

WHO-AIMS

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN PAKISTAN



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

PAKISTAN

2009



**Ministry of Health
PAKISTAN**

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

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website. http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

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

Pakistan's mental health policy was last revised in 2003. the mental health plan was also last revised in 2003. The disaster/emergency preparedness plan for mental health was last revised in 2006. The mental health legislation was enacted in 2001 and it focused on the access to mental health care including access to the least restrictive care; rights of mental health service consumers; family members, and other care givers; competency, capacity, and guardianship issues for people with mental illness; voluntary and involuntary treatment; accreditation of professionals and facilities; law enforcement and other judicial system issues for people with mental illness; mechanisms to oversee involuntary admission and treatment practices; and mechanisms to implement the provisions of mental health legislation.

A national mental health authority exists which provides advice to the government on mental health policies and legislation. The mental health authority also is involved in service planning, service management and co-ordination and in monitoring and quality assessment of mental health services. Mental health services are not organized in terms of catchment/service areas.

There are 3729 outpatient mental health facilities in the country, of which 1% are for children and adolescents only. These facilities treat 343.34 users per 100,000 general population. The average number of contacts per user is 9.31. Forty-six percent of outpatient facilities provide follow-up care in the community, while 1% has mental health mobile teams. In terms of available interventions, 1- 20% of users have received one or more psychosocial interventions in the past year. 624 Community-based psychiatric inpatient units are available in the country for a total of 1.926 beds per 100,000 population. 1% of these beds in community-based inpatient units are reserved for children and adolescents only.

Five mental hospitals are available in the country; these are organizationally integrated with mental health outpatient facilities. In the last five years the number of beds in mental hospitals has raised up to four percent. In addition to beds in mental health facilities, there are also 0.02 beds for persons with mental disorders in forensic inpatient units and 1620 in other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc.

Twenty seven percent of the training for medical doctors is devoted to mental health, in comparison to 3% nurses and 11% non-doctor/non-nurse primary health care workers. In terms of refresher training, 16% of primary health care doctors have received at least two days of refresher training in mental health, while 5% of nurses and 13% of non-doctor/non-nurse primary health care workers have received such training.

The total number of human resources working in mental health facilities or private practice per 100,000 population is 87.023. The breakdown according to profession (raw numbers) are as follows: 342 psychiatrist, 25782 other medical doctors (not specialized in psychiatry), 13643 nurses, 478 psychologists, 3145 social workers, 22 occupational therapists, 102597 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors).

Forty five percent of psychiatrists work only for government administered mental health facilities, 51% work only for NGOs/for profit mental health facilities/private practice, while 4% work for both the sectors. As for nurses, 6582 work in outpatient facilities, 7018 in community-based psychiatric inpatient units and 43 in mental hospitals. In regards to other health or mental health workers, 101055 work in outpatient facilities, 1308 in community-based psychiatric inpatient units and 234 in mental hospitals. In terms of staffing in mental health facilities, there are 187 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 14 psychiatrists per bed in mental hospitals.

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 2.1 medical doctors (not specialized in psychiatry); 1.5 nurses (not specialized in psychiatry); 0.002 psychiatrists; 0.07 psychologists with at least 1 year training in mental health care; 0.008 nurses with at least 1 year training in mental health care; 0.005 social workers with at least 1 year training in mental health care; 0.002 occupational therapists with at least 1 year training in mental health care. The 1-20% of psychiatrists emigrates to other countries within five years of the completion of their training.

The government provides economic support for both consumer and family associations. Family associations have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. Government agencies (e.g., Ministry of Health or Department of mental health services); NGOs; professional associations, private trusts; and foundations, International agencies have promoted public education and awareness campaigns in the last five years. In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and the departments/agencies responsible for primary health care/ community health, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection, education, employment, housing, welfare, criminal justice, the elderly, and other departments/Agencies.

Introduction

Pakistan is a country with an approximate geographical area of 803,940 square kilometres and a population of 160,943,000 people (WHO, 2005). The main languages used in the country are Punjabi, Sindhi, Siraiki, Pashtu, and Urdu. The main ethnic group is Punjabi and the others are Sindhi, Siraiki, Pashtun, and Muhajir. The largest religious group include Muslims. In addition, there is a small Hindus and Christian population. The country is a low income group country based on World Bank 2004 criteria.

Forty-three percent of the population is under the age of 15 and seven percent of the population are over the age of 60. Sixty-eight percent of the population is rural. The life expectancy at birth for males is 62 and 63 for females. The healthy life expectancy at birth is 54 for males and 52 for females. . The literacy rate for men is 62% and the 37.5% for women. The proportion of the health budget to GDP is 3.9. There is less than one hospital bed per 100,000 population and 85 general practitioners.

Data was collected at the end of 2008 and is based on the year 2008.

Domain 1: Policy and Legislative Framework

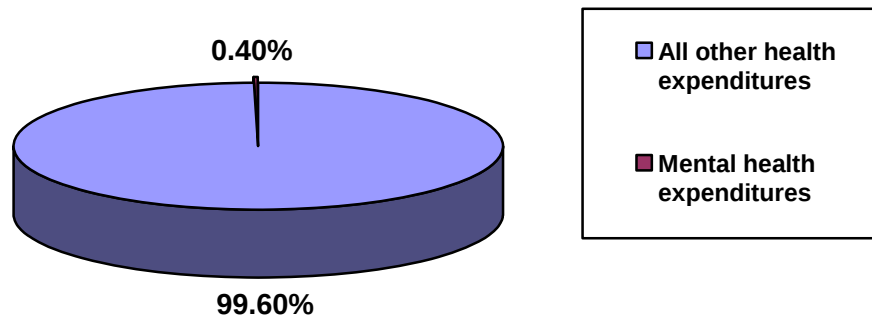
Pakistan's mental health policy was last revised in 2003 and includes the following components: (1) developing community mental health services, (2) downsizing large mental hospitals, (3) developing a mental health component in primary health care, (4) human resources, (5) involvement of users and families, (6) advocacy and promotion, (7) human rights protection of users, (8) equity of access to mental health services across different groups, (9) financing, and (10) monitoring system. In addition, a list of essential medicines is present. These medicines include Antipsychotics, Antidepressants, Mood stabilizers and Antiepileptic drugs.

The last revision of the mental health plans was in 2003. This plan contains the same components as the mental health policy but also includes reforming mental hospitals to provide more comprehensive care, and quality improvement. In addition, a budget, a timeframe and specific goals are identified in last mental health plan.

