Achieving Gross National Happiness Through Community-based Mental Health Services in Bhutan

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Introduction

Development is an inherent human desire, and the unique and dynamic concept of Gross National Happiness as a development philosophy and objective is generating substantial interest among many development partners of Bhutan. Nonetheless, some believe that development inevitably entails a negative effect on the mental well-being and happiness of the people. Others accept the premise that development facilitates and provides a platform for the fulfilment of many human needs. The argument is not whether development is good or bad, but how it can best be used to serve the purpose of enhancing human development and satisfaction with life.

Important dimensions of GNH, including preservation of our rich Bhutanese culture and traditions, preservation of our pristine environment, and good governance and human development, have been deliberated in many forums. In this article, we approach the concept from a mental health perspective.

Background

Concept of Well-being, Mental Health and Mental Disorders

Gross National Happiness, by definition, is closely linked to mental health, which is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community. Across cultures, concepts of mental health, as with GNH, include subjective well-being; perceived self-efficiency; autonomy; competence; inter-generational independence; and self-actualisation of one's intellectual and emotional potential, among others. It is generally agreed that the concept of mental health is broader than a lack of mental disorders. Mental health must address the entire spectrum of issues affecting the mental well-being of all sectors of society.

Mental and behavioural disorders, meanwhile, are understood as clinically significant conditions characterised by alterations in thinking, mood (emotions) or behaviour associated with personal distress and/or impaired functioning. Advances in neuroscience and behavioural medicine have shown that, like many physical illnesses, mental and behavioural disorders are the result of complex interactions between biological, psychological and social factors.

Global Scenario

Overall Burden due to Mental and Behavioural Disorders

Mental and behavioural disorders are common, affecting more than 1 in 4 people sometime during their lives; at any point in time, about 10 percent of all adult populations suffer from these disorders. They are also universal, affecting people of all countries and societies, individuals of all ages, women and men, rich and poor, from urban and rural environments. They have a significant economic impact on societies as well as on the quality of life of individuals and families. In 1990, it was estimated that mental and neurological disorders accounted for 10 percent of the total Disability-Adjusted Life Years (DALYs) lost worldwide due to all disease and injuries; by 2000, the figure had risen to 12 percent. And by 2020, it is projected that the burden will have increased to 15 percent and that depression alone will become the second-largest cause of disability around the globe. In particular, alcohol use also is a major cause of disease burden, especially for adult men.

In developing countries, the problem of mental and behavioural disorders is further complicated by the fact that emotional and psychological problems often present in the form of physical symptoms, which can result in misdiagnosis, mismanagement, waste of already meagre resources, and lack of satisfaction for both care seekers and caregivers. Thus, only a small minority of the 450 million people in the world suffering from a mental or behavioural disorder receives treatment. In addition to the sufferers, families also bear the negative impact of stigma and discrimination.

Common Mental Disorders and their Disease Burden

Mental and behavioural disorders present a quite varied picture. Some are mild, while others are severe. Some last just a few weeks; others may last a lifetime. Some are not discernible except by detailed scrutiny by experienced professionals, while others are impossible to hide even from a casual observer. This section focuses on common disorders that place a heavy burden on communities and that are generally regarded with a high level of concern. These include depressive disorders, substance and alcohol abuse, schizophrenia, epilepsy, mental retardation, Alzheimer's disease and disorders of childhood and adolescence.

The inclusion of epilepsy needs some explanation: Epilepsy is a neurological disorder; however, it was historically seen as a mental disorder and is still considered this way in many societies. Like those with mental disorders, people with epilepsy suffer stigma and severe disability if left untreated. The management of epilepsy is often the responsibility of mental health professionals because of the high prevalence of this disorder and the

relative scarcity of specialist neurological services, especially in developing countries.

Like physical disorders, mental disorders can appear together, such as anxiety and depression; individuals with substance use disorders often also have emotional disorders. Likewise, mental and physical disorders often appear together, which complicates treatment.

Determinants of Mental and Behavioural Disorders

A variety of factors determine the prevalence, onset and course of mental and behavioural disorders. Theses include social and economic factors, demographic factors such as sex and age, serious threats such as conflicts and disasters, the presence of major physical diseases, and the family environment.

Poverty

Poverty and the associated conditions of unemployment, low educational level, deprivation and homelessness are not only widespread in poor countries, but also affect a sizable minority of rich countries. Data from international studies have shown that common mental disorders are about twice as frequent among the poor as among the rich (Patel et al. 1999). Evidence also exists that the duration or course of disorders is determined by the socioeconomic status of the individual (Kessler et al. 1994; Saraceno & Barbui 1997). Mental disorders and poor economic status adversely affect each other and, therefore, the prognosis for mental disorders is better in people who have better resources.

Gender

The overall prevalence of mental disorders does not seem different between men and women. Anxiety and depressive disorders are, however, more common among women, while substance abuse and anti-social personality disorders are common among men (Gold 1998). Many reasons for the higher prevalence of depressive and anxiety disorders among women have been proposed, including genetic and biological factors.

Age

Overall, the prevalence of some disorders tends to rise with age; predominant among them is depression. Some disorders are age-specific, such as Alzheimer's disease.

Conflicts and Disasters

Conflicts and disasters, both manmade and natural, cause immense suffering to humankind and can cause mental disorders. The most frequent problems associated with severe catastrophes are post-traumatic stress

disorders (PTSD), which have a prevalence of 0.37 percent, according to GBD 2000

Major Physical Disorders

The presence of major physical diseases affects the mental health of individuals as well as of families. Most of the serious disabling or life-threatening diseases, including cancer, have this impact. The case of HIV/AIDS is a particularly stark reminder of the close association between physical and mental disorders: HIV is spreading rapidly in many parts of the world, with as much as one-third of populations in some countries affected, and the mental health consequences of this epidemic are substantial. Many individuals suffer psychological consequences because of infection. The effects of intense stigma and discrimination against people with HIV/AIDS also play a major role in psychological distress. In addition, family members suffer the consequences of stigma and, later, of the premature deaths of their infected loved ones.

Family and Environmental Factors

Mental disorders are firmly rooted in the social environment of the individual. A variety of social factors influence the onset, course and outcome of these disorders. All people go through a series of significant events in life, minor as well as major. These may be desirable (such as promotion at work) or undesirable (bereavement or business failure). It has been observed that there often is an accumulation of life events immediately before the onset of mental disorders (Brown et al. 1972; Leff et al. 1987).

Situation Analysis And Scope Of Community Mental Health Development In Bhutan

Prevalence of Mental Disorders in Bhutan

Data from Health Facilities

Many of us like to believe that Bhutan is the last Shangri-la and that there are not many patients with mental disorders here. This may be both true and false. The truth is that indications from various sources point out that there may be less mental disorders in Bhutan than other countries. However, this does not mean that there are no mentally ill people in the country. So far, very little reliable data is available on mental disorders here, in large part because, until very recently, health workers did not easily detect mental disorders due to lack of knowledge and experience. Since a national mental health programme started in 1997, including training health workers on the management of mental disorders, the number of cases identified has steadily increased. For example, the number of mental

disorder cases reported by hospitals has risen significantly (Annual Health Bulletins, 1993-2002).

