life [4].

Stigma creates a variety of challenges for people who are already struggling with mental illness or suicidal ideation including a reluctance to seek help or treatment; a lack of understanding by family, friends, co-workers or others; fewer opportunities for work, school or social activities; bullying, physical violence or social exclusion; the belief that you'll never succeed at certain challenges or that you can't improve your situation. Reducing stigma associated with mental illness and suicidal ideation is key for community members to feel safe and supported to seek help and to therefore, reduce deaths by suicide and burden of disease associated with mental illness.

Early Detection of Suicidal Ideation & Mental Illness

In the treatment of health problems, early detection is key whether describing cancer or the common cold. Mental illness and suicidal behavior is no different with early detection and treatment paramount to reducing the severity, duration and disease burden associated with

psychological disorder.

It is also imperative for those who have attempted suicide to have access to intervention and counselling support; this intervention has the capacity to reduce the likelihood of future suicide as well as resolve underlying causes of distress.

In the same way as community members are aware of how to recognize and respond to physical ailments, education can increase literacy regarding recognizing and responding to the symptoms of mental illness and suicidal ideation. Increased literacy leads to earlier help seeking behavior, thus ensuring treatment occurs in a timely matter which reduces the impact of the illness on the daily functioning of the individual, the family system and ultimately the community.

Research indicates that while older people are more likely to take their life by suicide, young people (12-24 years old) are more likely to attempt. A previous suicide attempt is a major risk factor for not only future attempts but death by suicide. Thus, the extension of existing Adolescent Friendly Health Services to include clinical counseling and therapy is a must for early detection and intervention for mental health and suicide. It is also important that these services be accessible for young people and taken to where young people congregate rather than expecting young people to come to them.

Encouraging Help Seeking

Help seeking is the process of finding and receiving support from others for a problem an individual feels they cannot fix by themselves. For example, if your car is not working properly, you may seek help from someone who knows more about cars, like an elder or a mechanic. In this way, people who are struggling with psychological distress are encouraged to ask for help from others, both skilled and unskilled. Help-seeking behaviour starts with an individuals' attitudes toward asking for support; if they feel the response will be negative or unhelpful that may influence their willingness to seek support. Self-directed efforts such as researching symptoms and treatments are also forms of self-help, as are efforts to maintain psychological wellness or mental health. In order to enable help-seeking, evidence-based information must be provided in accessible forms, across a range of platforms as well as directions for how, when and where to seek professional support.

Limiting Access to Means

Methods used for suicide differ among communities, genders and occupations. Understanding the means of suicide is important as it can guide preventive interventions for restricting access to the lethal means for suicide. One preventative strategy for suicide is to restrict access to easy to use and easily accessible means for self-harm such as insecticide, medications and ropes/keras/belts.

In Bhutan, hanging is the most common means (78%) in completed suicide and consumption of drugs/substances or poisoning (54%) in attempted suicide. While screening for suicidal ideation, health workers or mental health professionals must assess the suicidal intent of an individual as well as whether they have made plans to take their life, and alert caregivers to restrict access to the means of suicide. It is more difficult to restrict access to implements for hanging with keras,

belts and scarves being part of the national dress and likely available in every household in the country. Further discussion and awareness raising with community members, health workers and gatekeepers must occur to emphasize the role of restricting access to the means to harm oneself as a primary prevention measure for suicide reduction.

Procurement, supply, and distribution of pesticides is regulated by the Pesticide Act of Bhutan 2000 however some pesticide products are readily available in the markets and shops. 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 must be made aware and educated on the pesticide act, and the rules and regulations.

THE STAKEHOLDERS

The Community

Communities play a crucial role in suicide prevention and provide bridges between community needs, national policies and evidence-based interventions that are adapted to local circumstances [5]. Communities can reduce risk and reinforce protective factors by providing social support to vulnerable individuals, engaging in follow-up care, raising awareness, fighting stigma and supporting those bereaved by suicide [5]. Perhaps most importantly, communities help by giving people a sense of belonging. Social support within communities can help protect vulnerable persons from suicide by building social connectedness and improving skills for coping with difficulties.

Community linkages and partnerships are vital for reaching individuals and households. Community members are in the unique position to identify people at risk of suicide or noting emerging issues. It is often a friend or family member who notices a loved one is struggling or that their behaviour or appearance has changed. They are also best placed to enquire about the welfare of others as they have an established trusted relationship. Community empowerment is vital in encouraging the public to check on their peers and encouraging help seeking. If community members know what to say and how to respond if someone says they are thinking of hurting themselves, people will be more likely to access support and deaths may be prevented. In fact, 22 respondents to the 2014 Study on Reported Suicide Cases in Bhutan noted that general counselling support from the community may have prevented the death of their loved one. Village health workers (VHWs) are a classic success story of how community engagement in primary health care services can improve health outcomes.

Providing support to neighbors during sickness and death is an age-old social capital prevalent across communities in Bhutan. Such practices must be promoted and encouraged, particularly in fast growing urban communities in Bhutan. While rapid development and declining social supports have greatly affected how Bhutan society operates, the values promoted in GNH can be built upon to preserve or mitigate the effects of rapid social changes.

Village Health Workers

The Village Health Workers (VHW) Program was first introduced in 1978 and expanded nation-wide in 1980s. Currently there are 1150 VHWs working across the country to bridge the gap between the health sector and community. VHWs are a valuable resource in terms of early detection of mental illness and suicidal ideation as well as the promotion of mental health and help seeking. Further, VHWs can support their communities by dissemination of health information and provision of simple treatment and first aid for mental health.

Volunteers

Volunteers play an enourmous role in Bhutanese society, from collecting rubbish to planting trees to spending time in civil service organisations. Volunteering is about helping others and making a meaningful contribution to a better community. In this way, volunteers are an important frontline resource who, like village health workers, can support the early detection of mental illness and suicidal ideation and promote help seeking behaviour. Volunteer organisations are also a wonderful source of social capital, respected and supported by their communities and are thus in the privileged position to support help seeking in their communities.

The Monastic Body

In a highly spiritual Bhutanese society, religion and spirituality may engender social cohesion and provide a supportive community. Cultural beliefs and practices are also protective factors for both mental illness and suicide. Most religious discourse focuses on human value, morality and the preservation of human life. Buddhism also recognizes suicide risk factors such as alcohol and drug use as the root of misdeeds and the negative accumulation of karma as a result of suicide.

Involvement of the central monastic body for health programs goes back as far as 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. The 2014 study into Reported Suicide Cases in Bhutan indicated half of those who attempted suicide or were psychologically distressed sought treatment from a traditional healer and performed religious rituals. To further support suicide prevention activities, local traditional healers, practitioners, monastic and lams will be exposed to modern counselling programs. Further, monastic will be trained as traditional doctors and dispensers, and some on the science of mind and matter which will then be rolled out in schools. These development activities can be further adapted to address psychosocial problems which could be combined with education regarding the early detection of mental illness and suicidal ideation.