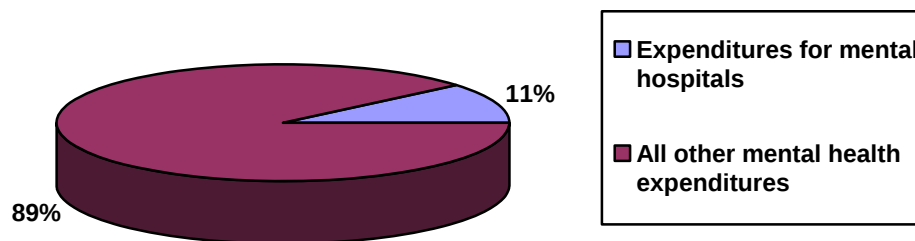
A disaster/emergency preparedness plan for mental health is present and was last revised in 2006. The last piece of mental health legislation was enacted in 2001, which focused on the (1) access to mental health care including access to the least restrictive care, (2) rights of mental health service consumers, (3) family members, and other care givers, (4) Competency, capacity, and guardianship issues for people with mental illness, (5) voluntary and involuntary treatment, (6) accreditation of professionals and facilities, (7) law enforcement and other judicial system issues for people with mental illness, (8) mechanisms to oversee involuntary admission and treatment practices, and (9) mechanisms to implement the provisions of mental health legislation.

0.4% of health care expenditures by the government health department are devoted to mental health. Of all the expenditures spent on mental health, 11% are devoted to mental hospitals. The rate of spending on mental hospitals is lower than other low and middle income countries (LAMICs) as Pakistan did not inherit large mental hospitals, except the one at Lahore that is being downsized, and more facilities are being set up at the district hospital level (secondary level). 5% of the population has free access (at 80% least covered) to essential psychotropic medicines. For those that pay out of pocket, the cost of antipsychotic medication is 3% and antidepressant medication is 7% of the one day minimum daily wage in the local currency. None of the mental disorder is covered by social insurance schemes. The cost of antipsychotic medication is 2 dollars per day, and the cost of antidepressant medication is 5 dollars per day.

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



A national human rights review body exists which has the authority to oversee regular inspections in mental health facilities, review involuntary admission and discharge procedures; review complaints investigation processes; and the review body has the authority to impose sanctions (e.g. withdraw accreditation, impose penalties, or close facilities that persistently violate human rights). 100% of mental hospitals had at least one review/inspection of human rights protection of patients in 2008, while 6 % of community-based inpatient psychiatric units and community residential facilities had such a review. 100% of mental hospitals and 5% of inpatient psychiatric units & community residential facilities have had at least one day training on human rights protection of patients in the last two years.

Domain 2: Mental Health Services

A national mental health authority exists which provides advice to the government on mental health policies and legislation. The mental health authority also is involved in service planning, service management and co-ordination and in monitoring and quality

assessment of mental health services. Mental health services are not organized in terms of catchment/service areas.

There are 3729 outpatient mental health facilities available in the country, of which 1% is for children and adolescents only. These facilities treat 343.34 users per 100,000 general population. Of all users treated in mental health outpatient facilities, 69% are female and 46% are children or adolescents. The users treated in outpatient facilities are primarily diagnosed with neurotic, stress related and somatoform disorders (33%) and mood disorders (30%).

The average number of contacts per user is 9.31. Forty-six percent of outpatient facilities provide follow-up care in the community, while 1% has mental health mobile teams. In terms of available interventions, 1- 20% of users have received one or more psychosocial interventions in the past year. 33% of mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round. Day treatment facilities are not available in the country.

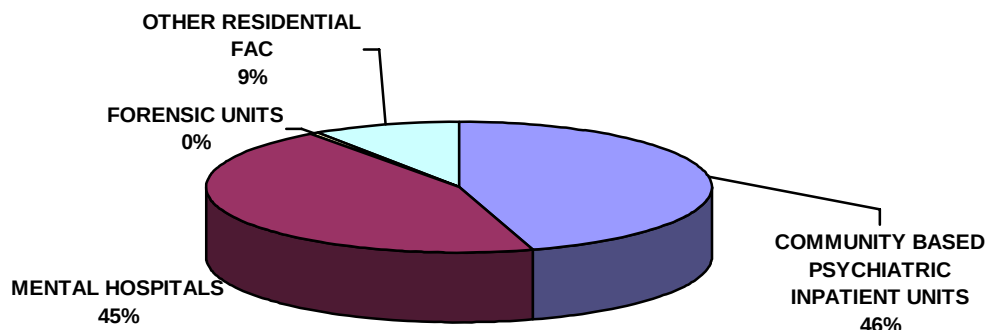
Six hundred and twenty four (624) Community-based psychiatric inpatient units are available in the country for a total of 1.926 beds per 100,000 population. 1% of these beds in community-based inpatient units are reserved for children and adolescents only. 75% of admissions to community-based psychiatric inpatient units are female and 18% are children/adolescents. The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following two diagnostic groups Mood [affective] disorders (46%) and neurotic, stress related and somatoform disorders (32%). On average patients spend 17 days per discharge. 1-20% patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. 34% of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility. Community residential facilities are not available in the country.

There are five mental hospitals available in the country for a total of 1.9 beds per 100,000 population. 100% of these facilities are organizationally integrated with mental health outpatient facilities. The number of beds has raised 4% in the last five years. The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: (1) mood [affective] disorders (31%), and (2) neurotic, stress related and somatoform disorders (24%). The average number of days spent mental hospitals is 49.9. Eighty-four percent of patients spend less than one year in mental hospital; 8% of patients spend 1-4 years; 3% of patients spend 5-10 years; and 4% of patients spend more than 10 years in mental hospitals. 1-20% patients in mental hospitals received one or more psychosocial interventions in the last year. 100% of mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

In addition to beds in mental health facilities, there are also 0.02 beds for persons with mental disorders in forensic inpatient units and 1620 in other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. In forensic inpatient units 76% of patients spend less than one year; 24% of patients spend 1-4 years; 0% of patients spend 5-10 years; and 0% of patients spend more than 10 years.

