



**NATIONAL COMMISSION
FOR HUMAN RIGHTS**

TASKEEN 
SEHATMAND PAKISTAN

Malpractice in
Mental Health in Pakistan:

A CALL FOR REGULATION

National Commission for Human Rights, Pakistan

Aug 2022



Malpractice in
Mental Health in Pakistan:

A CALL FOR REGULATION



**NATIONAL COMMISSION
FOR HUMAN RIGHTS**

TASKEEN 
SEHATMAND PAKISTAN

Authors

*Khushbakht Sohail,
Dr. Taha Sabri,
Dr. Mekaiel Zia,
Khushbakht Memon*

NCHR Oversight

*Rabiya Javeri,
Chairperson NCHR*

Design and Layout

Aliza Aslam

Acknowledgements:

We would like to thank Dr. Rubeena Kidwai, Dr. Ali Madih Hashmi, Dr. Salma Siddiqui, Dr. Sumara Masood, Fatima Hussain, Nauman Qureshi, Katherine Usman, Meera Afzal, Maryam Suheyli, members of Pakistan Mental Health Coalition (PMHC) and all those consulted for their detailed review and inputs. Their expertise has been invaluable in ensuring that this report is accurate and up to date.

A special thank you to Members of NCHR Manzoor Masih, Nadeem Ashraf, Anis Haroon, Farkhanda Aurangzeb and Tariq Javed for their untiring efforts to promote and protect human rights.

Published Aug 2022



Table of Contents

Foreword by Chairperson NCHR Rabiya Javeri Agha	1
Executive Summary	3
Chapter 1 Introduction and Background	5
Chapter 2 Methodology	12
Chapter 3 Findings and Analysis	14
Chapter 4 Policy Recommendations	32
Annex A International Human Rights Instruments that Guarantee Mental Health as a Human Right	36
Annex B List of Stakeholders Consulted	39
Annex C NCHR Data Requisition Request Sent to the Provinces and ICT	42
Annex D Data Responses Received from the Provinces and ICT	46

Foreword

A few months ago, the National Commission for Human Rights received a troubled call informing us that the caller's friend and roommate Rukhsana* had been forcefully locked in a rehabilitation center and psychiatric clinic in the outskirts of Islamabad for 9 days. NCHR took immediate action, and with police and officials from the Health department in tow, rescued Rukhsana, a 35 year old woman with an MPhil who serves as a senior level employee at a Multinational Company. She was sane, but shaken.

In a detailed interview at the Commission, it transpired that Rukhsana's abduction and incarceration was an attempt by her parents to convince her to marry the man of their choice. The anger and frustration that she felt towards an unwelcome arranged marriage was diagnosed as 'depression' by a local psychiatrist, who then referred her to the psychiatric clinic and rehabilitation center where she was detained without consent. The fact that a mental health clinic was complicit in abducting a healthy adult woman raises important questions about the regulation of mental health facilities in Pakistan.

While all the provinces and ICT have Mental Health Acts, this legislation is outdated and there is little to no implementation of these Acts. Despite being signatory to WHO's Mental Health Action Plan 2013-2030, Pakistan has no national mental health plan, nor has the Government made sufficient budgetary allocations to address mental health. Other than psychiatrists, mental health practitioners including counselors, psychologists, and therapists, are not regulated or licensed by any national accreditation body.

Limited regulation of the mental health sphere means that anyone can offer mental health counseling, treatment and rehabilitation services without accountability. This is particularly alarming in Pakistan, where estimates indicate that approximately a quarter of the population (over 55 million people) suffer from common mental disorders. Data estimates that approximately 80% of these remain untreated.

Young people, particularly women, suffering from mental disorders are often told they simply need to get married to resolve their problems. Thousands of troubled persons are also taken to shrines where they are beaten and chained to have jinns exorcized. Ignorance and the limited availability of qualified mental health practitioners has led to quackery and opportunism. Archaic methods of drugging patients-even using electric shock therapy- are commonplace. Consent, confidentiality, and care are compromised in many situations.



