

Mental health and psychosocial support for the internally displaced persons in Bannu, Pakistan

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Following armed conflict in the North Waziristan Agency, a mental health and psychosocial support initiative was launched for internally displaced persons in Bannu, Pakistan. This was convened by volunteer mental health professionals, in collaboration with a variety of agencies (provincial government, military, humanitarian agencies) in a security compromised region. As part of the initiative, monthly camps were held for a period of six months. Mental health needs were assessed. A multi-disciplinary team (psychiatrists, psychologists, psychiatric nurses and psychosocial workers) offered mental health care to 680 people who attended the camps, of which 28% were under the age of 18 years old. Twenty-one percent returned for follow-up, while others were followed-up in the community by psychosocial teams. Estimates of common mental disorders were found. Both pharmacological and psychological treatments were offered, according to existing guidelines. Active efforts were made to conduct holistic assessments and avoid a pure biomedical approach. This also provided an opportunity for training non specialist staff and led to formal (World Health Organization) mental health gap action plan training for primary care staff.

Keywords: internally displaced persons, mental health, Pakistan

Introduction

Background

Pakistan has had its share of conflict related trauma. This is especially true for the North Waziristan Agency (NWA) in the north western part of Pakistan, adjoining the province of Khyber Pakhtunkhwa (KPK) on one side

Key implications for practice

- Humanitarian crises provide opportunities for collaboration between mental health professionals and humanitarian agencies to strengthen existing services
- Estimates of common mental disorders in an IDP population have been found, with 60% of this morbidity existing before displacement
- There is a dire need for a public mental health approach to address the existing burden of mental disorders

and Afghanistan on the other. It is part of a Federally Administered Tribal Agency (FATA), which refers to a semi-autonomous region under the control of the federal government through a special law called Frontiers Crime Regulations (FCR). This region is known for its difficult terrain and old, virtually unchanged tribal lifestyle termed as *pashtunwali*, where a *jirga* is consulted for disputes. Parochial structures and arcane traditions have tended to disregard health needs, especially for vulnerable segments of the population, such as women and children. As a result, formal health facilities are scarce, which barely cover basic healthcare needs. (United Nations Office for Coordination of Humanitarian Affairs (OCHA), 2014). Traditionally, the majority have been highly sceptical and sometimes hostile in terms of western medicine,

particularly vaccines. The impact of such hostility is reflected in the fact that NWA reported the highest number of polio cases among all the districts of the world in 2014 (USAID, 2014). However, there has been a growing awareness and acceptance of western medicine in recent years, with most people beginning to travel to other cities in KPK for specialised care.

Due to a non-existent, non-functioning border with Afghanistan and a predominantly Pushtun population, NWA and its adjacent territories have suffered over two decades of incessant conflict, social service neglect and unmitigated humanitarian fallout. Militants frequently spill over from adjoining areas of Afghanistan into tribal agencies to take refuge, and vice versa. The unending nature of the armed conflict and violence has led to profound adversity with reference to mental health care in the region (Khalily, 2011). From 2007, until quite recently, there was an ongoing armed conflict in NWA that was finally halted by a military operation started in June 2014. Operation Zarb-e-Azb led to mass civilian evacuation so that terrorists could be identified and targeted through land and air attacks. As a result, over one million people (74% women and children) were displaced into the neighbouring district of Bannu, in KPK (United Nations High Commissioner for Refugees, (UNHCR), 2014)

Mental health and displaced populations in the region

A consequent rise in common mental disorders in post-conflict/displaced populations around the world is well established (Salah et al, 2013; Turnip, Klungsoyr, & Hauff, 2010; de Jong, Komproe, & van Ommeren, 2003). At the same time, the lack of capacity of overburdened countries to respond to mental health needs of conflict-related, displaced populations is also well documented (Quosh, Eloul, & Ailani, 2011). Evidence suggests that in addition to war-related conflicts, daily stressors and traumatic events

contributed significantly towards mental health problems in Afghanistan, a neighbouring tribal region (Miller, et al., 2008; Panter-Brick, et al., 2009). Additionally, a high prevalence of common mental disorders has also been reported in the tribal regions of Pakistan and Afghanistan (Cardozo, et al., 2004; Scholte, et al., 2004; Mufti, et al., 2005; Hussain, Chaudhary, Afridi, Tomenson, & Creed, 2007). These rates are nearly twice as high as reported elsewhere in Pakistan (Mirza & Jenkins, 2004) and much higher than other developing countries facing conflicts and therefore, need to be interpreted carefully (Bolton & Betancourt, 2004; Ventevogel, 2005). Similarly, a high rate of psychiatric morbidity has also been reported in Afghan refugees (Kassam & Nanji, 2006; Naeem, et al., 2005). A previous armed conflict with the Taliban in 2009 displaced three million people in KPK, Pakistan. Mujeeb (2015) found significant levels of psychological distress in that population, but the estimates of common mental disorders in internally displaced persons (IDP) in Pakistan have not been documented.