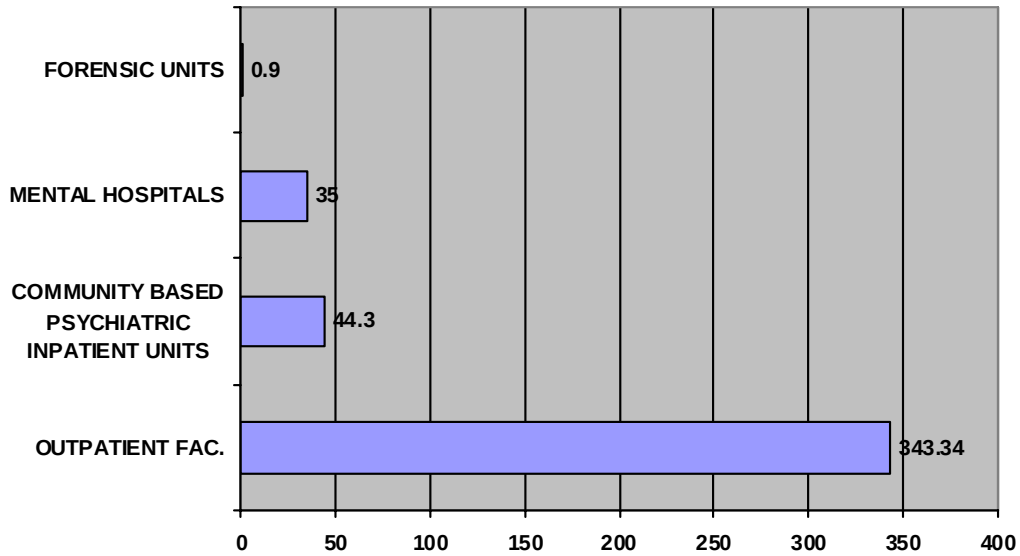
1% of all admissions to community-based inpatient psychiatric units and 30% of all admissions to mental hospitals are involuntary. Over 20% of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, in comparison to 6-10% of patients in mental hospitals. The density of psychiatric beds in or around the largest city is 2.15 times greater than the density of beds in the entire country. Such a distribution of beds facilitates access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



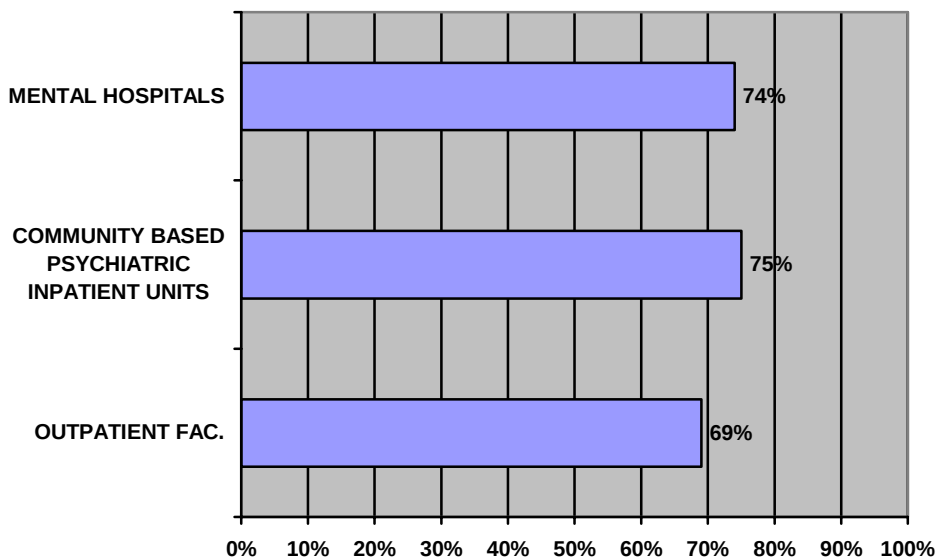
The majority of beds in the country are provided by mental hospitals, and community based psychiatric inpatient units.

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



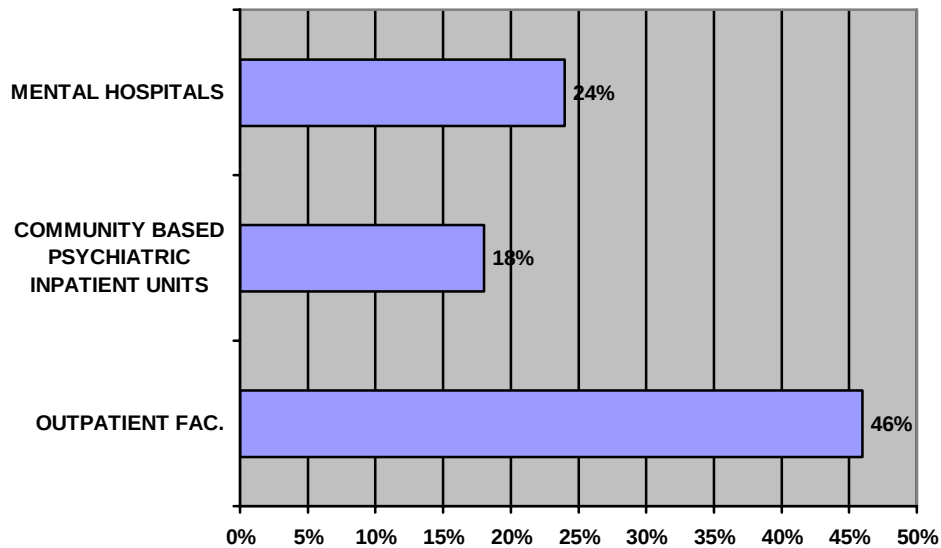
The majority of the users are treated in outpatient facilities, inpatient units and in mental hospitals respectively, users treated in forensic units is quite low.

**GRAPH 2.3 - PERCENTAGES OF FEMALE USERS
TREATED IN MENTAL HEALTH FACILITIES**



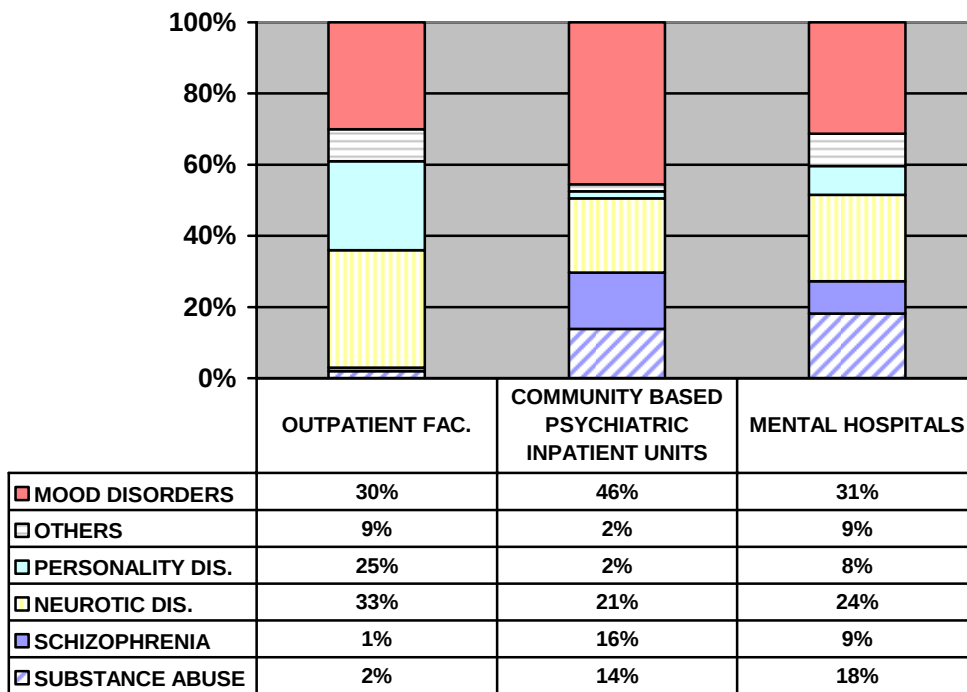
Female users make up over 69% of the population in all mental health facilities in the country. The proportion of female users is highest in inpatient units and lowest in outpatient facilities.