RABIYA JAVERI AGHA
CHAIRPERSON

*National Commission for
Human Rights (NCHR)*

Under the NCHR Act 2012, NCHR has a broad mandate which involves, amongst others, five core functions;

- **Complaint Redressal**
- **Watchdog/Advisor to Government**
- **Researcher**
- **Leader for Advocacy on critical issues**
- **Policy Advisor**

During the process of developing this report, NCHR started with redressing the complaint regarding Rukhsana, served as a watchdog by reviewing relevant mental health legislation and its implementation, launched its advocacy campaign for regulation in mental health, provided policy recommendations for the government, and drafted an updated Mental Health Act for ICT and the provinces in collaboration with Taskeen Sehatmand Pakistan, a non-Profit working towards the prevention of mental illness in Pakistan. NCHR also collected quantitative data on the number and types of mental health facilities registered throughout Pakistan, interviewed mental health practitioners, and along with Taskeen, surveyed service users and collected data.

This report is the product of in-depth research, interviews, case studies, and discussions with key stakeholders, including both mental health practitioners and those seeking mental health services, across the country. I would like to acknowledge the initiative taken by NCHR Member Minorities Manzoor Masih, Member Balochistan Farkhanda Aurangzeb and the team that went to rescue Rukhsana; the work of our Researcher Khushbakht Sohail; the support of our partners at Taskeen, especially Mr. Irfan Mustafa, Dr. Taha Sabri and Dr. Mekaiel Zia; and the constant efforts of NCHR members Nadeem Ashraf, Tariq Javed, and Anis Haroon; and our broader team. It is with your dedication that we are able to shed light on these important issues.

Rukhsana's story is just one of many horrific stories that take place regularly throughout the country. We need to talk about mental health openly and without discrimination. It is time for Pakistan to realize that invisible disabilities, such as mental health, are one of the most neglected yet essential issues for development and human rights in the country.

Executive Summary

Conflict, natural disasters, poverty, socio-cultural problems, low literacy, and lack of access to health services have led to the development of a significant burden of mental illness in Pakistan. Poor mental health disproportionately affects underprivileged women and youth.

While there is a paucity of local research, estimates show that approximately 1 in 4 Pakistanis over the age of 18 will be affected by a mental health condition at some point in their lives, of which over 80% will not be able to access mental health support.¹ In reality, this number is likely under-reported because of the stigma attached to mental health disorders preventing seeking help and lack of mental health awareness among the masses. In addition, this burden of mental illnesses prevents those affected from achieving their full potential, reduces their productivity and prevents them from being effectively employed. The economic ramifications of this have been estimated to cost the national exchequer \$6.2 billion USD.²

In addition, Pakistan has limited tools to cope with this burden of mental illness. There are very few qualified mental health practitioners in a country of approximately 220 million people. Those mental health facilities and practitioners that do exist are unregulated, with few accountability mechanisms in place, leaving room for malpractice and unethical conduct to occur. While limited legislation and policy based on the Mental Health Ordinance 2001 does exist, it is largely outdated and mostly unimplemented, particularly after the devolution of healthcare to the provinces.

The National Commission for Human Rights (NCHR) and Taskeen Health Initiative (Taskeen) have collaborated to identify the gaps in mental health policy, legislation, licensing, qualification, and ethical mental health service delivery in order to highlight the human rights violations and malpractice that those with mental health issues face as a consequence. Through data collection, surveys, interviews, and case studies, this report has organized findings across seven themes, including gaps in mental health legislation, regulation and licensing; issues with confidentiality and privacy; misrepresentation of credentials and qualifications; inappropriate or unethical provider behavior; issues in diagnosis and treatment; miscellaneous problems in care; and problems faced by women and girls that cut across themes.

This report has also detailed evidence-based policy recommendations across five major themes, including raising public awareness; legislative actions; mental health licensing bodies; mental health regulatory authorities; and other recommendations. These recommendations have been developed in consultation with experts in the fields of psychiatry, psychology, health policy and public health. They are centered around end user concerns and experiences in order to ensure the highest quality of care for vulnerable people. The implementation of these changes is an absolute necessity to ensure effective and ethical delivery of mental health services in Pakistan.

¹ Junaidi, Ikram. "80pc Pakistanis Lack Mental Health Treatment Facilities." DAWN.COM. Dawn News, October 11, 2021. <https://www.dawn.com/news/1651249>.

