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Who am I?

ASSESSMENT OF PSYCHOSOCIAL NEEDS AND SUICIDE RISK
FACTORS AMONG BHUTANESE REFUGEES IN NEPAL AND AFTER
THIRD COUNTRY RESETTLEMENT



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Introduction

Reason, aims and limits of the assessment

In 2010 an alleged disproportionately high number of suicides among Bhutanese refugees resettled in the US, and an equally alleged disproportionately high number of succeeded and attempted suicides among Bhutanese refugees in the camps in Nepal came to the attention of humanitarian and governmental agencies. The anecdotal nature of the reports, based mainly on media accounts, and the superficial nature of the proposed explanations to the phenomenon highlighted the need for an investigation into the issue and for the development, in case data were confirmed, of a series of recommendations to *prevent suicides*.

With these general aims, in January 2011, the International Organization for Migration, in coordination with UNHCR and PRM, conducted a three-week assessment on psychosocial wellbeing and suicide risk factors among Bhutanese refugees in Nepal, and the ones resettled in the United States. The specific objectives of the rapid appraisal study were to:

- 1) Confirm the magnitude of suicides among Bhutanese refugees in camps and upon resettlement, in absolute terms and in comparison with other populations, and analyze statistical correlations and chronological trends, in order to identify risk categories and factors.
- 2) Investigate possible cultural explanatory systems for suicide, and if a specific “culture” of suicide existed in the camps.
- 3) Investigate if general levels of distress in the camps could create an environment for suicide, possible causes of and responses to distress and possible co-existence of mental health problems in the ones, who attempted or committed suicide.
- 4) Review overall psycho-social and mental health services provided to the refugee population in general and more specifically related to suicidal cases.
- 5) Observe refugee resettlement processes in order to identify gaps and possible improvements which might prevent or mitigate mental uneasiness, including suicide.

The study suffered from limitations. First, the direct assessment took place in Nepal only; data and information about suicides upon resettlement were reconstructed based on fragmented media reports, informal reports and institutional notes. As a consequence, findings are partial and should be complemented with an assessment conducted with resettled

Bhutanese refugees in the US. Second, pre-existing data about committed and attempted suicides in the camps and the socio-demographic characteristics of the population were consolidated and provided to the assessment team only at the end of the mission. As a result, the other actions of the assessment were not directed by investigative hypotheses based on the epidemiological evidence. As a consequence, the results represent a qualitative and inductive cross-analysis of the various sets of findings. Moreover, analysis of the resettlement processes relied on direct observations only, and the observed issues were cross-checked with the Agencies involved in the provision of the different services during two debriefing sessions only.

General information on Bhutanese refugees in Nepal

Nepalese families started to migrate to south Bhutan at the end of the 19th Century, and reached a population of approximately 200,000 individuals. The Nepali-speaking Bhutanese, called Lotshampas, had been allowed to maintain their traditional rites, language and customs, but in the mid-to-late 1980s, laws were passed in Bhutan that marginalized their citizenship rights. Following a crackdown on protests, more than 100,000 Lotshampas fled Bhutan in 1990, and the vast majority of them sought refuge in Nepal. Since then, the refugees have been living in seven camps in southeast Nepal. Bhutanese refugees in Nepal (107,000 prior to the advent of resettlement) enjoy a comparatively high level of integration with the local community, with whom they share ethnic characteristics, language and cultural values, a comparatively good level of basic services and a comparatively high degree of participation in the organization of the camps and political representation (IOM 2008, various 2007, Ranard 2007). In 2007, after 17 years of unsuccessful talks between the governments of Nepal and Bhutan, all Bhutanese refugees in Nepal became eligible for resettlement to a third country. By the end of 2010, 40,420 had already resettled, most to the USA (34,353), while an additional 54,709 are in the pipeline (IOM 2011). 17,533 refugees (24% of the current camp population) have not as yet expressed an interest in resettling to a third country.

General information on refugee mental health and suicide

Suicide is a public health issue, which affects 16 per 100,000 globally, and is the third leading cause of death among young people worldwide. At least in 80% of the cases, suicides are directly associated with mental disorders, especially depression and alcohol and substance abuse (all figures, WHO, 2010).

Refugees are usually considered at higher risk for mental disorders than non-refugee populations (Lindert et al. 2008, Marshal et al. 2005). Indeed, several risk factors may characterize refugees' experiences, including direct or witnessed experiences of violence and the breakdown of original reference systems. The refugee experience can also bring challenges to self-concept and to individual and group identities due to legal constraints, the necessity to re-adapt to new social, economic, cultural and symbolic structures, and to the concurrent deprivation of original social support and relational systems and traditional coping networks (Papadopoulos 2008). Research aimed at substantiating this assumption has been inconclusive. For example, a review of 14 studies conducted on 15,000 refugees resettled in 7 countries, including Australia, Canada, New Zealand, Norway, UK and USA, showed no difference in rates of depression between the refugee and resident populations (Fazel et al. 2005a, Fazel et al. 2005). Other systematic reviews of studies analyzing the rates of psychopathologies among refugees (Steel et al. 2009, Lindert et al. 2009) have highlighted how results differ in relation to populations, social conditions in the present and variety of

experiences of the past. They can be also affected by methodological biases. As a consequence, avoiding pre-judgments and adopting a person or population-centred approach is to be preferred in research, identification and clinical responses to mental disorders in refugees. Moreover, the results of a recent qualitative research on protection of vulnerable asylum seekers in reception centres in Europe highlight how psychosocial vulnerability in these situations results not only from the characteristics of the individual but also from the possibilities and services offered by the system in which the individual is going to be integrated (Muneghina et al. 2010). As such, the same refugees can be differently vulnerable if they resettle in the US versus another country, or in different towns within the same country.

Likewise, research analyzing if refugees are at higher suicide risk than resident populations has been inconclusive (Silove et al. 2007), mainly due to the fact that samples are not representative. For example, the 112/100,000 annual rate of suicides among detained asylum seekers in UK in 1998/2007 is frequently reported in literature, but this figure is misleading. Whilst it is nine times higher than the rate in the general population, it is quite close to the suicide rate among the detained British population, and therefore more likely to be related to detention as opposed to refugee-specific vulnerabilities. Regardless of whether refugees are more at risk of suicide than the general population, they are subject to specific suicide risk factors, including lack of help-seeking behaviour, stigma, social isolation and separation from ethno-cultural communities (Cohen 2008), prior history of unmet mental health problems, and the fact that possible suicidal tendencies are not shared with the helpers, or are considered by helpers as part of a manipulative strategy to foster resettlement or avoid deportation (CSP 2010).

Bhutanese refugees' vulnerabilities

Avoiding categorizations and default attribution of mental vulnerability, it can be noted that different stressors may have characterized the life of Bhutanese refugees. Prior to and while fleeing from Bhutan some individuals were subject to violence, threats and torture (Thapa et al. 2003). With the flight from Bhutan, their original communities were dissolved, since many families and groups were separated or left behind. Moreover, the socioeconomic status of many families has been affected dramatically by the events, and refugees have been living for 20 years in a suspended situation, facing several protection challenges (HRW 2006) and, because they are not allowed to work legally, experienced a devaluation of their professional skills and social roles. At the same time, during 20 years of common life in Nepal, refugees have been proactive and able to reconstruct new community ties and ethno-cultural identities. Indeed, they do actually run much of the camp services and do actively participate in the community life of the camps. However, with the resettlement, those new ethno-cultural communities are being dissolved again, at least geographically, since refugees are resettled to many different states and towns. While resettlement is considered to be the best option for many of them, and in certain cases local chapters of associations are being established among resettled Bhutanese refugees in US, the effects of the loss of community networks, ties and interactions on their individual and group identities can't be underestimated, especially in relation to suicide.