More than 1,500 patients with mental disorders attended the psychiatric clinic in Jigme Dorji Wangchuck National Referral Hospital in Thimphu in the past four and half years, among whom 590 (40 percent) had depression and 459 (31 percent) had anxiety and stress-related disorders. Epilepsy, at 116 (8 percent), and alcoholism, at 111 (7 percent), are other common disorders. Psychoses (96, or 6 percent) are relatively rare when compared to depression and anxiety. Many people associate mental disorders specifically with "madness" or psychosis ; however, this data shows that the vast majority of the patients who attend the psychiatric clinic suffer from depression and anxiety disorders. Men and women are represented in equal proportion in all disorders except depression and anxiety where females predominate; males predominate in alcoholism and substance abuse (see Figure 3). All age groups are represented, but depressed patients are mostly adult.

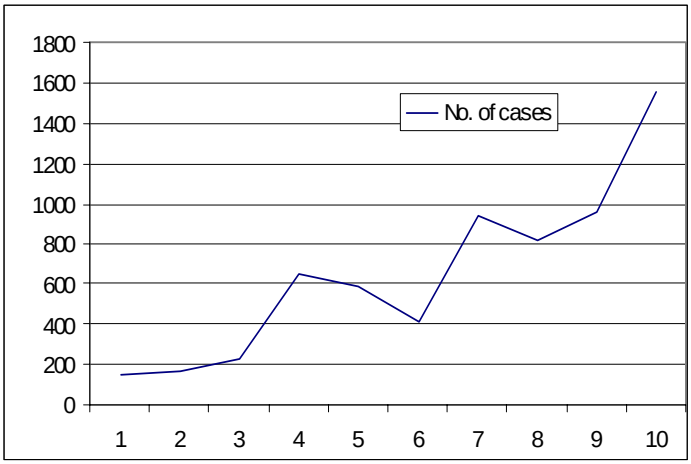

Figure 1: Increasing trend in the number of cases of mental disorders reported by health facilities in Bhutan, 1993-2002

Almost 20 percent of the patients seen from July 1999 to September 2001 were younger than age 20. A closer look at their illness pattern (see Figure 4) revealed that the majority of them suffered from stress-related and anxiety disorders (34 cases). The increasing competition to achieve better academic results in the face of limited seats for higher studies, or for job opportunities due to the increasing number of students graduating from school each year, appear to be the main reasons for the increase in anxiety and stress-related disorders among youth. Epilepsy (23 cases) and depression (22 cases) are other common

problems. Together, these three groups of disorders account for about 82 percent of disorders seen in children and adolescents. Substance abuse, psychosis, mental retardation and bipolar mood disorders together constitute the remaining 18 percent in this age group.

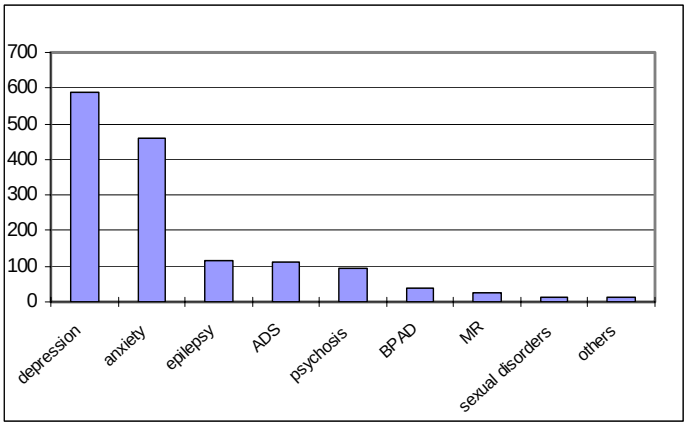

Figure 2: Number of patients with mental disorders seen at the psychiatry outpatient department in JDWNRH

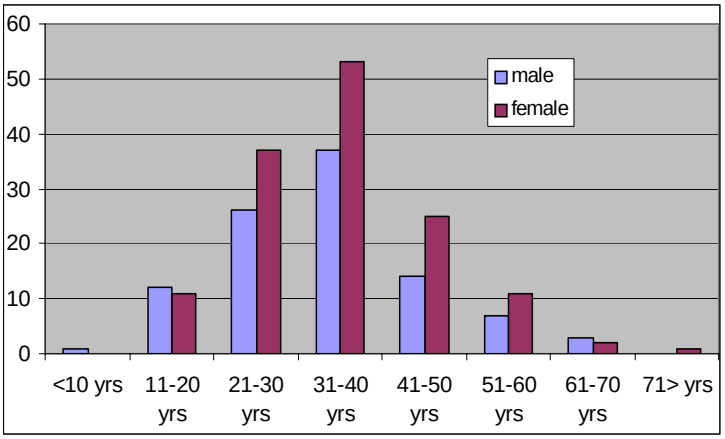

Figure 3: Age and sex of patients with depression in the psychiatric outpatient department in JDWNRH, July 1999-September 2001 (n= 325)

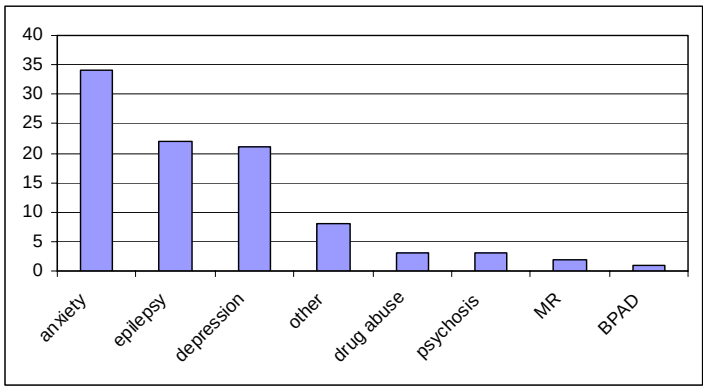

Figure 4: Type of mental disorders in patients younger than age 20 in the psychiatric outpatient department in JDWNRH, July 1999-September 2001 (n=94).

A WHO psychiatrist Dr. R. S. Murthy, who visited Bhutan in 1987 and 1999 observed a steady increase in the number of neuropsychiatric disorders reported over the decade. Dr. Murthy also observed a high number of "headache cases" reported by health facilities (headache was reported as a disease category by both hospitals and BHUs until 2001) and argued that these cases may have represented stress-related anxiety and emotional disorder cases. Table 2 **s**hows that, until 2002, both hospitals and BHUs reported many cases of headache, which ranked between fourth and seventh among the most common disorders treated in our health facilities. It would be interesting to find out where the 83,000 cases of headaches reported by hospitals and BHUs in 2001 have gone. Are the headache cases now being reported as musculo-skeletal aches and pains, or in another category? What percentage of these cases had a primary mental disorder such as anxiety or depression?

Table 2: Number of "headache cases" reported by health facilities, 1998-2001

	Hospital			Basic Health Unit		
Year	Number of cases	Percentage	Ranking	Number of cases	Percentage	Ranking
1998	26039	4.91	4th	33262	6.34	6th
1999	22679	4.64	7th	51698	9.24	4th
2000	24538	4.81	6th	58122	10.21	3rd
2001	25302	5.07	7th	58329	9.46	4th
2002	------	----	--	------	-----	--

Data from Community Studies in Bhutan

A pilot study in 2002 in 19 geogs of three districts (Paro, Bumthang, Trashigang), covering a population of about 45,000, examined the prevalence of mental disorders and attitudes and practices regarding their treatment. It found 273 confirmed cases of mental disorders in that population, for a prevalence rate of less than 1 percent (see Figure 5). However, we have to be cautious in interpreting this result, because this population may not be representative for the whole country, and because the sample size is small. But the study did point out that all types of severe mental disorders – schizophrenia, depression, suicide, alcohol and substance abuse, epilepsy and mental retardation – are prevalent in the country. Of the 273 confirmed cases, Alcohol Dependence Syndrome (ADS), with 83 cases, is the most common problem, followed by epilepsy, 69 cases; depression, 49 cases; mental retardation (MR), 39 cases; psychosis, 17 cases; and suicide, 16* cases.. In terms of percentages, Alcohol Dependence Syndrome constituted 30 percent; epilepsy, 25 percent; depression, 18 percent; MR, 14 percent; psychosis, 6 percent; and suicide, 6 percent.

