

## **DEVELOPMENT OF MENTAL HEALTH CARE IN PAKISTAN PAST, PRESENT & FUTURE**

### **Prof. S. Haroon Ahmed**

Ladies and gentlemen, I would like to begin from the very beginning in the Indian subcontinent, supernatural influences were and are supposed to be the cause of mental illness and so the treatment. Some relief was provided by indigenous systems like (a) Ayurveda, literally meaning science of life (b) Siddha system, popular among Tamils, (c) Unani or the Greek system made popular during the Muslim rule and (d) more recently Homeopathy.

The first mention of something like a mental hospital is at Dhar (near Mandu) in Madhya Pradesh which was established by Mohammed Khilji (1436-1469) where Maulana Fazalullah Hakim was its physician. During British rule of India, history of psychiatry is history of establishment of lunatic asylums. The first asylum was established in Bombay in 1745 at a cost of Rs. 125/- and the second at Calcutta in 1784 which were meant for Europeans. The Indian Asylum Act of 1858 was replaced by Lunacy Act of 1912. The term Lunatic Asylum was changed to Mental Hospital in 1922. (Somasundaram, Psychiatry in India, 1984).

At the time of partition of the subcontinent in 1947 there were about forty mental hospitals in India. Pakistan inherited two of them – the Lahore mental hospital (Punjab) established in 1840 has 1400 beds and the one at Hyderabad (Sindh) was set up in 1865 with 450 beds. (now Sir, C.J. Institute). In Peshawar (Frontier Province) was in 1964 with 100 beds. Much effort was made to build mental hospitals in Karachi (Sindh) and Quetta (Baluchistan) but for financial reasons they were fortunately shelved. Fortunately because we do not have to face the problems of closing them down as in the United Kingdom today.

At present there are about 3000 beds in state sector (a little more than 2000 in mental hospitals and about 1000 in state run teaching medical institutions). In private sector estimated beds are approximately 2000. There are 2500 psychiatrists in Pakistan mostly located in major cities.

### **Beginning of Organized Efforts**

The history of development of mental health care will not be complete without mention of initiatives taken by psychiatrists in India and Pakistan.

In 1929 Berkley Hill founded the Indian Association for Mental Hygiene. It was affiliated to the National Council for Mental Hygiene in Great Britain. In 1935 the Indian division of the Royal Medico – Psychological Association was organized. The first meeting was held in 1939 which was attended by 20 psychiatrists from India and Sri Lanka. The presidential address “A century of Psychiatry in the Punjab” was given by Dr. Lodge Patch.

The Indian Psychiatric Society was born on 7 January, 1947 at Delhi. Among the founding members was Col. Dhunjibhoy and I have the honor to attend his lectures at Dow Medical College, Karachi in 1950-51.

### **First Mental Health Day**

In 1958 two distinguished physicians in Karachi became interested in mental health. Col. M. H. Shah started 'Mental Hygiene' and Dr. S. M. Afzal Habib formed 'Mental Health' Associations. They remained dormant till 1960 when Social Services coordinating Committee of Government of Pakistan decided to hold the first 'Mental Health Day' in Pakistan during the World Mental Year. It was held in Karachi on 25<sup>th</sup> November, 1960. Psychiatrists and psychologists from all over Pakistan participated. The program included seminars, discussions, poster and painting exhibition. This activity brought, not only Col. Shah and Dr. Afzal Habib together but attracted Dr. G. A. Ashgar, Dr. A. Aziz and Dr. Rashid Choudhry from Lahore. This was also the time when Dr. Zaki Hasan, a neurologist, became interested in psychiatry. (This even impressed me also to opt for psychiatry in spite of tremendous resistance from family and friends).

### **Pakistan Association for mental Health**

In 1965, work on organizing Pakistan Association for Mental Health was started. My humble self was assigned the task of convenership. Justice ® Nasir Aslam Zahid drafted the constitution and Pakistan Association for Mental Health (PAMH) was registered in 1970.

The landmark activity of PAMH was an ambitious seminar in 1972. It was attended by psychiatrist and psychologist from all over Pakistan. Prof. G. M. Corstairs a social psychiatrist from Edinburgh was special guest. The recommendation made were still valid today. The second venture, the Institute of Behavioral Sciences was started as late as 1997. It is still a dream and a fraction on ground. I will take about it later.

