This assessment is the result of a coordinated effort between the Ministry of Health of Bhutan and the World Health Organization (WHO): The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Bhutan. The goal of collecting this information was to enable policy makers to develop information-based mental health plans with clear base-line information and targets.

The WHO-AIMS study revealed that there are 63 combined community-based outpatient and inpatient facilities, 1 day treatment facility, and no country level mental hospital. The report also highlights some of the major gaps in the mental health system of Bhutan. For example, Bhutan has a mental health policy and plan, but no mental health legislation. There are also no human rights monitoring or inspection of mental health facilities. In addition, primary health care workers receive little training in mental health services.

Since 1997, Bhutan has provided psychiatric training to almost all the primary health care doctors and nearly half of other health workers. In addition, psychotropic drugs are provided free to patients at all levels of health care system. Also, there have been some advocacy and awareness campaigns. Despite these advances, several challenges remain. For example, there are few trained professionals, a limited amount of funding, and a lack of awareness about mental disorders in the population. The principal objectives in the next few years will be to consolidate the training of health workers and to establish community-based treatment and rehabilitation centres for patients with psychoses and for alcohol and drug dependent patients.

WHO-AIMS

# WHO-AIMS Report on Mental Health System in Bhutan

World Health Organization

Ministry of Health
Bhutan

# WHO-AIMS Report on

# Mental Health System

# in Bhutan

*A report of the assessment of the mental health system in Bhutan using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).*

*Thimphu, Bhutan*

*2006*

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The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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The WHO-AIMS project is coordinated by Shekhar Saxena.

## Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Bhutan. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Bhutan to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Bhutan has a mental policy and plan but no mental health legislation. Financing is mainly oriented towards training of health workers and providing essential drugs. Treatment, including the supply of psychotropic drugs is provided free by the government. No human rights monitoring or inspection of mental health facilities exists.

There is a Mental Health Program unit, run by a program manager and a technical adviser, in the Department of Public Health under the Ministry of Health. The number of users per 100,000 population is 487 in outpatient, 15 in inpatient and 5 in day treatment facilities. There are 7 beds in residential facilities per 100,000 population. The majority of patients seeking mental health outpatient services have a mood or anxiety disorder diagnosis. However most people admitted to inpatient services have a mood disorder, alcohol or substance abuse, or a schizophrenia diagnosis. With the exception of a couple of beds in the prison medical services, which are used for all types of patients, there is no separate forensic unit. While involuntary admissions are quite common, patients are usually brought in by families and relatives, and restraints and seclusion are rarely applied.

Primary health care workers have minimal or poor training in their pre-service training curricula, and this poses a serious challenge to our goal of providing community based mental health services. However, with almost 50 percent of trainees receiving in-service training during the last few years, their ability to detect and treat or to refer cases has increased significantly. Now, having reviewed the teaching curricula of the Royal Institute of Health Sciences and of psychiatrists teaching in the institute, we expect that more recent graduates will have better knowledge and skills to manage common mental disorders in the community.

There are 146 human resources working in mental health per 100,000 population. While rates are particularly low for psychiatrists and psychiatric nurses, other disciplines such as clinical psychologists, social workers, drug counselors and occupational therapist are not available at all in Bhutan. Psychiatrists and all other health workers work exclusively for the government, as there are no private health care services in Bhutan. The distribution of services is more or less even in all parts of the country since services are integrated to existing health care infrastructure. There are no consumer associations; however, families are encouraged to actively participate in the treatment and rehabilitation of patients. One member of the family is usually admitted along with the patient so that they care observe and learn through various stages of the treatment and rehabilitation.

The Mental health program and IEC Bureau in the Health Ministry oversee public education and awareness campaigns. There are links with other relevant sectors but there is no legislative or financial support for people with mental disorders.

Data are collected and compiled by facilities to a varying extent and an annual report is produced by the Health Ministry in a journal called "Annual Health Bulletin". There has been little research on mental health published in indexed journals over the last five years. Some research on non-epidemiological clinical/questionnaires assessment of mental disorders and services has been conducted.

Mental hospitals and special facilities for children and adolescents do not exist in the country. Access to mental health facilities at the moment is uneven across the country, favoring those who live in or near the capital city Thimphu. However, with the completion of training of health workers in all parts of the country, it is expected that mental health services will provide 100% coverage.

In the last few years, the number of patients with mental disorder seeking help from the health care system has grown significantly throughout the country. Lack of human and financial resources for community mental health is a significant barrier to progress in the treatment of patients in the community.

# WHO-AIMS COUNTRY REPORT FOR BHUTAN

## Introduction

Bhutan is located in South Asia with an approximate geographical area of 38,394 square kilometers and a population of 672,425 (2005 Census). The proportion of the population under the age of 15 years is 33.1 % and the proportion of population above the age of 60 years is 7.2 %. 69.1 percent of the population is rural.

The main language used in the country is Dzongkha, and the main ethnic group is "Drukpa", with mixed Tibetan and Bhutanese origin. Religious groups include Buddhists and Hindus.

Bhutan is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 10%. The health budget is devoted primarily to public health. The per capita total expenditure on health is not known, however per capita government expenditure on health is Nu. 1944 (US $ 43). The life expectancy is 66 years and literacy rate is 60 percent.