Apart from the community disaggregation, the many bureaucratic and logistical frustrations that a mass resettlement operation necessarily provokes may account as risk factors. In particular since procedures require that all members of a family need to take a collective

decision about resettlement across generations, and no elderly or vulnerable individual should be left behind, tensions and family conflicts may arise between those who want to leave and those who want to stay. Research has shown that family conflicts and devaluation of traditional family support systems have a direct impact on mental wellness of individuals in Nepal. For example, the married son is usually expected to assume responsibility for older adults in his family. Lower anticipated support from the eldest son along with an increase in general inter-generational family conflicts correlate with depression in parents (Gautam et al. 2010). Furthermore, the necessity to adapt in a very short period to a new cultural and socioeconomic context can threaten the refugees' self-concepts and create disorientation (Papadopoulos, 2004). This is particularly true for Bhutanese refugees in resettlement countries, since they would resettle from an environment in which they shared core values, languages and habits with the local population to one that is completely foreign. Regardless, none of these already known elements could alone explain the disproportionately higher number of suicide cases among Bhutanese refugees as opposed to other communities with similar characteristics (e.g. Burmese refugees in Thailand), nor could they explain why certain individuals commit suicide and others do not. Hence, the necessity to conduct the investigation emerged.

Methods

The assessment was conducted 5-19 January, 2011 in Damak, by a team comprised of an IOM psychosocial expert, a consultant psychiatrist, an epidemiologist and two translators (one is a public health specialist and the other is a psychosocial counsellor). The assessment consisted of:

Data collection and statistical analysis

Data of Bhutanese refugee suicides and attempted suicides in the camps was extracted from the UNHCR database. Only certified cases were considered for the study, 53 uncertified cases were excluded. The analyzed socio-demographic profile included gender, social group, religion, age, marital status, educational level, stage in the resettlement process, and presence of specific protection vulnerabilities (identified by UNHCR) both at the individual and family level. The groups of refugees who committed (67 individuals) or attempted (64 individuals) suicides were compared with a control group of 189 refugees randomly selected in the UNHCR database. The characteristics of the control group were compared with the known socio-demographic composition of the camp population and were found to be consistent with it. Association between suicides, attempted suicides, a composite group encompassing both subgroups and the different socio-demographic factors were analyzed using chi squared tests, crude and stratified odds ratios and a multivariate analysis (multiple logistic regression with backward fitting¹).

For cases of suicide in the US, files were created with the information that could be gathered through media reports, and information obtained by authorities and resettlement agencies. These data were presented descriptively.

Interviews with families among the general population of the camps

¹ Multiple logistic regression modeling allows to investigate association between several factors (exposures) and an outcome, accounting for various associations between the exposures

16 interviews were conducted with families randomly selected among the ones not affected by suicide in Beldangi II, Sanischare, Goldhap and Khudunabari camps. One interview was excluded from the qualitative analysis for possible motivational biases. The interviews took place with all family members who felt so inclined, in their homes, in the form of a discussion. Interview questions were aimed at identifying:

- a) Feelings that, according to family members, characterized their days over the past three months. This was achieved through an open-ended question, followed by a request to each individual member to rate on a scale from 1 to 10 a list of 7 feelings, derived by a previous study on the semantics of distress in Nepal (Van Ommeren et al. 2002). Scores were averaged per family, per item per family, and per item across the population.
- b) Self reports from families on the main causes for the feelings identified above were collected through open-ended questions.
- c) Ways families and individuals usually use to cope with distress, through open-ended questions. Most recurrent answers were categorized and summed across the population.
- d) Concepts of suicide among the community, through open-ended questions about attitudes towards people who committed or attempted suicide, possible reasons for suicide, and closed-ended questions which asked interviewees to categorize suicide in the following terms: crime, sin, understandable reaction to the hardship or normal fact of life. Further, building on Kohrt and Hruschka's (2010) description of self and identity and psychological uneasiness in Nepal in terms of the ethno-physiological concepts of "Man" (heart-mind, feelings), "Dimaag" (brain-mind, thought), "Saato/Aatma" (spirit-soul, possession) "Ijjat" (social status-honour, social shame) and adding to these "Karma" (destiny, bad-destiny), respondents were asked to attribute suicide to one or more of the above mentioned concepts. Responses were summed per item.
- e) Thereafter, a series of open-ended questions attempted to investigate possible uneasiness specifically related to the near future, i.e., the resettlement process (or being left behind) and finally, which measures to prevent suicide the respondents would find effective both in the camps and upon resettlement.

Focus group discussions with adolescents, women and the elderly

Three focus group discussions were conducted with groups of women, the elderly and adolescents of both sexes, in order to balance possible underestimation of the perspectives of these represented categories and possible reluctance of members other than the male within the household to freely voice their thoughts during the family interviews. The focus group discussions followed the interview guide presented above, readapted for use with larger peer-groups.

Interviews with individuals who attempted suicide and post-mortem interviews with families of individuals who committed suicide

A random sample of 16 families whose members committed suicide and individuals who attempted suicide was extracted from the UNHCR database, and consent was obtained from those 16 families prior to the interviews. During the interviews, which followed an identical interview guide for both suicide attempters and family members (whose relative committed

suicide), data was collected on the characteristics of affected individuals, including: social factors, history of mental illness, history of medical illness, and status of resettlement processing at the time of suicidal ideation. During the suicide probe, means of suicide and events surrounding suicide, including self-identified cause, psychological and social stressors were assessed with screening for depression, suicidal ideation, bipolar disorder, psychosis and other symptoms. Furthermore, the presence of negative feelings immediately prior to the suicide or attempt, including the 7 feelings used in the interviews with the general population was investigated through self-reports of attempters and observations shared by family members. Finally, attempters and families of completed suicides by a family member were asked to attribute their attempt or their relatives' suicide to the ethno-physiological concepts of "Man" (heart-mind, feelings), "Dimaag" (brain-mind, thought), "Saato/Atma" (spirit-soul, possession), "Ijjat" (social status-honour, social shame) and "Karma" (destiny, bad-destiny) and responses were summed per item for comparison with the non-suicide group.

Interviews and focus group discussions with stakeholders

Interviews and focus group discussions were conducted with 50 stakeholders, including staff of international organizations, non-governmental organizations, community leaders, mental health and psychosocial professionals, service providers, political and religious leaders and traditional healers. The interviews followed an interview protocol with open-ended questions that were read qualitatively. The questions were aimed at grasping local discourse of psychosocial and suicide concepts across different subcultures/subgroups, understanding the rationale and procedures of the assistance provided in general and in the Mental Health and Psychosocial (MHPSS) response domain in particular. Meetings and focus groups with service providers, including traditional healers, focused particularly on the organization of services, and challenges encountered in their provision.

Through observations, literature (project reports) review, and focus group discussions with professionals and service providers, the MHPSS and MHPSS-related services were mapped and analyzed alongside the Inter Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Emergency Settings' pyramid for intervention. In particular, for any level of the pyramid the following was analysed: a) if essential services exist, b) their scope and rationale, and c) if dedicated staff were selected or had received consistent corporate trainings in accordance with the professional requirements of the service.

Results

Scope of the problem

At the Bhutanese refugee camps in Nepal from 2004 until present there were 67 certified suicides and 64 certified attempted suicides. In addition, there were 53 uncertified cases of suicides and attempted suicides in UNHCR files, but uncertified cases were excluded from the analysis.