It also marked the beginning of polarization of ideas and personalities. Dr. G. A. Ashar decided to establish Mental Disorder Society and Dr. Rashid Choudhry Lahore Mental Health Association at Lahore.

### **Lahore Mental Health Association**

After gathering useful data the association succeeded in starting first Halfway House in 1973. In 1977 it moved to its new premises and assumed the name of its sponsoring body "Fountain House", of New York. Fountain House at Lahore is the first and model centre with wide range of rehabilitation activities including agro-therapy.

There are individuals and organizations promoting mental health and related fields according to their perception and goals. They are Dr. Nusrat Awan and Dr. Laeeq Mirza in mental retardation and rehabilitation Dr. Zaheer Khan, Dr. Khalid Mufti and Dr. Abdul Malik in drug dependence. To name a few organizations they are Edhi Foundation, Karwane Hayat, Institute of Behavioral Sciences, War Against Rape, 'Daste shfquat' an association for child abuse in Sindh and Bedari, Rozan and Sahil in the Punjab. Human Rights Commission of Pakistan is actively taking interest in the rights of mentally ill, specially those in Prison. Pakistan Medical Association has taken up the issue of torture and organizing training workshops.

After the World Mental Health Day in 1960. The second most important event was the First International Conference of Pakistan Psychiatric Society held at Karachi in 1975. A few word about Pakistan Psychiatric Society will be in order here.

### **Pakistan Psychiatric Society**

During one of the bigger ventures of Pakistan Medical Association, the PMA-BMA joint conference in December 1966 at Karachi, seven psychiatrists met and mooted the idea of an organization. (Dr. Afzal Habib, Dr. G. A. Asghar, Dr. Rashid Choudhry, Dr. N. d. Choudhry (Dhaka), Dr. H. A. G. Kazi, Dr. Iftikhar Akhter, Dr. Rehana Beg and Dr. S. Haroon Ahmed)

We met at every annual and biennial meetings of PMA at Lahore, Peshawar, Karachi, Dhaka and Chittagong and in between. Initially the task appeared simple but consensus building on all issues took its time.

The constitution of Pakistan Psychiatric Society was eventually adopted on 1<sup>st</sup> March 1969 and the organization was registered on 17<sup>th</sup> February, 1973 at Karachi.

The preliminary meeting for the first psychiatric conference was hosted by Dr. Malik Mubbashar at the newly setup department of Psychological medicine at the then Central Government Hospital, Rawalpindi. One of our well meaning and generous member offered to stand the bill. In his opinion we were hardly 20-25 psychiatrists and a conference meant a dinner and a coffee. He generously offered Rs. 5,000/- But the first psychiatric conference was conceived differently.

The objective of the Pakistan Psychiatric Society was to collectively raise the voice in favor of the silent and often violent sufferers. The first few issues raised were proper teaching and training at undergraduate levels, to educate the profession (family physicians) and made people aware about mental illness. We believed that awareness will bring pressure on the Government and political will.

In accordance with me objectives we invited another neglected specialty – the G.P's encouraged them to have their first congress in association with the

Pakistan Psychiatric Society S. H. Naqvi, the secretary of college and family physician helpful. It was a great success and we continued to hold joint conveyances for more than ten year. Since then with few upheavals Pakistan Psychiatric Society has matured and its office bearers have served the cause with dedication. It is obvious today.

### **Major Institutions and Setting Trends**

In 1964-65 a breakthrough was brought by two individuals. At K. E. Medical college Lahore Dr. Rashid Choudhry, the then superintendent of Mental Hospital succeeded in starting outpatient and later admission facility. In Karachi Dr. Zaki Hasan stretched his goodwill and convinced the Federal Government to expand the neurology unit into a Department of Neuropsychiatry at Jinnah Postgraduate Medical Centre. The next land mark was the effort of Dr. Khalida Tareen, who started child and Family Psychiatry department at Mayo Hospital, Lahore in 1975. Either Prof. Arshad Hussain and Columbia Missouri, has single distinguished of organizing central psychiatry workshop at almost all the 12 confirms. In early seventies a humble department of psychological medicine was started by enthusiastic Dr. Malik Mubbashar at the then central Government Hospital, Rawalpindi. Since then it has grown beyond recognition to win the status of Institute of Psychiatry. In 1986 it was designated as WHO collaborating centre in mental health research and training. Now all medical colleges and postgraduate institutions have department of Psychiatry imparting education at undergraduate and postgraduate level. Though there are considerable disparity in various departments, nevertheless, most of them include behavioral science at undergraduate level and have postgraduate level and have postgraduate training programs. The college of Physicians and surgeons have streamlined the examination and evaluation system for membership and fellowship.