There are 1,078 beds and 145 medical doctors, including specialist doctors working in the public sector. As aforementioned, there are no private health care services in Bhutan. In terms of primary health care, there are 35 physician-based primary health care units (29 district hospitals and 6 Basic Health Units, Grade 1) and 170 non-physician-based primary health care clinics or Basic Health Units. Traditional and indigenous systems of medicine are also provided free by the government along with modern health care services. There are more than 30 indigenous doctors and 36 indigenous compounders providing services in 22 indigenous units that are based in district hospitals.

The mental health care system is community oriented, however, due to a lack of trained health workers at the primary health care level, patients have been treated mainly in the district and referral hospitals during the last few years. With the completion of training of all non-physician health workers in the next few years, it is expected that mental care services will reach the community. Overall, resources for the mental health system are very scarce, and the only way to improve and sustain mental health services is to integrate mental health care with general health care services.

## Domain 1: Policy and Legislative Framework

### Policy, plans, and legislation

Bhutan's mental health policy was formulated in 1997 as part of the country's 8th Five-Year Plan of development. The national mental health policy includes the following components: development of community mental health services, development of a mental health component to primary care, human resources, involvement of users and families, advocacy and promotion, equity of access to mental health services across different groups, financing, quality improvement and a monitoring system.

Also in 1997, a comprehensive mental health plan was developed for the first time in Bhutan with the following components: community mental health services, development of a mental health component in primary health care, human resources, involvement of users and families, advocacy and promotion, equity of access to mental health services across different groups, financing, quality improvement and a monitoring system.

Contained in the mental health plan is a budget, a timeframe and specific goals with respect to improving mental health services in the country. Some of the goals identified in the last mental health plan such as training of primary care health workers on mental health and psychiatric skills have been achieved within the last few years.

A list of essential medicines is present and includes the following: psychotropic medication, anti-psychotics, anxiolytics, antidepressants, mood stabilizers and anti-epileptic drugs. The addition of antipsychotic medication to Bhutan's essential drug list is also a recent achievement of Bhutan's national health plan.

A disaster/emergency preparedness plan for mental health is not present. In June of 2006, Bhutan was present at a WHO sponsored meeting in Thailand on psychosocial aspects of risk management. Following this meeting, a framework on disaster risk management including preparedness for mental health in Bhutan was proposed to the government for implementation.

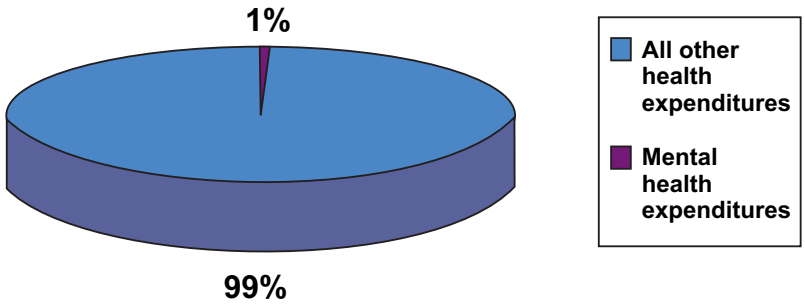
Separate legislation for mental health is not available in the country. However, the Bhutan Penal Code, which was enacted in 2004, contains clauses to safeguard the interests of people with mental illness in the criminal justice system, including the provision of adequate treatment.

### Financing of mental health services

An estimated one percent of health care expenditures by the government health department are directed towards mental health. In terms of affordability of mental health services, 100 % of the population has free access to essential psychotropic medicines. In addition, all mental disorders are covered by social insurance schemes. For those who pay for their medicines out of pocket, the cost of either antipsychotic or antidepressant

medication is Nu. 10 ($0.23 USD) per day, approximately ten percent of one day's minimum daily wage.

**GRAPH 1.1 – HEALTH EXPENDITURE TOWARDS MENTAL HEALTH**




### Human rights policies

A national human rights review body does not exist in the country.

## Domain 2: Mental Health Services

### Organization of mental health services

A national mental health authority exists and is responsible for the following: providing advice to the government on mental health policies and legislation, service planning, service management and coordination, and monitoring and conducting quality assessments of mental health services. Mental health services are organized in terms of catchment / service areas or districts and sub-districts.

### Mental health outpatient facilities:

There are 63 outpatient mental health facilities available in Bhutan, none of which are for children and adolescents only. All 63 facilities are fully integrated with mental health inpatient units. Mental health outpatient facilities treat 5,266 people or 783 users per 100,000 population. Of all users treated in mental health outpatient facilities, however, it is unknown how many are female and how many are children or adolescents.

The primary diagnoses of users treated through mental health outpatient facilities are mood (affective) disorders (22%) and neurotic, stress-related and somatoform disorders (17%). The average number of contacts per user is 1. All outpatient facilities provide

follow-up care in the community; however there are no mental health mobile clinic teams.

In terms of available treatments, only some (21-50%) of the patients in outpatient facilities have received one or more psychosocial interventions in the past year. All 63 mental health outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

**Day treatment facilities**

There is only one mental health day treatment facility available in the country. There is no day treatment facility for children and adolescents only. The facility treats 35 patients or 5.21 users per 100,000 population. Slightly less than half of the users in the day treatment facility are female and an estimated 29 % are children or adolescents. On average users attend 150 days of treatment per year.