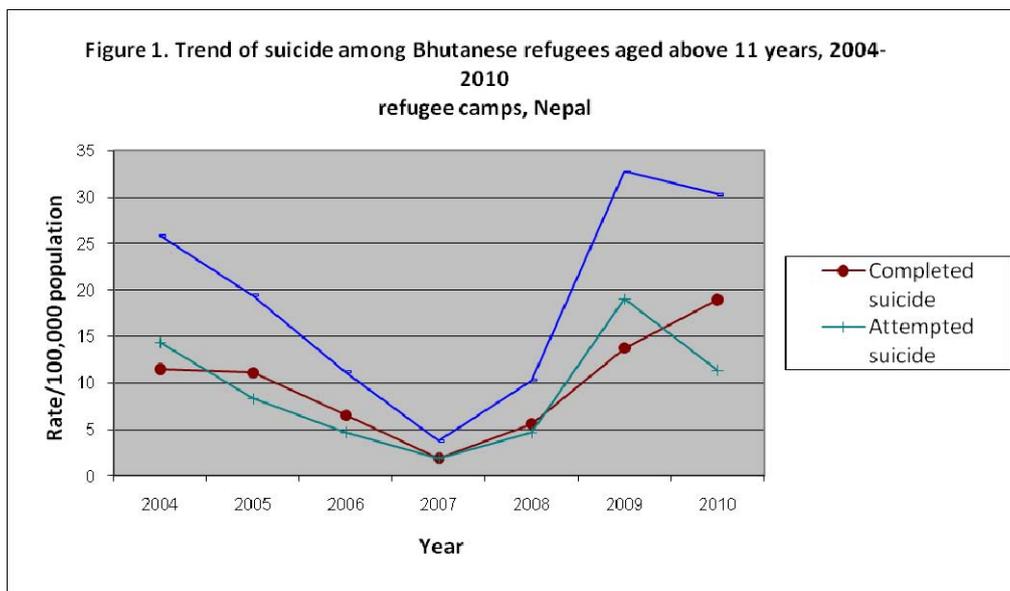
The report captured 12 cases of Bhutanese refugee suicides upon resettlement to a third country from 2007 until present, but it is acknowledged that this information is incomplete and, moreover, that there is no information on suicide attempts

Table 1 compares suicides among Bhutanese refugees in the camps and upon resettlement and other populations.

Table 1. Comparison of rates of suicide across different populations

World	US	AUS	Nepal	Jhapa	Camps	After Resettlement	Resettlement in the US	Resettlement 2009-2010
16	11.1	10.5	10.6/29.9	16.3	20.76	27.3	31.5	35

The official suicide rate in Nepal (10.6/100,000) is likely to be under-reported. Indeed, if the number of suicides reported by the national police for the first ten months of 2010 is compared with the population estimates of the World Bank for 2009, the rate reaches 29.9/100,000. The difference between the official and the estimated rate is such that it makes it impossible to consider any rate reliable. As a result, the rate of suicide in Jhapa District, home to six of the seven refugee camps, was used for comparison instead. The rates of suicide in the Bhutanese refugee camps in Nepal and among Bhutanese refugees resettled in the United States are significantly higher than the rates in the US, in the world and in Jhapa district. The rate of suicide among refugees after resettling to the US is triple the rate in the general population; more than double the rate in Jhapa district; and significantly higher than in the camps. Suicide is a crime in Nepal, and under-reporting is likely for the figures in Nepal and Jhapa. It is noted, however, that the study excluded 53 uncertified cases within the camps, and the number of suicides upon resettlement may also be underestimated.



Trends of both suicide and attempts from 2004 onward show a progressive reduction in number of cases from 2004 to 2007, the minimum frequency in 2007 and a progressive, unprecedented increase from 2008 to 2010. 2007 was the year when resettlement became an option for Bhutanese refugees. The peculiar trend in the data of 2007 can be therefore explained by two concomitant occurrences. The new development could have provided a short-lived psychological protection against suicide and, also, the burden of the registration process on the surveillance and reporting system in 2007 may have resulted in an under-reporting of information on vulnerabilities, including suicides.

Almost all suicides among Bhutanese refugees happen through hanging.

The rates of suicides in the camps and upon resettlement, the comparative analysis between those rates and the ones of other populations, and the trends of suicides in the last 7 years confirm the magnitude and relevance of the problem and call for a timely response in the camps, and even more so in the resettlement and integration processes.

At-risk populations

Socio-demographic characteristics of individuals who committed or attempted suicide were compared with a representative control population randomly selected from the UNHCR database to identify characteristics associated with suicide or suicide attempt.

Table 2: Age, sex and religion in the control group, attempted suicide and completed suicide cases among Bhutanese refugees, refugee camps, Nepal (2004-2010)

Characteristic	Control (no-suicide) n=189		Attempted suicide n=62		P-value (Chi-squared test or t-test) for comparison with controls	Completed suicide n=67		P-value (Chi-squared test or t-test) for comparison with controls
	N	%	n	%		n	%	
Age group (yrs)								
<=40	124	65.6%	46	74.2%	0.210	36	53.7%	0.053
>40	65	34.4%	16	25.8%		31	46.3%	
Mean age ± SD	33.6 ± 16.8		30.5 ± 16.3		0.182	41.9 ± 17.3		<0.001
Gender								
Male	92	48.7%	25	40.3%	0.252	38	56.7%	0.258
Female	97	51.3%	37	59.7%		29	43.3%	
Religion								
Hinduism	102	54.0%	37	59.7%	0.137	19	28.3%	0.027
Christian	6	3.2%	1	1.6%		1	1.5%	
Buddhism	55	29.1%	20	32.3%		11	16.4%	
Kirat	26	13.8%	2	3.2%		5	7.5%	
Missing	0	0.0%	2	3.2%		31	46.3%	

While women attempt more, and men succeed more, consistent with trends worldwide, overall gender is not significantly associated with odds of suicide. People who completed suicide are generally older than both attempters and the controls (mean age 41.9 vs. 30.5 and 33.6, respectively; $p < 0.001$).

None of the casts/ethnic groups or religion had significant association with suicide.

Refugees, who have experienced **Gender Based Violence (GBV)** were more likely to attempt or complete suicide than those without experiences of GBV (crude odds ratio 8.9, CI 1.9—25.6, $p < 0.001$). The association was strong in both the attempted and completed groups, and remained significant when adjusted for other variables in the logistic regression model.

Analysis did not reveal significant association of suicides with the number of specific needs codes at the individual level (the codes were extracted from the UNHCR database), but there

was an association with the number of specific needs codes at a family level. Refugees in the dataset had from zero to 16 specific needs codes per family. The average number of specific needs codes was 2.6 (CI 2.3—2.9) in the control group and 4.1 (CI 3.5—4.7) in the combined group. When refugees were categorized into groups with ≤ 3 codes and >3 codes, there was a significant association of the larger number of codes with suicides. Refugees with >3 codes were 2.7 times (CI 1.5—4.9) more likely to complete suicide than refugees with ≤ 3 codes ($p < 0.001$). In the group of attempters the association was weaker (OR 1.9; CI 1.04—3.50), but still statistically significant ($p = 0.033$).

When number of codes were categorized into four groups (0, 1-5, 6-10, 11-16), there was a trend: odds of suicide increased with increasing number of codes (p for trend < 0.001).

There was an association between suicide and mental illness in the family. Refugees with mental illness in the family are 1.9 times (CI 1.2—3.0) more likely to commit suicide than those, who have no recorded mental illness in the family ($p < 0.01$). However, this association did not reach statistical significance in the regression model.

Mental disability or mental illness at the individual level was not significantly associated with suicide. This is consistent with reports of service providers that show that only two among the individuals who completed or attempted suicides in the camps have ever been under mental care prior to the event. However, this is likely due to inadequate mental health surveillance and identification system rather than actual lack of association of mental illness with suicide, as discussed later in this paper.

