

Psychiatry in Pakistan: 1947-2006: A new balance sheet

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Abstract

This review deals with the evolution of psychiatry in Pakistan since its inception in 1947. It describes the situation of psychiatric services, education and research through the years 1947-2006, presenting a picture of existing mental health scenario, suggesting the ways for improvement and comment on possible future developments. It concludes with the prediction of a revolutionary change in the current shape of psychiatry throughout the world and especially in Pakistan whereby psychiatry will change to organic-based discipline of a wider "Neurosciences".

Introduction

Pakistan: Background information: Pakistan is strategically important country in South Asia which is known for its geographic importance, its political situation and a rich culture. The predominant religion of the country is Islam and of the 159,196, 336 population, 97% are Muslims. Pakistan has more than 17 languages and numerous dialects; the composition of population is as: Punjabis-48%, Sindhis-12%, Pashtuns-8%, Mohajirs-8%, Saraikis-10%, Baluchis-2%, Brahuis-1% and the remaining others.¹ The official languages are Urdu and English. Among the other demographic features: the annual growth rate is 2.09%, population age structure is 0-14 (39%), 15-64 (56.9%), 65 years and over (4.1%), 1.05 male(s)/female, infant mortality rate of 70.45 daeths/1,000 live births, life expectancy at birth of 62.4 years for males and 64.44 years for females.² The literacy rate of total population is 48.7%, which according to local definition is 'anybody, aged 15 and above who can read or write'. With this low literacy background, a large number of people believe in supernatural things as a cause of their ill health and therefore seek help from shamans and other alternate practitioners.³ The average annual income of the individuals is US \$ 630 and the country has suffered from decades of political disputes, violence, terrorism, lawlessness, problems with safety and security which has lead it towards economic problems, rising poverty, joblessness and on top of that significant economic disparity.⁴ Because of the current foreign aid, the economy of government has improved but still more than 39% of population is below poverty line.⁵ The health care facilities

include 946 hospitals, 4554 dispensaries, 5290 Basic Health Units and sub health centers, 907 Mother and Child Health Centers, 552 Rural Health Centers and 289 TB Centers primarily run by provincial governments. There are 100131 doctors registered with the Medical Council and 18029 specialists. There is output of around 5000 medical graduates from both public and private medical colleges.⁶ The total number of psychiatrists is 300 for such a large population is a grossly small number. There are 125 psychiatric nurses, 480 mental health care psychologists and 600 mental health care social workers.⁷ About 0.4% is being allocated to mental health out of the total health care budget.⁸ The mental health in Pakistan has remained under debate for quite sometime in the background of low number of mental health practitioners, stigma attached to psychiatric care, poor facilities, limited awareness, illiteracy(<50%), concept about mental illness, alternate practitioners for mental health and low priority of government for mental health in the country.

Current Mental Health Scenario: Though a few studies conducted in Pakistan, the following tables will give an over all figure for all the four provinces which has been extrapolated from various sources⁹ (Tables: 1-5)

Table 1. Mental health morbidity pattern in Sindh

Mental illness	Urban	Rural
Depression	8%	9%
Schizophrenia & similar disorders	2.5%	2%
Psychosomatic disorders (dissociative/somatoform)	9%	2%
Seizure disorder	2%	2%
Substance abuse & related disorders	6%	3%
Obsessive compulsive disorder	1.2%	1%
Others	NA	NA

Table 2. Mental health morbidity pattern in Punjab.

Mental illness	Urban	Rural
Depression	8%	9%
Schizophrenia & similar disorders	2.5%	2%
Psychosomatic disorders (dissociative/somatoform)	9%	2%
Seizure disorder	2%	2%
Substance abuse & related disorders	6%	3%
Obsessive compulsive disorder	1.2%	1%
Others	NA	NA

Table 3. Mental health morbidity pattern in Baluchistan.

Mental illness	Urban	Rural
Depression	4%	2.5%
Schizophrenia & similar disorders	1%	1%
Psychosomatic disorders (dissociative/somatoform)	2%	1%
Seizure disorder	2%	2%
Substance abuse & related disorders	8%	4%
Obsessive compulsive disorder	2%	1%
Others	NA	NA

Table 4. Mental health morbidity pattern in NWFP.

Mental illness	Urban	Rural
Depression	5%	3%
Schizophrenia & similar disorders	2%	2.5%
Psychosomatic disorders (dissociative/somatoform)	2%	1%
Seizure disorder	2.5%	2%
Substance abuse & related disorders	8%	8.5%
Obsessive compulsive disorder	1%	1%
Others	NA	NA

A similar comparison of institution-based pattern of psychiatric disorders with a community based clinic pattern revealed the predominance of depression as given in Table 5.

Table 5. A comparison of institution-based pattern of psychiatric morbidity JPMC: Jinnah postgraduate Medical Institution, Karachi, Pakistan.