**Community-based psychiatric inpatient units**

There are 63 community-based psychiatric inpatient units available in the country with a total of 100 beds or 14.9 beds per 100,000 population. As aforementioned, the psychiatric inpatient units are fully integrated with mental health outpatient facilities. There are no beds in the community-based psychiatric inpatient units reserved for children and adolescents only. 50% of admissions to community-based psychiatric inpatient units are female, and it is unknown what percentage of admissions are children and adolescents.

Diagnoses of patients admitted to community-based psychiatric inpatient units are primarily from the following three diagnostic groups: mood disorders (32%), mental and behaviour disorders due to psychoactive substance use including alcohol (27%), and schizophrenia (19%). 23% of all admissions to community-based psychiatric inpatient units are involuntary. (N.B. Admitting diagnoses were estimated based on the information on discharge diagnoses.)

The average number of days spent in the community-based psychiatric inpatient units per discharge is 27.71. Of all admitted patients, less than 1% were physically restrained or secluded at least once in the past year in these facilities.

A majority (51-89%) of the community-based psychiatric inpatient units received one or more psychosocial interventions in the past year. All community-based psychiatric inpatient units (hospitals and a few Basic Health Units) had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) and 30 Basic Health Units had all psychotropic drugs, with the exception of mood stabilizer drugs available in the facility

## Community residential facilities

There are no community residential facilities in Bhutan.

## Mental hospitals

There are no mental hospitals in Bhutan.

## Forensic and other residential facilities

There are no forensic inpatient units, and therefore, forensic cases with mental disorders are not segregated from other patients. Forensic patients, however, are typically kept under police custody.

Additional residential facilities include: a 50-bed facility for juvenile delinquents, a 15-bed facility for drug detoxification and rehabilitation, and a five-bed residential facility for the elderly. Furthermore, a residential facility for victims of domestic violence and rape is currently under construction.

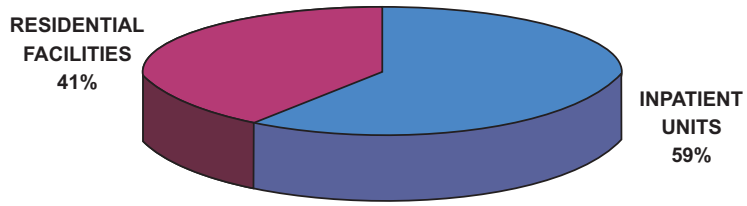
## Human rights and equity

As aforementioned, the majority of all admissions to community-based inpatient psychiatric units are voluntary however; a small number patients are involuntarily admitted by families or police.

Most of the psychiatric beds in Bhutan are located in the psychiatry ward (10 beds) of [hospital] in the largest city Thimphu. Every district hospital has beds which can be used by psychiatric patients. However, many of these beds are not reserved for psychiatric patients. Consequently, this analysis uses 100 beds as an estimate of the number of beds reserved for psychiatric patients. As such, there is equal access to mental health inpatient services by rural users. There is also equal access to mental health services for other minority users in the country and almost all facilities employ a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent.

## Summary Charts

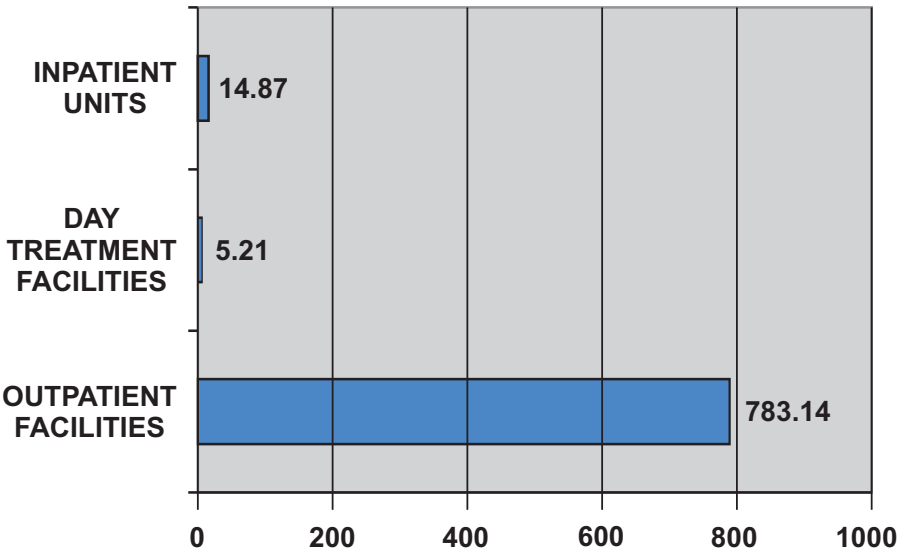
**GRAPH 2.1 – BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES**




Summary for Graph 2.1

The majority of beds in the country are located in community-based psychiatric in-patient units, followed by residential facilities, both inside and outside the mental health system.