Mental health care in Bannu

The district of Bannu had an indigenous population of one million. For the two million people now residing in Bannu, current mental health services are limited to a single psychiatrist, with mental healthcare not prioritised in Pakistan, as in many other low and middle income countries (LMIC) (Saxena, Thornicroft, Knapp, & Whiteford, 2007). Additionally, the country lacks a mental health policy since the devolution of health responsibility to the provincial governments in 2011. Despite repeated emergencies, only fragmented and sporadic efforts have ever been made in terms of developing an emergency mental health response, disseminating training, involving stakeholders or advocacy at a national level. The disaster/emergency preparedness plan

for mental health has also been defunct since 2006 (World Health Organisation (WHO), 2009).

As a result, mental health services in Bannu are typical of those offered in most other peripheral districts in Pakistan (Bolton, 2013). The role of a psychiatrist tends to be narrowed down to clinical responsibilities even in a tertiary care hospital. That, too, focuses mainly on a biological model of practice of psychiatry. Bannu had a teaching hospital comprised of one professor of psychiatry with no other faculty to support him. Despite an academic title, the job description is very much non academic, with pronounced administrative and medico-legal responsibilities that compromises clinical care. Additionally, there were few teaching/training activities conducted by the department.

Therefore, most people with mental disorders sought private consultations (provided largely by the same psychiatrist, after working hours). Limited in-patient facility was available for female patients only, especially for those who had travelled a long distance. There was a psychologist engaged at the psychiatry department, but who had been working without pay for seven months. All cases of drug dependence were referred to a private facility nearby, which was not supervised by qualified staff. Despite the humanitarian crisis, the medical college in the city remained shut for summer holidays and no medical students were involved in health care.

Another major barrier to mental health care delivery to IDPs in Bannu was that the district is a highly sensitive and security compromised zone, as the Pakistan Army had taken control as soon as IDPs began to arrive. Even the hospital was considered a soft target and was guarded round the clock, with armed guards present inside the emergency room. It was not possible to execute any (humanitarian) interventions without security clearance from the army. In addition, travelling within the district was

considered unsafe. As a result, community based activities were extremely hard to coordinate/conduct.

While it was clear that such an emergency situation required immediate attention in order to address mental health care needs, the key question remained: whose responsibility was it to coordinate any initiatives? The government (Health Department & Provincial Disaster Management Authority) was struggling to provide basic needs to IDPs, so any additional agenda was a burden beyond their capacity. Mental health professionals have no prescribed responsibility beyond their departments. The military had the expertise, but had no precedence to provide psychosocial support to a civilian population. National nongovernmental organisations (NGOs) do not have the capacity, nor the expertise, to address the issues, while international NGOs tend to focus on general health care needs only.

Mental health and psychosocial support initiative

It was under these difficult conditions that a mental health and psychosocial support (MHPSS) initiative was designed on humanitarian grounds by a volunteer team of mental health professionals from Islamabad, the capital of Pakistan (distance 298 kilometres, with a travel time of five hours by road). All efforts were made to collaborate with the Provincial Disaster Management Authority (PDMA) KPK, Army Field Hospital, Department of Psychiatry at the teaching hospital, national and international NGOs. The initiative included monthly mental health camps at the teaching hospital in Bannu for six months, conducting mental health gap action plan (mhGAP) training (WHO, 2010) for primary care staff and psychosocial training for community health workers (CHW). (This article describes the experience of the mental health camps only.)

Methods

The objectives of these camps were to:

1. Assess mental health needs of the IDPs;
2. Provide psychosocial support to the displaced families;
3. Identify and treat those suffering from mental disorders;
4. Assess needs and provide specialist care to children;
5. Dispense essential psychotropic medication;
6. Provide hands-on training to the health care and psychosocial staff.