Village Leaders

Dzongkhag and Gewog administration are best placed to support community initiatives. As part of this action plan, a pilot project will be facilitated to enhance community resilience which can then be replicated in other community systems which will be most effective if supported by village

leaders. Often, village leaders are called upon by members of the community to support families during difficult times. What we know about the development of mental illness and suicidal behaviour is it is often triggered by distressing circumstances. Village leaders are in the unique position of not only being able to help with the issue at hand, but also to speak to families about taking care of their mental health and directing them to services if they require further support.

Royal Bhutan Police

The Royal Bhutan Police also has a crucial role to play as first responders in suicide prevention. The Suicide Prevention Unit was established within the Crime Prevention Division of the RBP, Headquarters; the unit coordinates suicide prevention programs of the RBP across the country. Being arrested, involved in a domestic dispute or being part of an investigation can be very stressful and thus, the RBP are not only in a position to detect psychological distress but to reduce the impact of arrest by referring individuals in need to support services.

Often the RBP are called to intervene during suicide attempts and the referral of these individuals for ongoing support is paramount. In this way not only can the RBP help to reduce stigma regarding help seeking but also normalize stress responses to difficult situations.

The Media

Numerous studies have demonstrated the link between media reporting on suicide and contagion or imitative suicidal behaviours [6]. It is imperative media reporters understand their responsibility to report suicide news sensitively, and with a message that there is hope and prevention available for the community.

Media and the entertainment industry play a key role in shaping public opinions about mental health and illness. In Bhutan mass media (print media, radio, television, movie industry, and social media) has previously served as a good platform for health promotion. Current examples include movies addressing drug use, substance misuse, HIV prevention, and difficult relationships, all of which are risk factors for suicidal behaviour. People with mental health conditions are often depicted as dangerous, violent and unpredictable and violent acts by a person with a mental health condition are typically sensationalized; while there are fewer articles that feature stories of recovery or positive news concerning similar individuals. Entertainment frequently features negative images and stereotypes about mental health conditions, and these portrayals have been strongly linked to the development of fears and misunderstanding [7]. Thus, the broad reach of the media and entertainment industry could be harnessed to promote mental wellness and provide education on suicide and intentional self-harm.

Stigma remains a major barrier availing mental health services and suicide prevention efforts. Stigma hinders people from seeking or accessing services such as counselling and post-vention support. Mass media could be utilized to focus on promoting positive mental health, encouraging social support in communities and de-stigmatizing mental illness. Overwhelmingly, those who died by suicide as reported in the 2014 Study on Reported Suicide Cases in Bhutan were unaware, they had a problem and their loved ones stated increased awareness on the causes of suicide may have prevented their death. Dissemination of public awareness

information to assure the general public that suicides are preventable and mental illnesses are treatable like any other physical illness is most effectively done through mass media campaigns. With modernization, social media such as face-book, twitter, YouTube and We-chat are penetrating fast into the lives of Bhutanese and provide another good opportunity to disseminate appropriate messages on good mental health and suicide prevention.

SELECTIVE STRATEGIES

Selective strategies are targeted approaches for subgroups that may be at increased risk for suicidal behaviors such as marginalized groups, young people and the elderly. Comprehensive training for gatekeepers is essential in supporting them to identify risk factors and the presence of symptoms of mental illness so they may intervene, either by providing treatment or referring those at high risk to services who can provide indicated interventions.

THE STRATEGIES

Screening for Mental Illness & Suicidal Ideation

Early detection of mental illness and suicidal ideation is a critical prevention strategy. The majority of people who die by suicide have some contact with support services which represents a tremendous opportunity to identify those at risk and connect them with mental health resources. Yet, most assessment tools utilized in schools, drug and alcohol and healthcare settings do not screen for suicide risk. Suicide risk also fluctuates over time and embedding risk screens into regular interventions is a key to early detection and therefore timely intervention.

Some psychological disorders increase one's risk of suicidal ideation or suicidal behaviors. These include major depressive disorder, bipolar affective disorder, psychotic disorders, substance misuse disorders and some personality disorders. Early identification and treatment of these disorders improves treatment outcomes, reduces distress in both the individual and their family and decreases the burden of disease. As previously stated, the majority of these psychological disorders develop in adolescence; hence provision of youth friendly counselling services as an adjunct to physical and sexual health services will further bolster early intervention efforts.

Counseling & Follow Up

Therapeutic counselling services focus on how people are functioning in their daily lives, both personally and socially and address any emotional, social, work/school or physical issues which may be adversely impacting on the individual. The process helps people improve their sense of wellbeing, alleviate feelings of distress and resolve crises. Other functions of counselling are to provide an assessment, diagnosis and treatment plan for more severe symptoms which may or may not include the use of medication. A cornerstone of counselling is the therapeutic relationship between counsellor and client which supports the individual to address maladaptive behaviour patterns by the application of treatment frameworks.

Due to the safe space developed in a therapeutic counselling relationship, continued monitoring of symptoms can occur as well as follow up for those discharged from hospital, rehabilitation centers and prisons to ensure continued reassessment of suicide risk, review of treatment effectiveness, and re-evaluation of previously detected 'at-risk' mental states.

Referral of Complex or At-Risk Clients

If, during the course of a counselling relationship it is identified that the individual requires more specialized care; that is if their suicide risk has increased or their psychological symptoms have worsened, the option to refer the client for more specialized care becomes vital. While there are limited referral options at present, counsellors are encouraged to refer a client to a basic health unit or regional hospital for assessment and treatment or containment for safety.

Supporting Care Givers

Families and caregivers of those with mental illnesses play vital roles in safeguarding and improving the health and wellbeing of the people they care for. However, people caring for individuals experiencing psychological distress or a suicidal crisis often have limited access to resources and support. A suicidal crisis has a significant negative impact on the overall health and wellbeing of caregivers who may experience persistent stress, shame, anxiety, and guilt [8], resulting in 'caregiver burden'; the emotional, social, and/or financial stress placed on caregivers. The ability of support persons to appropriately respond to psychological distress or suicidal crisis is influenced by previous experience, knowledge, and available social and personal resources.

The availability of appropriate information and resources to families and caregivers by health practitioners may help to reduce caregiver burden and improve the outcomes for the person experiencing psychological distress or a suicidal crisis. Treatment models with proactive caregivers' involvement have demonstrated significant positive improvement for individuals experiencing acute suicidal crisis. The provision of appropriate training, information and resources to health service providers to support caregivers is equally important.

THE STAKEHOLDERS

Schools & Higher Education

Students constitute an important social and demographic group in the country. Students spend a significant amount of time with teachers and friends who are in a prime position to recognize the signs of psychological distress and/or suicidal ideation and to encourage and support help seeking.

Young people are particularly vulnerable to emotional distress and suicidal ideation. For many, it is a time of great challenge and stress as they negotiate social and romantic relationships, changes in familial support, school stress, fluctuation in emotional states, exposure to drugs, alcohol and social media as well as expectations around employment and independent living. In 2016-17, approximately 18% of suicide cases were young people (0-12 years old), about 21% were adolescents (12-24 years old). The Global School Health Survey (GSHS) reported about 11% of students aged 13-17 have attempted suicide and about 14% had suicidal ideation with a plan.