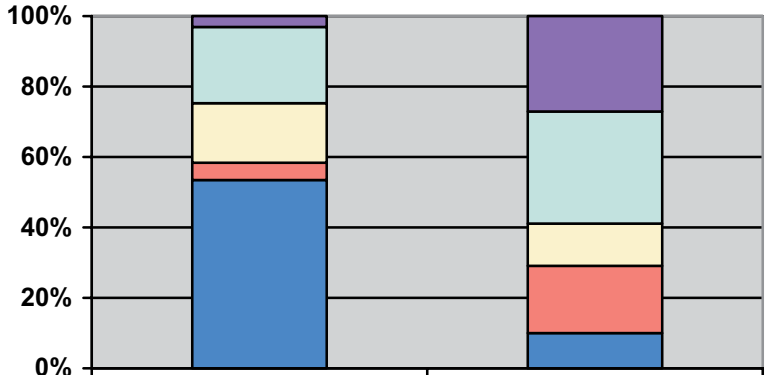
**GRAPH 2.2 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)**




Summary for Graph 2.2

The majority of the users are treated in outpatient facilities, while the rate of users treated in inpatient units and day treatment facilities is significantly lower.

**GRAPH 2.3 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**




| | OUTPATIENT FACILITIES | COMMUNITY-BASED INPATIENT PSYCHIATRIC UNITS |
|---|---|---|
| SUBSTANCE ABUSE | 3% | 27% |
| MOOD DISORDERS | 22% | 32% |
| NEUROTIC DIS. | 17% | 12% |
| SCHIZOPHRENIA | 5% | 19% |
| OTHERS | 54% | 10% |

Summary for Graph 2.3

The most common diagnoses in outpatient facilities include mood and neurotic disorders, whereas in community-based inpatient psychiatric units mood disorders, substance abuse disorders and schizophrenia are the most common diagnoses.

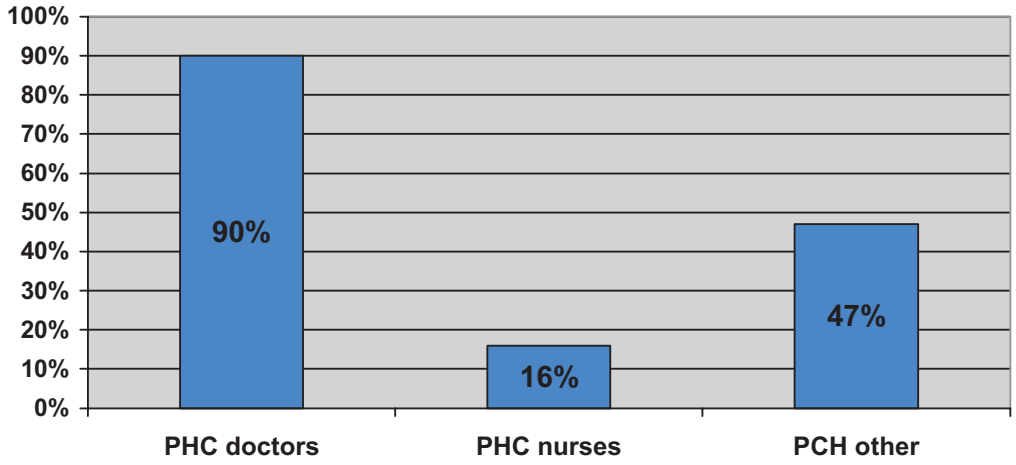
## Domain 3: Mental Health in Primary Health Care

### Training in mental health care for primary care staff

There is no medical college in Bhutan. Physicians train outside of the country in the Indian subcontinent. While there is no definitive measure on the number of undergraduate (first degree) training hours devoted to psychiatry and mental health-related subjects for medical doctors, estimates range from as little as two weeks to two months.

Nine percent of medical training for nurses and ten percent for non-doctor/non-nurse primary health care workers is devoted to psychiatry and mental-health related subjects. In terms of refresher training, 90% of primary health care doctors have received at least two days of refresher training in mental health, while 16% of nurses and 47% of non-doctor/non-nurse primary health care workers have received such training. Non-doctor/non-nurse primary health care workers function independently to provide mental health services in the community, while nurses work with medical doctors. Therefore, the amount of refresher training devoted to mental health for non-doctors/non-nurses is considerably greater.

**GRAPH 3.1 – % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR**



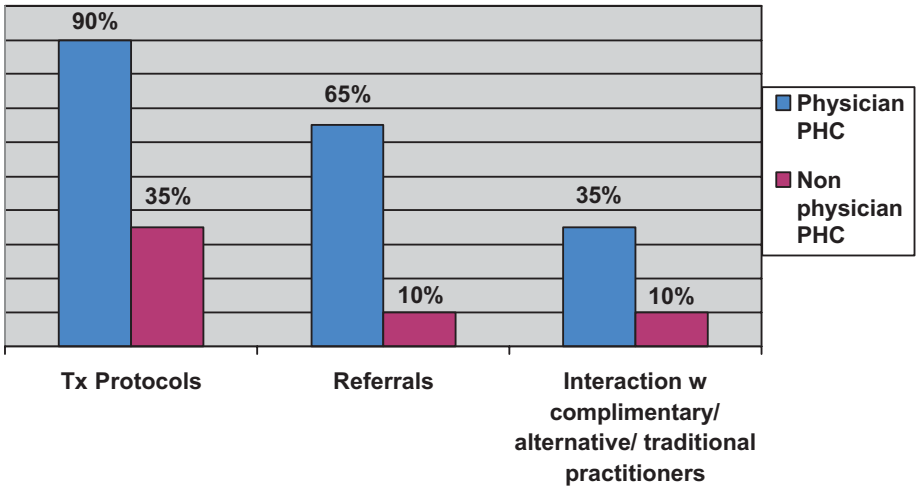

### Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based primary health care clinics, a majority (between 80-100%) have assessment and treatment protocols for key mental health conditions, in comparison to only some (between 21-50%) in non-physician-based primary health care clinics