Table 3: Logistic regression of completed suicide on number of special codes in the family, GBV and age group

Parameter	Odds Ratio	95% CI	P-value
>3 special needs in the family	2.07	1.10-3.86	0.023
GBV	4.84	1.06-22.04	0.041
Age >40	1.77	0.97-3.23	0.062

Though the rate of suicides has been increasing since the start of resettlement and recognizing that the resettlement process poses additional stress on the refugees at both the individual and community levels, it should be noted that the statistical analysis did not produce evidence of association between a resettlement status (categorised as “in the resettlement pipeline” vs. “not in the resettlement pipeline” by UNHCR) and suicides at the individual level. Considering that there was a large proportion of the refugees whose resettlement status was uncertain and also complex impact that resettlement may have on different sub-groups at different points of the process, it was decided not to quantify the effect of this factor.

In summary, results highlight that in camps victims of Gender Based Violence, and individuals living in highly vulnerable families (such as the ones presenting more than 3 UNHCR specific needs codes) are more likely to commit or attempt suicide. As such, these categories should be prioritized in any envisaged suicide prevention initiatives. Older (mean age 41.9) individuals and people with a history of mental illness in the family are, perhaps, groups of higher concern, but results are not conclusive in this respect.

The information gathered on suicide cases in the US is not as complete as the one for the camps. There is no information on suicide attempts. Moreover, many socio-demographic characteristics of the population, including previous GBV history are unknown, making it impossible to compare data with a control group, or with the completed and attempted suicide groups in the camps. The gender distribution of the identified completed suicides is 8 males and 4 females. Age distribution differs from the one in the camps. Seven cases are below 36, three are above 60, and only two are between the ages of 36 and 59, one of which under 40. The median age of the population committing suicide in resettlement countries is therefore lower than in those who committed suicide in the camps, but it is impossible to evaluate if this difference is statistically significant, or if it reflects a trend in the general resettled refugee population. Regardless, it provides an indication of the age group to prioritize in prevention activities.

More anecdotal information gathered from the media is summarized in Table 4

Table 4: Some characteristics of suicide populations in resettlement countries

Description	Number	Age
Designated only providers for the family	4	(20-31)
Mothers with several children with no support network	2	(30-40)
Non providers	3	(60plus)
No information	3	

Four individuals, who committed suicide upon resettlement, had been allegedly designated to provide for the entire family by the supporting agency in US, due to their “marketability”. In at least 3 cases, they were not the traditionally designated providers, being younger or women, or both. In at least two cases, the concerned individuals committed suicide after their first work experience or returning home from work.

Two females, who completed suicide were both mothers of 4 children, and both were separated from their original family and support networks. They were resettled in Australia and New York State respectively, therefore the possibility of a copycat effect is unlikely in this specific case.

To summarize, the majority of known cases of suicide among the Bhutanese refugees outside Nepal occurred in the US, but there is no sign of differentiation in the rates of suicides according to destination within the States. The refugees committing suicide in the States appear to be younger than the ones committing suicide in the camps. In all identified suicides of individuals below 40 there seem to be an association with excess of responsibility imposed on non-traditional providers towards the family or with excess of responsibility in females separated from their families and/or other social support networks.

Suicide and mental health

While epidemiological analysis, based on documented events, did not show any significant correlation between mental illness and suicide, and raw data confirmed that almost no completed or attempted suicide case was ever referred for mental problems before the events took place, it is widely recognized that suicide is accompanied by mental health disorders in at least 80% of the cases worldwide. The mental disorder is often not the sole cause, but a co-cause. In some cases it can be a result of the same causes that ultimately lead to suicide. Alcohol and substance abuse disorders, which are often associated with suicide, can be in some cases a form of self-treatment for the same psychological causes that result in suicide rather than being the direct cause of suicide. In order to understand better the possible relationship between mental disorders and suicide in the camps in Nepal, nine post-mortem interviews were conducted with families of people, who committed suicide, and 7 interviews with individuals who attempted suicide in the camps. Since the socio-demographic characteristics of the attempted and completed suicide groups were not known at the time of the interviews, the age groups of the interviewees are not consistent with the ones of the “suicide” population, with an overrepresentation of individuals below 35 (10/16) and especially below 18 (4/16) and an under-representation of individuals above 36. Therefore results of this exercise are to be read as an indication of general trends.

All individuals considered in the interviews but one, committed or attempted suicide by hanging, consistently with the overall suicide pattern in the camps.

In 14 cases the completed or attempted suicide was impulsive, in one case only it was planned. One case was probably a homicide vested as a suicide.

Reasons cited for suicide were mainly shame (8/16), responsibility burden (5/16), feeling unsupported (4/16) and alcohol intoxication (2/16), however the main reason was always accompanied by other factors. The following scenario depicts the narrative that was most common:

Resettlement → Family separation / eldest brother or father dies / early marriage → responsibility of family falls on a non-traditional member → increasing distress of this person → shame / feeling like a failure → feeling overwhelmed by emotion → feeling that it was better to die.

Table 5: Most frequent risk factors for suicide during clinical interviews (post mortem and with attempters)

Risk factor	Number of cases/16
Untreated mental illness	9
Alcohol abuse	8
History of suicide or attempt in the close family	5

Among risk factors, mental illness identified by a professional psychiatrist using a clinical interview, therefore subject to individual professional evaluation, was extremely common. Alcohol and substance abuse, but not necessarily at the pathological threshold level, were also common. History of suicide in the family is also quite high. In the case of mental illness,

the diagnoses spanned the spectrum of mental disorders. Various forms of depression (6/16) bipolar disorder (2) and psychosis (2) were identified. Alcohol abuse was present in 8 cases, often in combination with other mental disorders.

Social stressors that preceded suicides most commonly cited include family and interpersonal factors, the latter mainly related with marital relations. Resettlement in itself was cited only once.

All respondents stated that they were aware that suicide was common in their society and had heard about hanging as a means of dying. There is a dearth of awareness however, on alternatives to suicide and knowledge that there is treatment for emotional distress.

The interviews revealed the following commonalities and patterns in the characteristics of those who completed or attempted suicide:

- Most suicides are impulsive and happen by hanging.
- Suicides are due to a confluence of factors.
- Prevalence of untreated mental illness is high.
- There is clustering of mental illness and history of suicide in the family
- Alcohol is a risk factor.
- Shifts of family responsibilities into non-traditional providers and family conflicts, including those caused by resettlement seem to play a role.
- Shame plays a huge role in suicidal thinking, and in suicidal cases there is a high level of intolerance to strong emotional states.

Distribution of mental disorders in the suicide group was compared with the distribution of mental disorders in the camp population, registered by AMDA in 2010. Among the suicide cases and attempts, depression and alcohol abuse were disproportionately prevalent (Table 7), which is consistent with global trends.

Table 7: Comparison between disorders: Referrals to AMDA versus attempted and completed suicide cases.

Illness	AMDA cases 2010	16 Interview cases
Major Depression	8.8%	37.5%
GAD	24.9%	12.5%
PTSD	0.1%	0
Psychosis	22.1%	12.5%
Epilepsy	21.7%	0
Alcohol Abuse	1.6%	50%
Drug Abuse	0.2%	6.3%
Suicide Attempt	0.2%	94%
Somatisation/Other	20%	N/A
Totals	1025 cases	16 cases

Triggers for the suicide attempt were loneliness, isolation, and most of all, feeling shame associated with social stressors and risk factors. The concept of suicide has been common in this population from before the attempt, but has not been publicly discussed with viable alternative options to suicide.