These camps were actively advertised through banners, and notifications were sent to all health facilities in the area. Pamphlets and hand-outs were distributed in the outpatient department (OPD) of the hospital, mobile unit announcements were made in the city, and announcements were also made on radio and in local mosques after the Friday prayers. A small media conference was also held in order to raise awareness of the prevalence of mental disorders and the need to provide mental health care to IDPs.

Volunteers included five psychiatrists (including a child psychiatrist) and a psychologist. The local psychiatry team included a psychiatrist, a psychologist, a medical officer, four nursing staff and a pharmacist. International Medical Corps' (IMC) field staff included three psychologists and two psychosocial workers. Both genders were equally represented in the multi-disciplinary team in order to address any potential barriers for IDPs. The Army Field Hospital provided logistical support for the camps.

Assessment procedures

Although assessment was an ongoing process, the first two camps focused more on assessing needs and resources, developing systems, engaging hospital staff, training

health professionals (including nurses) and obtaining essential medicines.

Multiple consultation rooms were set up in the department of psychiatry. Each person was registered and their demographic details recorded. Active efforts were made to conduct holistic assessments by small teams consisting of a psychiatrist, a psychologist/social worker and a nurse. A separate clinic for children and adolescents was held by the child psychiatrist, a psychologist and a nurse. The displaced population spoke a different dialect of Pashto and for most, this was their first-ever contact with an allopathic (modern) health service. Fortunately, all psychologists and nurses were able to converse directly and interpret for the psychiatrists where necessary. In the first two camps, clinicians conducted assessments while other team members observed, interpreted and helped to reinforce instructions and advice. This method of working also provided a huge opportunity for hands-on training of nurses and field staff. Later, joint assessments were conducted where any one member (depending on the problem) could lead the interview and others would intervene where needed. The average duration of joint consultations varied between 15 to 20 minutes, but detailed interventions were continued by one member, when required. In many cases, the teams were able to offer follow-up within the community. In other cases, follow-ups were organised at the department of psychiatry. Supervision was offered for complex cases by the (two) senior clinicians.

Consultations and treatment

The consultations were not conducted on a (pure) biomedical model, but a more holistic, bio-psycho-social approach, was followed. In most cases, more than one member of the family or even the whole family presented as a *'case'*. This caused some difficulty for the psychiatrists who appeared keen to identify the *'most unwell'* person in the family to treat, but the child psychiatrist and field staff seemed quite comfortable with approaching

the family as a whole. Similarly, the expectations of the families were not always *'medical'*. Most seemed content leaving the room without a prescription. There were other expectations however, for example, one person asked if milk was also being offered. Nearly all families were keen for a nutritional supplement for their children, therefore this was later added, although it is not part of WHO's Essential Drug List (EDL).

Since all cases were seen by qualified mental health professionals and clinically managed, clinical diagnosis was recorded according to the International Classification of Disease (ICD 10), instead of recording the symptoms only (WHO & UNHCR, 2012). The primary diagnosis was selected according to Foulds' hierarchy (organic: epilepsy, dementia, mental retardation and drug dependence took precedence) (Foulds & Bedford, 1975). A diagnosis of physical illness was also recorded when required, and the patient referred appropriately.

Both pharmacological and psychological treatments were offered according to exist-

ing guidelines (WHO, 2010; WHO, 2013a). A list of medicines was prepared for the camps by modifying WHO's EDL (WHO, 2013b). Consensus was developed through discussions at a specialist forum (50+ specialists), through Facebook, which is an accessible and commonly used medium for professional communication in Pakistan. The criteria used to deviate from the EDL included: availability, tolerability and cost effectiveness. As cheaper versions of commonly prescribed newer drugs were easily available, and considered to be better tolerated, Risperidone and Escitalopram were also added. The final list included antidepressants (Clomipramine, Dothiepin and Escitalopram), anti-convulsants (Carbamazepine and Sodium Valproate), Risperidone, and Bromazepam. The required drugs for the first three camps were funded by informal donations, with the IMC providing a large supply sufficient for six months. No donations from the pharmaceutical industry were accepted. The psychological treatments commonly offered are described in Box 1.

