**[Closing the mental health gap](https://www.dawn.com/news/1773217/closing-the-mental-health-gap)**

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“A 50-YEAR-OLD man presented with myalgia, headache, loss of energy and appetite. He has lost seven kilograms in the last five months. He is sad with weeping episodes. He has difficulty waking up early in the morning and has lost his concentration. He has two handicapped children, ages seven and five, both completely blind. He is always thinking about them.”

The case above was reported by a doctor in Lower Dir last week after being trained to identify common mental disorders and offer pharmacological and psychosocial interventions in primary care. The training is part of a comprehensive, evidence-based and scalable model developed by the Ministry of Planning, Development & Special Initiatives (MoPDSI). In collaboration with the health department, KP, and the International Medical Corps, over 50 primary care doctors and clinical psychologists have been trained in five districts across KP thus far. The trained staff is now connected to a web portal through a mobile application, which allows them to confidentially send in data and seek supervision from experienced mental health specialists.

The intervention, designed to build the capacity of healthcare providers by implementing Mental Health Gap Action Programme (mhGAP) guidelines, is recommended by the World Health Organisation as a key strategy to integrate mental health at the primary healthcare level to overcome the gigantic treatment gap that exists in countries like Pakistan.

Consider: there are an estimated 1.5 million people in Lower Dir. It is estimated that 300,000 (20 per cent) of them are likely to suffer from a common mental disorder. Like 26 other districts in KP, there is no qualified psychiatrist in Lower Dir. In a few of these districts, there are either self-proclaimed psychiatrists with no formal qualification, or those with minimal qualification (diploma/MCPS) after one or two years of training at most, and practising mainly in the private sector.

It is not just the dearth of services but also the quality of care that is a concern.

KP has 37 districts. Peshawar, like other major urban centres, has high specialist resources with at least a dozen qualified psychiatrists in the public sector and an even higher number in the private sector. Then there are nine other districts that have a teaching hospital with at least two qualified psychiatrists. These districts can be said to have a moderate level of specialist resources. As far as clinical psychologists in the public sector are concerned, there are no posts outside teaching hospitals.

The indigenous burden of mental disorders in KP is compounded by security-related conflicts, economic crisis and climate hazards. The districts of Chitral and Kurram, for instance, are a troubling example of where high rates of suicide have been reported. Some parts of the province comprise a difficult terrain, which creates problems for residents to safely commute for accessing healthcare. The recent chairlift scare in Battagram is likely to induce severe post-traumatic reactions for affected families. But with a severe dearth of specialist resources and no existing services for mental health and psychosocial support (MHPSS) within the community, the only options for residents brave enough to seek help is to front the expenses and travel hundreds of miles for medical consultation in major cities, or resort to faith and faith healers.

It is not just the dearth of services but also the quality of care that is a concern. In our recent training workshops, it was evident that psychiatric practice, even in tertiary care hospitals, centres on a cursory biomedical approach. An average consultation lasts a few minutes, followed by a prescription heavily dictated by irrational polypharmacy. As is the case in the rest of the country, a powerful pharmaceutical industry seems to be subsidising these worrying trends.

Psychiatric outpatient clinics, both in the public and private sector, are overwhelmingly marked by throngs of despondent families, aspiring for scientific care but unlikely to get any. One example is the widespread practice of prescribing benzodiazepines (sleeping tablets), which are highly addictive. There is no regulatory system to check these practices. A particularly worrying case is that of a well-established institution in the province which offers in-patient care to a large number of patients supervised by unqualified staff — the ethics of which is highly disputable.

Across the province, the concept of psychological care barely exists. International humanitarian agencies have been investing in MHPSS services over the last few decades. These initiatives are project-based and time-limited, thereby unable to sustain or create any meaningful impact. Psychologists serving in these projects face job insecurity and few opportunities for supervision to strengthen their skills. Despite an alarming rise in the use of illicit substances, including methamphetamine crystals (ice), opioids, cannabis and alcohol, neither doctors nor psychologists are equipped to respond with basic psychosocial interventions. Worryingly, this gap is steadily being filled by unreliable commercial, often criminal, detoxification services.

Our experience of working with primary care physicians in KP showed that, depending on their parent institution, their knowledge and skills about mental disorders varies greatly. It is also not uncommon to find doctors who have graduated from Russia, China or Afghanistan with limited clinical skills. Almost all of them are involved in private practice and acknowledge that a vast majority of their patients present with mental health conditions. Unfortunately, they end up either dispensing a generic prescription or referring them to specialists without being able to offer a basic assessment themselves. Their interest in learning about managing these common conditions is encouraging, but they will need dedicated supervision for at least a period of six months before they can confidently and independently offer reputable and scientific care. This is particularly challenging, unless the role of psychiatrists in the teaching units is redefined.

The MHPSS plan by the MoPDSI is designed to offer evidence-based trainings on a large scale, provide ongoing supervision to the trained doctors and collect valuable relevant data. This can help change the landscape of mental healthcare in the province. To scale up this intervention, a strong coordinating mechanism is needed where all available resources can be utilised in a meaningful way.

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