To summarize, in addition to the vulnerable groups identified through the statistical analysis, refugees with untreated mental disorders, especially depression and bipolar disorder, the ones who abuse alcohol and those with a history of suicide in the family should be considered as categories at risk. Impulsivity emerges as a reason for suicide in this context, consistent with evidence of suicide in Asia (WHO, 2010). Results of the interviews confirm that family conflicts, perceived excess of responsibility towards the family, and shame of not being able to fulfil these responsibilities are risk factors and that history of vulnerability and of mental illness in the family also plays a role. Finally, suicide is familiar to the population, and therefore copycat effect may be an issue. More dangerously, even if familiar to individuals, suicide is usually not verbalized and discussed in the family and among peers in a preventive fashion. Therefore, tailored activities of awareness should be advocated.

Perceptions of suicide in the culture, and in the camps' culture

In trying to understand suicide in this context, it is important to look at how culture defines suicide in Nepal. By the Nepalese law, suicide is a crime. Hinduism also considers suicide a sin, but does not condemn it, and the same death rituals are dedicated to those who died of an accident or unnatural death, and those who committed suicide. Moreover, ritualized forms of suicide were practiced for many centuries. In "Sati" the widow would immolate herself on her husband's funeral pyre. With the non-violent practice of fasting to death, termed "Prayopavesa" those with no desire, ambition or family responsibilities could bring their life to an end. It is noted that these rituals are considered archaic and are stigmatized by spiritual leaders, populations, and traditional healers interviewed alike. According to Buddhism, suicide is seen as a very negative form of action, but it is not explicitly condemned. In fact, self-sacrifice may be appropriate for those who have attained enlightenment, but this is an exception. Indeed, for the Buddhist leaders and families interviewed, suicide was a negative action against the value of life. Christianity denounces suicide, which is considered a capital sin that does not allow religious funerals neither the burying of the corpse in sacred land.

Trying to identify the dominant perception or "culture" of suicide present in the camps, 16 families in the general population were randomly interviewed and focus group discussions with adolescents, women and elderly were separately conducted. One third of the respondents knew closely someone who had committed or attempted suicide, and suicide was generally familiar to all of them. It is noted that none of them had the opportunity to discuss the issue beforehand, in a guided manner. On an ethno-physiological level, Kohrt and Hruschka (2010) identified 4 main concepts along which identity and mental uneasiness could be explained in Nepal: "Ijjat" (social status-honour-social shame), "Man" (hearth-mind, feelings-bad feelings), "Dimaag" (brain-mind, thought-psychological disorder), "Saato/Aatma" (spirit-soul- possession). In the case of suicide, the concept of "Karma" (destiny-bad-destiny) could also play a role. In the interviews with families in the general population, the ones with attempters and during the post mortems, respondents were asked to attribute the act of suicide to one or more of these ethno-physiological domains. None of the respondents attributed suicide to "Saato-Atma" (possession). This is consistent with the information received in

focus groups with traditional healers. Traditional healers are often the first point of contact for cases of possession, but they do not have dedicated practices for people who feel suicidal or have attempted suicide, and they are not contacted by this specific group of clients. The majority of people who identified “Karma” specified that it is used as a justificatory (vis a vis the family of the deceased) rather than explanatory paradigm.

Table 8 Attribution of suicide to ethno-physiological concepts of identity by general population and families of suicide and attempters

Concept	General Families	Suicide families and attempters
Dimaag	23.2%	55%
Man	30.4%	25%
Ijjat	23.2%	10%
Karma	16%	10%
Saato-Atma	0	0

For general families suicide is mainly a question of “Man” (feeling) that the person is not able to manage or whose intensity affects the brain. Feelings are considered a direct result of practical problems. In contrast, for affected families, suicide is born mainly in the brain-mind (“Dimaag”), and this dysfunction can be associated with protracted negative feelings. Therefore the perception of the general population and the one of the affected families are slightly different in this respect.

For most of the respondents in the general population, suicide is primarily an understandable but not acceptable response to hardship (10/16 families). For older respondents, suicide remains a sin or a crime (10 individuals across families). Interviews showed a generational shift in attitude, best articulated by the words of a 46 years old woman, who stated “For me it was a sin. It is still unacceptable, but I understand why people do it, because I myself lost hope and energies at times”.

Consistently, there is a generational dynamic in the attitude towards people who attempted suicide. Elderly or older population tend to be judgmental, or fearful-uneasy towards the persons who survived an attempt, while the younger generation is more understanding, would not change attitude towards the attempter and would seek ways to help and support.

When asked to identify factors leading to suicide, most respondents referred to a combination of high emotional burden (“Man”), the inability to think in the moment (“Dimaag”), and what they define as “sour temper” – a personality trait conducive to impulsive actions. The high emotional burden possibly leading to suicide for the general families interviewed is mainly attributed to five causes: *poverty, being unable to fulfill responsibilities towards the family, past experiences related to flight from Bhutan (among the elderly), physical illness, and family conflicts/family separation (not limited to, but including resettlement-related conflicts and separation).*

When asked to identify reasons why Bhutanese refugees commit suicide post-arrival, they cited family separation, difficult cultural adaptation, frustrated expectations and the difficulties in adjusting to strict working rules.

To summarize, Nepalese culture and its various religious beliefs and practices do not provide explanatory paradigms for suicide. Suicide seems not related with the deep culture of refugees. In the camps there isn't a specific suicide-culture. However, there is a generational shift in the population's perception of what is happening. While for older generation suicide is still a sin and provokes fear or judgment, for the younger generation suicide is primarily an understandable response to the predicaments of the present. In general, families tend to associate suicide with an emotional burden, provoked by social factors that reach a level that affects the individual's capacity for thinking. This is particularly harmful in "sour tempered" individuals, those more prone to impulsive actions. Results therefore confirm impulsivity (as a behavioral trait), family conflicts and family separation, inability to fulfill responsibilities towards the family, and resulting social shame all as risk factors. Results highlight the role peer support could play, especially among younger generations. Results also emphasize that although suicide is a familiar concept, it is not discussed and socialized towards a preventive end.

Level of distress in the community

For many in the general population suicide is a question of feelings, it is therefore important to determine whether feelings which are spread in the community create an environment for suicide. When general families were asked to self-identify the feeling that characterized their days in the last weeks, the two most commonly self-reported feeling were "Chinta" (worry), and "Tenzions" (tension) (9/16). If instead individual members of the family were asked to rate a feeling from a given list on a scale to one to ten, the highest average scores are attributed to "Dukha" (grief) (8.4) "Tenzion" (tension) (8.3) "Chinta" (worry) (7.8), "Pir" (anxiety) (7.7) and "Dar" (fear) (5.6). Therefore, negative feelings are prevalent in the general population. The majority of respondents (12/16) believe the same level of distress is present in the entire community, but reasons may vary. The generalized level of distress is consistent with the list of referral to the AMDA's mental health services in the camps. Indeed, the highest number of patients other than those with epilepsy, are diagnosed with General Anxiety Disorder (GAD) (225/1096) and psychosomatic complaints.

It is noted that negative feeling scores are higher in families in the resettlement pipeline than in families who have yet to express an interest in resettlement (7.66 vs. 6). Within families, negative feelings are more prevalent among the elderly and the providers (in 14/16 families the eldest or the provider was the higher scorer). The resettlement process usually catalyzes the discourse of the families, when they are asked to identify the causes of distress. In particular, internal family conflicts due to decision-making plays a role. Many elderly and adults within families feel pressured into resettlement. This point was emphasized during a Cultural Orientation class conducted a month prior to departure. During one of the sessions, family members were asked, among other questions, if the choice to resettle in a third country was due to their own desire or whether the choice was made because someone else in the family wanted to go for resettlement. To respond, they were instructed to select a red chip (favor to the others), a yellow chip (mixed) or a green chip (own will). During the week of observations, more than half of the participants above the age of 40 chose the red chip.