There are 103 fulltime school guidance counsellors (SGCs) in central, higher and middle secondary schools. Counsellors provide preventive programs, psycho-educational programs, peer helper programs and remedial programs such as one to one counselling, group counselling and critical incident response. School counselling programs can reach out to students exposed to risk factors like drug use, bullying, alcohol misuse, and other adverse life events. Identification and provision of timely and appropriate interventions can help improve and save lives of students at risk. In the long term, developing the skills of school guidance counsellors can enable early detection and intervention for suicidal ideation/behaviour which in turn, improves treatment outcomes. School counsellors and teachers need to be further supported to provide appropriate services to help students during disasters and stressful events.

The school parenting education and awareness (SPEA) program initiated in 2010 aims at raising awareness among parents on parenting, understanding a child's needs, addressing children's behavioural disorders and understanding mental illnesses. The SPEA program was further facilitated by the Ministry of Education (MoE) for families of the armed forces in Paro, Thimphu and Wangdue Phodrang and could be replicated for wider coverage.

It is important to note not all young people are equipped or have the desire to be involved in formal education. Alternatives to mainstream schooling must also be investigated; those students identified and offered complementary options to further their employment and development options. This supports growth, positive identity and self-esteem, all of which are protective factors for drug and alcohol misuse, the development of mental illnesses such as depression and anxiety as well as suicidal ideation.

Alcohol & Drug Services

The retrospective suicide survey (2014) identified that 58% of those who died by suicide had a history of alcohol misuse while 9% had misused drugs. Self-harm is common among those who misuse alcohol and drug and most (64%) suicide attempts occurred in the context of consumption of alcohol or drugs. Treating addiction problems among alcohol and drug users further bolsters suicide prevention activities. Creating standard operating procedures for follow up care after detoxification would further support systematic after care services. Further, there is a need for an adequate number of rehabilitation centers which also incorporate reintegration and vocational programs to make the transition back into the community smoother.

Drop-in centers (DICs) supported by the Bhutan Narcotic Control Agency, YDF and CPA provide outreach services, counselling, referrals, relapse prevention services and reintroduction program for self-help through alcoholics anonymous (AA) and narcotics anonymous (NA). DICs also conduct drug and substance abuse awareness programs in communities (depending on the availability of funds). Peer counsellors are important frontline service providers and are in a prime position to screen for mental illness and suicidal ideation. The current client assessment at DICs does not routinely include mental health status and risks for suicide. Suitable tools are required to identify suicidal behaviours among clients to prevent those at serious risk of suicide being missed.

With capacity building of peer counsellors, DICs will be able to recognize, identify and appropriately refer clients at risk of suicide. DIC services could further be promoted at schools and with young people to increase service utilization. Seventeen respondents to the 2014 Study into Suicide Cases stated improved counselling services for alcoholics/addicts may have prevented the death of their loved one.

NGO/CSO

All frontline workers employed in Civil Society Organisations, the non-government sector and substance misuse support services must receive a basic level training to enable a risk assessment and brief intervention. The Mental Health Facilitator Training course is already a core requirement for those registering with the BBCC and this training could effectively be extended to all NGO/CSO service providers. This creates a 'no wrong door' approach for vulnerable community members. That is, it doesn't matter which service the person accesses, the worker will be able to identify, recognize and improve referrals of mentally ill clients and those with suicide risk in their communities. Risks for suicidal behaviour are by nature dynamic and the more community and professional services groups sensitized to assessment and intervention or support, the more suicides may be prevented.

Individuals suffering from chronic diseases, the destitute, socially isolated those with severe financial stress, individuals diagnosed with a psychological disorder and those abandoned in old age are at higher risk of suicide. Marginalized community members such as those who identify as Lesbian, Gay, Bi-sexual, Transgender and other gender identities (LGBT+) and those diagnosed with HIV/AIDS are at a higher risk of attempting and completing suicide. Providers of maternal and reproductive programs, chronic disease prevention programs, HIV/AIDS programs, those in the banking industry and LGBT+ support services are partners in identification and referral of individuals in need of psychosocial care.

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 highlights the need for a deeper understanding of the problem faced by the senior citizens and instituting adequate social welfare for the elderly.

Such organizations frequently hold advocacy and information sessions which could be harnessed to organize events to speak about suicide prevention, 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.

INDICATED STRATEGIES

Indicated strategies are designed for individuals identified as high risk for suicidal behaviours. There are some factors which, if experienced by an individual previously, pose an increased risk of suicide in the future including:

- prior suicide attempts
- a psychiatric diagnosis
- a history of abuse
- a family history of suicide

Screening tools for suicidal ideation (see Selective Strategies) incorporate these risk factors and if a person is at increased risk for suicide, they can be supported by services specialising in assessment and intervention for mental illness and suicide. Other strategies include containment for crisis management and outpatient services.

The Strategies

Post-vention Services

Offering timely services to survivors (those who have lost someone to suicide such as an immediate family member, co-workers or close friends) is important to support bereavement in addition to a method of preventing suicide and the development of psychological disorders among survivors. Survivors are prone to depression and suicidal behaviours and as such require access to mental health support services, including access to key information on psychological wellbeing.

Institutional arrangements to provide post-vention services to the bereaved are currently not available however cultural and religious practices for the deceased may provide positive support during the bereavement period. The goal of the post-vention services include reducing further risk of suicidal behaviour, preventing suicide contagion by identifying other members at high risk for suicidal behaviour, and connecting high risk members to psychosocial services. All first-hand emergency responders, health workers, police personnel and school counsellors need to be trained to provide post-vention situations effectively.

Containment for At-Risk Individuals

Sometimes the stressors experienced by an individual overwhelm the emotional resources they have available to manage their distress. At these times, they may believe death is the only solution to their problems and make plans for taking their lives. During this high-risk phase, containment at a health service that can monitor symptoms and provide therapeutic intervention is indicated. While hospitalization is not a long-term solution to ongoing difficulties, it can certainly keep people safe when they do not have the resources to do it themselves.

THE STAKEHOLDERS

Prison & Detention Centers

Many studies have documented the high prevalence of psychological disorder in prison populations. Many disorders may be present before admission and can be exacerbated by the stress of arrest, legal proceedings, incarceration, prison conditions and the lack of availability of treatment, care and rehabilitation and, above all, the lack of, or poor access to, mental health services [9]. Psychological disorders may also develop during imprisonment itself as a consequence of prevailing conditions, poor monitoring of mental health symptoms and again, lack of access to services should signs of distress be present. The increased risk of suicide in prisons (often related to depression) is, unfortunately, one common manifestation of the cumulative effects of these factors [9].

There are numerous benefits to providing mental health care in prison and detention center environments. Addressing mental health needs improves the health and quality of life of both prisoners with mental disorders and of the prison population as a whole. This in turn can improve the working conditions of staff by reducing workplace tension and aggression thus improving morale. Ultimately, providing treatment and rehabilitation for prisoners increases the likelihood that upon release, the individual can lead a safe and productive life, which in turn reduces the likelihood that they will return to prison.