² Ashar Malik and Murad Khan, "Economic Burden of Mental Illnesses in Pakistan," *Journal of Mental Health Policy and Economics*, 19(3), pp. 155-166. https://ecommons.aku.edu/pakistan_fhs_mc_chs_chs/301/

CHAPTER

1

INTRODUCTION AND BACKGROUND

Introduction and Background

Poverty, conflict, compromised education, ill-health, violence and gender inequality are both causes and consequences of poor mental health in Pakistan. Poor mental health disproportionately affects women and girls. Patriarchal attitudes in society increase the risk of violence against women and girls, and research shows that 28% of women ages 15-49 have experienced physical violence, consequently leading to greater risk of poor mental health.³ Similarly, children and adolescents face high levels of physical violence and psychological aggression, exacerbating mental health.⁴ The lack of youth mental health programs mean that over 60% of Pakistan's population have no programs that cater to their specific needs. Coupled with limited access to physical and mental health services, Pakistan retains a significant burden of mental illness.

Estimates show that approximately a quarter of people in Pakistan suffer from mental health disorders and over 80% of those remain untreated.⁵ Mental health, defined as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community," is a human rights issue.⁶ Individuals suffering from mental health conditions are often unable to advocate for themselves or access mental health treatment and services, especially if they are unable to utilize their full psychological capacities. Those with mental health conditions are also particularly vulnerable to exploitation, neglect, physical and sexual abuse. The shame, stigma and mystery surrounding mental health conditions means that many are not even aware that they suffer from poor mental health, further preventing them from seeking appropriate support.

The annual report of the United Nations Office of the High Commissioner for Human Rights (OHCHR) explains that those who suffer from invisible disabilities like mental health conditions are also far likelier to suffer from declining physical health and significantly reduced life expectancy; 15-20 years less than the general population.⁷ Studies show that poor mental health is a growing issue in Pakistan, and 22%-60% of Pakistanis across major cities suffer from depression and anxiety.⁸ Studies also report that there are higher rates of symptoms of depression, anxiety and stress among university students, ranging from 70-85% of those surveyed.^{9 10}

³ Onaiza Qureshi, et al. "Country Profile: Pakistan." Taskeen Health Initiative, 2020.

<https://taskeen.org/en/wp-content/uploads/2020/11/Pakistan-Country-Profile-final.pdf>

⁴ United Nations Children's Fund (UNICEF), "Multiple Indicator Cluster Survey 2017-2018, Punjab," Bureau of Statistics, UNICEF, 2019.

<https://microdata.worldbank.org/index.php/catalog/3559/related-materials>

⁵ Junaidi, Ikram. "80pc Pakistanis Lack Mental Health Treatment Facilities." DAWN.COM. Dawn News, October 11, 2021.

<https://www.dawn.com/news/1651249>.

⁶ "Mental Health Fact Sheet," World Health Organization (World Health Organization, March 30, 2018),

<https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>.

⁷ "Mental Health Is a Human Right," The Office of the High Commissioner for Human Rights (OHCHR, May 24, 2018),

<https://www.ohchr.org/en/stories/2018/05/mental-health-human-right>.

⁸ Zafar Iqbal, Ghulam Murtaza, and Shahid Bashir, "Depression and Anxiety: A Snapshot of the Situation in Pakistan," *International Journal of Neuroscience and Behavioral Science* 4, no. 2 (2016): pp. 32-36, <https://doi.org/10.13189/ijnbs.2016.040202>.

⁹ Muhammad S Khan et al., "Prevalence of Depression, Anxiety and Their Associated Factors among Medical Students of Sindh Medical College, Karachi, Pakistan," *American Journal of Epidemiology* 163, no. suppl_11 (January 2006), https://doi.org/10.1093/aje/163.suppl_11.s220-c.

¹⁰ Saba Asif et al., "Frequency of Depression, Anxiety and Stress Among University Students," *Pakistan Journal of Medical Sciences* 36, no. 5 (2020), <https://doi.org/https://doi.org/10.12669/pjms.36.5.1873>.

The World Health Organization (WHO) estimated that Pakistan's suicide mortality rate (per 100,000 population) in 2019 was 8.9.¹¹ This means that an estimated 19,277 Pakistanis died by suicide in 2019. Suicide remains criminalized despite ample evidence that ending criminalization actually reduces the number of death by suicides (See below).¹² Suicide is the second leading cause of death for adolescents in South Asia.¹³ In 2019, a reported 25.7 million Pakistanis suffered from major mental health conditions, including depression, anxiety, and intellectual disabilities.¹⁴ In reality, this number is probably much higher due to low self-reporting as a consequence of the stigma attached to mental health disorders. Unaddressed mental health issues prevent hundreds of thousands of people from working productively. Those suffering from mental health disorders are also more likely to lose their jobs or be unemployed for extended periods of time. An Agha Khan University study in 2006 estimated that the cost of the prevailing mental health burden was \$4.2 billion USD to the country's economy annually.¹⁵ In 2022 numbers, this amounts to \$6.2 billion USD.