Number of Suicides Over the Past Five Years

This community study revealed that the proportion of cases seen in hospitals does not actually reflect the situation in the community. For example, a greater proportion of alcohol-dependent and epilepsy patients exist in the community, while the proportion of patients who seek help are more among those who suffer from depression and anxiety. Treatment-seeking behaviour can be influenced by many factors, including an individual's awareness and perception of health problems, attitude and accessibility to services and availability of services.

Prevalence of Substance Abuse in Bhutan

When we talk of substance abuse, many people tend to think in terms of only illicit drugs such as heroin or cocaine. However, it is important to know that the so-called "legal" drugs, such as alcohol, tobacco and *doma* (areca nut, betel leaf and lime), are more commonly used and are, therefore, responsible for the majority of the drug-related health and psychosocial problems here.

Alcohol

Alcohol represents a serious public health problem, being a common if not essential ingredient in all social events in Bhutan. No social or religious taboo against drinking exists. Alcohol is produced domestically, in most Bhutanese houses, as well as in three commercial distilleries. Alcohol dependence accounts for nearly one-third of all mental disorders (Mental Health Survey 2002). Even among survey respondents not identified as

having mental disorders, 13 percent of them drank daily. Average alcohol consumption is quite high, more than the limits set as safe for drinking.

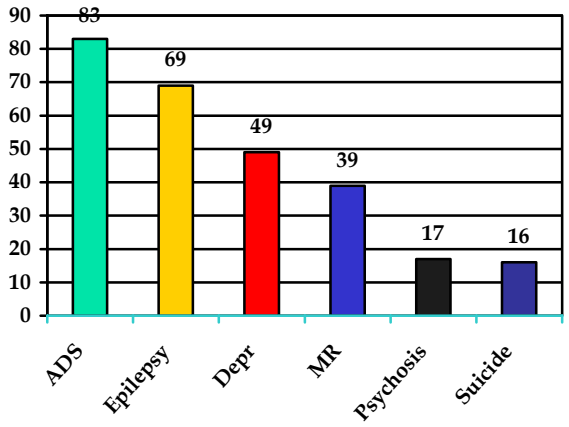

Figure 5: Number of patients with mental disorders (n=273) detected during community survey in three districts (Paro, Bumthang and Trashigang; total study population, 45,000)

Alcohol is now the No. 1 killer of young and middle-aged men in Bhutan. Reports on deaths from hospitals and BHUs across the country show that alcohol ranks between second and sixth among all causes of hospital deaths (see Table 3). Traffic police report that drunk driving is the most common cause of motor vehicle and traffic accidents in the country and, therefore, alcohol is the No. 1 killer on the roads as well. An analysis of deaths in the medical wards in JDWNRH during 2001, 2002 and 2003 found that, out of a total of 369 deaths in three years, 114 were due to alcohol-related causes, accounting for 30 percent of all deaths (see Table 4). Even so, this high figure excludes people who die in other wards, such as in the emergency department or surgical wards, due to alcohol-related traumas because of accidents, mainly in motor vehicles. Bhutanese women are not far behind men in this tragedy. For every two men, one woman is also dying in her prime due to alcohol.

Table 3: Number of alcohol-related deaths per year reported by health facilities (Ranking is based upon the highest number of deaths attributed to or caused by specific disease)

	Hospital		Basic Health Unit	
Year	No. of deaths due to alcohol	Ranking	No. of deaths due to alcohol	Ranking
2000	61	5th	75	2nd
2001	37	6th	43	4th
2002	--	--	88	4th

Table 4: Number of deaths due to alcohol per year in different age groups in the medical ward of JDWNRH, 2001-2003

	<20 years	20-29 years	30-39 years	40-49 years	50-59 years	60-69 years	70 > years	Total
2001	0	4	5	17	7	2	2	37
2002	0	0	8	11	8	6	1	34
2003	1	4	6	12	15	3	2	43
Total	1	8	19	40	30	11	5	114

Drugs

Substance abuse among Bhutanese adolescents is reportedly increasing year by year, although no reliable data are available. Nonetheless, information gathered from police, teachers and health workers across the country indicates that substance abuse is prevalent everywhere, including even Gasa, which is not yet accessible to motor vehicles. An informal study also showed that most drug abusers are males younger than age 25 and that the substances abused are mainly pharmaceuticals. This study indicated that drug abusers are found mainly in the two urban cities of Thimphu and Phuentsholing and that multiple drugs are abused, including sedatives, cough mixtures, painkiller injections. Inhalation of solvents such as glue, correction fluid and petrol is by far the most common form of abuse, initiated as young as age 10. Cannabis smoking also is common because of the easy accessibility and ubiquitous presence of the plant in Bhutan

Drug-related deaths, mainly due to overdose, also have been sporadically reported in recent years. Twenty-five adolescents who developed severe complications of drug abuse or withdrawal symptoms sought help in the psychiatric clinic in JDWNRH during the past four and half years. Until now, heroin, cocaine or psychedelic drugs are not reported in use in Bhutan.

The main sources of the common pharmaceutical drugs abused in Bhutan are pharmacy shops in border towns in India. A few pharmacy shops within the country were reportedly selling some of these drugs without prescriptions in the past. With the improvement of drug regulations, licensing of the pharmacy shops, and the enactment of the Medicinal Act 2003, it is expected that the sale of these prescription drugs over the counter will virtually cease. However, there are still reports of drug carriers and peddlers being caughtr.

The time is right for us to formulate and implement a comprehensive programme to deal with our drug problems in Bhutan. Like other mental disorders, drug abuse is a complex interaction of biological, psychological and social problems. While the role of health workers, teachers, police and family members is important, they alone will not be able to solve the problem. It requires the collective and concerted effort of all agencies, including drug regulation authorities and legislation, and welfare and social

services departments. Fortunately for us, our problem is still small and can be effectively managed if we act decisively now.

Learning from the Tobacco Eradication Campaign in Bhutan

A countrywide campaign and programme to eliminate the use of tobacco-based substances has resulted in a ban on the sale and use of tobacco products in public places in all districts except Thimphu. Efforts also are being made to include Thimphu in this campaign. If that is achieved, Bhutan will become the first country in the world to be declared tobacco-free, a remarkable achievement. Even so, the Mental Health Survey 2002 showed that 20 percent of the respondents used some form of tobacco, mainly in the form of chewing tobacco. Although the more visible form of smoking has decreased significantly, chewing and sniffing seem to persist.

The success of the Bhutanese tobacco-free initiative stems from two facts: First, tobacco is not indigenously grown or processed, and all tobacco products are imported. The other significant factor is the religious taboo against using any form of tobacco, which holds that according to Buddhist tradition, tobacco is sinful.

A significant lesson from this initiative is that it may be possible to use the same strategy to control the increasing drug problems in the country, since the traditional factors noted above also apply to substance abuse. However, the issue of alcohol control is completely different – and therefore will pose an enormous challenge.