Basic Health Units

Basic health units (BHUs) provide integrated health services to communities across Bhutan. Part of the role of BHUs in community health as it applies to mental health and suicide is general assessment and clinical management, consultation with specialists and containment. With the increased incidence of community members presenting with mental health concerns, suicidal ideation and suicide attempts, staff training in the assessment and identification of psychological disorder and protocols for responding to suicidal ideation, suicide attempts and intentional self-harm will further bolster suicide prevention and early intervention efforts.

Regional & District Hospitals

Regional and district hospitals serve a defined population within a health district and support primary health care. All hospitals provide in-patient and emergency services as well as assessment, containment and treatment of patients when necessary. In a similar way to BHUs, staff training in the assessment and identification of psychological disorder and protocols for responding to suicidal ideation, suicide attempts and intentional self-harm will further bolster suicide prevention and early intervention efforts. It is only after a patient has been assessed at a regional or district hospital that they could be referred for more intensive treatment if required, rather than the current system of sending most suspected psychiatric cases to JDW National Referral Hospital. In this way, skill development of hospital staff and thus increased confidence in responding to and treating mental health and suicide concerns greatly supports the Ministry of Health's mission of providing sustainable, responsive, equitable, accessible, reliable and affordable health services.

JDW National Referral Hospital

Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) Psychiatric Ward functions as the apex body in the country in terms of training and development of human resources in mental health as well as referral and treatment of mental disorders. Currently it provides daily outpatient services and in-patient services in its dedicated 20 bed ward (10 beds for psychiatry patients and 10 beds for alcohol and substance detoxification and treatment). The Psychiatric Ward provides expert intervention for complex and acute cases in Bhutan and as one of three teaching hospitals in Bhutan, JDWNRH has a significant role to play in up-skilling and developing the mental health care in the country. This may involve enhancing resources, flexibility in working arrangements and incorporation of new technology (ie: online therapy/tele-health) into existing structures.

SECTION – III

IMPLEMENTATION MECHANISMS AND ACTION FOR SUICIDE PREVENTION

Vision

A Nation with Zero Suicide

Goal

To prevent premature deaths due to suicide among the Bhutanese population

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 behaviours at national, Dzongkhags, Gewogs and community levels.

Objectives

Objective 1	Develop and support enabling systems & structures
Objective 2	Develop community capacity to respond to psychological distress and suicidal ideation
Objective 3	Improve access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide.
Objective 4	Improve the capacity of health services to assess and treat high risk individuals.

Key Assumptions

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:

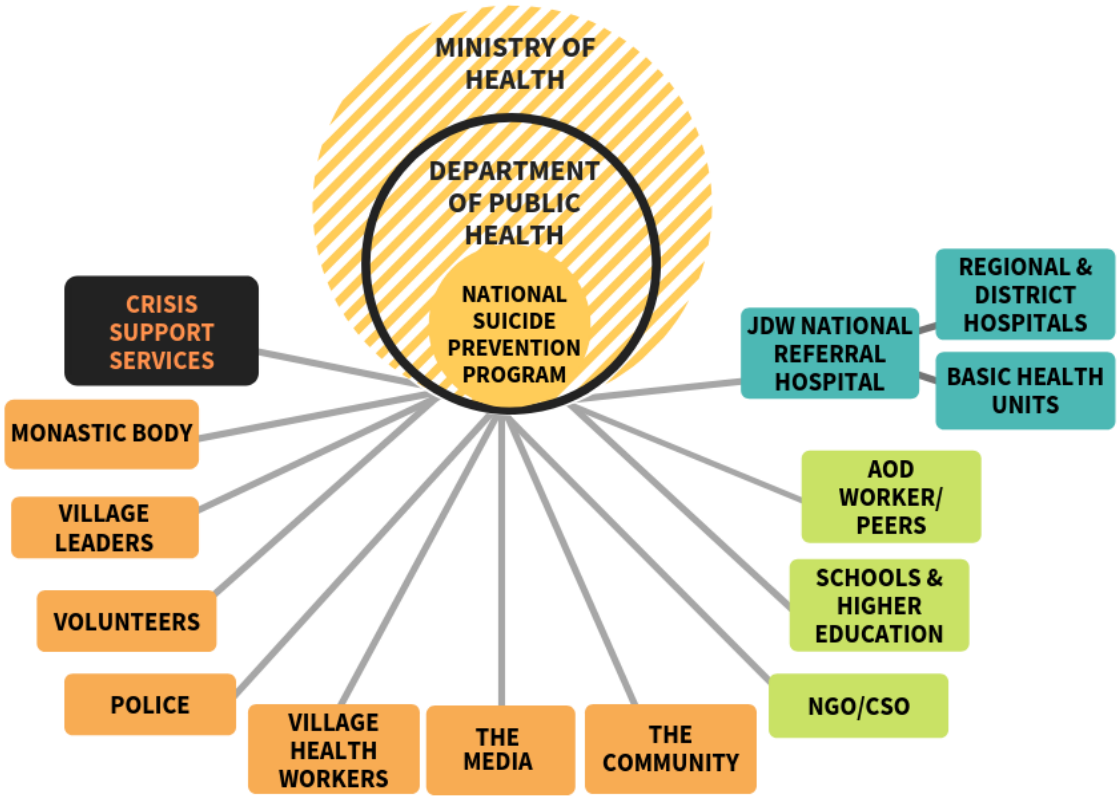
1. The political commitment of the government and proactive involvement to address suicide prevention remains unchanged and suicide prevention indicators are included in the GPMS.
2. NSPP unit is appropriately staffed and the SPB is diligently able to meet and function.
3. Other stakeholders effectively participate in implementing the plan.
4. Financial resources are available for implementing the program.
5. WHO and other donors provide continued partnership, support and guidance at the national level.

The continuity of suicide prevention is imperative. Lessons learnt will be documented and incorporated into the next phase of suicide prevention programming. The next Suicide Prevention Action Plan will be developed towards the second half of 2023 and implemented by 2024. Strengthening the health system in prevention and post-vention services, improving medico-legal investigations are likely to continue to be priorities. A focus on building a value-based community and strengthening social capital will be important. 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 and overall wellbeing.

Implementation

In order for a suicide prevention strategy to be coordinated and comprehensive, it requires specified finance, time and human resources [10]. Given the fiscal realities and governmental resource constraints, action plans need to be realistic and implemented through a financially sustainable model in order to accomplish the goals. This action plan has been developed through a consultative process of the stakeholders including the Dzongkhag Health sectors to ensure the interventions listed reflect realities on the ground. 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.

Organogram: National Suicide Prevention Coordination



A multi-stakeholder approach is the cornerstone for the implementation of the action plan. Each stakeholder or implementing partner must ensure that, the suicide prevention action plan is included in the government performance management system (GPMS) and allocate financial resources through proper planning for implementation of the action plan. The action plan is not an aspirational document, but an actionable deliverable national work plan. The document emphasizes action and activities will be integrated into sectoral plans using the available funding to be implemented by identified agencies.

Progress against targets will be assessed quarterly by written report and biannually by face to face report. Overall progress and fidelity to the plan will be assessed annually. The overall effectiveness of the multi-sectoral mechanism in implementing suicide prevention activities will be measured by the performance measures:

- Suicide prevention included in the GPMS;
- Police and health investigations of suicide conducted by trained officers;
- Integration of suicide prevention in the continuous quality assessment indicators in health;
- School children (students) reached with psychosocial counseling; and
- Adults counseled for suicidal ideation through gatekeepers' programs at the DICs, HISCs and Rehabilitation Center.