Family separation, due to the resettlement process, also plays a role. In many cases, refugee families decided to send part of the family for resettlement ahead of others. Those who submitted a "Declaration of Interest" in 2007 and 2008 departed quickly, but with the passage

of time the processing queue has grown considerably. Even with the massive increase of requests, integrity of case assessment is necessary to grant confidence in the beneficiaries and to meet the requirements of the resettlement countries. This can result in a lengthy separation between family members in third countries and those remaining in Nepal. According to UNHCR almost 25% of the caseload pending to be completed is in such a situation, and since October 2010, all pending cases have been prioritized for more rapid assessment. Compounding this uncertainty is the fact that most refugees, due to the third countries' procedures, are not told their exact resettlement destination until very late in the process, and therefore there is the fear of not being reunited with their loved ones. Another issue of concern is that family in Nepal and among the refugees is defined along male lines. Due to logistical considerations, resettlement happens in small family groups only. This can result in married women being separated from their original family, which was also reported in the interviews and focus groups as one of the main causes of distress. It should be noted however that before any split of families are done, objective assessments related to socio-economic dependency are conducted. If married women are separated from their maternal family, there may have been other considerations of family support coming into play.

There are non-resettlement sources of distress in the camps as well. Reasons for discontent include hardship of refugee life, insufficient food rations, increase in interpersonal violence in the camps, and the consequent fear that children are now more likely to join gangs or commit “untraditional” acts. Shame for not being able to provide enough for the family was also expressed, especially in relation to comparison with other families, including the ones who can afford better living standards due to remittances from resettlement countries. These results are not consistent with those of a needs assessment conducted in Beldangi II by a joint TPO-Healthnet-Institute of Psychiatry’s at Kings College in London team. In the TPO- IoP study current practical problems including lack of food, shelter, and blankets were more prevalent than resettlement related issues (Semrau, Luitel & Jordans 2011).

When asked to identify their usual ways of coping with the identified feelings, most of the respondents referred to individual coping methods, including walking alone in the forest (7), getting involved in practical work (6) and reflection (3). Beyond individual coping mechanisms, interviewees responded to emotional burdens by talking within the close family (10). Some of the youngest respondents referred to leisure activities, most often involving alcohol consumption (6). Existing psychosocial services in the camps were never spontaneously reported as a possible response. Religious practices were reported by only three individuals, including two elderly and a religious scholar. When specifically asked if they knew about dedicated services in the camps, only one individual referred to TPO counseling services, one to AMDA mental health team, and two to the Caritas school-based child friendly spaces.

In summary, the level of distress in the population is generally high, characterized by grief, tension, stress and worries. It appears to be higher in families in the resettlement process, and within the family among the eldest and the providers. In the general population, as in the suicide population, reasons for distress include family conflict and separation, such as family conflicts in relation to the decision to resettle, family separation due to delays in the resettlement process, maternal-paternal family issues, as well as the fact that some adults in the camps may agree to resettle just not to be an obstacle to the decision of younger members of the family, by whom they traditionally need to be supported in the future. While resettlement catalyses the discourse, other causes emerge in the discussion, including hardship, decline in food rations, increased gang and

community violence. Most notably in the general population as well as in the suicide group, shame for not being able to provide for the family is a main cause of distress. Existing coping responses are mainly individual or related to those familiar and close friends. This raises a series of concerns in the resettlement country context, where Bhutanese refugees may feel overwhelmed, the peer network breaks down, and family conflict arise, especially since referral to religious and traditional practices does not seem to have a strong protective function. That none of those interviewed spontaneously referred to mental health and psychosocial services existing in the camps as a possible response is significant. Very few respondents identified existing mental health providers as a source for help. This raises questions regarding community awareness about these services or regarding their suitability for meeting the needs of the population. Finally, a natural semantic and conceptual tendency to disregard the feelings and define them through their social causes is widespread among the population.

Analysis of mental health and psychosocial support services offered or lacking in the camps, in the resettlement process and in resettlement countries

According to the Interagency Standing Committee's Guidelines on Mental Health and Psychosocial Responses in Emergency Settings, mental health services and psychosocial responses after an emergency situation should be organized across the four tiers of the intervention pyramid, and these four levels of intervention should be strictly interconnected.



(IASC 2007)

It is not within the scope of psychosocial programs to provide basic services and security. It is, however, within the scope of psychosocial programs to make sure that basic services and security are provided in a way that is considerate of the emotional, social and cultural specificities of the population and the situation, avoiding further harm, and fostering participation. Specialized psychiatric and psychological services, for their part, should be offered at primary, secondary and tertiary health levels, according to the gravity of needs.

The pyramid was used to analyze the provision of mental health and psychosocial services in the three assistance systems involved in this study: the camp, the resettlement process, and in one of the countries of destination, the US.

Social, emotional and cultural considerations in the provision of basic services

In the camps. Basic services, such as health, education and nutrition, have been provided now for some 20 years, with a high level of community participation. Participatory approaches, including organized forms of democratic representation, have granted cultural consistency in the provision of services. People lament a decline in the quality of the services provided due to resettlement, and information on how these services are going to be re-organized at the end of the resettlement operation needs to be enhanced. These concerns are justified. All UNHCR and WFP implementing partners (AMDA – Health; Caritas – Education; LWF – Shelters, Sanitation, Water, Food Distribution) are greatly affected by resettlement. They depend on refugee workers to do the actual work, and as a result of resettlement the best-and-brightest of their staff are departing for resettlement. Those implementing partners are constantly required to hire and train new staff and, increasingly, those new employees have lesser and lesser competence to shoulder the responsibilities. As a result, the services provided at the camp level have been negatively affected since the start of resettlement activities, and the situation is only going to get worse.

In the resettlement process. Some gaps can be identified at the basic services level.

UNHCR staff has received training in interview and (non-psychological) counseling techniques. Moreover, IOM staff involved in medical assessments may have received some training related to psycho-social issues and support. It would nonetheless be beneficial for all UNHCR and IOM staff to be provided with a more comprehensive training in “psychosocial needs in resettlement” which could help them better understand the psychosocial needs of the population and do no harm approaches.

With regard to information on resettlement, there is a distinction between pre-resettlement processing information (i.e. before refugees declare an interest) and information provided after the case actually has been submitted and is being processed. For the former, information is provided in many ways to the population, including mobile counseling teams, bi-monthly poster campaigns, weekly radio bulletins, an average of 50 participatory information sessions per month, and tailor-made information sessions for the vulnerable, older, disabled, women at risk, and youth, alongside country specific sessions for US, Canada, Australia. This includes general information on resettlement as a durable solution and the services offered in the various resettlement countries.

For the latter, comprehensible explanations of different times and procedures in relation to the different resettlement countries should be better disseminated to avoid distress and unnecessary paranoia. During the focus groups and interviews, indeed, interviewees demonstrated little understanding of the difference in timing and steps in the processing of the request according to different countries of resettlement, and tended to read country specific differences in the process, between neighbours or friends, as a problem with their file. Methods to make the available information system more accessible to the population could be envisaged.

In the US. Basic services, including shelter, social services and health referrals are provided for a relatively short period of time. These are perceived as temporary solutions by a population that has, for the past 20 years, enjoyed a more continual support system in the Bhutanese camps in Nepal. Information about rights and responsibilities in a language that all resettled refugees can understand is not always provided. Directories with existing referral possibilities for different problems are not always provided. In general, it does not appear that refugees are fully cognizant about the scope of services offered nor do they fully appreciate the timeline by which they are expected to become self-sufficient. Furthermore, it does not appear that self-sufficiency in a short period of time is even realistic for this population.

