

Mental Health Care delivery: 14 months into the Monsoon Floods of 2010

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Conflicting Interest:
None declared

This article has been peer reviewed

Article Submitted on:
22nd May 2011

Article Accepted on:
26th August 2011

Funding Sources:
None Declared

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COMMENTARY

Cardinal Roger Mahony, in his letter, Creating a Culture of Life wrote “Any society, any nation, is judged on the basis of how it treats its weakest members - the last, the least, the littlest.” Truly, the most accurate measure of a civilization is how it treats those in need. A future historian could very well judge us on how we treated and what we did in our capacity as mental health professionals in the aftermath of the recent floods in Pakistan. An unprecedented 160,000 square kilometers, an area larger than the territory of England, was devastated resulting in internal displacement of nearly 1/10th of the country’s population.[1] A joint report from the World Bank and Asian Development Bank estimated damages of around US\$ 9.5 billion in terms of crops, infrastructure, public and private property.[2]

The initial response to the disaster was commendable. Two factors were instrumental in providing timely and effective relief. Firstly, the aid/support was funneled directly to reputable local Non-Governmental Organizations (NGOs) /nonprofit private enterprises resulting in timely and efficient relief for many families/communities. Secondly, the collective response from the local and international community was overwhelming. Examples of the established traditions of altruism and philanthropy in Islam could very well be seen. A survey in 1998 reported that a third of all indigenous philanthropy in Pakistan amounting to Rs. 14 billion per year was from people with little or no income, other than this voluntarism accounted for an additional 58% giving.[3] As a personal observation, the authors saw uncountable accounts of individuals literally opening their doors to those in need; with single room houses which barely provided shelter for a single family accommodating 10-12 households under the same roof.

Although the initial response was substantial,

history repeated its lesson that relief efforts peak a few weeks and then gradually dwindle off in the long run. Nearly 14 months into the disaster, much has been normalized and most relief programs have wound up their operations. But as these marginalized individuals return to the milieu of economic difficulties and social capital erosion, their risk of mental disorders increases substantially and here onward arises the requirement of mental health care and rehabilitation.

Initially, mental health care delivery was provided through various professional bodies and individual organizations; however, their efforts could not be scaled up to meet the needs of individuals who are at risk. Adding to the burden of these services were the background prevalence of depression estimated to be nearly 32% prior to the flooding, and additionally the unsupervised prescription of tranquilizers, especially benzodiazepines that occurred in good faith in the period immediately following the flood.

Given that there is one registered medical practitioner for every 1,466 individuals, and almost one registered mental health care provider in a million people,[4] of which a majority works in private care settings, the public health care system cannot realistically meet the current demands of the country.

This situation is not unique to Pakistan and the World Health Organization (WHO) proposed that mental health care in low-and-middle income countries that lack a critical mass of specialized care providers (psychiatrists, psychologists, psychiatric nurses and social workers), should be integrated into primary care and provided in a decentralized manner in order to meet the needs of the community.[5]

Recently, a collaborative program between WHO and Pakistan Institute of Medical Sciences was organized to equip primary care providers in Pakistan with adequate knowledge to recognize and manage basic mental disorders.

The program jointly funded by the British Council and the Tropical Health and Education Trust (THET) comprised of forty hours of structured training to build basic skills and core concepts through didactic lectures and interactive role plays. The main focus of the teaching program was on recognizing common psychiatric conditions which are a source of concern in the community, particularly depression, anxiety, psychosis and substance abuse.

The World Organization of Family Doctors (WONCA) launched an appeal to its 120 member organization on behalf of The Aga Khan University, The College of Family Medicine, Pakistan and the Pakistan Society of Family Physicians to help coordinate such a program to aid their flood relief efforts.

Logic in this regard guides us that investing even a small portion of our limited resources into training primary care staff in this regard can significantly alter the mental health care delivery system in the affected areas.

Following are some key recommendations that future programs must incorporate:

- An independent body should conduct a national mental health needs assessment survey to establish baseline mental health states and needs.

- Training of existing primary care staff to recognize and manage basic mental disorders in primary care settings.
- Funding for the provision of safe and essential medications.
- Upgrading referral centers to meet the increasing mental health needs as identified by the mental health needs assessment survey.
- Merit-based deployment of staff and infrastructure.
- A subsequent monitoring cell, preferably involving the initial survey team, to supervise, support and monitor outcomes of the program.
- Intersectoral collaboration with alternative care providers, homeopathic physicians, faith healers and Hakims etc. through registration and subsequent licensing by the Ministry of Auqaff.
- An unbiased public-private partnership model that balances the chasm between service and financial benefits.

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