GRAPH 2.4 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS

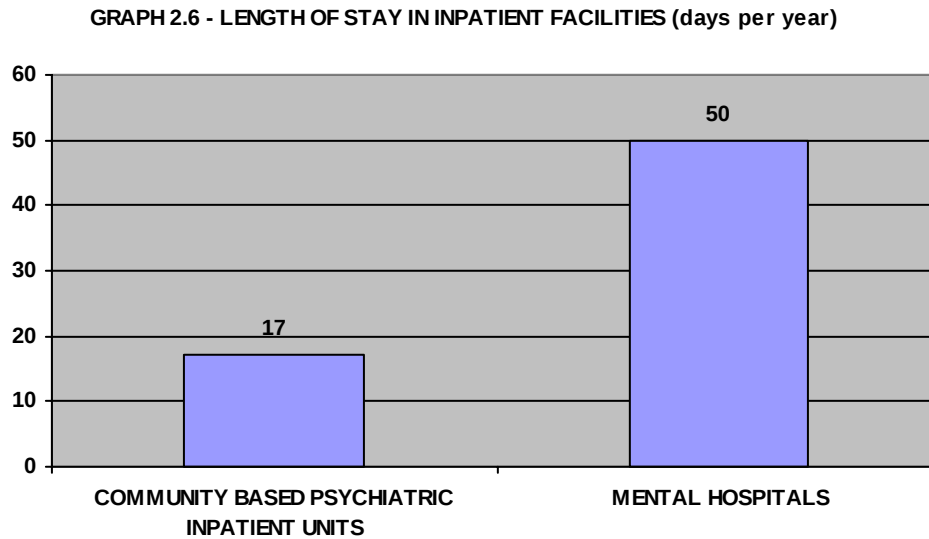


The percentage of users that are children and/or adolescents varies substantially from facility to facility. The proportion of children users is highest in mental health outpatient facilities and lowest in community based psychiatric inpatient units.

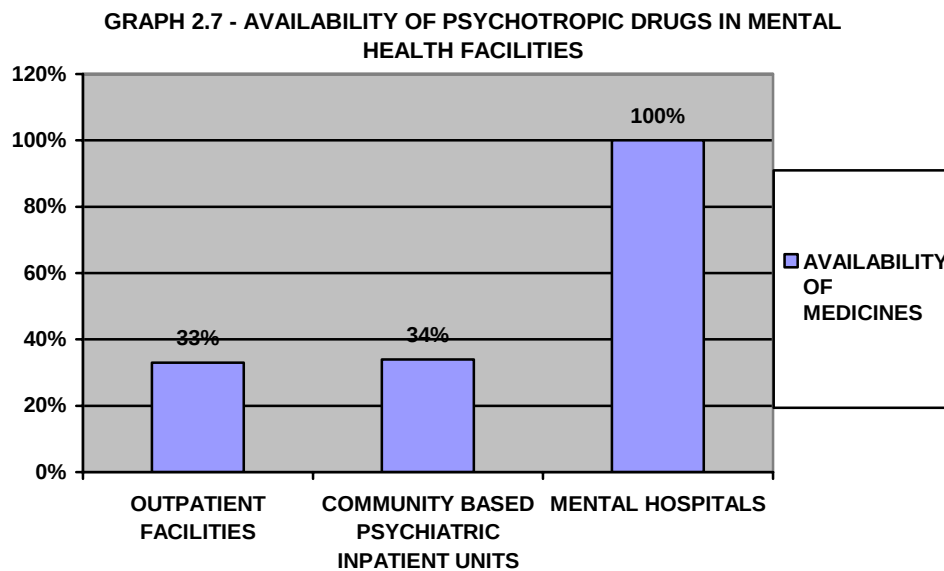
GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



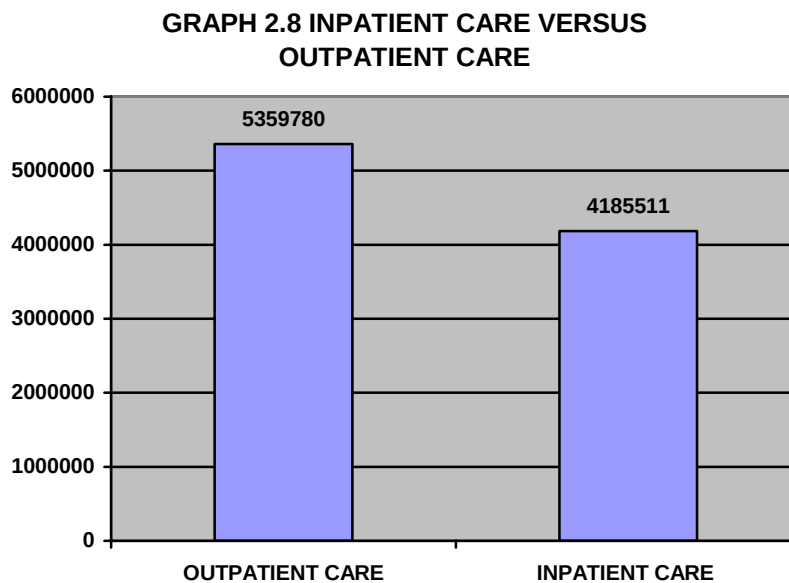
The distribution of diagnoses varies across facilities: in outpatients facilities neurotic disorders and mood disorder are most prevalent, within in-inpatient units again mood disorder and neurotic disorder diagnoses are equally most common, and in mental hospitals mood disorder are most frequent.



The longest length of stay for users is in mental hospitals, while the community residential facility is not available in Pakistan.



Psychotropic drugs are mostly widely available in mental hospitals, followed by inpatient units, and then outpatient mental health facilities.