Box 1: Components of psychological interventions offered

Intervention	Components
1 Psychoeducation	<p>Explain the nature of problem/symptoms/ disorder/ treatment</p> <p>Avoid using drugs to cope with distress/ symptoms</p> <p>Behavioural activation: continue normal daily routines as far as possible; culturally appropriate relaxing activities; regular physical exercise; regular sleep cycles</p>
2 Supportive counselling	<p>Address psychosocial stressors</p> <p>Help ventilate</p> <p>Reassure, where needed</p> <p>Problem solving</p> <p>Identify and enhance coping mechanisms</p> <p>Mobilise social networks</p>

Intervention	Components
3 Behavioural therapy (Instructions for the parent/carer)	<ul style="list-style-type: none"> Make a list of problems Identify the most important problem behaviour to start with Give clear, simple and short commands that emphasise what the child should do, rather than not do All family members should be consistent about rules Be consistent about what the child is allowed/not allowed to do Focus on praise or reward desirable behaviour Do not punish (hit the child), instead withhold rewards (e.g. treats or fun activities) Use a short and clear-cut 'time out' after the child shows problem behaviour, instead of punishment Put off discussions with the child until you are calm Avoid severe confrontations or foreseeable difficult situations
4 Stress management	<ul style="list-style-type: none"> Progressive muscle relaxation Breathing exercises
5 Psychosocial support for bereavement	<ul style="list-style-type: none"> Listen without pressing the person to talk. Assess needs and concerns Explore the meaning of grief Encourage culturally appropriate mourning and adjustment Provide or mobilise psychosocial support

Results

Demographic details

A total of six camps were held at monthly intervals. The total number of patients assessed in the camps was 785. One hundred and five cases were follow-ups, so index cases were 680. Out of the index cases, 55% were male and 45% were female, while 24.3% were under the age of 18. Of the children

and adolescents, 65% were male and 35% were female. Only 1.6% were reported to be over the age of 65, while 64% of cases were adults between the ages of 19 and 50. Sixty-five percent of index cases were IDPs, while 27% were residents of Bannu. With regard to marital status, 56.5% were married, 15% widowed and only 1% divorced. A higher percentage of single men (46.5%)

presented in the camps than single women (35%). Polygamy was noted to be quite common in men, but the exact figures are unknown as this detail was not recorded. Two-thirds of those assessed were illiterate and could only speak Pashto. All literate individuals could speak Urdu as well. Men were four times more likely to be literate and able to speak Urdu than women. These demographic details are shown in Table 1.

Diagnostic categories

Of IDPs, 60% (259 out of 434 cases) reported onset of symptoms before displacement, i.e. preexisting mental illness, 18.7% reported symptoms following displacement and for 21.3% onset of symptoms were not recorded. Nearly 13% cases received a dual diagnosis and 7.6% did not receive an ICD diagnosis. A majority of those adults who received a diagnosis of ‘*behavioural and emotional disorders*’ suffered from mental retardation. Co-morbid physical illnesses were also recorded in 14.68% of the cases.

The top six disorders were ranked according to their total occurring frequencies (obtained by adding primary and secondary diagnoses), with 82.5% of adult diagnoses and 77.5% of under-18 diagnoses included in these categories. Table 2 shows the diagnostic categories.

Treatments

Both pharmacological and psychological treatments were offered. Seventy-five percent of the drugs prescribed were anti-depressant drugs, 10% were anti-psychotics, and 8% were anti-convulsant medications. Of the 1.9% cases prescribed Benzodiazepines, most were already dependent on the drug. Only 6% cases received more than one drug. 28% of cases were not prescribed any drug. Table 3 summarises pharmacological treatments.

The majority of cases (60%) were offered both pharmacological and psychological treatments. Nineteen percent were only

Table 1. Demographic details

Variable	Categories	Follow-up patients					
		Male N (%)	Female N (%)	Total N (%)	Male N (%)	Female N (%)	Total N (%)
Ages (years)	<12	66 (9.7)	33 (4.8)	99 (14.6)	7 (6.7)	2 (1.9)	9 (8.6)
	13–17	43 (6.3)	23 (3.4)	66 (9.7)	4 (3.8)	4 (3.8)	8 (7.6)
	18–35	167 (24.6)	145 (21.3)	312 (45.9)	26 (24.7)	26 (24.7)	52 (49.5)
	36–50	59 (8.7)	67 (9.9)	126 (18.5)	12 (11.4)	13 (12.3)	25 (23.8)
	50–65	33 (4.8)	33 (4.8)	66 (9.7)	7 (6.7)	3 (2.9)	10 (9.5)
Total	>65	6 (0.9)	5 (0.7)	11 (1.6)	0 (0)	1 (0.9)	1 (0.9)
		374 (55)	306 (45)	680 (100)	56 (53.3)	49 (46.7)	105 (100)