Mental illness	1997 JPMC N = 6,152	1997 Community Clinic N = 700
Depression	29.27%	51.6%
Schizophrenia	11.41%	6.9%
Anxiety disorder	3.65%	5.6%
Manic depressive disorder	4.01%	0.7%
Dementias	1.04%	2.1%
Epilepsy	4.8%	16.1%
Drug dependence	0.78%	1.6%
Psychosomatic disorders	0.21%	9.1%

A number of different studies mainly clinic based report varying rates for prevalence of depression. According to a country profile report by WHO Emro region, 10-16% of general population in Pakistan suffers from mild to moderate psychiatric illnesses in addition to the 1% suffering from severe mental illnesses.¹⁰ Extrapolation of prevalence rates for depression in Pakistan yields approximately 8,437,406 out of the 159,196, 336-population figure.¹¹ A study by Mirza and Jenkins¹² found that prevalence of anxiety and depressive disorders in Pakistan was 33%, associated with female sex, middle age, low level of education, difficulties with finances and

relationship problems. In a community based psychiatric clinic among all the patients who were seeking psychiatric help, 47% were found to be suffering from depression.¹³

In a community-based study¹⁴ conducted on an island of Karachi among adult women belonging to fisherman community, the point prevalence of depression was 7.5%. In another study conducted in Punjab, the adjusted prevalence of depressive disorders was 44.4%: 25.5% in males and 57.5% in females.¹⁵

There is a great need for more community-based studies along with improvement in data record keeping system in order to build a national data base.

Mental Health Services: The historical evolution and current context

At the time of independence in 1947, there were three asylum-like hospitals each at Hyderabad, Lahore and Peshawar with a total of 2000 beds. These were in a miserable shape with no psychiatrists and managed by medical officers only. These hospitals were called "Mad Houses" and patients were often brought in chains.¹⁶ This state of affairs went on for a number of years until the government decided to establish the first psychiatric units each at the Jinnah Postgraduate Medical Centre, Karachi and Government Mayo Hospital, Lahore in the years 1965 and 1967 respectively. Gradually, it was realized that there was a need for development of individual psychiatric units in all government hospitals which were attached with medical colleges. A number of such units in teaching hospitals were then established with acute shortage of mental health professionals. Many small psychiatric hospitals were opened in private sector throughout the country which were run by non-psychiatrists and allied mental health professionals. The establishment of psychiatric services at rural health centers and basic health units has remained a dream to date. At the moment, there are about 2,940 psychiatric beds available with the public sector while private sector in Karachi, which is the largest city, the number of existing psychiatric beds is 4529. The total estimated number of beds in private sector of the country are approximately 2000. Significant improvement in services was witnessed especially in Lahore where the old Lahore Mental Hospital was re-designated as a full institute, Sir Cowasji Institute at Hyderabad was elevated to a teaching hospital and major teaching hospitals were upgraded. Peshawar also made some progress over the years, while Quetta (Baluchistan) remained mediocre. Karachi (Sindh) has shown significant progress in private sector with active psychiatric units. One such unit was instrumental in bringing a revolutionary change in terms of awareness raising and referral. Many other non-

governmental organizations started psychiatric services at very nominal or no cost at all which gave great boost to the services. Some of these services include free provision of medications. With the help of private sector, services are now easy to avail and there is no waiting time unlike that in many developed countries.¹⁷ The private psychiatrist's fee would range from Rs. 200 (\$3.5) to Rs. 2000 (\$35) per consultation. The major typical and atypical psychotropic medications are easily available. The brand products are very expensive while the me-too products and those produced locally are relatively affordable. Over the years, psychiatric man power increased in number though still far from adequate for such a large population. At the moment there 250-300 psychiatrists available in the country. The recent brain drain has caused a blow to the existing services.¹⁸ There are 125 psychiatric nurses, 480 mental health care psychologists and 600 mental health care social workers.⁷ A large number of psychiatric patients are seen by family practitioners and alternate therapists and only 5-10% of the patients reach the psychiatrist mainly for the reasons of stigma, low awareness and cost factors. Regarding the different types of psychiatric services, forensic psychiatry is almost non-existent, very small number of child psychiatrist, practically few psychotherapists, and no geriatric, addiction, rehabilitation, learning disability or liaison psychiatrists.¹⁹

The alternate practitioners/shamans: A shaman in Pakistan is popularly known as "baba" or "pir". The other type of healer which is a religious healer is known as "sufi" who does not fall into the category of shamans but is well respected in the community and brings relief through holy verses and some other religiously sanctioned rituals. They are the disciples of saints and a large number of people have faith in their healing powers, hence shrines and other holy places are flocked by the masses, irrespective of educational or ethnic background, seeking cure especially for mental illness. It is also believed that Sufi saints are effective healers and even after their death has spiritual influence by virtue of which they can cure or provide relief. The shamans however, have no prescribed qualifications; their spiritual powers are either conferred upon or acquired through meditation, elaborate religious rituals or lengthy spiritual training. The number of practicing shamans is very high, only in Karachi, there are about 400 such practitioners. They practice at their residences, clinics, shrines or mosques and explain mental illness on the basis of possession by the evil spirit, by jinni or by magical influences cast by enemies. The treatment given includes amulets, spiritually treated water, burning incense or reciting incantations.²⁰ In Pakistan, where there is a dearth of psychiatrists, prevalent stigma for mental illness, poor socio-economic conditions and vast majority of population

living in rural areas depend more on shamanic treatment who have conferred benefits to patients suffering from grief reactions, reactive depression, psychosomatic disorders and anxiety neurosis.²⁰ Many shamans in Pakistan also act as medicine-men and would prescribe some medications.