The Aga Khan Medical College is the only undergraduate college which has introduced psychiatry at undergraduate level Dr. Shaheen Hussain who sloka the department a Dr. Abul Faizi who's chairman should be complemented.

If the trend setting in the practice of scientific psychiatry and carrying out need based research started at the department of Neuropsychiatry at Jinnah Postgraduate Medical Centre, Karachi, the lead in teaching and training was taken by the King Edward Medical College and Postgraduate institute at Lahore. The Institute of Psychiatry at Rawalpindi can now be singled out not only for its quality teaching and training but the most significant contribution is its community mental health program. Brig. M. Shoaib was the bioenear in introducing psychiatry in Armed Forces which was furthered by Gen. Ishrat Hussain as Brig. Fazal Haq.

### **The Present Issues**

It appears we have partly established the need for an infrastructure for the care of mentally ill patients. The media and opinion makers have come around to be

sympathetic. It may appear collous but after detail diagnostic evaluation the continued care of chronically ill should be passed on to trained mental health workers. We do not leave the breed. The psychiatrist should begun to concentrate on treatable problems. Currently they are treated with tonics, vitamins, antacid and analgesics by G.P. I would therefor, like to plead the case of patients with low profile and high prevalence disorders. They remove diagnostic orphans.

The high profile mental disorders are schizophrenia, mania, major depression, drug dependence and mental retardation. The cumulative prevalence is accepted to range between 50-10%, the world over.

More recently alarming figures are quoted about the prevalence of depression alone. In a recent study conducted in a community several miles from this place has confirmed the fear earlier reported by Mumfor, Hussain, Creed and Tomenson have published their findings (Psychological Medicine: 30, 395-402, 2000) which shows overall prevalence of depressive disorder at a phenomenal 44% (25.5% in male and 57.5% in females). Are they masked depression?

1. Masked depression frequently present with general debility, fatigue, palpitation, low blood pressure, gas, indigestion, gola, constipation, aches and pain and various eating disorders including obesity. The treatment so often offered are tonics, vitamins, anti-gas, analgesics and more recently the socalled brain energizers, beside iniscriminate use of benzodiazepines. Prof. Ejaz Tareen has been organize books for a louf theme but-OTC dispensation continues. I would like to enumerate few more low profile disorders:
2. The gender-related disorders (in males) masturbatory guilt, jiryana, qatra, potency disorder and premature ejaculation; (in females) premenstrual tension, dysmenorrhoea, menopause, and disorders associated with childbirth, lactation, abortion, birth control, child bearing and child rearing etc.
3. Children constitute 45% of our population. They express their distress by change in behavior, like performance at school, truancy, in discipline and few experiment with drugs. The gastro-intentional disorders, enuresis and headache are more frequent physical symptoms. The border line intellectually subnormal children in a normal school appear to be 'playful' and 'sharp' but notinterested in studies. They are distressed children who are trying to cope.
4. Post-Traumatic Stress disorder (PTSD)is a condition which is usually the outcome of traumatic situations beyond human endurance. We have been diagnosing them as depression, hysteria or malingering.
5. There is a window in almost every second house which opens to a wide world – the T.V 'Besides' urbanization, slumization, migration and changing life style has forced people to adopt novel causing fousiration by raising bectations novel stress management behavior.

## **Broadening Base of Psychiatry**

For long psychiatry was linked with terms like lunatic, mad for mental. The 'lunatics' were kept outside the cities in Lunatic Asylums and so were those treating them. Then came post Freudian era when psychoanalysis and couch arrived with a host of jargons. This period rehabilitated the psychiatrists back in the community and they enjoyed working with an aura of mystery. They seemed to like this 'know all' distant, and even, dreaded image. The isolation increased further with the development of an entirely new language of psychoanalysis. Then the Freudian prophecy began to come true that one day when we know more about human brain, the current theories will replace the organic basis of mental illness.