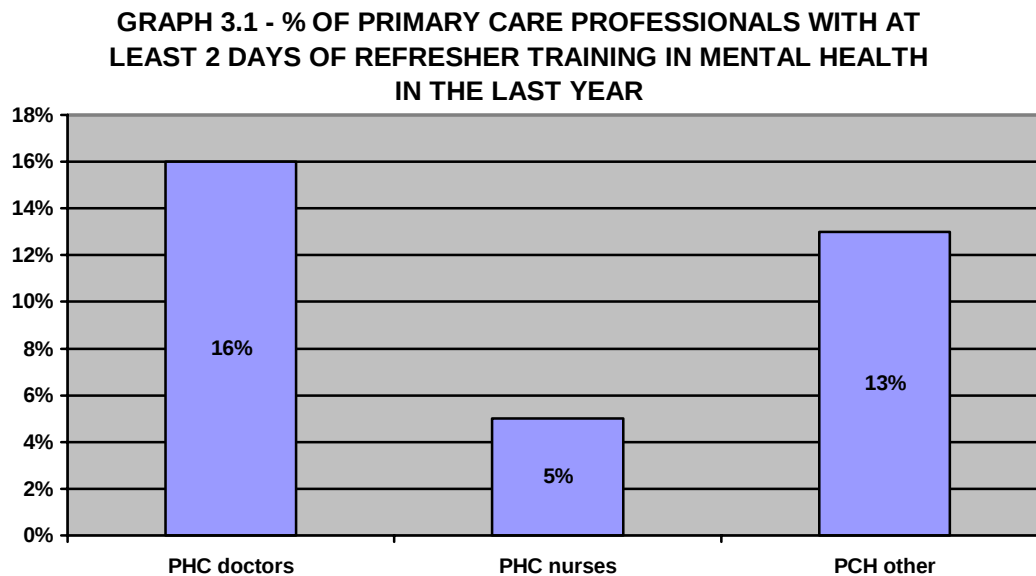


The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals, residential facilities and general hospital units) is an indicator of extent of community care: in Pakistan the ratio is 1.28:1. This means that there is slightly more than one outpatient contact per day spent in inpatient care.

Domain 3: Mental Health in Primary Health Care

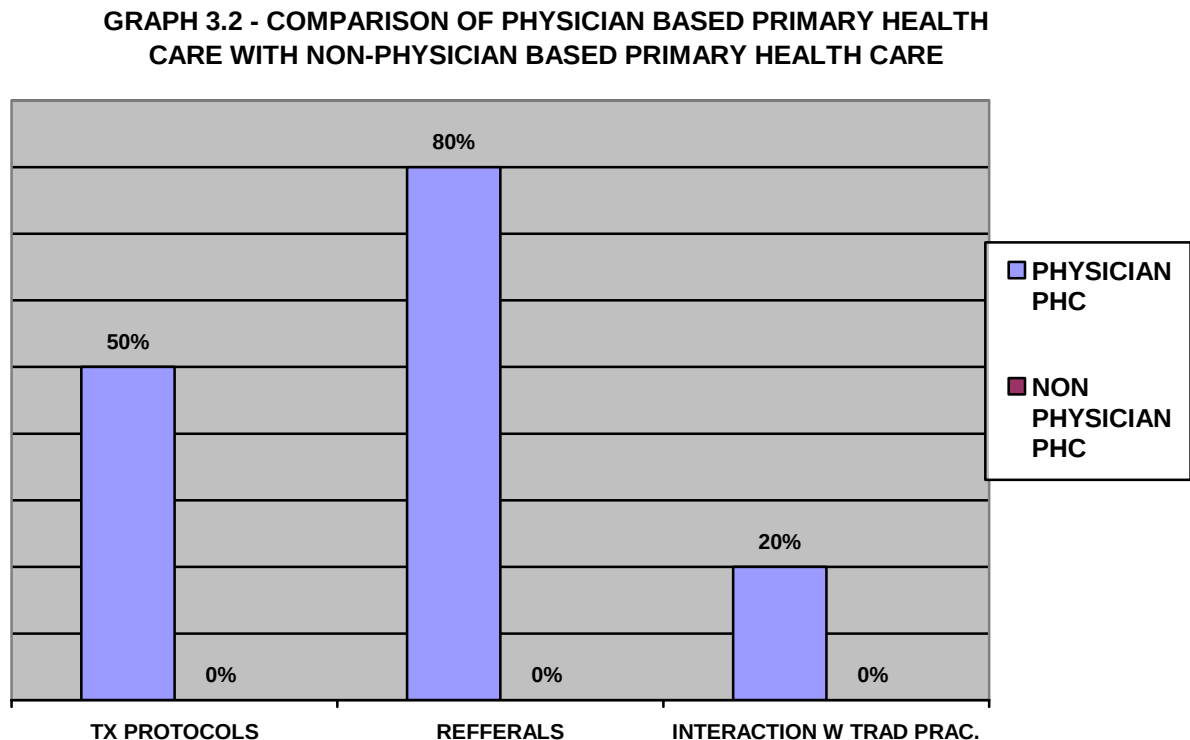
Twenty seven percent of the training for medical doctors is devoted to mental health, in comparison to 3% nurses and 11% non-doctor/non-nurse primary health care workers. In terms of refresher training, 16% of primary health care doctors have received at least two days of refresher training in mental health, while 5% of nurses and 13% of non-doctor/non-nurse primary health care workers have received such training.

Graph 3.1: Percent of primary health care professionals with at least two days of refresher training in mental health in the last year



Only physician-based primary health care clinics are present in the country. In terms of physician-based primary health care clinics, some (between 21 - 50%) has assessment and treatment protocols for key mental health conditions available. 21 - 50% of physician-based primary health care doctors make on average at least one referral per month to a mental health professional. None of the non-physician based primary health care clinics make a referral to a higher level of care. In terms of professional interaction between primary health care staff and other care providers, 1-20% of primary care doctors have interacted with a mental health professional at least once in the last year. 1-20% of physician-based PHC facilities have had interaction with a complimentary/alternative/traditional practitioner, in comparison to 1-20% of mental health facilities.

Graph 3.2: Comparison of physician-based primary health care with non-physician based primary health care



Nurses and non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications, in any circumstance. Whereas, primary health care doctors are allowed to prescribe psychotropic medications without restrictions. As for availability of psychotropic medicines, a few of the clinics (1-20%) of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a nearby pharmacy all year long in comparison to a majority of clinics (51-80%) in non-physician based primary health care.