The plan full plan evaluation will be conducted towards the latter half of 2023. Based on the experience of this implementation, the next phase of the action in suicide prevention will be launched.

Development Mechanism

This action plan has been developed through a consultative process of the stakeholders including the Dzongkhag Health sectors to ensure the interventions listed reflect realities on the ground. 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.

Each activity was graded on a 10-point scale in five domains:

Domains	Scale (1 to 10)
Effectiveness	Not Effective to Very Effective
Cost (from lowest to highest)	Very Expensive to Inexpensive
Feasibility	Feasible to Not Feasible at all
Public Health Benefit	No benefit to Highly beneficial
Cultural Acceptability	Not acceptable to Highly acceptable

Activities scoring an aggregate of above 60% were included on 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 action and activities will be integrated into sectoral plans using the available funding to be implemented by identified agencies.

Agency Focal Persons

There will be a focal person for every agency to ensure greater coordination in implementing the suicide prevention action plan through the following actions:

- The head of the agency will appoint a focal person of the agency through an executive order;
- The agency focal person will network various units with the organizations responsible for implementation of the activities of the action plan;
- The focal person will use his/her decisions to identify challenges, recognize progress and conduct reviews whenever necessary within the organization and
- The focal person will be responsible for completing and forwarding quarterly reports regarding implementation and attending biannual progress review meetings at the invitation of the NSPP.

In the inevitable situation when a focal person is not able to conduct the functions for the suicide prevention action plan, he/she will approach the organization and propose for a substitute. Appointment of a new focal person will be communicated to the NSPP (Coordinating Body).

Dzongkhags and Local Government Mechanism

Implementation of the suicide prevention work plans will occur at the local government level; Dzongkhags, Thromdes and Gewogs. Therefore, Dzongdags, Thrompons, DT Chairpersons, and Gups have the major responsibility to ensure appropriate implementation of suicide prevention work plans. The best approach for a coordinated response is to incorporate Dzongdag's Suicide Prevention Response Team (DSPRT) into under the chairmanship of Dzongdag. The team will constitute an appropriate representation of agencies including people from the education sector, medico-legal investigations of RBP, and representatives of the health sector and NGO/CSO as mandatory members with other existing multi-sectoral mechanisms invited as required. Since each Dzongkhag /Thromde may differs in need and style of functioning, it is best left for the Dzongkhags/Thromde to form the local mechanism for suicide prevention response.

Functions of the Dzongkhag's Suicide Prevention Response Team (DSPRT)

The key functions of the Dzongkhag's Suicide Prevention Response Team (DSPRT) are:

- Suicide prevention and rescue efforts operated under the direct notice of Dzongkhag;
- Organize joint yearly planning among stakeholders within the Dzongkhag for suicide prevention;
- Ensure mental health issues and suicide prevention programs are included in the GPMS (Government Performance Management System);
- Ensure effective response to rescue suicide attempts and refer deliberate self-harm incidents for treatment;
- Ensure each suicide attempt and death is discussed in the GT and DT to determine appropriate measures and interventions to prevent future attempts;
- Compile a quarterly report comprising completed and attempted suicide data from the Dzongkhag including recommendations to prevent similar suicides and attempted suicides in the Dzongkhag;

- Submit reports to the National Suicide Prevention Program (National Coordinating Body) and
- Ensure recommendations are integrated into quarterly reviews of the overall Dzongkhag plan.

SECTION – IV

ACTIVITIES AND MILESTONES FOR OBJECTIVES

Objective 1 Develop and support enabling systems & structures

Rationale: A framework incorporating universal, selective and indicated strategies requires effective and efficient systemic supports in order to be successful. Systems and Structures enables appropriate and timely services provided to people who need them, when they need them.

Summary of Key Actions:

1. Improve and maintain data & information on suicide.
2. Develop medico-legal and forensic investigation systems.
3. Review and develop mental health and suicide prevention/intervention curriculum.
4. Improve referral and follow up linkages between service providers.
5. Provide crisis support services for those in psychological distress.

Activity	Sub-Activity	Indicator	Target	Lead Agency	Other linkages	2018-19	2019-20	2020-21	2021-22	2022-23
1. Improve and maintain data and information on suicide	1.1 Maintain a registry of Intentional Self-Harm and Deaths by Suicide to improve timely availability of national data on suicide	Review and improve the efficacy of the National Suicide Registry	National level suicide registry maintained	NSPP	All agencies including districts	X	X	X	X	X
	1.2 Produce annual suicide statistics including data from HMIS, NSR, SPU, SGC and provide feedback to relevant agencies	Review the HMIS to include additional collection points for intentional self-harm and suicide/attempts	HMIS Report	NSPP	All agencies including districts		X			
		Maintain School Guidance and Counseling database including self-harm, suicidal intent and suicidal ideation	100% of SGCs submitting school counseling service reports	NSPP	DYS, Principals, DEOs, TEOs	X	X	X	X	X
		Generate and submit periodic report from SPU	Quarterly report	NSPP	RBP, SPU	X	X	X	X	X
	1.3 Generate national level evidence for mental health and suicide to improve programming and service provision	Conduct national level mental health and suicide risk survey and compile report for dissemination	1 report by November 2022	NSPP, MHP	All agencies including districts		X	X	X	
	1.4 Produce annual implementation report of the National Suicide Action Plan	5 reports (1 report annually)	Number of annual reports produced	NSPP	All agencies including districts	X	X	X	X	X
2. Develop medicolegal and forensic investigation systems	2.1 Upgrade forensic units in the regional referral hospitals (RRH) to provide comprehensive forensic services	Train forensic and crime focal points in certificate courses in forensic, crime and medico-legal investigations.	> 5 district hospitals providing basic forensic services	DHSP, DMS	NSPP			X	X	X
		Train Forensic Specialist and deploy in RRH	Deploy one Forensic Specialist in each RRH	DHSP, DMS				X	X	X
		Train Laboratory Technologist on Forensic Pathology and deploy in RRH	Deploy one Laboratory Technologist at each RRH	DHSP, DMS				X	X	X