Index cases	Follow-up patients							
	Variable	Categories	Male N (%)	Female N (%)	Total N (%)	Male N (%)	Female N (%)	Total N (%)
IDP status	IDPs		239 (35.1)	195 (28.7)	434 (63.8)	37 (35.2)	31 (29.5)	68 (64.8)
	Non-IDPs		95 (14)	96 (14.1)	191 (28.1)	19 (18)	17 (16.2)	36 (34.3)
Total	Not known		40 (5.9)	15 (2.2)	55 (8.1)	0 (0)	1 (0.9)	1 (0.9)
			374 (55)	306 (45)	680 (100)	56 (53.3)	49 (46.7)	105 (100)
Marital status	Single		174 (25.6)	106 (15.6)	280 (41.2)	20 (19)	14 (13.3)	34 (32.4)
	Married		198 (29.1)	180 (26.5)	378 (56.5)	36 (34.2)	32 (30.5)	68 (64.8)
Total	Widow		1 (0.3)	14 (4.6)	15 (2.2)	0 (0)	0 (0)	0 (0)
	Divorced		1 (0.1)	6 (0.9)	7 (1)	0 (0)	3 (2.9)	3 (2.9)
No of children (married cases only)			374 (55)	306 (45)	680 (100)	56 (53.3)	49 (46.7)	105 (100)
	1-4		81 (20.4)	70 (17.6)	151 (37.9)	13 (14.2)	15 (16.4)	28 (30.7)
Language	5-8		80 (20)	79 (19.8)	159 (39.9)	16 (17.5)	12 (13.1)	28 (30.7)
	9+		20 (5)	27 (6.8)	47 (11.8)	3 (3.29)	5 (5.49)	8 (8.79)
Total	Issueless		16 (4)	16 (4)	32 (8.0)	4 (4.39)	3 (3.29)	8 (8.79)
	Not known		1 (0.3)	8 (2.0)	9 (2.3)	-	-	-
Literacy	Urdu+Pashto		198 (49.7)	200 (50.3)	398 (100)	56 (36)	49 (35)	105 (91)
	Pashto only		182 (26.8)	39 (5.7)	221 (32.5)	41 (39)	8 (7.6)	49 (46.7)
Total	Not known		168 (24.7)	252 (37.1)	420 (61.8)	13 (12.4)	41 (39)	54 (51.4)
			24 (3.5)	15 (2.2)	39 (5.7)	2 (1.9)	0 (0)	2 (1.9)
Total			374 (55)	306 (45)	680 (100)	56 (53.3)	49 (46.7)	105 (100)
	Yes		166 (24.4)	30 (4.4)	196 (28.8)	35 (33.3)	8 (7.6)	43 (41.0)
Total	No		186 (27.4)	263 (38.7)	449 (66)	20 (19)	41 (39)	61 (58.1)
	Not known		22 (3.2)	13 (1.9)	35 (5.1)	1 (1)	0 (0)	1 (1.0)
Total			374 (55)	306 (45)	680 (100)	56 (53.3)	49 (46.7)	105 (100)

Note: Exact ages, especially in case of women and older people were not known.

Table 2. Diagnostic categories (ICD 10)

	Adults						Under 18					
	Primary diagnosis		Secondary diagnosis		Combined		Primary diagnosis		Secondary diagnosis		Combined	
	N	%	N	%	Frequencies	N	%	N	%	N	%	Frequencies
1	212	41.2	21	34.4	233	13	7.9	2	1.2	15		
2	71	13.8	8	13.11	79	1	0.6	-	-	1		
3	62	12.0	4	6.55	66	15	9.1	1	0.6	16		
4	18	3.5	3	4.91	21	52	31.5	8	4.8	60		
5	23	4.5	-	-	23	27	16.4	-	-	27		
6	26	5.0	-	-	26	1	0.6	-	-	1		
7	20	3.9	1	1.63	21	1	0.6	-	-	1		
8	2	0.4	9	14.75	11	17	10.3	12	7.3	29		
9	11	2.1	9	14.75	20	6	3.6	1	0.6	7		
10	11	2.1	2	3.27	13	2	1.2	1	0.6	3		
11	9	1.7	-	-	9	3	1.8	1	0.6	4		
12	10	1.9	2	3.27	12	1	0.6	-	-	1		
13	4	0.8	2	3.27	6	-	-	-	-	-		
14	3	0.6	-	-	3	-	-	-	-	-		
15	31	6.0	-	-	-	21	12.7	-	-	-		
16	2	0.4	-	-	-	6	3.6	-	-	-		
Total	515	100	61	100	543	166	100.0	26	-	191		

Notes: * The top six categories for adults. + The top six categories for the under 18 age group. The term mental retardation is used according to ICD 10.

offered psychological interventions, while 13% of the patients were given pharmacological treatments only. Table 4 shows a summary of the psychological interventions offered.