Community Mental Health Programme Development in Bhutan

In many countries during the second half of the 20th Century, a shift in mental health care from that of custodial/institutional care to community-based care became possible because of the greater availability of effective psychotropic drugs, which made it possible for most patients to remain in their own homes; the growth of human rights movements and democratic processes in treatment decisions and the growing realisation of the need and contribution of the family to the treatment and rehabilitation of patients. The following are the characteristics of providing care in the community:

Services that are close to home, including general hospital care for acute admissions and long-term residential facilities in the community;

Interventions related to disabilities as well as symptoms;

Treatment and care specific to the diagnosis and needs of each individual;

A wide range of services that address the needs of people with mental and behavioural disorders;

Services coordinated between mental health professionals and community agencies;

Ambulatory rather than static services, including those that can offer home treatment;

Partnership with caregivers and meeting their needs and
Legislation to support the above aspects of care.

With proper budgetary planning and allocation of resources, introducing an effective mental health programme into primary health care (PHC) can reduce overall health costs. The key concepts of PHC such as accessibility, availability, acceptability, affordability and community participation are especially relevant to the care of mentally ill persons, as services need to be provided to them in an integrated manner, often over prolonged periods. Mental health care, unlike other areas of health, does not generally demand costly technology; rather, it requires the sensitive deployment of personnel who are properly trained in the use of relatively inexpensive drugs and psychological support skills on an outpatient basis (WHO 1999). Studies carried out in different countries have shown that around 10 to 20 percent of patients who are already seeking help at the primary health level have psychiatric problems. Therefore, the effectiveness of PHC and patient satisfaction can be markedly improved by applying appropriate interventions.

In addition to the treatment of mental disorders, mental health principles and skills can improve the health delivery system and thus reduce the ever-increasing threat of dehumanisation of modern medicine. Proper mental health inputs in general health programmes like immunisation, nutrition and maternal and child health services, as well as in education and welfare, can enhance the acceptance of these health and welfare programmes.

For centuries, Bhutan had remained an independent and isolated country, embarking on modern development only in the 1960s. The First Five-Year Plan of development began in 1961, with an emphasis on road building and infrastructure development. Subsequent Plans included development of modern education, health, agriculture and livestock. Four decades of planned development have resulted in rapid progress and improved the health and quality of the life of Bhutanese. It is striking to note that between 1984 and 2000, infant mortality decreased from 142 to 60.5, maternal mortality decreased from 7.7 to 3.8, the crude death rate decreased from 13.4 to 8.6, and life expectancy increased from 48 to 66 years. Bhutan also has achieved one of the highest GDP per-capita incomes in South Asia within this short span of development.

Even so, such a rapid pace of development and progress, with however cautious an approach, is not without its consequences. The Bhutanese people, who have hitherto enjoyed a very simple and contented way of life, tempered by its cultural and religious beliefs, are now being suddenly exposed to the realities of the modern world. There are already signs of change in the dress code among our younger generation due to the influence of TV, which was introduced to the country only in 1999. Mobile

phones, introduced just in November 2003, also are becoming a common commodity.

The risks of rapid development eroding or undermining the closely knit family bonds and social cohesion of Bhutanese society – and ultimately, GNH – is high, which may lead to an upsurge in mental and behavioural disorders. Therefore, the mental health needs of the people are becoming increasingly essential in the health planning of Bhutan. The disparity between total needs and the currently very limited mental health infrastructure requires using and improving the resources already available. Because Bhutan has a fairly well developed primary health care system, a community-based mental health programme is highly likely to succeed. The country implemented its first such programme in 1997, during the Eighth Five-Year Plan (see inset below).

Various strategies were adopted, including integrating mental health care services into existing general care services. The first priority was to identify specific activities to be carried out by different levels of health care facilities, such as hospitals and BHUs. Accordingly, training programmes for different levels of health workers were developed and implemented. At the same time, advocacy and public awareness programmes were launched to sensitise Government leaders and the public. Essential psychotropic drugs were included in the essential drugs programme and supplied to health facilities.

Now, a core mental health team comprised of one trained national psychiatrist and three psychiatric nurses exists in the country. A psychiatric clinic, psychiatry ward and day care centre have been established in JDWNRH. Several batches of district medical officers have participated in basic psychiatric skills training; they now provide basic psychiatric services in the district hospitals. Many nurses have participated in the training and orientation course on mental health. A manual on mental health care for health workers, along with mental health education materials for the public, has been published. The teaching curricula of Royal Institute of Health Sciences students in the subjects of psycho-sociology and mental disorders have been updated, and a two-week clinical attachment course in the psychiatric department for trainees has begun. The essential drugs list was revised to include psychiatric drugs at the level of district hospitals and BHUs. Topics on common mental disorders have been included in the Standard Treatment Manual for health workers. Common mental disorders are included in the general health information reporting system. Lastly, collaborative work on mental health issues with the education, welfare and law enforcement sectors has begun.

At the community level, among other activities, a pilot study on community knowledge, attitude and practices on mental health was conducted. For the first time in the history of modern medicine in Bhutan, representatives from traditional healers (*Drungtshos*) and religious leaders

were included in the survey, in planning, focus-group discussions, and the actual field survey. This experience of modern and traditional health practitioners working together gave important additional understanding of each other's perspectives on mental health, and how to work more closely in the future. The survey also proved to be valuable hands-on training for the health workers, who hitherto did not have much experience in detecting mental disorders. The survey process likewise sensitised the community on mental illnesses. Therefore, it was a learning experience for both surveyors and community representatives. This method of consultation with community leaders also indicated that they could be trained to identify mental disorders in the community. Because of the survey, many new patients are receiving treatment, again underscoring the linkages with GNH.

Finding Common Ground: Modern And Traditional Mental Health Services Work Together

Bhutan has a long history of Buddhism and indigenous medical practice, which are deeply rooted in our culture and traditions. Even today, religious and traditional systems of medicine command great respect and faith among Bhutanese. Many of our senior citizens and non-Western-educated individuals prefer to seek treatment from traditional practitioners due to their shared knowledge and beliefs. A closer look at indigenous psychiatry practice reveals that many of the psychiatric disease entities and methods of treatment have a close resemblance to modern psychiatric syndromes and disorders.

Mental disorders from the traditional perspective

Traditionally, mental disorders are said to be caused when the *rlung*, translated as "wind" or "life-wind" of the *snying*, or heart, gets disturbed by various forces such as worry, overwork, strain, sorrow, anger, sudden shock or fear. These manifest psychologically in the early stages as over sensitivity, anxiety and emotional instability. According to the traditional system of medicine, there are five causes of insanity, which may work alone or in conjunction with one another. They are:

Karma: Karmic mental disease implies a specific link with destiny (predisposition), a ripening of the seeds sown by former actions. For such karmic disease, there is no medicine except Dharma (religion); nothing else is effective in counteracting negative karma. This is true for psychosomatic as well as psychiatric disorders.

Grief-worry: This psychological basis of insanity is the same as the basis for enlightenment, depending on attachment to material things, greed and anger. It also depends upon whether it is accepted and worked with as the key to liberation; if it is not, it becomes a subconscious cause of denial, repression and mental illness. A combination of somatic medicines, herbal mixture, moxibustion, and the practice of the Dharma is used.

Physical (humoral) imbalances: When the humors function normally, they support the health of mind and body. When they function incorrectly, they cause disease. Excess psychological and emotional qualities associated with each humor aggravate the mental condition.