Domain 4: Human Resources

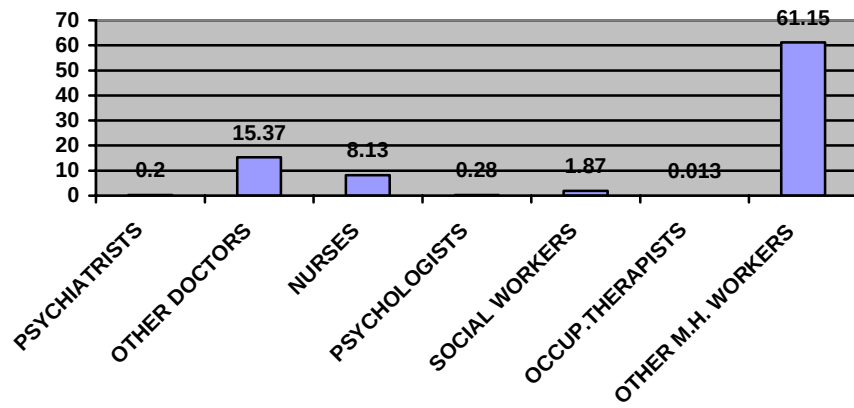
The total number of human resources working in mental health facilities or private practice per 100,000 population is 203.07. The breakdown according to profession is as follows: 342 psychiatrist (0.20 per 100,000), 25782, other medical doctors (not specialized in psychiatry - 15.37 per 100,000), 13643 nurses (8.13 per 100,000), 478 psychologists (0.28 per 100,000), 3145 social workers (1.87 per 100,000), 22 occupational therapists (0.01 per 100,000), 102597 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health

assistants, medical assistants, professional and paraprofessional psychosocial counselors - 61.15 per 100,000).

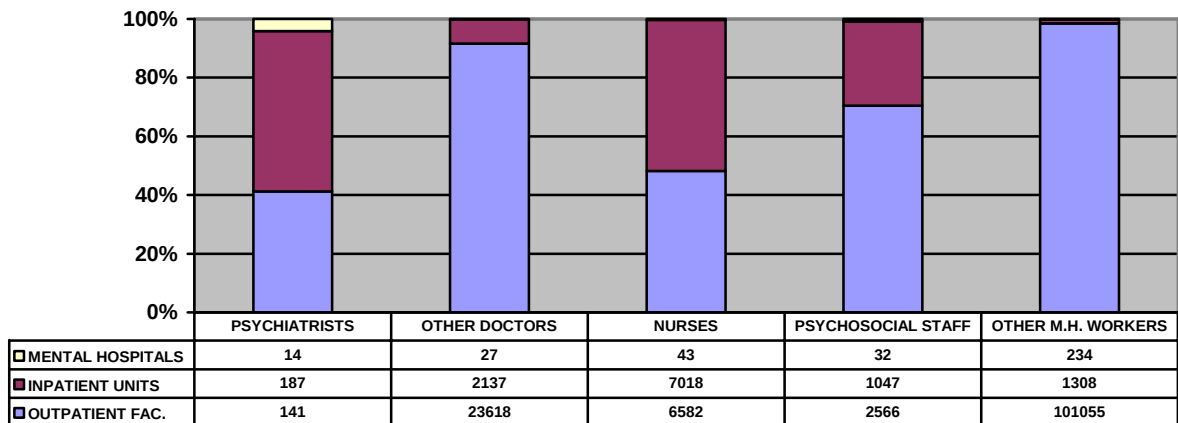
Forty five percent of psychiatrists work only for government administered mental health facilities, 51% work only for NGOs/for profit mental health facilities/private practice, while 4% work for both the sectors. 37% of psychologists, social workers, nurse and occupational therapists work only for government administered mental health facilities, 40% work only for NGOs/for profit mental health facilities/private practice, while 23% work for both the sectors. Regarding the workplace, 141 psychiatrists work in outpatient facilities, 187 in community-based psychiatric inpatient units and 14 in mental hospitals. 43476 other medical doctors, not specialized in mental health, work in outpatient facilities, 41260 in community-based psychiatric inpatient units and 27 in mental hospitals. As for nurses, 6582 work in outpatient facilities, 7018 in community-based psychiatric inpatient units and 43 in mental hospitals. 2566 psychosocial staff (psychologists, social workers and occupational therapists) work in outpatient facilities, 1047 in community-based psychiatric inpatient units and 32 in mental hospitals. As regards to other health or mental health workers 198000 work in outpatient facilities, 5308 in community-based psychiatric inpatient units and 234 in mental hospitals. In terms of staffing in mental health facilities, there are 187 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 14 psychiatrists per bed in mental hospitals. As for nurses, there are 7018 nurses per bed in community-based psychiatric inpatient units, in comparison to 43 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 6355 per bed for community-based psychiatric inpatient units, and 266 per bed in mental hospitals.

The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 2.29 times greater than the density of psychiatrists in the entire country. The density of nurses is 0.15 times greater in the largest city than the entire country.

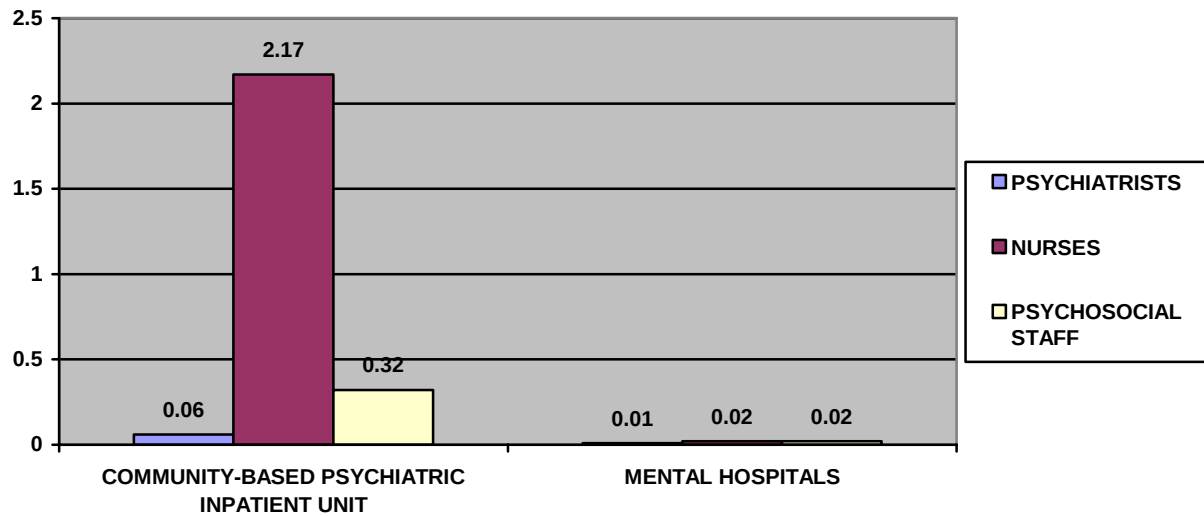
GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