Follow-ups

After the first two camps, follow-up cases were also noted. It was encouraging that 21 % of cases (in the last four camps) were reviewed at least once on follow-up. Half of the patients who did follow-up only spoke Pashto. Similarly, over 60% were illiterate, and their demographic details are also shown in Table 1. Sixty percent of follow-up cases were diagnosed with depression, and 14.2% of cases had not received any medication, but were still followed-up.

Other findings

Special issues relating to women Contrary to common belief that the female population might not be encouraged to access healthcare, 45% of all cases were women. However, in the under-18 sample, the male to female ratio was 2:1.

Divorce is uncommon, as it is considered dishonourable, but polygamy is common. As a result, nearly all women facing mental health issues live with persistent insecurity and the threat of their husbands’ re-marrying, and thereby continuously compromise in marital conflicts. Another sensitive issue relates to contraception, which is largely considered prohibited in Islam. If a woman is reluctant to have more children, the husband is more likely to re-marry. In our sample, nearly half of all married patients had five or more children, and 47 patients had more than nine children.

Special issues relating to children

Children can be seen to fall into one of three categories, listed below.

1. Children with pre-existing, undiagnosed disorders that may need further investigation, regular medication and follow-up (such as epilepsy).

Table 3 Pharmacological Treatments

Drug	Primary prescription		Additional prescription		Total frequency	
	No	%	No	%	No	%
1 Anti-depressant	387	56.91	12	29.27	399	75.14
2 Anti-convulsant	45	6.62	-	-	45	8.47
3 Anti-psychotic	40	5.88	17	41.46	57	10.73
4 Mood stabiliser	17	2.5	-	-	17	3.20
5 Benzodiazepine	1	0.15	12	29.27	13	2.45
6 No drug prescribed	189	27.79				
7 Not recorded	1	0.15				
8 Total	680	100	41	100	531	100

Table 4. Psychological interventions

	Intervention	N	%
1	Psychoeducation	207	30.4
2	Supportive counselling	158	23.2
3	Stress management	92	13.5
4	Behavioural therapy	38	5.6
5	Psychosocial support for bereavement	34	5.0
6	No intervention	148	21.8
7	Not recorded	3	0.4
Total		680	100.0

2. Children with pre-existing, but diagnosed conditions that do not necessarily need regular medication nor immediate professional psychiatric care (such as mental retardation).
3. Children with no pre-existing problems, but who have developed behavioural and mild psychological problems due to displacement.

Special issues relating to minorities

According to military sources, there were 22 Hindu and 24 Christian families among IDPs who were not integrated into the community for their protection. The Hindu families were housed on the top floor of a Hindu temple, and the army had made special arrangements to deliver rations at their doorstep in order to avoid incidents. None of these families were represented at the hospital, so their access to health care remains a matter of concern.

Discussion

Although other MHPSS initiatives in humanitarian settings have been reported from Pakistan (Budosan & Aziz, 2009; Humayun, 2008; Shah et al., 2014), this is likely to be the first intervention in a highly secured military zone in Pakistan. These camps demonstrate an effective model for emergency mental health response via collaboration between government agencies (Provincial Disaster Management

Authority), mental health professionals (volunteers/departments), military and humanitarian agencies, in an insecure and challenging context, and without commercial sponsorship. The initiative aimed beyond just providing immediate mental health care to IDPs by strengthening local services (Epping-Jordan et al., 2015; Pérez-Sales et al., 2011). To our knowledge, this is the first instance in Pakistan where estimates for common mental disorders, both for adults and children, were identified in an IDP population from a tribal region. These camps helped in engaging local services and provided an impetus for setting up a mental health agenda in the region. It was encouraging that during this initiative, the humanitarian forum formed the first ever MHPSS taskforce in the province (Humanitarian Response, 2015).