		Train Autopsy Technician on Forensic Pathology and deploy in RRH	Deploy one Autopsy Technician at each RRH	DHSP, DMS				X	X	X
		Provide comprehensive forensic services by forensic unit	2 forensic units providing comprehensive services by 2023	DHSP, DMS	DoMSHI/ MSQU (DMS), RRHs			X	X	X
	2.2 Formalize existing relationship between RBP, MoH and the KGUMS for autopsy, toxicology, forensic and medico legal services	Develop clear ToR and sensitise stakeholders	2019-2020	MoH	RBP, KGUMS			X		
	2.3 Develop forensic and criminal investigation procedure guidelines for suicide cases	Develop procedure for investigation of suicide cases	One procedure developed	NSPP	RBP			X		
3. Review and develop mental health and suicide prevention/ intervention curriculum	3.1 Review and revise the pre-service curriculum of health workers in nursing and health assistants to include suicide prevention, counselling and post-vention services using mhGAP	Review and revise the preservice curriculum of health workers in nursing and health assistants to include suicide prevention, counselling and post-vention services by 2023	Pre-service curriculum revised by 2023	NSPP	FNoPH,		X	X	X	X
4. Improve referral and follow up linkages between service providers	4.1 Strengthen referral linkages among rehabilitation and counseling services of YDF, CPA, DYS, SPU, NCWC, HHC, RENEW, HISC, schools, colleges, institutes, BNCA, RBP, Lhaksam and health facilities for the follow up of individuals who have attempted suicide or who have suicidal ideation	Develop standard referral pathway and associated forms	2019-2020	NSPP	YDF, CPA, DYS, SPU, NCWC, HHC, RENEW, HISC, schools, colleges, institutes, BNCA, RBP, Lhaksam and health facilities			X	X	X
		Train stakeholders in referral mechanism and embed in processes	100% of agencies implementing the referral mechanism by 2023	NSPP				X	X	X
5. Provide crisis support	5.1 Provide dedicated emergency helpline and support	Secure dedicated service desk for suicide prevention at HHC	One service desk for mental health crisis	NSPP	HHC		X	X	X	X

services for those in psychological distress	services for mental health and suicide prevention		management							
		Develop standard of care and crisis help line for suicide prevention	One standard of care	NSPP	HHC		X	X		
		Train HHC staff on the standard of care and crisis help line for suicide prevention	>95% of staff trained on the standard of care and crisis help line for suicide prevention	NSPP	HHC		X	X		
		Evaluate helpline services on crisis counseling and referral services of HHC	1 evaluation per annum	NSPP	HHC	X	X	X	X	X
		Investigate feasibility of providing online counseling	1 report by 2022	NSPP	HHC		X	X		

Objective 2

Develop community capacity to respond to psychological distress and suicidal ideation

Rationale: Universal strategies target the entire population and provide information on mental health, suicide, intentional self-harm as well as encouraging help seeking and where to go for support. Universal strategies encourage community members to play an active role in their wellbeing as well as supporting the wellbeing of others. These strategies are most effective when they incorporate cultural/religious beliefs and are thus further supported by monastic bodies.

Summary of Key Actions:

1. Develop information and promote understanding of mental illness and suicidal ideation.
2. Encourage community members to seek help if they aren't mentally healthy.
3. Develop the capacity of Community Based Support Systems (eg: volunteers of RENEW, Drop in centers, Health Information and Service Center, Rehabilitation Centers, and health workers including HHC, Women Child Protection Units maternal and reproductive programs, chronic disease prevention programs, HIV/AIDS programs, LGBTIQ support services, RBP, selected focal points from Dratshang and Lhak-Sam peer volunteers) to identify the signs of mental illness and suicidal ideation
4. Conduct advocacy on suicide prevention among law makers, law enforcers and local government (LG) leaders (dzongkhags, thrompons, gups and mangmis) including their role in suicide prevention.
5. Educate the community and pesticide handlers, procurement agencies, dealers, commission agents etc regarding the role of limiting access to means to harm oneself.

Activity	Sub-Activity	Indicator	Target	Lead Agency	Other linkages	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
1. Develop information and promote understanding of mental illness and suicidal ideation	1.1 Develop and promote print advocacy materials for mental health, suicide, deliberate self-harm and lifestyle challenges	Develop appropriate pamphlets and posters related to mental health, suicide, deliberate self-harm and lifestyle challenges	Range of information available in both English & Dzongkha & through a range of sources	MHP (MoH)	HPD, District Health Sectors		X	X	X	X
		Promote advocacy materials during public events and in-service organizations	>90% of Service organizations aware of availability of materials	MHP (MoH)	HPD, District Health Sectors		X	X	X	X
		Develop website for information repository as well as print copies	One central repository for MH related information	MHP (MoH)	NSPP		X			
	1.2 Utilise media to decrease stigma, encourage help seeking and educate the public regarding mental health and suicide	Develop appropriate messages for mass media	1 Media Strategy by 2020	JAB	MHP, NSPP, (MoH) HPD, JDWNRH		X	X	X	X
		Broadcast risk and protective factors of suicide and programs on mental health and resiliency using mass media	10 broadcasts in 5 years	JAB	BBS and radio	X	X	X	X	X
		Print coverage/ stories involving lams, mental health experts and famous personalities	10 articles in 5 years	JAB	Print media	X	X	X	X	X
		Conduct Choshed Lerim through mass sermons, television and radio broadcasts, and visit schools and institutions	Twice a year (10 times in 5 years)	JAB	Monastic Body, NSPP	X	X	X	X	X

2. Encourage community members to seek help if they aren't mentally healthy	2.1 Develop a media toolkit and sensitize media on responsible media reporting on suicide and mental illness	Media toolkits developed	1 toolkit for responsible reporting of suicide and mental health	JAB	NSPP, MHP		X			
		Sensitize all media organizations	95% of media organizations	JAB	BICMA, MoIC, BMF			X	X	X
		Notify all media organizations on responsible reporting	>98 %	JAB	BICMA, MoIC, BMF			X	X	X
	2.2 Pilot community action plan activity and write process for duplication in other Dzongkhags	Develop community action plan framework for facilitation	One community package	NSPP			X			
		Facilitate community program to develop community action plan in high risk Dzongkhags	Facilitated in three Dzongkhags	NSPP	Dzongkhags, thrompons, thromde ngotshabs gups, tshogpas, communities			X	X	X
	2.3 Conduct advocacy campaigns	Number of advocacy activities conducted by MSTF/ CBSS members	Minimum 2 advocacy programs conducted per year	Member secretary of MSTF/ CBSS	LG (MoHCA)MHP, RUB		X	X	X	X
		Engage youth groups and youth organization in mental health & help seeking	>75%	Member secretary of MSTF/ CBSS	DYS, YDF		X	X	X	X
		Engage people over 60 in community activities	>75%	Member secretary of MSTF/ CBSS	MoH		X	X	X	X
	2.4 Advocate community members including VHWs to identify and support individuals at risk of suicide and refer to health facilities and agencies who can help	Train VHWs on suicide prevention and mental health	90% of VHWs trained by 2023	VHWP	DHO, NSPP		X	X	X	X
		Promote help-seeking in communities through adverting availability of services across the continuum of care	>80% of population reached by 2023	VHWP	DHO, NSPP		X	X	X	X