Air or rlung: Mental and emotional strain causes the winds or airs to increase. Thinking and concentrating on something too much, worrying about unfinished projects and unattainable goals, grieving over family troubles, and becoming upset over lost articles – all are said to disturb the wind and thus the mind. Generally, it is said disease of wind stem from over-engaging in desire, lust and attachment. Beside excitability and sadness, other symptoms are that the person will speak whatever comes to mind, will not remember what is said and will be unable to concentrate or finish anything. He may cry all the time and become abruptly angry without reason. He is restless, anxious and tense. Treatment methods include restoring nutrition, providing a pleasant and bright environment, allowing sexual relationships, talking to the patient "sweetly," and breathing exercises. Other treatment methods are moxibustion, massage therapy and herbal incense burning.

Bile: Psychiatric disturbances caused by bile render a person mad in a violent and rough manner, the humor bile being an outcome of aversive-anger. Anger and hatred therefore promote the overproduction of bile. The patient speaks harshly and is abusive to other people. He is disruptive and breaks things indiscriminately, and may injure or even kill other beings. He is constantly angry, dwells on past annoyances, and is high-strung. Treatment methods include physical restraint, a cool and quiet environment, and "cold foods."

Phlegm: Confusion, ignorance and sloth promote the production of phlegm. The person who becomes mad because of excess of the humor phlegm displays a pathologically phlegmatic nature. He is completely withdrawn, silent, inactive and sullen. Such as person refuses to eat and tends to roll his eyes upwards and to have dizzy spells. In addition to being silent, he is especially closed-minded. Treatment methods include affectionate treatment to encourage him to socialize, exercise, massage, herbal medicines, and hot medicine bath.

The modes of mental disorders associated with the three humoral types can be said to correspond generally with modern classification of known psychiatric disorders; madness cause by phlegm corresponds to catatonic types of schizophrenia, violent types resemble paranoid schizophrenia, and wind types resemble bipolar mood disorders.

Poisons: Toxins are held to be a direct cause of insanity. In such cases, the mind becomes completely confused, strength wanes and the radiance of good health disappears, especially in the face. The mental confusion of psychiatric disturbances caused by poison is called "deep illusion". The victim does not know at all where his mind is going or he may alternate

between normal lucidity and completely illusionary thinking and unawareness. Poison may be a specific toxin, the poisonous combination of otherwise non-toxic foods and beverages, or a build-up of toxic substances in the body. Herbal and animal medicines are used to treat these cases. Modern mental disorders such as those caused by alcohol, substance abuse, and organ failure of the kidney or liver closely resemble these symptoms.

"Demons" or "evil spirits": These cause insanity by taking over the action of body, speech and mind. This negative energy penetrates the conscious psyche of an individual because the person is psychologically weak and has no resistance. The "ghost" or "demon" may be the sole cause of the insanity or may be present along with humoral or poisonous causes. The symptoms of the presence of a "ghost" in psychiatric disturbances are that the person's behaviour changes abruptly and he acts very differently than before. How he acts depends upon the type of "ghost" affecting him. Treatment is elaborate, with many tantric "anti-ghost" rituals and religious medicines, or herbal treatment. The modern classification of disorders such acute psychotic episodes, "possession" state, multiple personalities, dissociative conversion disorders also present in a similar fashion.

In traditional medicine, the importance of community and family as sources of care cannot be overstressed. Traditional/indigenous practitioners can validate patients' concerns because of shared beliefs, such as those in spirits, ghosts, demons and gods as the cause of illnesses. At the same time, they can offer enormous assistance and support to people needing to accept stress or change in relationships, environment/seasons, or the aging process. Traditional/indigenous practitioners also are usually wise elders and know how to listen and talk to people. As counsellors, they may give valuable advice, make useful comments or give explanations. This can reduce or take away people's guilt, worries and other painful feelings. A particular contribution can be made to the individual's understanding of death and dying, as well as dealing with pain and bereavement.

Because traditional/indigenous healers usually live in the same community, they are easily accessible. Indigenous medicines are made from natural herbs and plants, which are locally available and do not cause serious side effects; generally, these medicines are quite affordable since they are locally processed with the help of traditional equipment and raw materials. Finally, the system of diagnosis through such methods as checking pulse and urine or consulting astrology books is more reassuring to patients who normally would be highly reluctant to discuss physical or emotional problems with a modern doctor.

Limitations of Modern Health Care in the Bhutanese Context

While modern health care is highly effective in treating many different types of disorders, it has limitations, especially in illnesses and syndromes caused by psychosocial problems. In the context of mental health, much

depends upon how people perceive their problems and seek remedies for them. For example, modern health care may not be effective in treating those who complain of chronic headaches or body aches and pains. This is because chronic stressors in the patient's environment or their own emotional adjustment problems frequently cause such pains. Across the developing world, it has been well established that most patients prefer to present physical symptoms to doctors rather than express their social or emotional problems. In addition, although modern prescription drugs can be quite potent for many disorders, some may cause serious side effects if used for lengthy periods. Hence, indigenous medicines, which have not only fewer side effects but also are culturally acceptable and easily accessible, may play an important role.

As noted above, modern health care is not widely understood or accepted by much of the Bhutanese population, for a number of reasons: Firstly, modern health care is relatively new to the country, having been introduced only 40 years ago; thus, adequate popular knowledge about the health care system is lacking. Moreover, lack of modern education for a large proportion of the population compounds this wariness. For example, patients often complain that they have to give their own "diagnosis" to modern doctors because they must relate all their symptoms. This misunderstanding is not surprising, given that most Bhutanese have very simplistic ideas about diseases, syndromes, signs and symptoms and tend to confuse these concepts. Local dialects also have few terms to describe modern disorders, making effective communication difficult.

The other major problem is the perception by many patients that modern doctors do not understand that illness can be caused not only by biological disturbances but also by possession by spirits, ghosts and demons, as well as the wrath of gods. A popular local saying is that "medical treatment should go hand in hand with performing the religious rites and rituals" to achieve a cure. That this belief occupies a very important place in the culture is amply demonstrated by the fact that many patients request early discharges from hospital wards so they can go home and perform religious ceremonies with a lama/monk.

Prospects for Integrating the Two Systems

Because mental health and religion share many commonalities and goals, this area needs full utilisation to both balance the needs of the people and root the Community-Based Mental Health programme in the culture of the country. A project to formally integrate traditional medical practices and modern mental health care will be implemented; among other things, this project will emphasise the teaching of the Dharma and use of traditional practices such as meditation and yoga, which have both protective and promotional aspects for mental health.

The programme will identify the strengths in the religious and traditional systems of medicine and make it part of the training of all categories of personnel and as part of public mental health education. All these require close cooperation and active participation of the religious and traditional healers in the country. Particular areas of cooperation between the modern health workers and the religious and traditional systems of medicine can be in the management of chronic pain syndromes and in hospice care.

The radical cure of many diseases is not possible even in the most advanced countries, with the most sophisticated technologies and medication. Most treatment regimens today adopt a preventive or control method in the progression of disease and disabilities. In the final analysis, a patient's perception and a feeling of satisfaction with treatment overrides any radical cure or success with treatment. For example, treatment of advanced terminal cancer requires a humane approach through love, caring, understanding and compassion rather than radical chemotherapy, surgery or radiotherapy. Unfortunately, many of us in the health profession lack these basic skills to heal and nurture human fear, pain and worries.

Traditional and modern medicine can complement each other; they do not need to compete. Sometimes one gives better results than the other; sometimes results are the same. Many people feel much better knowing that nothing is ignored in trying to make them well again. Bhutan has a unique opportunity to constructively harness a symbiotic working relationship between indigenous/religious practitioners and modern health care workers to provide culturally acceptable care to the largest number of people, and in so doing, to maximise GNH.