The majority of physician-based primary health care clinics (between 51-80%) make more than one referral per month to a mental health professional. In addition, some non-physician based primary health care clinics (between 21-50%) refer patients monthly to a higher level of care (e.g. mental health professional or physician-based primary health clinic).

As for interaction between primary health care staff and other mental health professionals, 21-50% have interacted with a mental health professional at least once in the last year. In addition, physician-based PHC facilities and mental health facilities have had some (21-50%) interaction with a complimentary/alternative/traditional practitioner in the last year, in comparison to only a few (1-20%) of the non-physician based clinics.

**GRAPH 3.2 – COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE**




## Prescription in primary health care

Non-doctor/non-nurse primary health care workers are only allowed to prescribe the psychotropic medications supplied by the government to the health centres. In contrast, primary health care doctors are allowed to prescribe without restriction. As for the availability of psychotropic medicines, all or almost all (between 80-100%) physician-based primary health care clinics as well as non-physician based PHCs have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a nearby pharmacy all year long.

## Domain 4: Human Resources

### Number of human resources in mental health care

The total number of human resources working in mental health facilities is 984 (146.33 per 100,000 population). The breakdown according to profession is as follows: 2 psychiatrists (0.29 per 100,000 population), 100 other medical doctors, not specialized in psychiatry (14.87 per 100,000 population) and 370 nurses (55.02 per 100,000 population). The figure for nurses includes nurses without specialized mental health training. At present, there are no psychologists, social workers or occupational therapists in Bhutan.

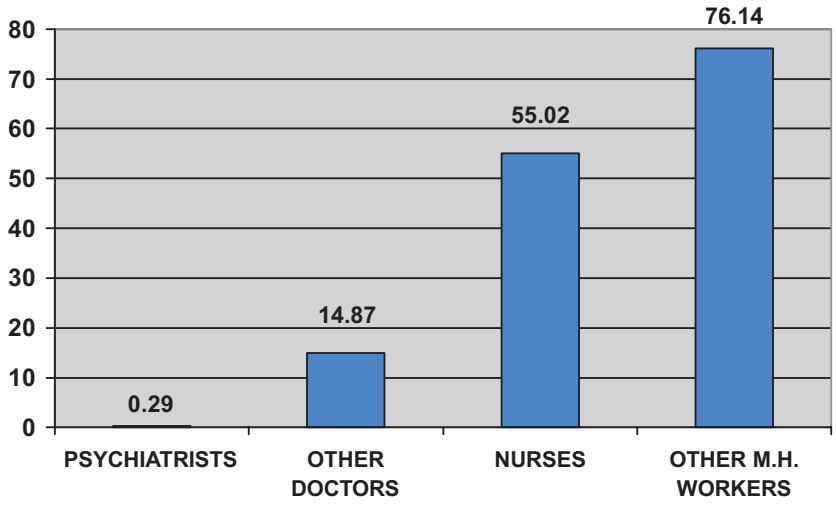
There are no private practice or for profit mental health facilities in Bhutan and, therefore, all health and nursing staff work for government administered mental health facilities.

Regarding the workplace, two psychiatrists work in both the outpatient facilities and the community-based psychiatric inpatient units. 100 medical doctors not specialized in mental health work in both the outpatient facilities and in the community-based psychiatric inpatient units. With regards to other health or mental health workers, 512 work in outpatient facilities and in community-based psychiatric inpatient units.