Despite resentment by the mental health professionals, the shamans enjoy the acceptance of large masses of people who approach them for their mental health problems with less fear of stigma, low cost and easy accessibility. The current number of psychiatrists cannot effectively deal with the magnitude of mental health problems existing in the country and hence these shamans are sharing the burden though unofficially. In a doctoral study¹ it was emphasized that collaboration between shamans and psychiatrists may go a long way in addressing the mental health problems of the country. However, the system in Pakistan is also liable to abuse as there is a very loose grip on malpractices and in some shamanic practices, adverse outcomes have been reported including adverse reactions from drugs which are mentioned above, delay in getting appropriate medical treatment in cases of organic pathologies and even death during the rituals. It has been established that these shamans act as good counselors and psychotherapists and can be very useful for masses keeping in mind the dearth of professionals for a very large population²⁰.

Community Psychiatry Projects

1-Manora Health Project: This project was established under the aegis of Hamdard University, Karachi. The overall objective of this project was to provide basic preventive and curative health services to the deprived community of Manora Island with special emphasis on mental health services. The project started in beginning of year 2000 and at the end of third year in 2002 the evaluation showed remarkable progress and the common prevalent problems came down: depression declined from 11% to 4%, psychosomatic disorders from 3% to 2%, substance abuse from 2% to 1% while schizophrenia and seizure disorder remained same that is 1%. This has proved to be a model project by virtue of its ability to bring down the morbidity pattern of the island to an appreciable level. If this model is replicated nationally, the health scenario will show tremendous improvement.²¹

2- Fountain House Project: This project has been instrumental in providing in-patient and out-patient services to the residents of Lahore. Besides, it has an extensive program for rehabilitation of psychiatric patients in the community. The project is serving with distinction over a number of years. It has also trained a number of mental and allied health professionals working now in various parts of Pakistan. This model is akin to the famous New York

fountain house model.²²

School Health Programs: Training of school teachers on psychological issues is being undertaken by various non-government organizations and also by a public service set up where so far 150 education administrators from all provinces have been given orientation training. Such programs are instrumental in increasing the referral rates for patients needing psychiatric attention and hence form an important component of psychiatric services⁸.

Awareness raising programs: media and newspapers/books: A good number of programs on television and radio are being televised and broadcasted in which a number of mental health professionals have participated. The print media has also published a number of articles on mental health issues which are being reflected in more people seeking psychiatric help especially in the last two years. A number of books are written by distinguished psychiatrists and allied mental health professionals which has given boost to the understanding and subsequent presentation for intervention. Two worth-mentioning documentaries by the names of "Daachi" and "Manjhi" have reflected the mental health problems in a sensitive way depicting the predicaments of sufferers and their health care seeking approaches.²³

Current situation: When we come to service, though the major teaching hospitals have established separate departments of psychiatry but in most of the cases they are not well equipped specially in terms of psychiatric manpower both skill and number wise. Still Pakistan has very low number of psychiatrists and these too are continuously being drained by the developed countries especially by the western world where they are being offered so attractive package and lifestyle that it will become very difficult for them to come back and serve the nation.²⁴ It is not surprising that there are a large number of Pakistani psychiatrists in United Kingdom, United States, Canada, Australia and New Zealand apart from those in Middle East, Africa and South East Asia. A number of dedicated psychiatrists were threatened, bullied and harassed by fellow colleagues who either forced them to quit or deterred them from coming back to the country and offer services. The current feudal psychiatry is fortunately being eroded by young generation of psychiatrists. There is also acute shortage of allied mental health professionals. In view of poverty, low health budget, high cost of medicines there is huge economic burden on the patients.²⁵ There are some inherent weaknesses which include: hospitals not following the intake/admission criteria, no separate unit for subspecialties, no appropriate long stay units, no exit/discharge criteria, no rehabilitation services, no exchange of information between psychiatrists and family

practitioners, no proper advertisement of available services, no concept of day centers or day hospitals, ill developed community services, no central registry of patients and set policy for management systems in the psychiatric set ups and finally no internal referral system¹⁹. With this scenario, there is great need for improvement in service structure. The rural areas which are devoid of efficient services need attention. The government should provide a career structure to psychiatrists willing to work in rural areas and improve their salary packages.