Remaining Challenges In Mental Health Care In Bhutan

Bhutan is arguably one of the fastest developing nations in the world, having emerged from a medieval society and economy to a modern nation in the short period of 40 years. Numerous challenges remain for mental health needs, requiring further positive steps in development.

Funding

The ninth FYP (2002-2007) has identified mental health programme development as one of the priority areas of the Ministry of Health. However, to translate this policy into reality, much remains be done, among which mobilising resources and funding are essential components. No separate budget is allocated to the mental health programme, and lack of a separate budget is a serious constraint to further development. However, WHO and DANIDA are providing financial and technical assistance to the programme.

Shortage of Trained Mental Health Professionals

Despite the formation of a core mental health team at the National Referral Hospital, a significant human resource gap still exists. Some medical officers and staff nurses are to be sent for short courses and training outside the country as soon as possible. After their training, they will run the mental health activities in the Regional Referral Hospitals until fully qualified mental health teams are available there as well. Expatriate mental health workers may be recruited to work in the country until sufficient national workers have been trained. A dearth of education materials exists for trainees of the RIHS and for public education.

Infrastructure

The successful implementation of community-based mental health care services will entail that more severe disorders and disabled cases will be identified, and referred, as well. Therefore, an effective referral systems needs to be in place for the successful implementation of the programme. Patients who require sophisticated diagnostic assessment, intensive care, multi-disciplinary treatment and rehabilitation also will require fully equipped referral hospitals with trained mental health professionals. A 10-bed psychiatry ward and a day care centre have been newly established in JDWNRH. These facilities will be able to provide specialist treatment of psychiatric cases referred from the districts, as well as providing training to health workers. The day care centre will facilitate education of patients and their families, provide support and rehabilitation to chronic mental patients, and organise individual and group therapy sessions and crisis management such as through use of telephone hotlines and other methods of communication. The formation of patient support groups such as for alcohol abstinence, for anxiety and depressed patients, and for families of psychotic patients, will be encouraged and supported. However, the facilities need to be strengthened both technically and logistically to be able to provide quality care and training. An efficient and mobile monitoring team is required if the programme is to make much progress in the field.

At the same time, the growth of the overall health infrastructure, while bringing basic health care closer to the people, also will bring forth two issues – namely, with more training of health workers and mental health campaigns in the community, the number of reported cases of mental disorders and substance abuse will increase significantly. In addition, wider coverage and increased accessibility to health care will eventually facilitate more people to seek help. More people with disabilities, psychological or otherwise, will survive due to improvements in care and will increase the burden to provide care.

Social Change

Development and social change affect mental health in a number of ways. It is well known that urbanisation, homelessness, unemployment, loss of social cohesion, forced idleness, changes in eating and exercise habits and the abuse of drugs like alcohol and tobacco make greater demands on the health of individuals. In the face of changing situations, it is necessary to recognise the behavioural components of development and build in safeguards.

Lack of Awareness on Mental Health

A lack of awareness about mental disorders and their causes and treatment methods persists in the community; also confusion is found among the general population regarding both modern and traditional practices. This knowledge gap may account for the high prevalence of myths, misconceptions and stigma for mental disorders and contributes to the delay or lack seeking treatment from health workers. According to the Mental Health Survey 2002, only frank psychosis is fully recognised as a form of mental disorder, while subtle symptoms of depression, anxiety and suicidal thoughts are not. The belief that epilepsy is contagious keeps many people from coming in close contact with epileptic patients, thereby depriving patients of help when it is most necessary. Alcoholism is not considered a public health concern, although it is very common and causes enormous problems to the individual as well as the family.

Need for Mental Health Legislation

People with mental disorders are often exposed to the criminal justice system. In general, there is an over-representation of people with mental disorders and vulnerable groups in prisons, in a number of cases because of lack of services, because their behaviour is seen as disorderly and because of other factors such as drug-related crime and driving under the influence of alcohol. Policies must be put in place to prevent the inappropriate imprisonment of the mentally ill and to facilitate their referral or transfer to a treatment centre instead. Furthermore, treatment and care for mental and behavioural disorders should be routinely available within prisons, even when imprisonment is appropriate. Policies concerning the confinement of vulnerable groups also need to be examined in relation to the increased risk of suicide, and there needs to be training strategy to improve the knowledge and skills of staff in the criminal justice system to enable them to manage mental and behavioural disorders.

At the same time, no explicit mental health act or legislation exists in the country. This has advantages in terms of decreasing stigma and providing flexible approaches to care. However, absence of an act also deprives of essential care patients who, for reasons of their mental disorders, do not agree to voluntary treatment. Mental health-related

legislation today includes the Narcotic Drugs and Psychotropic Substances Notification 1988 issued by the Home Ministry; a Narcotic Drugs and Psychotropic Drugs Act is being drafted. In 2003, the National Assembly enacted the Medicines Act, which, however, covers only pharmaceutical drugs used in the treatment of patients.

Now our priorities are to develop infrastructure and train service providers to be able to give the basic minimum mental health care and services to all our people at the community level. After achieving these, enforcement of legislation will ensure that not only are services utilised, but also that every needy Bhutanese will have access to basic minimum treatment, guaranteeing their basic human requirements. This process will ensure that we are one more step closer to fulfilling our goal of GNH.

Unemployment

In the next five years, about 50,000 young people will enter the job market in Bhutan. Not only is there a need to create more jobs, but job seekers also need to reorient their mindsets and acquire the necessary skills to take up available jobs. Labour force surveys in the country point out that many educated individuals prefer "white-collar" to "blue-collar" jobs. But because the scope of "white-collar" jobs is very limited in Bhutan, the majority of employment opportunities will be in service-related and construction industries, so many of these young people may remain without employment. Unemployment and poverty are closely associated with an increased incidence of mental disorders due to adverse life situations or stressors.

Increasing Education

Education has two mental health implications: firstly, and most specifically, increased education can help to identify mentally retarded children, since the education system is usually key in this regard. This would mean a growing gradual demand and development of services for these children. The second impact of education is a better understanding of human behaviour and a greater desire to find personal solutions to day-to-day problems, resulting in a greater demand for mental health services. Many Bhutanese who have had the opportunity to live in and enjoy the best health care services in the industrialised world already expect similar services in Bhutan.

Increasing Life span of Population

As the quality of life and health care improves, the life span of the population will increase. Population growth and expansion of the aging population will add to the demand for certain mental health services.

HIV / AIDS

HIV/AIDS infection in a population has a significant implication on mental health. Although the prevalence of HIV infection is currently low in Bhutan, it is steadily increasing. Studies have shown that besides those who practise unsafe sex, intravenous drug users also are high risks for contracting or transmitting HIV. These and other vulnerable groups in Bhutan continue to expand.