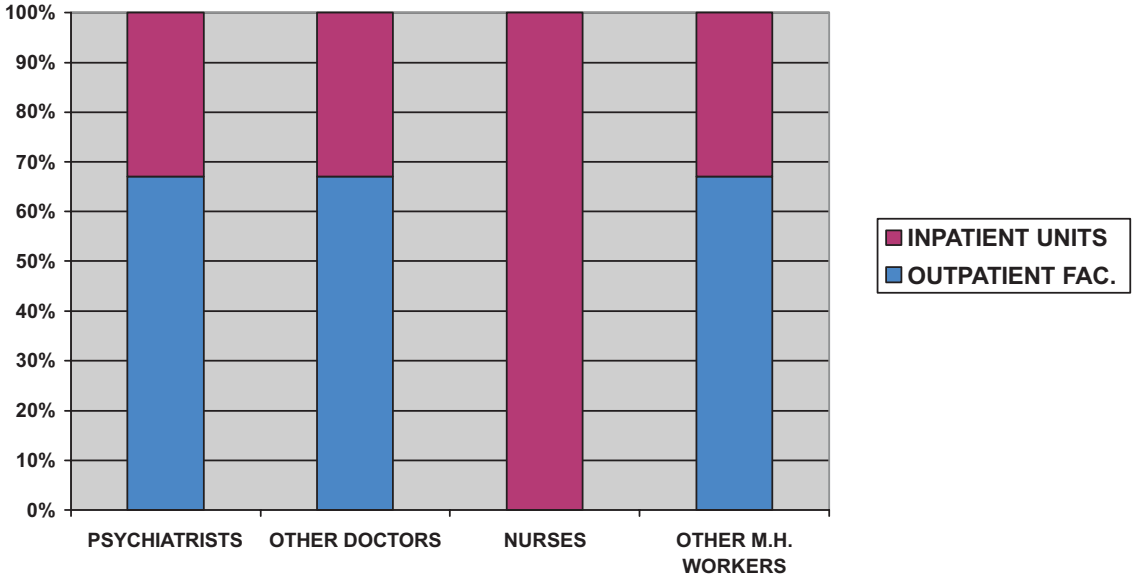
In terms of staffing in mental health facilities, there are .01 psychiatrists per bed in community-based psychiatric inpatient units. In addition, there are 3.7 nurses and .33 medical doctors per bed in community-based psychiatric inpatient units. Finally, for other mental health care staff (excluding psychologists, social workers, and occupational therapists) there are 1.70 per bed for community-based psychiatric inpatient units.

An overwhelming majority of the psychiatrists' and nurses' time is spent working in or near the largest city. The density of psychiatrists working in mental health facilities per capita in urban areas is 6.81 times greater than the density for the whole country. The density of nurses working in mental health facilities per capita in urban areas is 2.82 times greater than the density for the whole country.

**GRAPH 4.1 – HUMAN RESOURCES IN MENTAL HEALTH**
**(rate per 100.000 population)**



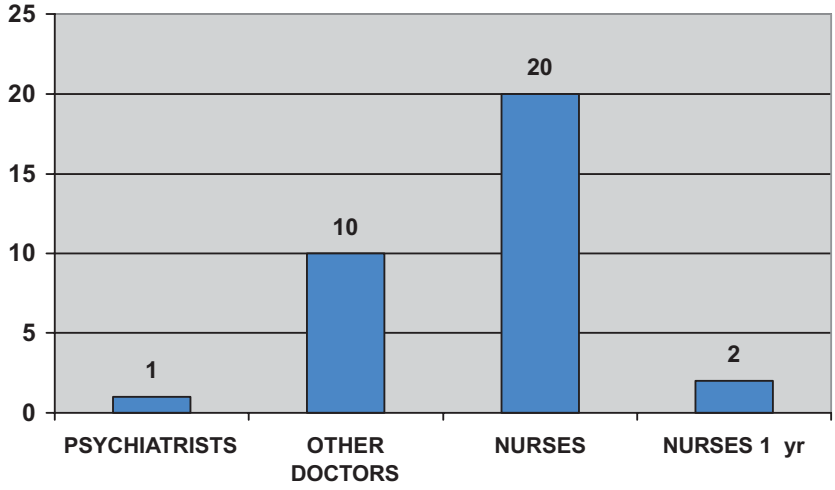

**GRAPH 4.2 – STAFF WORKING IN MENTAL HEALTH FACILITIES**
**(percentage in the graph, number in the table)**



## Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions is as follows: 1 psychiatrist (0.15 per 100,000 population), 10 other medical doctors not specialized in psychiatry (1.49 per 100,000 population), 20 nurses (2.97 per 100,000 population), 2 nurses with at least 1 year training in mental health care (0.30 per 100,000 population). There were no psychologists or occupational therapists graduating last year.

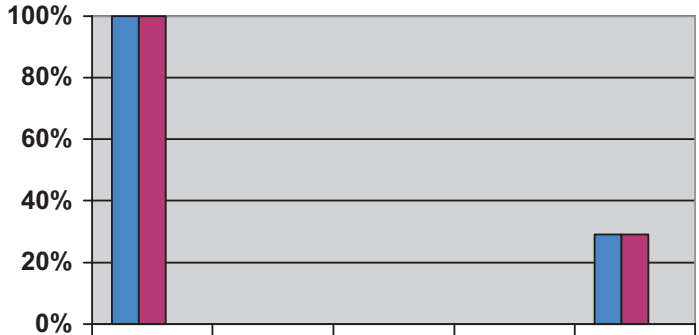
**GRAPH 4.3 – PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)**




No psychiatrists immigrated to other countries within five years of the completion of their training.

The following graph shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues:

**GRAPH 4.4 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR**




| | Psych. | MD | Nurses | Psychosocial | Other |
|---|---|---|---|---|---|
| Rational use of drugs | 100% | 0% | 0% | NA | 29% |
| Psychosocial interventions | 100% | 0% | 0% | NA | 29% |
| Child mental health issues | 0% | 0% | 0% | NA | 0% |

Psych = psychiatrists; MD =other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers, and occupational therapists. Others = other health and mental health workers

## Consumer and family associations

There are no consumer and family associations in Bhutan. Nonetheless, families of mental health patients are involved with the treatment and management of cases. There are two NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups. One NGO is working with abused women, while the other is working with substance abuse patients.