State of Mental Health Education

Psychiatric Education at Undergraduate Level:

Pakistan Medical and Dental Council (PMDC), the regulatory body for the medical profession at the national level, considers psychiatry as a compulsory subject for teaching at the undergraduate level in the country and hence initiated the teaching in behavioral sciences as a subject right from the first year of the local bachelor degree programme i.e. MBBS (Bachelor of Medicine and Bachelor of Surgery). This subject has now been incorporated in the discipline of Community Health Sciences that is taught in Year 1 to Year 4. In the last final year, the subject of Psychiatry is taught in the form few theoretical lectures and a clinical clerkship for a period ranging from 3-6 weeks and is examined in the final year as part of General Medicine paper.²⁶

Though the recognition accorded by PMDC is a compelling factor for all medical colleges to give due regard to the teaching and practice of psychiatry, however the importance given in terms of marks allocation in the MBBS final examinations has caused the discipline to make little headway in medical education at undergraduate level. Therefore, in the medical colleges, only a few lectures in Behavioral Sciences in the pre-clinical years, and just a few more in Psychiatry during the clinical years, together, with some 8-10 demonstrations in the Psychiatry unit are all that is done and considered enough practically to satisfy the requirement of PMDC. As a consequence, the undergraduate medical students are not motivated to study this important discipline. However, some private-sector institutes recognize the significance of proper structured training and separate examination in Psychiatry at the undergraduate level.

The undergraduate psychiatric education is, thus, in despair, which is in sharp contrast to the situation in developed world where a large component of the syllabus is devoted to Psychiatry and Behavioral Sciences during undergraduate education. In addition, many of the qualifying / licensing exams such as the PLAB for U.K. and the USMLE for U.S.A give a lot of weightage to assessment of knowledge in Psychiatry and Behavioral Sciences.⁹

The step taken by PMDC (introducing the subject of behavioral sciences in the early academic years) is definitely a positive step though there is a dearth of trained behavioral scientists to impart education in this subject. The need for a separate written and clinical exam in Psychiatry is now being felt acutely at undergraduate level. As majority of medical graduates opt to become family practitioners, need for comprehensive teaching at undergraduate level is essential. With the current state, family practitioners are not fully equipped with required knowledge of psychiatry.²⁷

Psychiatric Education at Postgraduate Level

In Pakistan, an autonomous body with a close liaison of PMDC and the Government of Pakistan regulates the postgraduate education and training in medical profession. This body is the College of Physicians and Surgeons Pakistan (CPSP) with its main office in Karachi and regional offices in almost all the big cities of Pakistan. The college offers Membership (MCPS) and Fellowship (FCPS) exams in various disciplines of Medicine including Psychiatry. The CPSP is also responsible for accrediting academic and clinical institutes for postgraduate training and education in the various fields of Medicine across the country. The CPSP with the help of subject experts prescribe a training curriculum that is structured, competence-based and time-framed. In addition, it also acts as a resource and guidance centre for postgraduate research and continued medical education for health professionals in the form of training workshops and seminars. In the context of opportunities for post-graduation, the College at present is offering only FCPS in Psychiatry and has stopped awarding memberships (MCPS). The FCPS programme is conducted in two steps, Part-I & Part-II. The eligibility for FCPS-I is one-year internship after graduation (with or without an exposure in Psychiatry) and is mainly based on assessment of clinical applications of basic science knowledge relevant to psychiatry. Both the written papers comprise multiple-choice questions of one best type. Those declared successful in FCPS-I undergo at least four years of training in the relevant discipline at CPSP-recognized institutions under the supervision of CPSP-approved supervisors. Exemption from FCPS I is granted to those with the qualifications of Diplomate American Board of Psychiatry and FCPS-I Bangladesh.

The candidates have to submit a dissertation, before sitting for FCPS-II exam. The dissertation has to be written under the supervision of the immediate supervisor. Recently the College has given a choice to the candidates in lieu of the dissertation to publish two research papers as a first or second author in the Journal of the College of Physicians & Surgeons, Pakistan, or in journals listed in the MEDLINE. The FCPS Part-II examination consists of two written

papers, OSCE and a clinical assessment of the candidate in the field of psychiatry by a panel of examiners appointed by CPSP. The written papers assess the problem-solving and critical thinking abilities of the examinee through problem-oriented questions. To date, following is the number of successful candidates since inception.

1963-1980	1981-1991	1991-2000	2001	2002	2003	2004	2005	2006	Total
4	8	38	11	8	13	17	2	6	107

1965-1980	1981-1991	1991-2000	2001	2002	2003	2004	2005	2006	Total
26	83	65	9	5	--	--	--	--	188

The CPSP has a strict system of accreditation that is based on standards and criteria developed by the experts of that specialty. Since very few institutions have the needed infrastructure, expertise and caseload, hence the college recognizes only a very few institutions for postgraduate training in Psychiatry. Most of these institutions are in public sector with just a few in military and the private sector. The total number of recognized slots for FCPS training is 17 and for DCPS it is 12. DCPS is a new exam instead of MCPS which has been withdrawn. The requirements for DCPS is MBBS must have completed one year of recognized training, out of which six month should be in the chosen specialty. Deficiency of house job in chosen specialty will be made up by equal period of residency. (i.e. extra six months' postgraduate training). Training Program comprise of two years' structured training in a CPSP accredited training institution under CPSP approved supervisor after registration.²⁸

In order to meet the needs of the country, some institutes have tried to provide postgraduate training opportunities⁹. One such endeavor in the public sector is Diploma in Psychological Medicine (DPM) in affiliation with Punjab University; Diploma in Psychiatric Practice (DPP) that is initiated in collaboration with institutes in Egypt and London under the supervision of renowned psychiatrists from Fountain House, Lahore. The DPP is now being withdrawn.