The Way Forward To GNH

Although our Community-Based Mental Health programme started less than a decade ago, we have the benefit of learning from the experiences of other countries. We cannot afford to make the same mistakes that others have made, such as keeping all mentally ill patients in institutions, mental hospitals or asylums. Effective medicines that will calm the patient much sooner are available and facilitate the patient's return home. We need to pick the best of all strategies and methods that other countries have used and that will be suitable to our culture and availability of resources. In addition, as already noted, we have a rare chance to integrate traditional and modern medical systems to improve patient satisfaction and cost effectiveness of treatment (see section, "Finding Common Ground"). In so doing, we can have one of the most comprehensive community-based mental health programmes in the developing world, which will contribute significantly to the enhancement of our Gross National Happiness. Other strategies to maximise GNH include:

Involve Communities, Families and Consumers

Communities, families and consumers should be included in the development of and decision-making on policies, programmes and services. This should lead to services being better tailored to people's needs and better used. Interventions should take into account age, sex, and cultural and social conditions to meet the needs of people with mental disorders and their families. In addition, involvement of stakeholders, such as the community, in the care of persons with mental disorders will lead to sharing of responsibilities and the cost of care, thereby helping to sustain and improve the efficacy of treatment.

Promote Intersectoral Collaboration on Mental Health

Because many of the macro-determinants of mental health cut across almost all Government departments, the extent of improvement in mental health of a population is determined, in part, by the policies of each department. In other words, all Government departments are responsible for some of the factors involved in mental and behavioural disorders and should take responsibility for solutions.

Intersectoral collaboration between Government departments is fundamental in order for mental health policies to benefit from mainstream Government programmes. In addition, mental health input is required to ensure that all Government activities and policies contribute to, and do not detract from, mental health. Policies should be analysed for their mental health implications before being implemented, and all Government policies should address the specific needs and issues of persons suffering from mental disorders. The following examples may be useful:

Some economic policies may negatively affect the poor, leading to increased rates of mental disorders and suicide. Many of the economic reforms under way in countries have as a major goal the reduction of poverty. Given the association between poverty and mental health, it might be expected that these reforms would reduce mental problems. However, mental disorders are not only related to absolute poverty levels but also to relative poverty. The mental health imperatives are clear: Inequalities must be reduced as part of strategies to increase absolute levels of income.

A second challenge is the potential adverse consequences of economic reform on employment rates. Any economic policy involving economic restructuring must be evaluated in terms of its potential impact on employment rates. If there are potentially adverse consequences, then these policies should be reconsidered or strategies put in place to minimise the impact. In particular, the work environment should be free from all forms of discrimination and acceptable working conditions have to be defined and mental health services provided, either directly or indirectly, through employee-assisted programmes. Policies should maximise employment opportunities for the population as a whole, and retain people in workforce, particularly because of the association between job loss and the increased risk of mental disorders and suicide. Work should be used as a mechanism to reintegrate persons with mental disorders in to the community. Government policy can provide incentives for employers to employ persons with severe mental disorders and enforce an anti-discrimination policy.

In addition, an important determinant of mental health is education. While current efforts focus on increasing the numbers of children attending school and completing primary school, the main risk for mental health is more likely to result from lack of secondary school education (10-12 years of schooling) (Patel 2001). Strategies for education therefore need to prevent attrition before the completion of secondary school. The relevance of the type of education offered – for example, introduction of life skills into the curriculum – also need to be considered.

Likewise, housing policies can support mental health policy by giving priority to mentally ill people in state housing schemes, providing subsidised housing schemes and, where practical, mandating local authorities to establish a range of housing facilities such as halfway homes and long-stay supported homes. Most importantly, housing legislation must

include provisions to prevent the geographical segregation of mentally ill people.

Lastly, policies for social welfare benefits and services should incorporate a number of strategies. First, the disability resulting from mental illness should be one of the factors taken into account in setting priorities among groups receiving social welfare benefits and services. Second, under some circumstances, social welfare benefits also should be available to families that provide care and support to family members suffering from mental and behavioural disorders. Third, staff in various social services needs to be equipped with the knowledge and skills to recognise and assist people with mental disorders as part of their daily work; in particular, they should be able to evaluate when and how to refer more severe problems to specialised services. And fourth, welfare benefits and services need to be mobilised for groups likely to be adversely affected by the implementation of economic policy.

Promote Mental Health and Raise Public Awareness

Public education should be a priority activity as the concept of modern mental health is new to Bhutan. Education should also include promotion of existing practices that are positive for mental health, such as community care, family support and rituals relating to childbearing, death and crisis situations. All modes of communication should be used so that the maximum number of people can benefit. Two types of education materials, one for the public and the other for patients, should be produced. One strategy to improve the implementation of programme activities would be to organise a "Mental Health Week" every year, coinciding with the observation of World Mental Health Day on 11 October. During this week, focus should be given to mental health activities such as organising health education programmes and training of health workers on mental health subjects.

The goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the basic needs of people with mental disorders. Care choices and their benefits should be widely disseminated so that responses from the general population, professionals, media, policy makers and others reflect the best knowledge. Well-planned public awareness and education programmes can reduce stigma and discrimination, increase use of mental health services, and bring mental and physical health care closer to each other.

In addition, a wide range of strategies is available to improve mental health and prevent mental disorders. These strategies also can contribute to the reduction of other problems such as youth delinquency, child abuse, school dropouts and workdays lost to illness. Interventions can target

population groups such as the elderly or children, or particular settings such as child-friendly schools.

Community-based Rehabilitation

It is envisaged that a significant proportion of mentally ill, mentally retarded and substance-dependent individuals will exist in the community who are not identified and treated or rehabilitated. Chronic untreated mental illnesses cause significant disabilities in the individual and a heavy burden to their families and to society. The community-based rehabilitation (CBR) programme of the Health Ministry has been focusing on the physically disabled. The day care centre in the psychiatry department at JDWNRH will be able to provide some support to mental patients residing in Thimphu. However, a comprehensive plan and strategy need to be developed in order to be able to rehabilitate all chronic cases in the community. As far as possible, cases should be identified and rehabilitated within their own communities using available agricultural and rural activities. In urban areas, there will be a need for sheltered workshops as well as rehabilitation facilities for drug detoxification and rehabilitation, child stimulation and rehabilitation for mentally retarded children.

Specific Activities for Different Levels of Health Facilities

Basic Health Units (BHU)

At the BHU level, preventive and promotional activities are identified for future priorities: sensitising the community in the area of psychosocial aspects of health and development programmes; strengthening mental health preventive measures as part of health programmes like nutrition, immunisation, iodised salt use, reproductive health and family planning; crisis intervention through volunteers in the community; and formation of self-help groups of parents with mentally retarded children and chronic mental illness. BHUs also will provide first aid and basic treatment in addition to case detection, referral and follow up of more obvious and severe mental disorders such as psychoses, mental retardation, substance abuse, alcohol dependence and epilepsy.

District and Regional Referral Hospitals

At the district hospitals, in addition to activities conducted at BHUs, detection, diagnosis and treatment of more subtle mental disorders such depression and anxiety, and training of health workers and VHWs on mental health skills, will be carried out. Regional referral hospitals will have specially trained mental health professionals with separate beds for treatment and rehabilitation.

Psychiatry Department of National Referral Hospital

The psychiatry department of JDWNRH will become the national referral centre and will function as the technical backstopping for district programmes. This centre will be involved in the diagnosis, assessment and treatment of difficult patients referred by regional, district hospitals and BHUs. This centre will have specialised treatment and rehabilitation facilities for the care of children, chronic patients and persons with drug dependence. The national referral hospital will organise teaching of the district medical officers. It will also organise pre-service clinical training of trainee health workers at RIHS.

Specific Responsibilities for Health Workers and Community Leaders, after Appropriate Training

All categories of personnel in health, welfare, education and other sectors of the community have an important role in the mental health programme. The following activities have been identified as priorities for different personnel. Each of these personnel will receive initial and periodic training to undertake the activities.