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

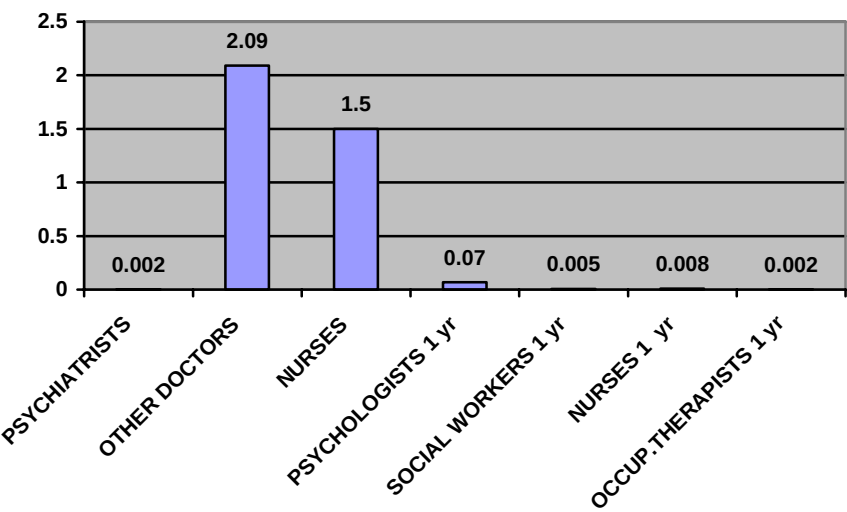


GRAPH 4.3 - AVERAGE NUMBER OF STAFF PER BED

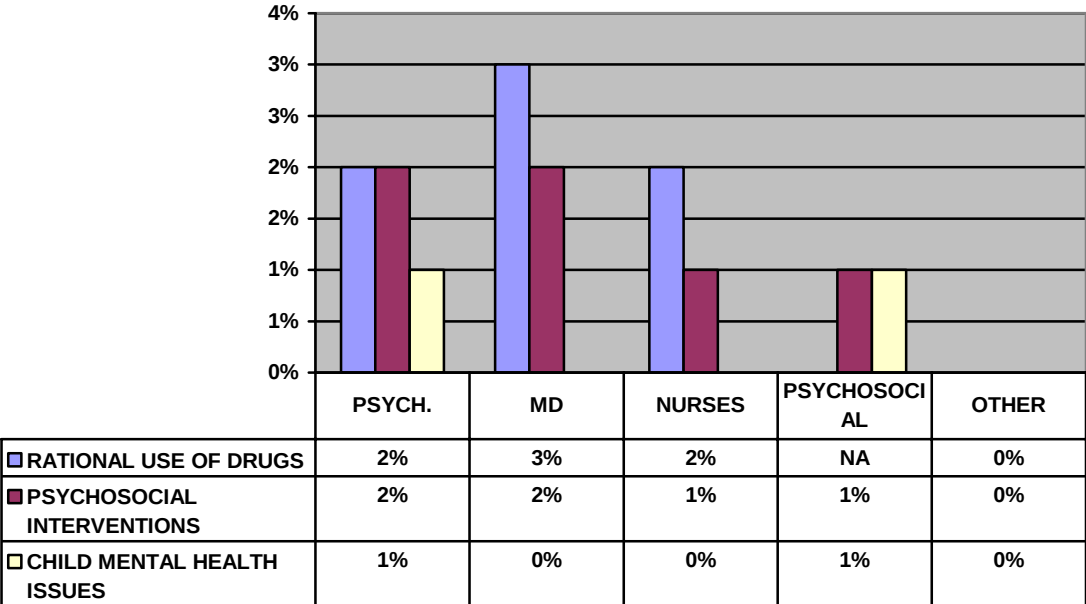


The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 2.1 medical doctors (not specialized in psychiatry); 1.5 nurses (not specialized in psychiatry); 0.002 psychiatrists; 0.07 psychologists with at least 1 year training in mental health care; 0.008 nurses with at least 1 year training in mental health care; 0.005 social workers with at least 1 year training in mental health care; 0.002 occupational therapists with at least 1 year training in mental health care. The 1-20% of psychiatrists emigrate to other countries within five years of the completion of their training.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



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

There are 8 users/consumers that are members of consumer associations and 6 family members that are members of family associations. The government provides economic support for both consumer and family associations. Family associations have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. Few (1-20%) mental health facilities have had interaction with both consumer and family. In addition to consumer and family associations, there are 18 other NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups.

Domain 5: Public Education and Links with Other Sectors

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies (e.g., Ministry of Health or Department of mental health services); NGOs; professional associations, private trusts; and foundations, International agencies have promoted public education and awareness campaigns in the last five years.

These campaigns have targeted the following groups: The general population; children; adolescents, women, trauma survivors; ethnic groups; and other vulnerable or minority groups. In addition, there have been public education and awareness campaigns targeting professional groups including health care providers (conventional; modern; allopathic); complimentary/ alternative/ traditional sector; teachers; social services staff; and other professional groups linked to the health sector.

The following legislative and financial provisions exist to protect and provide support for users: (1) provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled, (2) provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder, (3) provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders, and (4) provisions concerning protection from discrimination in allocation of housing for people with severe mental disorders. All of these provisions exist but are not enforced.

Government agencies (e.g., Ministry of Health or Department of mental health services); NGOs; professional associations, private trusts; and foundations, International agencies have promoted public education and awareness campaigns in the last five years.

In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and the departments/agencies responsible for primary health care/ community health, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection, education, employment, housing, welfare, criminal justice, the elderly, and other departments/Agencies.

In terms of support for child and adolescent health, 3% of primary and secondary schools have either a part-time or full-time mental health professional, and none of the primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. The percentage of prisoners with psychosis is 2-5%, while the corresponding percentage for mental retardation is 6-10%. Regarding mental health activities in the criminal justice system, a few (1-20%) of prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training, a few (1-20%) police officers and no judges and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, no mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders.