Similarly, the postgraduate education programmes offered by many public sector universities - under their respective Faculty of Medicine - in the form of Doctor of Medicine in Psychiatry (MD). It is a two-year research-based educational program completed under the supervision of qualified supervisors and had an extensive examination of academic, clinical and research skills at the end. The available postgraduate clinical programmes in psychiatry in Pakistan are summarized in the following Table 6.

Table 6. Postgraduate education programmes in psychiatry in Pakistan (Source: Gadit A.

Programme	Name	Duration	Prerequisite	Institute
FCPS	Fellow of the College of Physicians & Surgeons	4 years of structured, competence-based training after Part-I	1 year internship for Part-I	CPSP
MD (Psychiatry)	Doctor of Medicine	2 years with completion of research thesis	3-5 years prior experience in psychiatry	Many public sector universities mainly Punjab & Karachi Universities
DPM	Diploma in Psychological Medicine	1 year full-time course	2 years prior experience in psychiatry	PGMI/ Punjab University
DPP	Diploma in Psychiatric Practice	1 ½ years full-time course (6 weeks full-time in certain conditions)	1-3 years prior experience in psychiatric practice / 5 years in general practice	Institute in Egypt and London (Names of Institute)

Therefore, despite hopes and assumptions of provision of high quality postgraduate education in Psychiatry, there lingers the question about its feasibility. The existing ground reality of having very few training slots, a large number of trainees, dearth of trained teachers, varying standards of different qualifications make it difficult to get standardized quality training.

Once certified, there is no provision of higher specialist training for a period of at least three years on the pattern of UK with evaluation of practice-based efficiency, infact; the UK model is worth adopting.²⁹ There is no trend for CME credit maintenance and hence no program specifically designed for psychiatrists though there are many such programs for the general practitioners of course with no condition of maintaining credit certification, this is mostly prompted by the pharmaceutical companies with a view of improving sale as evidence has shown that the knowledge of even the most common disorder depression was not adequate among general practitioners²⁷. There is an example of a pilot study conducted on the basis of an E-Mental health education where training and supervision was imparted through computer-based video-conferencing system with suggestions of adopting this method by virtue of which training can be imparted to local mental health professionals.³⁰

It appears that still we are far behind in achieving the standards and in order to improve the existing scenario some steps are essential. In order to bring improvement in

psychiatric education, it is important to pay emphasis on the subject of behavioral sciences, design an appropriate undergraduate training program in line with one of the international modules, inculcation of research interest among medical students, either introduction of a separate paper of psychiatry or at least 25% of weightage in the paper of medicine, at postgraduate level more structured training program with exposure to subspecialties, designing a postgraduate curriculum and module, introduction of audit of training and performance, provision of higher specialist training at the level of specialist registrar, private-public partnership in provision of services, mobilization of more resources for mental health and maintaining of records.

Mental health research in Pakistan

At the time of Independence, in the year 1947, and in the following years, Pakistan faced a setback due to mass emigration of educated, well-trained and experienced Hindu population to India. Moreover, with the migration of refugees from India to the newly established Pakistan created an enormous problem of their rehabilitation. The national economy was at low ebb and scarce resources had to be diverted to rehabilitation of the migrants.

In these critical times, Pakistan was also faced with mounting problems in the health and education sectors. Pakistan was able to establish the Pakistan Medical and Research Council (PMRC) but this body was not able to develop and sustain a culture of research in the early days for the reasons of : a strong beaurocratic nature of the working of PMRC, lack of the incentives for research workers, lack in guidance and training of medical students in health related research, frequent changes in political setup of the country with resultant lack of consistency in efforts of PMRC and failure in disseminating information to donor agencies.⁹

Hence medical research has made a delayed beginning in Pakistan, and continues to be given low priority both in medical education and the health system. Most of the medical research is hospital-based till to date and individual initiated rather than problem-oriented and, therefore, has limited relevance to national needs. There is poor communication between researchers, the users of the research and the policy makers who are generally unaware of the need to use research-based policy options.

In Pakistan, there is a felt need for local data for patient care, health management, service delivery, education, training, community development, prevention of diseases and maintenance of health. There is inadequate emphasis on research methodology in the curriculum of medical, dental and other health professionals, besides a dearth of trained epidemiologists and bio-stasticians in the country.³¹

While only a few psychiatrists contribute to international journals, their collective research output is insignificant. Besides, very few foreign journals publish articles from Asian countries.