Health Workers

Health workers will be responsible for recognising and referring persons possibly suffering from different mental disorders, substance abuse and epilepsy; following up on treatment of patients to ensure their regularity and early recognition of side effects; providing community-level support to mentally ill persons and their families toward social reintegration and rehabilitation and providing community education about psychosis, epilepsy, substance abuse and mental retardation.

District Medical Officers

District Medical Officers will have additional responsibilities to diagnose, assess, treat and provide rehabilitation of mentally ill persons with both pharmacological and psychosocial interventions. They also will train, support and supervise health workers as well as refer and follow up patients in the districts.

Police Personnel

Police personnel will be trained to recognise acute mental disorders and undertake necessary action to protect the mentally ill and provide first aid and basic psychosocial intervention.

School Teachers

Schoolteachers will be responsible to educate children regarding accident prevention, risk- taking behaviour and drug abuse, along with

methods to increase self-esteem (life skills programme); early identification of childhood problems and referral to health facilities; first aid in emergencies such as epileptic seizures or hysteria; parental counselling about adolescence and risk-taking behaviours; early detection of sensory defects and referral; and promotion of positive attitudes toward the mentally ill.

Community Leaders

Community leaders will play an important role in advising health team about traditions and beliefs in the community; facilitate activities of health workers by, for example, organising village meetings; identify people in need of mental health care; assist in the rehabilitation of the mentally ill in the community, and collaborate with health workers to promote mental health in the community.

Provision of Essential Drugs and Logistics to all Health Facilities

Psychotropic drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders and prevent relapse. They often provide the first-line treatment, especially in the Bhutanese situation, where psychological interventions and highly skilled professionals are unavailable. Essential psychotropic drugs are already available in all health facilities. The varieties and quantity of these drugs supplied will depend upon the level of health facility and patient load. Newer and more effective drugs will be included in the essential drugs programme, supplied to health facilities as necessary.

Establish a Centre of Excellence for Research, Rehabilitation and Training

Research into biological and psychosocial aspects of mental health is helpful to increase the understanding of mental disorders and to develop interventions that are more effective. Such research enables us to understand variations across communities and to learn more about factors that influence the cause, course and outcome of mental disorders. Building research capacity should be an essential component of the Bhutanese programme in the future.

A centre for excellence in mental health research, rehabilitation and training will need to be established for the long-term sustenance and development of the programme. This centre will be the precursor to the development of a National Institute of Mental Health.

Monitoring of the Programme and Reporting System

The success of any programme will depend not only on the resources available, but also upon how the resources are utilised. Therefore,

monitoring of the programme is essential to achieve the goal of totally integrating mental health care into general health services. The responsibility of a monitoring unit would be to plan, train, support, supervise and coordinate the programme activities at the different levels of health care facilities. Monitoring would be done through simple recording and reporting procedures, as well as monthly and annual reports; providing support and guidance via telephone; making periodic field visits to district health units for supervision; and publishing monthly or quarterly mental health newsletters.

These activities not only will encourage the staff to integrate mental health with their work but also will maintain standards of care. This further will rectify the level of care (what is possible) and the limits of care (what is not possible) at each health care facility and category of personnel. Indicators of the Community-Based Mental Health programme will include not only health system indicators, but also that of patients, support systems and the community.

Conclusion

Many rich traditions and practices in Bhutan promote happiness and well-being. A spiritual dimension to health in general, and mental health in particular, will be valuable to understand personal adversities, responding with equanimity to illness, disability and suffering. The Buddhist traditions that the majority of our people follow see mind as inextricably linked to all phenomena, including illness and wellness. Traditional/indigenous healers are held in high regard and are often spiritual or moral guides. In addition, Buddhist rituals are performed right from birth to death, encompassing all major life passages. Most Bhutanese still prefer to seek help from the Buddhist clergy, an astrologer or an indigenous doctor for any illness before they approach modern health care services. Thus, religious practitioners and traditional/indigenous healers both occupy central places in the life of an individual and can make a tremendous contribution to the therapeutic process.

Bhutan's rapid social changes and increasing turn toward material values are bringing great stress to more people and may trigger the brain disorders that characterize mental disturbances. But as we have seen, the country has a unique system of housing many indigenous and modern health care services together in the same facility in many districts. Thus, representatives of the two systems already are working hand in hand to serve patients and are learning vast amounts from each other through knowledge sharing. Further decentralisation of the indigenous system of health care is expected in the near future, and indigenous health technicians will be placed at the village/community level, along with modern primary health care workers in Basic Health Units. Both similarities and differences exist between these two systems of medicine, and in order for the people to

get the full benefit and satisfaction of treatment from both, we need to look closely at and identify areas in which we can work together.. This represents the logical next step in taking the already established symbiotic working relationship to a new and crucial level in the important area of mental health. Such services will be accessible, affordable and acceptable, cost-effective and sustainable, in which everyone has a role and can participate actively, which gives satisfaction for both care seekers and providers.

Overall, Bhutan has achieved unprecedented peace and progress under the far-sighted and dynamic leadership of His Majesty the King Jigme Singye Wangchuck. We have reason to believe that the future will be even brighter: The Royal Government has a vision and a commitment – a vision to further the happiness of the people, and a commitment to achieve it. Successful implementation of such a comprehensive Community-Based Mental Health programme, which includes the best of both traditional and modern medicine, will make an incalculable contribution to the Kingdom and our overarching goal of Gross National Happiness.

Bibliography

Clifford, Terry. *Tibetan Buddhist Medicine and Psychiatry*. Samuel Wiener Inc., 1990.

Central Statistical Organisation, Planning Commission, Royal Government of Bhutan, *National Accounts Statistics Report 1980-1997.* Planning Commission.

Central Statistical Organisation, Planning Commission, Royal Government of Bhutan, *Bhutan at a glance 2002*, Planning Commission.

Dorji, Chencho. Draft Mental Health Survey Report – Bhutan 2004. Personal communication.

Dorji, Chencho. Community-Based Mental Health Programme of Bhutan 1999. Personal communication.

Dorji, Chencho. A Traditional Approach to Mental Health Care – Bhutan 2001. Personal communication.

Dorji, Chencho. Mental Health Legislation in Bhutan 2000. Personal communication.

Health Services Division, Ministry of Health and Education, Royal

Government of Bhutan, *National Essential Drugs Formulary 1998.* Ministry of Health and Education.

Health Services Department, Ministry of Health and Education, Royal Government of Bhutan, *The Medicine Act of the Kingdom of Bhutan 2003.* Health Department.

Health Services Department, Royal Government of Bhutan, *Annual Health Bulletins 1993 – 2002.* Health Department.

Health Services Department, Royal Government of Bhutan, National Health Survey Report 2000. Health Department.

Murthy, R. Srinivasa, Country Reports and Recommendations by the Short-Term WHO Consultant 1987, 1999. Unpublished.

Planning Division, Education Department, Royal Government of Bhutan, *Annual Statistical Report 2002.* Education Department.

Planning Commission, Royal Government of Bhutan, *Bhutan National Human Development Report 2000.* Planning Commission.

Planning Commission, Royal Government of Bhutan, *Eighth and Ninth Five-Year Plan Documents 1997-2002 and 2002-2007.* Planning Commission.

Planning Commission, Royal Government of Bhutan, *Bhutan 2020: A Vision for Peace, Prosperity and Happiness.* Planning Commission, 1999.

Royal College of Psychiatrists, *Psychiatry for the Developing World.* Blackwell Publishing, 1996.

World Health Organization, World Health Reports 1977, 1999, 2001. WHO.