Community and family support

In the camps. Caritas provides child-friendly spaces and activities on school grounds within the camps. Religious leaders and places for worship are available in the camps. The Transcultural Psychosocial Organization (TPO) has a community-based support program. Teams of community psychosocial workers, usually with only one-week training, provide psycho-educational inductions for camp populations, including basic family mediation, and the organization of peer-support groups. TPO community psychosocial workers reported that they conduct a series of up to five informal counselling sessions with individuals at risk, including the suicidal and victims of GBV. According to their reports, they are supervised by TPO counsellors, who have attended a six-month training course. If confirmed, using refugee volunteers, with only a secondary school background and one-week training to provide counselling to high risk refugees is a serious concern, and the supervision provided does not mitigate this concern.

In addition, community based organizations have their own initiatives to provide social support to individuals in need of such.

In the resettlement process. Resettlement coincides with the end of 20 years of community life; the transition is difficult, people are resettled in small groups in different countries and cities, and this result in a breakdown of established networks. Further, resettlement decisions provoke family conflicts. Family separation, especially for women separated from their original families, becomes a stressor. Some actions could be taken to better respond to those issues. For example, departures are not ritualized; there is no plan to ritualize the closure of the camps and create symbolic events, such as an archive of memories.

In Cultural Orientation classes, individuals and families jointly discuss the psychosocial issues connected with cultural shock, fears and expectations about the future, changing roles, cultural adaptation, and stress management, but the focus is more on the issues as opposed to the identification and management of the feelings that those issues may provoke.

In the US. It was not possible during the assessment to analyze how community and family support are organized in the US.

Focused non-specialized services

In the camps. Focused MHPSS services have been absent in the camps for many years. In 2009, TPO deployed two counsellors, trained in a 6-month counselling program, in each of the camps. The counsellors have been supervised by a clinical psychologist previously

visiting on a monthly basis and only since October 2010 on a bi-weekly basis. Counsellors provide problem-based counselling sessions (up to 5) to individuals referred by UNHCR, in centres located in each of the camps. In addition, they have been trained to deal with GBV cases. The level of focussed specialized services is therefore covered in the camps. Despite this initiative, the observations of this assessment show that these services are not well recognized or used by the population. Outreach is not developed or effective, and the problem-based counselling may not be the only or most appropriate tool to respond to the severity of some situations. Further, specific trainings for working with specific groups at risk have not been rolled-out in the timely manner required.

In the resettlement process. There is no recognition of these services.

In the US. The needs assessment did not cover this aspect. It is not known if counselling or similar services are provided in the US.

Specialized services

In the camps. Mental health services should be provided at the primary, secondary and tertiary health level. In the camps, mental health services have been provided within the primary health care system for ten years by the Association of Medical Doctors of Asia (AMDA). Mental health centres, each staffed with a mental health prescriber, have been attached to the health centres in each camp. Mental health prescribers are equivalent to general medicine undergraduates, with training in mental health. Their background is primarily psychopharmacological. Currently, these services are provided once per week, and on call. In 2010, there were 1025 visits, none among suicide cases or attempters prior to the event. It is not clear how outreach, case management and follow ups are organized, or if any such protocol exists. Recently, community health workers have been attached to the mental health centres. These are young community members without any dedicated training. They make appointments and deliver medicine. A psychiatrist visits each camp every second week to provide short consultations, but he is overwhelmed and primarily used to confirm and write prescriptions. In cases of psychiatric emergency, suicide attempts or other major episodes, refugees are referred to the closest psychiatric hospital, where they are accommodated and treated for up to two weeks. Specialized services other than psychopharmacological are not provided in the camps. AMDA mental health prescribers may refer cases to TPO counsellors if they think the case requires counselling, and TPO counsellors might refer to AMDA cases that need psychopharmacological support. The deficiency is this: psychotherapy other than pharmacological support is not available. Often, people with severe disorders are referred to TPO counsellors, who are problem-based counsellors and not psychotherapists, based on the wrong assumption that they may complement psychotherapeutically the work of the mental health prescribers. This is potentially dangerous for clients, and overwhelming for counsellors. This was recognized in the needs assessment: suicide attempters were followed by both AMDA and TPO staff, but there was no case management, nor any established plan or protocol for treatment or follow up.

In the resettlement process. During health assessments by IOM, mental health screening is conducted by general practitioners. Behavioural disorders, including substance abuse concerns are referred to a psychiatrist, who visits the IOM health centre once per week. The psychiatrist evaluates refugee patients, and produces a diagnostic report with recommended

plan for treatment. The patients then are referred to AMDA for treatment, and if necessary, are followed up by the IOM psychiatric consultant.

In the US. The needs assessment did not investigate this, but it appears as if there is no formalized protocol for the identification and referral of resettled refugees with special psychiatric or psychological needs.

Conclusions and recommendations

Results of this study confirm that the number of suicides among Bhutanese refugees in Nepal is disproportionately high, and that the rate among Bhutanese refugees resettled in the US is even higher. Results show that the number of completed suicide has been constantly increasing from 2007 onward, and that the number of suicides in the past two years (both in absolute terms and in proportion with the population of the camps) is the highest since 2004, and probably ever. A prevention and response strategy is required.

In general, suicide is a behavior. It is caused by a combination of risk factors and social stressors, resulting in emotional burden and possibly linked with mental pathologies that all converge in the moment when the decision is made. Behavior follows. Suicide behavior can also be inspired by cultural norms or by copycat effect.

The most rapid way to prevent a disproportionately number of suicides is to address the point of decision-making and behavior. Most importantly, all findings confirm that suicide among Bhutanese refugees is an impulsive act, not a planned one, which requires that prevention activity focuses on the decision making moment That would require to de-commercialize the most used tools for suicide, organize hotlines or similar services, provide protective community messaging, avoid or counterbalance a copycat effect. The most systemic, sustainable and comprehensive responses need to be also implemented in a manner aimed at a durable solution. These include identifying and targeting the most vulnerable populations, reducing risk factors and social stressors, improving treatment of associated mental disorders and risky behaviours, counteracting/reformulating inductive cultural norms, and enhancing the capacity of all services involved to respond in a holistic manner.

Bhutanese refugees commit suicide by hanging. It's impossible to prevent suicide by de-commercializing the tool – a rope or a shawl.

A hotline counselling/information system could be a solution, but the one existing in Nepal is not known in the camps and no hotline in Nepali is available in the US. Copycat effect appears to be a possible cause, both in the camps and in the US. Suicide is a very familiar concept in the population and is increasingly less stigmatized in the community. Compounding the problem, though suicide is a commonly recognized response to stressors among Bhutanese refugees – indeed, these events are well-publicized in the media – suicide is seldom discussed in groups in the camps or in the US. As a consequence suicide is at the same time familiar and unquestioned. While some of the above mentioned issues, such as the availability of hotlines, community messaging and preventing copycat effect can find some responses, more durable solutions to the core risk factors, social stressors and lack in the provision of services are more likely to be more effective in the short and long term.

This Needs Assessment Report identifies victims of gender-based violence and families with multiple risk factors as the most vulnerable to commit suicide (and other mental health risks).

Individuals above the age of 40 in the camps are more prone to suicide. In the US, younger Bhutanese, particularly those whom are thrust into “provider” roles are identified as being more prone to suicide. These groups should be therefore prioritized in prevention activities.