## Domain 5: Public Education links with other Sectors

### Public education and awareness campaigns on mental health

The Information and Communication Bureau, located in the Ministry of Health, is the coordinating body that oversees public education and awareness campaigns on mental health and mental disorders. In addition, other government agencies as well as one NGO and professional associations have promoted public education and awareness campaigns for mental health in the last five years. These campaigns have targeted the following groups: general population; children and adolescents and women. The following professional groups have also been targeted: health care providers, complimentary/ alternative/ traditional sector, teachers, leaders, politicians and other professional groups linked to the health sector.

### Legislative and financial provisions for persons with mental disorders

At present no legislative and financial provisions exist to protect and provide support for persons with mental disorders in Bhutan.

### Links with other sectors

Despite a lack of legislation in support of people with mental disorders, there are formal collaborations with the departments/agencies responsible for primary health care/ community health, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection and education.

There are no part time or full-time mental health professionals working at primary and secondary schools in Bhutan. Many of the primary and secondary schools, however, have school-based counsellors and health educators who conduct school-based activities to promote mental health and prevent mental disorders.

The percentage of prisoners with psychosis is less than 2%. The percentage of prisoners with mental retardation is also less than 2%. Regarding mental health activities in the criminal justice system, 1 – 20% of prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training, some police officers (21 – 50%) and a few (1 – 20%) judges and lawyers have participated in educational activities on mental health in the last five years.

None of the mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, 3% of people who receive social welfare benefits do so for a mental disability.

## Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. As shown in the table 5.1, however, the extent of data collection varies among mental health facilities and many country-wide data totals are unavailable. The government health department receives data from community based psychiatric inpatient units, and mental health outpatient facilities. Based on this data, a report was published which did not include comments on the data.

Some mental health research has been done in the last five years; however, there are very few publications on this research. The research has focused on the following: prevalence of mental disorders in the community, community's knowledge, attitude and practice related to mental disorders and operational research on management of mental disorders in the community.

All mental health facilities submitted data during the last year.

Only a few psychiatrists are involved in mental health research in Bhutan. There are no nurses working in mental health services presently involved in mental health research. The mental health research that psychiatrists have conducted in the last five years are on the following subject areas: epidemiological studies in community samples, epidemiological studies in clinical samples, non-epidemiological clinical/questionnaire assessments of mental disorders and services research. In the last five years, there have been a total of 38 indexed (per PubMed search) health-related publications on Bhutan, nine of which have been on the subject of mental health.

## Next Steps in Planning Mental Health

The 10th Five Year Plan of Development for Bhutan falls between the years 2007 and 2012. Therefore, this is an opportune time for the Mental Health Program to develop specific plans and activities.

**Training:**

A. The training of general health workers is the most important component of the mental health program, especially as mental health care services are integrated with general health care services. Activities under this objective will include:

- Development of training programs for health workers that includes an assessment of all mental health program activities that health workers implement in the field
- Implementation of refresher training for health workers at least once every three years, or more frequently as required
- Continuation of training of recent graduates from training institutions, as well as those who have not been trained to date (more than 50 % health workers, 75 % nurses and 10 % doctors)

B. Training of mental health professionals: This group of trained professionals will act as the technical backstop for the health worker training program, and will also conduct relevant training for different levels of health care workers. These professionals include:

- Psychiatrists: At least three additional psychiatrists need to be trained in the plan period, as the two existing psychiatrists will undergo sub-specialization in the areas of child and adolescent psychiatry and substance abuse disorders.
- Clinical psychologists: Presently there are no trained clinical psychologists in the country. We will need to train at least two or three clinical psychologists in the plan period.
- Psychiatric nurses: At present we have six (one year-trained) psychiatric nurses, including one who has gone abroad for further training and another running the mental health program. Therefore we need to train at least 10 psychiatric nurses in the next 5 years.
- Drug and Alcohol Counselors: As we are planning to open up an Alcohol and Drug Detoxification Treatment and Rehabilitation Centre in Bhutan, we need to train at least 20 counselors - 10 for community-based rehabilitation and 10 for residential rehabilitation.
- Psychiatric Social Workers: We expect to train at least 5 Psychiatric Social Workers in the next five years.
- Occupational therapist: At least three Occupational therapists will be trained in the next five years to work in two day centers and in the Drug Detoxification Treatment and Rehabilitation centre.

C. Training of other related and allied professionals: Brief trainings for allied professionals for the purposes of learning how to identify cases and to provide support

to patients under their care or custody, have already started and will be expanded over the next five years. The allied professionals include teachers, traditional and religious healers, policemen, jailors, community leaders and voluntary community health workers.

**Supply of essential drugs and other resources:**

- Essential psychotropic drugs including anti-psychotics, anxiolytic, antidepressants and anti-epileptic drugs are already available at all levels of care in Bhutan. Mood stabilizer drugs are available in all hospitals in Bhutan. There are plans to increase the range of these drugs as health workers become more experienced in managing cases in the health centres.
- As a greater number of health workers throughout Bhutan are trained in basic community-based mental health care, we plan to increase the number of beds reserved for psychiatric patients.
- Electro-Convulsive Therapy (ECT) is not yet established in the country. We are planning to set up two ECT units in two referral hospitals over the next 5 years.