Even in the local peer-reviewed journals, a dearth of scientific articles about mental health has been found. On searching the two most prestigious local journals, The Journal of Pakistan Medical Association (JPMA) and The Journal of College of Physicians and Surgeons, Pakistan (JCPSP) the situation was not encouraging. The JCPSP started its publication in the last quarter of year 1991 as a quarterly. It did not publish any article on Psychiatry till 1995. The first article was published in March-April 1995. JCPSP has so far published 64 articles on Psychiatry until November, 2006. The JPMA has published 42 articles from 2001-2006. If it is assumed that the journals not listed here (either for not covering psychiatry as a discipline or not being peer-reviewed) may also have some contributory articles, the list still would not go beyond a little over a hundred and thirty articles.

Publication of articles in the foreign journals is even more limited because of various reasons. A recent press report reveals that acceptance rate of scientific articles from Asia is very low by the international journals because it is assumed that research facilities in this part of the world are meager. It has been observed that only those articles find their way in the pages of reputed foreign journals in which co-author is of western origin.³²

The mental health professional conduct research mainly for the purpose of getting promotion and ascending the ladder of academic hierarchy, it is usually based on social issues, drug efficacy, patient turn over data and related themes but mostly descriptive type, need assessment and some epidemiological issues remains at the bottom of priority list and most of this research is hospital or clinic based rather than community based. Once the promotion is achieved at professorial level, the research contributions go down except the names appearing as joint authors in the publications of junior colleagues. Very few senior mental health professionals have produced monographs or books but none of these have found place in the current curriculum and reliance is still on foreign produced books. There are some constraints in conducting research which are paucity of time especially with busy clinicians, very little statistical support unless engaged with an academic institution of a university level, lack of training, and little knowledge about medical statistics especially the tests of significance, moreover, the representation in high impact international journals is low because of the afore-mentioned identified factors. Local developing world journals despite being indexed with index medicus still has to find place in the

high valued scientific literature from the developed world.

There was one journal by the name of Journal of Clinical Psychiatry published regularly from Lahore once upon a time but has disappeared eventually. The first journal of Pakistan Psychiatric Society by the name of JPSP was published in the year 2003 which was blocked politically and is now being produced again on net with a very little visibility.

Moreover, developing countries contribute only about 6% of articles to leading psychiatric journals. The reasons attributed to this fact are: low priority for research, lesser resources or limitations in research capacity and difficulties in reporting research due to language. Only four out of a total of 530 editorial board members of the ten psychiatric journals with the highest impact factor rating for the year 2000 were based in developing world.³³ An overwhelming majority (98%) of biomedical journals indexed in international databases are from the developed world. New evidence from developing countries is demonstrating the efficacy and cost effectiveness of treatments for common mental disorders, even in resource poor settings. Psychiatric studies from developing countries have been criticized because it is perceived that several of these studies have not investigated major psychiatric problems but have focused on non-significant problems, studies are donor-driven instead of national priorities, quality is poor, information generated is not well-documented but the facts that researchers have to work in extremely difficult conditions, psychiatric instruments used in developing countries to collect information are geared to western culture and their translation into local languages make their validity questionable, owing to the other common medical conditions low priority is given to mental health problems.³² Pakistan is one of the developing countries with huge mental health problems in the background of low health budget, low literacy, poverty, prevalence of many childhood and malnutrition related diseases, low research priority and motivation especially in the mental health area is a source of great dissatisfaction.

Comparison with the other developing countries:

Mental health research has gained much momentum in the neighboring country India that is evidenced by big representation of their mental health research contribution and similarly other countries in the regions are making efforts with the same force as in Pakistan. It is important to promote mental health research based on local needs in Pakistan in order to improve the local situation and to appear on the global arena along with the other developing as well as developed countries. The W.H.O. has taken a great initiative in promoting research in the developing countries and has recommended that in order to progress in

this direction it is essential to set a priority agenda, a research policy, research-friendly environment, capacity building and infrastructural support, availability of methodologies that do not require sophisticated infrastructural support and enhanced role of scientific journals and following these steps would help changing the current scenario in Pakistan.

Current Research Scenario: The current research is still very grim. There is a frightening increase in the incidence of mental illnesses that, if recognized and treated, may place a heavy economic burden on the families. In order to avoid this from happening, it is important that research should be carried out in order to understand the root causes, especially the social causes. This would help in identifying preventive aspect and planning mental health promotion strategies. It is also vital for the policy makers to understand the real issues, possible only through research, who then can devise effective policies and help in the promotion of research.

Currently, there are only a few books and booklets written by local authors but none of these are accepted as authentic document that students can follow and can be used in teaching. The reliance is still on foreign written textbooks. Under the present circumstances, it is essential that Pakistani authors produce authentic work in the form of textbooks and reference books, which focus the local problems, and identify the remedial strategies.³¹

In Psychiatry, there is a great need for community-based prevalence studies, which can form a rich database and help to understand the real magnitude of mental illness. Adequate funding for basic research is also scarce, especially for issues related to mental health due to low priority given to the discipline. There is a problem in getting appropriate funding as apart from W.H.O., no other international agency has shown interest in mental health research. Higher Education Commission of Pakistan has now developed interest in promoting research at all levels and it is hoped that improvement will be visible in due course of time.

It is imperative for the senior academicians to contribute scientific articles regularly and arrange for training of their junior counterparts. It is also important to generate interest right from the undergraduate level.