Across the results of the different analysis conducted, certain social stressors continually emerged as precursors for suicide: family conflicts, excessive responsibility for family members who do not traditionally fulfil “provider” role, and shame for not being able to fulfil these responsibilities. This point is relevant in both the Nepal and the US context. Further, it is noted that family conflicts and separation are associated with suicide, and in this context married women who are separated from their original families upon resettlement are particularly at risk.

All analyses converge in identifying GBV as a risk factor. This is particularly worrying in a situation in which woman resettle with the husband’s family, and may be deprived of the support provided by the original family, vis a vis the abusive husband, or in general.

Even though mental illness was not significantly associated with suicide in the epidemiological analysis, this lack of evidence is likely attributable to inadequate identification and surveillance systems. In fact, in-depth investigation confirms that depression and bipolar disorders are among the risk factors for suicide, as is alcohol abuse, especially among younger generations. Identification, response and surveillance of mental disorders should all be prioritized. A history of mental illness and especially a history of suicide in the family are also strong risk factors; such families require special attention, and should be regarded as the categories at risk.

The manner in which Bhutanese refugees cope with distress and bad feelings in this context appear not to include religious practices and strategies are mainly individual ones. Other than dealing with these feelings of distress individually and in solitude, individuals may socialize their pain with close family members. Younger generations may share feelings with friends. This limited range of options of coping strategies is particularly worrisome in a situation in which individual distress is high, peer support networks are breaking down due to resettlement, and families face separation, conflicts and internal tension. These concerns are augmented upon resettlement.

Another issue of concern is emotional illiteracy. The population is open to discuss problems but find it difficult to conceptualize feelings that are usually defined through or reduced to the problems causing them. The tendency to reduce complex emotional experiences to their alleged social cause, and the general difficulty in defining feelings makes it more difficult to control or manage a feeling that becomes overwhelming.

The general level of stress and worry in the community is high amidst the concerns of resettlement, refugee hardship, social hardship and perceived degradation of security in the camps. It is particularly important to note that some of the adults interviewed or observed during the study perceive resettlement as something they need to do in order to accommodate the desires of younger members of their families who, traditionally, are supposed to take care of them in the future. This is a complex phenomenon that affects all members of the family: the elderly, traditional providers, newly-appointed providers, those who advocate for resettlement and those who advocate against it and married women who, because of resettlement, may be separated from their original families.

The provision of mental health and psychosocial services in the camps had been limited to prescription of psychotropic medicines until 2009. In 2009 counselling services became available, but professional non-pharmacological psychotherapy is still not available in the camps or provided by individuals who are not adequately trained to offer it. Problem-based counselling services are provided by counsellors, who have been trained for 6 months at best. This would be a good practice to respond in an emergency, but as a systematic intervention the available services are not adequate. The capacity of counsellors is not sufficient to deal with the fourth level of the IASC pyramid, nor with all aspects of the third level, and there seem to be a mismatch between functions of counsellors and community psychosocial workers and their qualifications. Moreover, the general population is basically unaware of the existence of these services and does not associate them with solutions to their own problems.

In resettlement operations, the issues related with cultural shock and adaptation, stress management and family restructuring are holistically tackled in Cultural Orientation classes. However, these classes take place within a short period prior to departure, when families are usually busy with the logistics and emotional aspects of the move. The courses do not focus on addressing specifically the feelings of individual refugees towards the challenges of resettlement. Moreover the classes are not compulsory and while attendance is very high (close to 100%), those refugees who are most emotionally challenged are more likely than others to not participate.

This report did not assess the adequacy of psychosocial support in the US, but it is apparent that in order to reduce/mitigate mental health concerns for Bhutanese refugees in the US some form of analysis/intervention is required.

Recommended Urgent Responses

Identification and management of most vulnerable refugees who attempted suicides and families affected by suicide

- a) Deploy, for a period not less than one year, an international psychosocial expert able to coordinate responses at various levels of intervention and spearhead improvements in ongoing activities.
- b) Engage international experts for ad hoc activities and trainings. Create an expert network.
- c) Establish a protocol of interventions for assessing and targeting the most vulnerable groups specifically, and not only the community at large, e.g. victims of gender-based violence, families presenting more than 3 UNHCR special needs codes, persons with a family history of suicide.
- d) Establish a protocol for treatment and management of attempted suicides and support to families of completed suicides. This should include a comprehensive package, including clinical intervention, consistent counseling path (over a period of 3 months and not a one-off), and socializing and educational activities
- e) Enhance psychiatrist and psychologist presence in the camps and in resettlement processing

Prevention campaigns

- a) Popularize MHPSS services in the camps
- b) Popularize and socialize the concerns on suicide, suicide threats, and possible alternative responses, being careful to avoid a domino-copycat effect.
- c) Organize prevention campaigns through theatre and radio, focusing on emotion management.
- d) Establish focus group discussion targeting the most vulnerable categories, facilitated by skilled counselors, and using survivors as peer-supporters, on the theme of suicide prevention. Involve religious leaders and peer groups.
- e) Foster responsible coverage of suicides in the media that can be educating and effective in preventing suicides, including portray stories of individuals who have sought successful treatment for depression, alcohol, domestic violence, and avoid details on suicides (in both Nepal and the US).

Psychosocial activities in CO classes.

- a) Add a focus on feelings and resilience factors in cultural shock, stress management, and family sessions
- b) Conduct a 5-days course for CO trainers towards this aim.
- c) Add a 5-hour course on “Emotion Management, Peer Support and Referral, and Suicide Prevention” at the transit center in Kathmandu, when attention and attendance are higher.

Enhance health assessment

- a) Enhance Mental Health screening in country health assessment, through the roll out of an adapted version of the WHO MHgap tools (WHO, 2010)

Psychosocial attention in the resettlement process

- a) Enhance level of information on the actual conditions of resettlement
- b) Train staff in active listening and basic psychosocial support
- c) Keep the population updated on the resettlement issues through storytelling sessions or a dedicated barrack in each camp
- d) Make sure that female victims of GBV can be resettled with at least part of their original family, and that family with higher level of vulnerabilities (>3) are not resettled separately.
- e) Ritualize departures. Create web archives of memory or simply create a certificate or a video to give to all who depart. Symbolic objects connected with identity and roots can be important in preventing suicide in the moment of decision.
- f) Allow refugees to carry with them protective objects upon departure (sacred stones, other items) for the same reasons.

The above-mentioned recommendations (a-d) are already implemented to varying degrees. Resulting activities should be maintained and enhanced

In the US

- a) Conduct a similar assessment in the US
- b) Conduct an induction to resettlement agencies on findings of this assessment
- c) Avoid placing all responsibility for the family on one provider, especially if this would be a non-traditional provider;
- d) Establish courses on emotion management and suicide risk for refugees upon arrival
- e) Establish a hotline or a Nepali component in an existing hotline (for the US and Nepal)

Recommended mid-term actions

In the camps

- a) Restructure MHPSS services in line with task competencies in the pyramid of intervention.
- b) Provide training for medical providers on the WHO MHgap tools.
- c) Create a non pharmaceutical psychotherapeutic expertise, through resident training and mobilization of national professionals.
- d) Invest in long-term, in-service training in “advanced counseling skills” (based on family and systemic paradigms) for a group of professionals identified through local centers, in conjunction with an international expert network
- e) Conduct short-term specialized training courses focused on services for suicidal cases, gender based violence victims and people with depression.

In the US

- f) Establish a *universal* protocol for mental health care for refugees upon arrival.
- g) Develop a curriculum and train resettlement staff in psychosocial approaches to social care.
- h) Build capacity of local mental health service providers in transcultural models and cultural competence.
- i) Provide specific cultural orientation and coaching for families upon arrival.

Implementation of the plan should take into account sustainability, impact on resident population in Nepal, resettled populations in the US and duplicability in other resettlement operations.

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