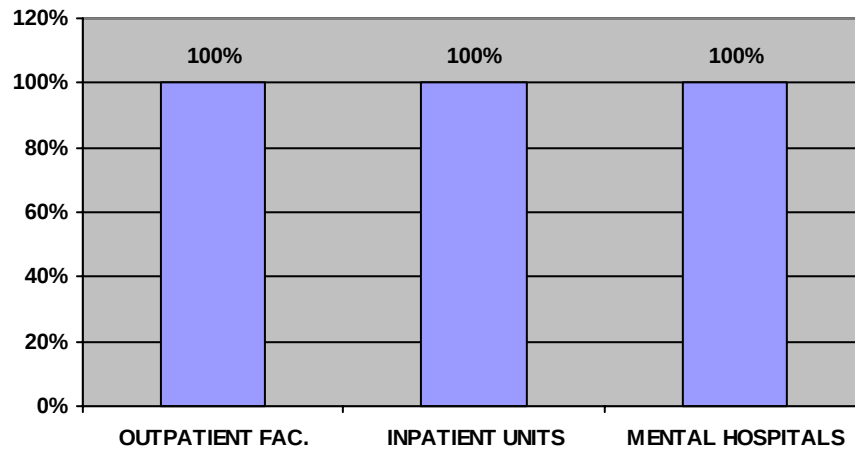
Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. Although, mental health facilities collect data on mental health (see Table 6.1), the government health department received data from all of the mental hospitals; community based psychiatric inpatient units, and mental health outpatient facilities. Based on this data, a report was published without comments on the data. In terms of research, 6% of all health publications in the country were on mental health. The research focused on epidemiological studies in community samples; epidemiological studies in clinical samples; non-epidemiological clinical/questionnaires assessments of mental disorders; services research; biology and genetics; policy, programmes, financing/economics; psychosocial interventions/psychotherapeutic interventions; and pharmacological, surgical and electroconvulsive interventions

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%	100%	NA
N° inpatient admissions/users treated in outpatient facilities	100%	100%	100%
N° of days spent/user contacts in outpatient facilities.	100%	100%	100%
N° of involuntary admissions	100%	100%	NA
N° of users restrained	100%	100%	NA
Diagnoses	100%	100%	100%

**GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH
FACILITIES TRANSMITTING DATA TO HEALTH
DEPARTMENT**



Strengths and Weaknesses of the Mental Health System in Pakistan

Pakistan's mental health policy was last revised in 2003. The mental health plan was last revised in 2003. A disaster/emergency preparedness plan for mental health was last revised in 2006. The mental health legislation was enacted in 2001. A national mental health authority also exists which provides advice to the government on mental health policies and legislation. The mental health authority is involved in service planning, service management and co-ordination and in monitoring and quality assessment of mental health services. There are 8 users/consumers that are members of consumer associations and 6 family members that are members of family associations. Family associations have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. In addition to consumer and family associations, there are 18 other NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups. Mental health providers and primary care staff work in interaction and efforts are being carried on to enhance interaction among these facilities in the country. Twenty seven percent of the training for medical doctors is devoted to mental health, in comparison to 3% nurses and 11% non-doctor/non-nurse primary health care workers. In terms of refresher training, 16% of primary health care doctors have received at least two days of refresher training in mental health, while 5% of nurses and 13% of non-doctor/non-nurse primary health care workers have received such training.

Mental health policy, plan and legislation do exist in the country but are not implemented. The health system is not well established and lacks sufficient resources. Community work is limited to a few tertiary care hospitals and in big cities. Only 1% of 1.926 beds per 100,000 population, in the community based psychiatric inpatient units are available for children and adolescents. Community based residential facilities and day treatment facilities are not available in the country. Training at the graduation level is meager that only three psychiatrists graduated in the last year in academic and educational institutions. The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 2.29 times greater than the density of psychiatrists in the entire country. The density of nurses is 0.15 times higher in the largest city than the entire country. The density of clinical psychologists and social workers, working in government sector is quite low. None of the mental disorder is covered by social insurance schemes. Only 0.4% of health care expenditures by the government health department are devoted to mental health. Of all the expenditures spent on mental health, 11% are devoted to mental hospitals. Psychotropic drugs are mostly widely available in mental hospitals, followed by inpatient units, and then outpatient mental health facilities. The following legislative and financial provisions exist to protect and provide support for users: (1) provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled, (2) provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder, (3) provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders, and (4) provisions concerning

protection from discrimination in allocation of housing for people with severe mental disorders. All of these provisions exist but are not enforced.

Efforts are there to promote equity of access to mental health services but more is required as the density of psychiatric beds in or around the largest city is 2.29 times greater than the density of beds in the entire country. Such a distribution of beds facilitates access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

Next Steps in Strengthening the Mental Health System

The Mental health law's response to changed social and professional attitudes, in the form of the new ordinance, though much belated, is a fitting one. However, many gaps in the law still remain. Also, steps such as the establishment of the Federal Mental Health Authority can only be judged by performance over the course of the coming years.

Despite the progress made in comparison with the old law, the current law still falls short of standards in relevant international conventions.

The Universal Declaration of Human Rights and its extension with regard to individuals who are mentally disabled—the Declaration of the Rights of the Mentally Retarded, can be useful guides to action. Briefly put, the latter declaration makes seven guarantees to individuals who are mentally disordered: equal rights to the maximum degree of feasibility; proper education, care, and treatment for self-development; the right to economic security and a decent standard of living; the right to live with one's own family or the closest possible alternative; the right to a qualified guardian, if necessary; protection from exploitation, abuse, and degrading treatment, and restricted civil and criminal liability; and the right that any restriction of rights must be legally monitored, must not be arbitrary, and must be subject to appeal and periodic review.

Although these principles cannot be incorporated into our domestic law, by itself, they do provide standards that we must strive to meet. The recent ordinance has brought us one step closer to such compliance. But many problems still remain, so it has become ever more important that the law be subjected to periodic review by a team of experts who measure its performance with reference to the above-mentioned standards, and suggest the necessary reforms.

Psychiatric training in Pakistan is at the very early stages, at both undergraduate and the postgraduate level. The health system is not well established with significant resources. Including psychiatry as a separate subject in the medical curriculum can help future doctors to recognize and to some extent treat mental health problems. It is also important that more family physicians and general practitioners are trained in recognizing mental health problems. It is not possible to arrange training in the fields of forensic psychiatry, psychotherapy, geriatric psychiatry, drug and alcohol abuse, child psychiatry and learning disability, due to a lack of training consultants. Arranging the training around cases from subspecialties certainly can help in recognizing these problems. However, lack of supervision in these fields compromises training.

The patients are mostly looked after by their families in Pakistan. It is therefore important that training is focused on community based psychiatry. Drug abuse problem in Pakistan is on a rise and most patients are treated by non psychiatric doctors. It will make some sense to include more cases of drug abuse as a vital part of the training system. Psychological therapies are not readily available in Pakistan. Psychologists mostly provide counseling using an eclectic approach. There is currently no psychotherapist working in national health system in Pakistan. Interactive work with trained clinical psychologist can play a vital role in terms of psychotherapies and counseling. Placing more emphasis on training in psychotherapy will certainly improve psychiatric care. Family is an important resource, and psychotherapies in this area can be used to improve patient care.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Pakistan. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change.

Data was collected on six domains of the WHO-AIMS tool, Policy and Legislative Framework; Mental Health Services; Mental Health in Primary Health Care; Human Resources; Public Education and Links with other Sectors; and Research and Monitoring.

Results will enable Pakistan to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.