For psychiatry the later part of this century i.e. 1960 onwards, has brought tremendous new knowledge. In barely forty years the ground covered was much more than in the last four centuries. As I have intressed the development from almost ring side. The major breakthrough were made in the field of psychopharmacology, biochemistry and imaging. WHO, through dynamic and visionary Dr. Norman Sartorius changed the practice of psychiatry world over. While ICD10 (and DSM III of APA) broke the psychoanalytic basis of classification, the community psychiatry and 'minimum medication formulary' paved the way for affordable mental health care for a larger population.

The market economy has added a new dimension i.e. economics of mental health care. The competitive world of today has realized the relationship between mental health and productive potentials – creativity, quality of work, work hour loss and compensation etc. U.N has labeled Job Stress as the 20<sup>th</sup> Century World Wide Epidemic.

## **Beginning of New Millennium.**

At the beginning of a new century, it is time to take stock of the situation, learn lessons from the past and innovate while incorporating our cultural advantage. I would like to cite example of mental hospitals and mental health act, to make a case for the need of a workable Mental Health Policy. Bare minimum structural changes suggested are:

- (1) to abolish mental hospital and set up small hostel – like accommodations in every district and even Tehsils. It will only need restructuring the available money and manpower.
- (2) To link the department of psychiatry at teaching hospitals to such hostels and the direction of institutions should be diverted to community.
- (3) To train a new breed of mental health workers - Community Mental Health promoters.

In my opinion these are bare minimum pre-requisite which will make the proposed Mental Health Act implementable.

To clarify the perception I have briefly talked about, allow me to share with you the outline of experiments we have embarked upon at the institute of Behavioral Sciences.

## **Institute of Behavioral Sciences**

The Institute (IPC) is a project of Pakistan Associate to mental health, started in 1997 generated by a Board from a pre-tab. Struction within three days we are boost of new custom made bilding for launcus and consuming mental health program. Our objection is to human family board to treat patients, in cause award reman simbys.

### **General objectives**

- I. To evolve a community oriented (family involvement), cost effective (affordable) and culturally relevant (acceptable program of treatment and after care of patients).
- II. To develop local need based program in the filed of behavioral sciences: teaching training, research and psycho-education.

### **Specific Objectives**

#### **1. Community Mental Health**

- ◆ Extensive, regular and acceptable form of mental health education in a defined area for family physicians, social workers, opinion makers as well as the public.
- ◆ Regular mental health camps in defined localities with basic medicine dispensed free of cost.
- ◆ Follow up facility at IBS for those seen in camps or referred from the defined community / area.

#### **2. Crisis Intervention / Distress Response Centre**

Open 24 hour and equipped to (I) collect maximum information about the patient i.e. interview as many relations and concerned persons as possible (ii) identify a key relative (iii) provide immediate treatment (medicine, counseling) (iv) assign a mental health worker (Promoter) for follow-up and possible induction in Home Based Treatment (if residing within the defined catchment area). The entire procedure should be completed within 24 hours.

### **3. Home Based Treatment**

To harness the family bond and provide culturally relevant and affordable treatment and after care, the IBS is poised to launch the concept of Home Based Treatment. A new breed of Community Mental Health Promoters (CMHP) are to be trained (according to curriculum already drawn).

### **4. Diagnostic and Observation Unit**

For those who may be required to be under active diagnostic or the therapeutic purposes for few days, (2-3 days), Community Mental Health department premises will be used. (the inpatient facility)

### **5. Sub-acute Rehab Unit / Hostel**

This unit will be set up at a separate site, preferably in a semi-rural locality.

### **6. Teaching and Training Programs**

The programs will focus on Community Mental Health Promoters (CMHP), clinical psychologists, undergraduate medical students (FCPS, MD), social workers and other disciplines within the Behavioral Sciences area of study.

### **7. Research on Clinical & Social Issues**

Research will be carried out on clinical and health behavior. The social issues identified as critical are:

National characteristics, attitude formation, interest and apathy, the role and place of religion, spiritualism, faith and belief system, women and their aspirations, child bearing and child rearing, role of state and family towards children, crime and criminality, the place of art, literature and music in our life etc.

**Dear colleagues, past is history and to learn; present is to live it up and you do it better if linked to a social cause and have hope in future.**