3. Develop the capacity of Community Based Support Systems (CBSS) to identify the signs of mental illness and suicidal ideation	3.1 Establish mental health screening and assessment of risk for suicide in all CBSS	CBSS and MSTF members trained on identification of mental illnesses including suicidal risk factors	90% of CBSS and MSTF members trained in basic counseling and screening	DHO, NSPP	CBSS organizations, LG, MHP (MoH)	X	X	X	X	X
		Members trained in basic counseling and screening (MHF)		DHO, NSPP			X	X	X	X
		Members aware of client information for mental health and suicide	Include where to access information in training package	DHO, NSPP			X	X	X	X
	3.2 Conduct CPDAP UPC Workplace Substance use prevention workshop for selected officials of Government/Non-Government/ Private organizations and corporations	Review CPDAP UPC and include suicide screening and intervention protocol and training	One suicide screening and intervention protocol	BNCA	NSPP		X			
		Identify target organizations and facilitate training	20 government/ non-government/ private/ corporations covered by 2023	BNCA	Relevant agencies	X	X	X	X	X
	3.3 Expose monastics to modern counseling programs and support adaptation to address psychosocial problems	Develop education package for monastics in identification of mental illness and counseling	>50% of monastics sensitized to package	NSPP	Monastic body		X	X	X	X
	3.4 Strengthen service delivery of Suicide Prevention Unit of the RBP with clear TOR	Develop clear ToR	1 ToR	RBP	MoH		X			
		Train officials of SPU	100% of SPU officials trained	RBP	MoH		X			
4. Conduct advocacy on suicide	4.1 Brief and advocate suicide prevention among law makers,	Lam Netens and Uzins sensitized on suicide prevention and promotion of	> 95% of Lam Netens and Uzins sensitized	Dratshang Lhentshog	NSPP and Dratshang Lhentshog	X	X	X	X	X

prevention among law makers, law enforcers and LG leaders including their role in suicide prevention.	law enforcers and local government	mental wellbeing								
	4.2 Conduct advocacy on suicide prevention among LG leaders	DHO sensitize LG	> 95 % by 2023	DHO	MSTF/CBSS NSPP, DLG (MoHCA, MoWHS)		X	X	X	X
	4.3 Prepare policy brief and advocate to parliamentarians and law enforcement agencies	Develop policy brief and advocate to parliamentarians and law enforcement agencies on mental health and suicide prevention strategies	> 90 % of by 2023	NSPP	Secretariat of NA & NC		X	X	X	X
5. Educate the community and pesticide handlers, procurement agencies, dealers, commission agents etc regarding the role of limiting access to means to harm oneself	5.1 Sensitize the community and pesticide handlers, procurement agencies, dealers, commission agents about limiting access to means	Include section in community training and IECs	One training package and IEC	NSPP	Community		X	X	X	
		Include reducing access to means in CBSS training	One training package	NSPP	DHO		X	X	X	
		Develop information package for pesticide handlers, procurement agencies, dealers, commission agents regarding Pesticide Act of Bhutan (2000)	>80% of pesticide handlers, procurement agencies, dealers, commission agents sensitized	NSPP	MoA		X	X	X	X

Objective 3

Improve access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide

Rationale: Targeted approaches for subgroups that may be at increased risk for suicidal behaviors such as marginalized groups, young people and the elderly. Comprehensive training for identified gatekeepers is essential in supporting them to identify these factors and in turn, prevent future suicide.

Summary of Key Actions:

1. Standardize screening for mental illness and suicidal ideation.
2. Enhance capacity for counseling and follow up services to be provided in adolescent friendly health services, schools, higher education centers, drug and alcohol services and NGO/CSO services.
3. Enhance referral systems for complex or at-risk individuals.
4. Provide enabling support for parents and caregivers of people with a mental illness/at risk of suicide.

Activity	Sub-Activity	Milestone	Target/ Indicator	Lead Agency	Other linkages	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
1. Standardize screening for mental illness and suicidal ideation	1.1 Establish mental health screening and assessment of risk for suicide in schools, VHWs, counseling services and health facilities	Develop standardized risk screen for all services	One standardized screen	NSPP	BBCC, MoH, KGUMS		X	X		
		Develop standardized screening tools for mental illness	Screen for depression, anxiety, postnatal depression, alcohol misuse & psychosis	NSPP	BBCC, MoH, KGUMS, Psychiatric Unit, JDWNRH		X	X		
		Train VHWs, counseling services and health facilities	90% of VHWs and health facilities trained	NSPP	VHWs, counseling services and health facilities			X	X	X
		Train school guidance counsellors	90% of School Guidance Counsellors trained	NSPP	DYS, MoE, Psychiatric Unit, JDWNRH			X	X	X
2. Enhance capacity for counseling and follow up services to be provided in adolescent friendly health services, schools, higher education centers, drug and alcohol services and NGO/CSO services	2.1 Enhance existing counseling support programs in schools and higher education providers	Increase provision of counseling services in secondary schools	90% of Secondary Schools with Counsellors	MoE	RCSC, DYS	X	X	X	X	X
		Develop training manual on identification & treatment of mental health problems, suicidal ideation & basic counselling skills	1 manual developed	MoE	DYS, RENEW, Colleges of Education, Royal Academy, SGCs, BBCC	X				
		Train Cluster Trainers	120 Cluster Trainers trained	MoE	DYS, DEOs, TEOs, Principals, School Guidance Counsellors		X			
		Train teachers on identification & treatment of mental health problems, suicidal ideation & basic counselling skills	95% of teachers trained	MoE	DEOs, TEOs, Principals, School Guidance Counsellors, TPSD		X	X		
		Strengthen peer support program in schools for	90% of Secondary Schools with Peer Helpers	MoE	DYS	X	X	X	X	X

		identification, support and referral among students in need of services	Programme							
	2.2 Set up response services to provide outreach therapeutic counseling in schools and higher education facilities	Scope project and provide recommendations for outreach service	Report available for dissemination	MoH	AFHS, NSPP,		X	X	X	X
		Train focal persons in adolescent friendly health services on identification & treatment of mental health problems, suicidal ideation and basic counselling skills	>80% of AFHS providing basic mental health & suicide screening	MoH	AFHS			X	X	X
		Provide AFHS as outreach service	>25% of AFHS provided in outreach	MoH	AFHS				X	X
	2.3 Extend Life Skills Education program to include mental health topics	Compile mental health topics for inclusion in Life Skills Education Program	Mental Health Topics Developed	MoE	MoH, NSPP		X	X		
		Orient the Principals on program	90% School Principals oriented	MoE	MoH, NSPP		X	X		
		Train teachers and school counselors on included topics	>50% of school counselors trained	MoE	MoH, NSPP		X	X	X	X
	2.4 Train school principals and DEOs on CPDAP-UPC School-based on substance use prevention, suicide screening and intervention	Review Universal Prevention Curriculum, include suicide screening and intervention protocol	1 suicide screening and intervention protocol	BNCA	NSPP, MoE/ MoHCA	X	X	X	X	X
		Conduct training for school principals and DEOs from LG administration	>80% of school principals and DEOs trained by 2023	BNCA	MoE/ MoHCA	X	X	X	X	X
	2.5 Expand de-addiction and detoxification services in hospitals and BHUs	Train health workers on CPDAP UTC Course for Basic counseling skills for addiction professionals and ensure implementation in the health	100% of hospitals and BHUs providing de-addiction and detoxification services	Mental Health Program	JDWNRH, FoNPH	X	X	X	X	X

		facilities								
	2.6 Enhance existing counseling support programs in drug and alcohol rehabilitation centers	Develop SOPs on follow up care after detoxification	100% of rehabilitation centers and CSOs utilizing SOP	BNCA	NSPP, CSOs, rehabilitation centers				**X**	**X**
		Develop suicide prevention and mental illness intervention skills in alcohol and drug services	1 Training Manual developed	BNCA	NSPP, MoH		**X**	**X**	**X**	**X**
3. Enhance referral systems for complex or at-risk individuals - See 1.4 Improve referral and follow up linkages between service providers										
4. Provide enabling support for parents and caregivers of people with a mental illness/at risk of suicide	4.1 Provision of Family Support and Counseling Services as part of general mental health care in BHUs and hospitals	Inclusion of working with family's chapter in Mental Health Manual	One chapter in Mental Health Manual	NSPP	MoH		**X**	**X**	**X**	**X**
		Working with Families section included in worker training on suicide prevention	One section in training package	NSPP	MoH, BHUs, VHW, DMS		**X**	**X**		
		Family support resources for counselors and health workers to utilize	100% of health workers using family support resources	NSPP	MoH, BHUs, VHW, DMS		**X**	**X**	**X**	**X**