About the camps

In view of the high security restrictions, geographical distance, dearth of mental health resources locally and lack of an institutional initiative, convening these camps was the only viable option to support IDPs. In our experience, these camps were helpful in assessing needs, providing direct care, engaging local agencies, developing referral links and initiating capacity building. We found that presence of experienced professionals in the field was highly valuable in terms of setting practice trends and

providing direct supervision, more so than the usual trend of deputing junior psychiatrists/psychologists (even with long distance supervision) into a humanitarian setting. Unlike traditional '*medical camps*', active efforts were made to conduct multi-disciplinary assessments in order to avoid a purely biomedical approach and avoid risk of over-medicalisation (Ventevogel, 2014). Considering the strongly ingrained biological model of medical practice, both from a clinician's perspective and consumer expectations, it was encouraging that at least 28% of those attending the camps were not prescribed any drugs, and 15% of these also returned for a follow-up.

Another objective was to encourage task sharing by involving non specialists, as this has been established as an effective approach for providing mental health care in resource poor settings (van Ginneken, et al., 2013). Initially, it was time consuming to supervise other members (including psychologists, psycho-social workers and nurses) and oversee their involvement in the consultation process. However, this proved to be a worthwhile investment, as delegating tasks allowed clinicians to focus on the more severe cases. This also offered a valuable opportunity for training the mental health care team in the hospital and psychosocial field staff.

Through advocacy, the provincial government agreed to appoint another psychiatrist at Bannu, but unfortunately no appropriate candidate was found during that period. However, the psychologist in the department began conducting independent clinics afterwards.

The need for training primary care staff following a humanitarian emergency in Pakistan is known (Budosan & Aziz, 2009; Budosan, 2011). Alongside the camps, mhGAP trainings were conducted in the last three months (will be described in an upcoming article). These were attended by a total of 58 primary care staff. The training modules were prepared according to the

need assessment from the camps. The local department of psychiatry set up a helpline for GPs to enable them with a referral system. In addition, psychosocial trainings for community workers were conducted by collaborating NGOs who continued to provide support for another six months after the camps.

Findings from the camps

1. This initiative offered an opportunity to assess mental health care needs in a conflict hit area. A vast majority of the IDPs (at least 60% cases) had pre-existing mental disorders. About 15% of cases were residents of Bannu seeking second opinions. Since these camps were organised in a tertiary care hospital, mainly advertised through local health facilities, and referred to as a specialist activity for mental health problems, it was unsurprising that most people were found to be suffering from mental disorders.
2. Although the diagnosis of depression was used for moderate and severe cases only, the high prevalence might still be an indication of a trauma reaction. It is known that expression of trauma symptoms is culturally-tied, and some posttraumatic stress disorder (PTSD) symptom clusters, including avoidance/numbing, have been found to have fluctuating salience depending on cultural factors (Hinton & Lewis-Fernandez, 2011). In our experience, symptoms of PTSD were frequently reported by IDPs, particularly the sounds of '*rumbling airplanes in [their] heads*', but none fulfilled the full diagnostic criteria. For example, flashbacks were usually fleeting and not repetitive. Symptoms of hyper-arousal were common, but pronounced emotional detachment or numbness was not reported. One 4-year-old child screamed for an hour at the sight of army personnel (in uniform) while waiting,

- but was successfully calmed down during the clinical intervention.
3. Some demographic findings are consistent with the trends of seeking mental health care previously studied in another district of the same province (Shah et al., 2014). For example, a majority of those who sought help were in the age range of 19–50, with a near equal representation of both genders. In that sample, only 8% were under the age of 18, whereas ours had a much larger proportion of children and young adults (over 24%). It was encouraging that 21% of patients returned for a follow-up visit in our monthly camp.
 4. The most commonly prescribed medication consisted of anti-depressant drugs. This is not surprising considering the high prevalence of pre-existing depressive disorders. However, it is quite possible that these medicines were also being prescribed as a symptomatic treatment for anxiety or insomnia (in view of conscious efforts by the team to discourage benzodiazepines). Additionally, it has also been shown that longer-term psychological interventions in similar situations could actually help better in symptom reduction and enhancing coping strategies than medical treatments (Ayoughi, Missmahl, Weierstahl & Thomas, 2012). In addition, low level psychological interventions developed in non conflict affected areas of Pakistan have also been shown to be effective, and might be helpful within this humanitarian context (Rahman, Malik, Sikander, Roberts & Creed, 2008).
 5. The camp also provided insights into the existing mental health practices of the region. Like other parts of the country, KPK offers a purely biomedical approach towards mental health care. Routinely, dozens of patients are seen every day by psychiatrists with no more than a few minutes' consultation. Protracted and untreated cases of psychological complexity and dissociative disorder received little or no attention. It was also apparent that there was wide variation in prescribing practices: trends of poly-pharmacy and use of multiple brands were quite common. There was also a tendency to order relatively expensive investigations like EEG and CT scans/MRI without clinical indications. The care offered to the children, especially those suffering from mental retardation, was far from satisfactory. One family with two children suffering from mental retardation had spent Rs.1.8 million (over USD 28,000) on health care without much help.
 6. Another relevant finding was that not all essential drugs were available in the district, including depot anti-psychotic injections. There is little regulation by the provincial government. What is available, both in terms of the medicine and its brand, is purely determined by the marketing success of the pharmaceutical companies (Khan, 2006).