Mental Health Legislation: The government has repealed the Mental Health Act of 1912 and promulgated a new mental health law in the year 2001. The ordinance provides for the prevention of mental illnesses, promotion of mental health literacy, establishment of community based services and will emphasize on protection of human rights of the patients. With the existing scenario of gross violation of human rights, this legislation is commendable as it has

incorporated this issue. Ironically, this new mental health legislation lacks the description of specific roles and effectiveness in mental health action and programmes attributed to each sector of governmental and non-governmental organizations. Specific and religious promotive, preventive and rehabilitative actions are not identified. The same is true for interventions involving vulnerable age groups, psychological needs and orientation to training and research activities. The missing part is realization of equity-i.e., equal access and equitable distribution of health resources, continuity, community participation and periodic review. The federal health authority as well as the provincial one was not established properly, no training was imparted to those who were hand picked, private sector was totally ignored which now forms the major component of mental health sector and it was widely publicized. With the existing health budget and infrastructure, the implementation of this act will not be possible unless government enters into partnership with non-governmental organizations and private psychiatric set-ups. The legislation so far has not shown its effectivity and has remained a beautiful piece of document.³⁴

10th Five Year Plan-2005-10: The plan aims at working towards: adoption of biopsychosocial model, integration of mental health in health care at all levels, public-private partnership, formation of bilateral links between the teaching hospitals and the peripheral units, the public health approach to health care and participation of the public representatives. Some strategic themes also include: man power development, public education and awareness, de-stigmatization through promoting mental health literacy, service development and provision, development of "Mental Health Friendly Hospitals", facilities for substance dependent persons, development of sub-specialties like child, old age and forensic psychiatry, development of a national institute of Elderly Health, setting up of crisis centers through organized multi-sectoral collaboration.³⁵

The National Health Policy: The national health policy of Pakistan concentrates on poverty alleviation, priority attention to primary and secondary sectors of health to replace the earlier concentration on tertiary care and seeing good governance as the basis of health sector reform to achieve quality care. The mental health policy was first formulated in 1997 which addressed issues of advocacy, promotion, prevention, treatment, rehabilitation and intersectoral collaboration. It envisaged to train primary care providers, to establish resource centers at teaching hospitals and psychiatric and detoxification centers. There was provision for crisis intervention and counseling services, special facilities for mentally handicapped and up gradation of large mental hospitals. The allocated mental

health budget is 0.4% of total health care expenditures. As such the policy for mental health is not comprehensive and do have multiple lacunae.

Development of the mental health policy.³⁶ The mental health field is affected by many policies, standards and ideologies that are not necessarily directly related to mental health. While formulating such a policy, it is necessary to consider the social and physical environment in which people live along with ensuring intersectoral collaboration. There are recommended steps by W.H.O., for developing policy: Step 1: gathering information and data based on population needs which can be extrapolated from prevalence and incidence studies, Step 2: gathering evidence for effective strategies by reviewing the local and international literature and visiting local services, Step 3: consultation and negotiation by listening to various stakeholders and to make proposals that blend their different views with the evidence derived from national and international experience. Step 4: exchange with other countries in terms of experience sharing in order to learn about both the latest advances in more developed countries and about creative experiences and lower cost interventions in less developed countries. Help from international experts is also worthwhile. Step 5: deals with setting of principles and objectives aiming at improving the health of population, responding to the people's expectations and providing financial protection against the cost of ill health. Step 6: Involvement of other sectors like: financing, legislation and human rights, organization of services, human resource training, promotion, prevention and rehabilitation, essential drug procurement and distribution, advocacy, quality improvement, information systems, research and evaluation of policies and services and intersectoral collaboration. Finally in step 7: to identify the roles and responsibilities of different sectors like: governmental agencies (health, education, employment, social welfare, housing, justice), academic institutions, professional associations, general health and mental health workers, consumer and family groups, providers, non-governmental organizations (NGOs) and traditional health workers. Once these steps are followed, a proper mental health plan can be developed stepwise culminating in implementation and subsequent evaluation.

Are the steps being followed? Ironically, Pakistan has a dearth of prevalence and incidence studies as research has not been an important and strong component among the health professionals³¹. There are hardly any organized national studies on mental health morbidity, the information management system is deficient and there is no compulsion on hospitals to send vital statistical information to the central bureau of statistics and hence figures about mental diseases are not easily available. The current figures which

are frequently quoted are because of the efforts of few devoted researchers. The information about existing services is not fully available with the government and hence in their citations, the government would usually mention the work of one department in Rawalpindi and would normally ignore any other source of information. There is an incomplete list of stakeholders with the government and hence it is deprived of the vital information in connection with services and individual contributions. There is 0.4% mental health budget which is grossly insufficient, no health card or health insurance through the courtesy of government. The involvement of other sectors is not in full potential and their expected role is ill defined. Under the circumstances, despite a tall claim has been made in the country profile report produced by W.H.O., the question remains whether there is a mental health policy? The dearth of mental health research negates the existence of any such policy as it is essential for a proper mental health policy to utilize the health research findings. To make a modest beginning, it is worth exploring the 'Newfoundland provincial policy framework model'³⁷. Producing show-case documents just for the sake of creating pseudo-impression will lead us to nowhere as it is high time when mental health should be taken seriously.