Objective 4

Improve the capacity of health services to assess and treat high risk individuals

Rationale: Supporting individuals at increased risk for suicide ensures adequate assessment and treatment for mental illness and suicide. These programs may also be delivered as outpatient services.

Summary of Key Actions:

1. Develop mental health assessment and intervention services at prisons/detention centers, basic health units and hospitals.
2. Provide post-vention support services for survivors and their families.
3. Enable containment practices at basic health units and hospitals for at risk individuals.

Activity	Sub-Activity	Milestone	Target/ Indicator	Lead Agency	Other linkages	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
1. Develop mental health assessment and intervention services at prisons/ detention centers, basic health units and hospitals	1.1 Establish counseling and mental health services in Prisons and Juvenile detention centers	Provide counseling and mental health services in Prisons and Juvenile detention centers	>95% of Prisons and Juvenile detention centers being provided with services	NSPP	MHP, RBP				X	X
	1.2 SOP for suicidal ideation, suicide attempt and intentional self-harm	SOP developed for assessing and responding to suicidal ideation, suicide attempts and intentional self-harm	3 SOPs developed	NSPP	MoH		X	X		
		Train counselling/ mental health professionals and other service providers on application of SOPs	100% of health professionals, >80% of other providers trained	NSPP	MoH		X	X	X	X
2. Provide post-vention support services for survivors and their families	2.1 Develop post-vention interventions and support their delivery through basic health units and hospitals	Postvention package developed	One package developed	NSPP	DMS	X	X			
		Train health workers on the standard protocol and to improve care for post-vention support service individuals who have attempted suicide or inflicted self	90% of health facilities providing standard protocol to improve care for individuals who have attempted suicide or inflicted self-harm	NSPP	DMS		X	X	X	X
		Develop appropriate information and resources for families and caregivers for use by health practitioners	One package developed	NSPP	DMS		X	X		
3. Enable containment practices at basic health units and hospitals for at risk individuals	3.1 Develop training for health professionals for mental health assessment and suicidal ideation/intent	Training developed for health professionals to assess mental illness and suicide	90% of health practitioners trained	NSPP, MoH	Regional Hospitals, District Hospitals			X	X	X

SECTION – V

FINANCING AND BUDGET

This is a comprehensive 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 the table below, the action plan has a variety of activities with integrated funding, minimal funding and full funding. 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.

Category of Activities by Funding Needs

Integrated 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
- Improving crisis support services
- Suicide prevention in EMTs, VHWs, community healers
- Curriculum for in-service at FNPH
- Review HMIS ICD –Coding
- Training of school guidance counselors
- Strengthening peer support programs in schools
- In-school orientation of schoolteachers by school management
- Mental health assessment and suicide screening in health facilities
- Expansion of the CBSS program

Minimal Funding

- Promoting responsible media reporting
- Setting up forensic units in two regional hospitals
- Training on mental health and suicide screening for DICs, HISCs, Rehabilitation Centers

Full Funding

- Mass media production and dissemination including social media
- Setting up 24-hour crisis helpline
- Assessments (clinical practices for follow up of self-harm and suicide attempts)
- Hiring technical experts for curriculum and assessments
- Postvention and service protocols and trainings

- Training programs in KGUMS and other higher education facilities
- RBP Suicide Prevention Unit
- Developing SOPs for suicide investigations for health and RBP
- Document Best Practice 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 and communities through the implementation of 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. Strengthening forensic and medico-legal services which are necessary but currently inadequate is addressed in this plan. Similarly, data and information systems, 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, staffing, capital and organizational system.

The tentative cost to implement the comprehensive action plan is Nu. 55 million or a yearly budget of Nu 11 million. The funding for the implementation of activities will have to be ensured through planning and the activities implemented by various sectors such as Education, Health, RBP, KGUMS, BNCA, Local Governments and NGOs through the implementation of three levels of strategies: Universal, Selective and Indicated interventions reaching grass root communities and individuals exposed to suicidal risk factors. On average, the yearly budget per agency will be approximately Nu. 0.900m to Nu.1.000m. 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 applications and philanthropic sources will be considered for securing additional funds for implementing the action plan.

Economic Evaluation

This is the second phase comprehensive national suicide prevention action plan. On completion of the implementation of the action 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.

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APPENDIX A: GLOSSARY [11]

Suicide: The act of intentionally causing one's own death.

Suicidal Ideation: Thoughts of engaging in suicide-related behavior.

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 behaviors are influenced by interacting biological, genetic, psychological, social, environmental and situational factors [12].

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.

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).

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 [13].

Affected by Suicide: All those who may feel the effect of suicidal behaviors, including those bereaved by suicide, community members, and others.

Bereaved by Suicide: Family members, friends, and others affected by the suicide of a loved one (also referred to as *survivors of suicide loss*).

Intentional Self-Harm: An intentional act of causing physical injury to oneself without wanting to die [14]. Also referred to as non-suicidal self-injury or deliberate self-harm (DSH).

Mental Health: Includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood [15].

Mental Illness: Also called mental health disorders, refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, and addictive behaviors.

Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function [16].

Behavioral Disorders: Behavioral disorders are an umbrella term that includes more specific disorders, such as conduct disorder and 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 are 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 understanding that feelings and behaviors are affected by thoughts. CBT typically has a cognitive component (helping the person develop the ability to identify and challenge unrealistic negative thoughts) and a behavioral component. CBT has strong evidence in the treatment of mood and anxiety disorders as well as drug and alcohol disorders. It may also be used in the treatment of psychotic disorders once the client has recovered from the acute phase.

Family Counselling or Therapy: Family counselling or therapy is a supportive and educational treatment which can include negotiated problem-solving or crisis management work. It is a recommended therapy for people with psychosis, alcohol use disorders or drug use disorders. Family counseling involves the affected individual and their family and is often facilitated as single sessions over a period of months.

Motivational Enhancement Therapy: Motivational enhancement therapy is a structured therapy, typically lasting four sessions or less, to help people with behavior change. It involves an approach to motivate change by using the motivational interviewing techniques and has strong evidence as a therapy for people with alcohol use disorders or drug use disorders.

The purple and turquoise ribbon symbolises Suicide Prevention and Awareness. It serves as a reminder that suicide is preventable and talking saves lives.