**Advocacy and IEC activities:**

These activities will be strengthened in order to increase the level of awareness of mental health, to reduce stigma related to mental disorders and encourage people to seek treatment.

- The ongoing project to integrate traditional and religious approaches to mental health care with modern psychiatric care will be strengthened so that people suffering from mental disorders receive timely and appropriate care.
- Advocacy meetings and functions to celebrate occasions such as World Mental Health Day and Mental Health Week should become a part of regular programmed activities. These activities should also be formally included in Bhutan's annual mental health budget.
- IEC materials such as posters, calendars, pamphlets and audio-visual aids will need to be developed and distributed to all parts of the country.
- We will increase the use of mass media such as television, radio, newspaper to disseminate mental health information to all people.
- We will utilize street shows, dramas and films to dispel myths about mental disorders and educate people on protecting their mental health.
- We plan to scale-up the Prevention of Alcohol Use in Children pilot project, first implemented in a remote district (Zhemgang) in 2004-2005, to include all districts throughout the country. The project will include first hand discussions, facilitated by mental health professionals and drug counselors, with community leaders, business people, school teachers, health workers and traditional and religious leaders and government administrators on the prevention of alcohol and drugs in the community.

**Monitoring and Evaluation (M&E) and Health Management and Information System (HMIS):**

Monitoring and evaluation is a weak area, not only for mental health, but also for the entire health system in Bhutan. In order to strengthen this aspect of the program, we will need to support the work of the monitors by allocating adequate resources for travel, relieving them of their fulltime duties to focus on M&E activities and providing them with standardized monitoring tools and checklists.

The HMIS has improved significantly over the past few years but needs to be continuously updated to include new indicators that effectively measure improvements to the mental health system and its services. For example, we now propose that all BHUs report the five most common mental disorders such as psychosis, depression, anxiety, alcohol use disorders and epilepsy. The HMIS diagnostic categories should be compatible with ICD categories.

**Research and surveys**

Research and surveys are crucial to providing guidance on developing appropriate policies, plans and strategies. Due to a lack of trained professionals and other resources, however, little has been done in this area. The mental health program has completed a pilot survey in three districts in Bhutan to study knowledge, attitude and practices among health workers regarding mental disorders and to measure the number of cases in these three districts. This pilot study was effective in identifying cases in the community and initiating treatment for them. It also served to educate the community on mental disorders and train health workers on the detection and diagnosis of cases. If funding is available, we hope to conduct similar studies in the rest of the country over the next 5 years.

**Drugs and alcohol rehabilitation centre**

Drug and alcohol dependency has become a significant and growing public health problem in Bhutan over the last few years. If this problem is not addressed now, it will escalate and overwhelm our health services. Already alcohol has become the number one killer of middle-aged men in Bhutan, and its impact on women is also significant. Drug abuse is predominantly among the youth, and with a growing number of young people graduating from school with limited job opportunities, there is the risk that this problem will escalate. At present, there are limited resources and facilities to treat cases of substance abuse. A 15-bed rehabilitation centre in Thimphu is funded by an NGO and run by recovering addicts. However, this facility is unable to respond to the existing demand for drug treatment and rehabilitation. Many of these addicts are now attending rehabilitation centers in Sikkim and Darjeeling. Patients diagnosed with a psychiatric disorder and drug addiction are often treated in the 10-bed psychiatry ward in Thimphu.

Therefore, a proposal has been made in this five-year plan to establish a Drug and Alcohol Treatment and Rehabilitation Centre in Thimphu. This proposal is in concordance with the enactment of the Narcotics and Substance Abuse Act of the Kingdom of Bhutan.

**Mental health rehabilitation centre**

Modern mental health care services arrived in Bhutan only in late 1990s. Today there are many psychiatric patients not receiving adequate treatment or rehabilitation, many of whom have been disowned by their families or chose to live on their own.

As awareness of the treatment and rehabilitation of mental illness grows, family members of chronic patients have been bringing them in for treatment and rehabilitation. In the absence of sufficient rehabilitation centers in the country, however, psychiatry wards and district hospitals are overwhelmed and do not have the capacity to provide long-term care. These facilities are only able to provide treatment to short term, acute cases and patients rarely stay longer than two months at a time.

In the 8th and 9th FYP, the health ministry planned to establish a Treatment and Rehabilitation Centre in Bumthang, however, this project was postponed pending the recruitment of trained mental health professionals who could run the facility and a sufficient demand for its services. We believe that the time to establish the rehabilitation center has arrived, although we still lack an adequate number of trained professionals. Presently, there is a great demand for long-term treatment and rehabilitation of patients with mental disorders. This facility should be integrated with other community-based rehabilitation centers, which have also been proposed as part of the Community-based Rehabilitation Program of the Health Ministry.

We would like to emphasize that the Treatment and Rehabilitation Centre will not and should not become an asylum, simply looking after mentally ill people throughout their lives. Therefore, the goals of establishing this facility as well as the protocols for admission must be made explicit to all stakeholders. The duration of stay in the Rehabilitation Centre should not exceed six months, and only under exceptional circumstances should patients stay for more than a year. Relationships with other rehabilitation centres, such as the home for the disabled, will need to be established in order to ensure that patients without long-term housing can have somewhere to live.