Discussion

Where do we stand? From 1947 to 2006, almost 59 years have passed since the independence of the country and many countries with this age have done wonders in overall upkeep of health care and specially the mental health. The scenario though is improving, but at a very low pace. With the exception of very few institutions, the subject of behavioral sciences which has been introduced by the PMDC in the early years of medical teaching is not being taken serious enough, low number of behavioral scientists cannot alone to be blamed for this, there are no structured rotation program for senior medical students which means a calendar indicating topics, patient sessions, log book and evaluation strategy with weightage in the final year marking system. Low interest by students in the subject of psychiatry despite few institutions' model teaching/training program is understandable in view of no separate paper in psychiatry and very low representation in the paper and clinico-oral of the subject of General Medicine. Regarding the postgraduate education, hardly any recognized center follow structured program emphasizing adequate patient exposure, ongoing continuing medical education programs, research, exposure to subspecialties like, child, geriatric, forensic and rehabilitation psychiatry etc. There is no rural exposure, little training in cultural issues, low emphasis on liaison service and multidisciplinary team approach, no standard methodology for continuous monitoring and

evaluation. There is no devised system for audit and psychiatric administration. It is precautionary not to say a word about the selection criteria of evaluators and examiners lest it is not politically biased and motivated. It is also worth noting that during postgraduate training how many of the prospective specialists are monitored and assessed for culturally relevant mental state examination, adequate case note management, observation of prescribing practices and its justification, communication skills, ethical behavior and understanding. No provision of higher specialist training after certification as mentioned earlier. Major departments in teaching hospitals are not well equipped, psychiatric man power is not sufficient, rather it getting problematic with brain drain.

There is also acute shortage of allied mental health professionals. In view of poverty, low health budget, high cost of medicines there is huge economic burden on the patients.⁶ The hospitals also don't follow the intake/admission criteria, no separate unit for subspecialties, no appropriate long stay units, no exit/discharge criteria, no rehabilitation services, no exchange of information between psychiatrists and family practitioners, no proper advertisement of available services, no concept of day centers, day hospitals, ill developed community services, no central registry of patients and set policy for management systems in the psychiatric set ups and finally no internal referral system.

Research has not made any substantial advancement. It appears that still we are far behind in achieving the standards and in order to improve the existing scenario some steps are essential. In order to bring improvement in psychiatric education, it is important to pay emphasis on the subject of behavioral sciences, design an appropriate undergraduate training program in line with one of the international modules, inculcation of research interest among medical students, either introduction of a separate paper of psychiatry or at least 25% of weightage in the paper of medicine. At postgraduate level more structured training program with exposure to subspecialties, designing a postgraduate curriculum and module, introduction of audit of training and performance, provision of higher specialist training at the level of specialist registrar, private-public partnership in provision of services, mobilization of more resources for mental health and maintaining of records. There is a need for development of research culture especially in the areas of need assessment. Along with these efforts the medical fraternity can force the government to allocate higher budget, reduce poverty, bring social justice and harmony, improving political scenario and creating better incentives for the mental health professionals in order to avert brain drain and make efforts in providing a conducive environment to the public which could help them

in promoting sound mental as well as physical health.¹⁹

What lies in future? With the increasing awareness through media and some pressure on the government, there may be a possibility of availability of adequate funding for the promotion of mental health. However, the active participation of NGOs and the private medical sector may give a boost to the existing fragile system. It will not be surprising that the private sector will gain upper hand in promoting and establishing mental health in true sense. The general practice pattern in Pakistan will change eventually in line with the shared care model. This optimism is based on increasing motivation among the general practitioners and recently introduced MRCGP training and examination for family practitioners in Pakistan. Continuing medical education program will go at a faster pace and more community based psychiatry will come in picture. With the new generation of psychiatrists, the old 'feudal psychiatry' will meet its eventual death and the magnitude of bullying and harassment will meet its fate through a possible appointment of "Medical Ombudsman". Though, biological psychiatry is the main mode of practice at the moment but there is every likelihood of psychotherapeutic models being increased and become part of the trend. There is a growing interest in genetics the world over and Pakistan will not remain immune to its importance in psychiatry.

In the next 59 years, it is likely that the literacy rate will increase and hence the people will have more insight and education about mental illnesses, there will be more advocacy for people with mental illness, there will be more collaboration with other disciplines, ethical issues will be given due importance and there will be more understanding about gene expression in vulnerable individuals, dynamics of various psychopathologies, relation of physical illness with the mental disorder, effect of aging on mental health and the causation of symptoms on the basis of some organicity. There will be a question as to whether neurology and psychiatry will remain as separate disciplines or will become one discipline of "Wider Neurosciences". Will psychiatry become "Organic Psychiatry" in its totality? One thing is for sure that the shape of psychiatry will not remain the same as it is in the given moment in time.

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