Major barriers/limitations

The main limitation of this experience was the obvious disproportionate amount of resources compared to the population affected. Also, since the camps were held at a tertiary care facility, access to the hospital was a major barrier for many people. Time was another major constraint during these camps as, due to security concerns, travelling was not possible after dark. Also, over 100 patients were seen at each camp, mostly without a break. Documentation was therefore, sometimes impossible, which was the primary reason for missing data. Another barrier was that of language and culture. There was a huge language barrier as two-thirds of the patients could only communicate in Pashto. Even the Pashto speaking professionals had difficulty conducting interviews because of the dialect spoken by most IDPs. There were also limitations in exploring psychological processes or

delivering therapeutic interventions (sometimes through an interpreter). In addition, there were pronounced socio-cultural inhibitions, especially for women, to seek medical attention and advice from a doctor, especially if male. Most women had their faces covered in the waiting area and some remained reluctant to uncover, even during the consultation. A related clinical observation was that most patients (especially men) were unable to discuss emotional difficulties. This could partly be because the tribal culture does not encourage emotional expressions, although Pashtun women are known to express their feelings (Grima, 1993). Sometimes, there was difficulty in obtaining detailed information or collateral accounts because close family members or key informants were not available.

Most members of the team shared their own limitations in offering psychotherapeutic skills and dealing with stress related disorders. Clear gaps in knowledge and skills in child and adolescents' mental health care were reported, for example in Iraq (Ai-Obaidi, Budosan, & Jeffery, 2010), were also identified in our experience. The team travelled together for these camps, and that time was also utilised to explore clinical needs and developing skills. One of the key challenges identified as a major obstacle to implement psychotherapeutic interventions recommended by the WHO stress related guidelines was the limited availability of mental health resources in developing countries (Tol, et al., 2014). What is not as clearly documented is that sometimes the existing mental health resource might also not be adequately trained for these interventions.

Lastly, despite our best efforts, long term sustainability of these efforts is yet to be seen. Lack of political will and sustained efforts to reinforce training of health care staff are major concerns. In addition, most humanitarian agencies might be present in Bannu for a limited time only.

Conclusion

Ventevogel et al. (2012) described the challenges of providing integrated mental health care in a much more fragile and resource poor context covering a population of a million population. They also highlighted the need for investing funds towards achieving longer term goals. The Bannu initiative was an encouraging experience in a highly secure, but not so resource poor setting. It helped mobilise relevant resources in the short term, but sustainable efforts are much needed for an effective outcome. Generating political will be a key challenge in the region. The goal should be to set up a primary health care system in NWA and strengthen the existing system in Bannu, so that mental health care could be integrated as an essential component (Saxena & Setoya, 2014). A paradigm shift towards a public mental health approach is much needed for psychiatric departments throughout the country. These would need to redefine their roles to integrate within community initiatives. The primary care staff must be trained according to mhGAP guidelines as a priority in all districts.

It is also advisable to make a mental health disaster/emergency preparedness plan for countries like Pakistan, so that MHPSS initiatives can be promptly organised (van Ommeren et al., 2015; Ventevogel et al., 2015). Following a humanitarian crisis, and in the absence of local specialists, short term rotations should be considered to support clinical services. A monthly mental health camp, for at least six months, can greatly help support local services. Opportunities for providing psychosocial support in the community should be coordinated between different agencies including district health offices, academic departments of psychiatry and humanitarian agencies.

Lastly, extensive and robust advocacy for mental health needs and services at the national and provincial levels is essential.

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