The Case for Decriminalizing Suicide¹⁶

Pakistan is one of 20 countries in the world who have not yet decriminalized suicide. Despite the figures estimated by the WHO, tracking suicide is difficult due to low levels of reporting, high stigma, and criminalization which in turn perpetuates more stigma. Criminalizing suicide means that in Pakistan, as in only 20 other countries in the world, those who have attempted suicide can be subject to prosecution, fines, and prison time (1-3 years). The argument for maintaining the criminalization of suicide is that it deters people from attempting to take their own lives. However, evidence shows that it does not prevent people from taking their lives- it simply prevents them from seeking help if they survive. Improved mental health services and psychosocial support, reduced stigma around mental illness, and restricting the means of suicide (for example, pesticide control), do help reduce suicide attempts.

Because suicide is criminalized under Section 325 of the Pakistan Penal Code, many do not report cases of suicide or attempts at suicide in order to avoid the stigma and criminalization. This means that the data on suicide is incomplete, and the situation may be more dire than available data makes it seem. Moreover, families often spend resources to hide suicide attempts instead of getting survivors the help they need to avoid police harassment and litigation. Survivors and their families are also often victims of extortion attempts, and can pay hefty bribes to emergency responders to prevent them from reporting attempted suicide.

¹¹ "Suicide Mortality Rate (per 100,000 Population) - Pakistan 2019," World Health Organization, Global Health Observatory Data Repository (WHO), accessed April 19, 2022, <https://data.worldbank.org/indicator/SH.STA.SUIC.P5?locations=PK>.

¹² Taskeen Pakistan, "Decriminalizing Suicide: Saving Lives, Reducing Stigma," United for Global Mental Health, (Taskeen, 2021). <https://taskeen.org/en/wp-content/uploads/2021/09/UGMH-Suicide-Decriminalization-Report-Pakistan%C6%92.pdf>

¹³ United Nations Children's Fund (UNICEF), "The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health," October 2021, pp. 39. <https://www.unicef.org/media/114636/file/SOWC-2021-full-report-English.pdf>

¹⁴ Ibid., 32.

¹⁵ Ashar Malik and Murad Khan, "Economic Burden of Mental Illnesses in Pakistan," Journal of Mental Health Policy and Economics, 19(3), pp. 155-166. https://ecommons.aku.edu/pakistan_fhs_mc_chs_chs/301/

¹⁶ Taskeen Pakistan, "Decriminalizing Suicide: Saving Lives, Reducing Stigma," United for Global Mental Health, (Taskeen, 2021).

Those who attempt suicide often suffer from acute mental illness and criminalization often exacerbates their suffering. Moreover, criminalization disproportionately affects those from lower socioeconomic backgrounds. Decriminalizing suicide will open up avenues for compassion and treatment, and reduce the stigma and suffering of survivors.

Currently, the Senate of Pakistan has passed a suicide decriminalization bill, but it has not yet been passed by the National Assembly.

Deficiencies in mental health policy, legislation, and access do not exist in a vacuum. One of main reasons for these is low mental health literacy among the Pakistani population. First, the mainstream idioms of distress and explanatory models of mental illness used in mental health practice evolved in the Western world, and may not be culturally relevant for large swathes of Pakistan's population.¹⁷ In the South Asian region, many mental illnesses manifest as psychosomatic symptoms like fatigue, unexplained aches and pains, high blood pressure, indigestion, nausea and other gastrointestinal issues.¹⁸ Physical symptoms like these, combined with the lack of awareness and acceptability of mental health issues often delay diagnosis. Only after a myriad of tests fail to pinpoint any underlying physical illness is a mental illness diagnosis considered.

The overall lack of awareness and knowledge around mental illness in Pakistan sets up fertile ground for non-evidence based practice and malpractice. It also results in increased stigma against mental illness. At an individual level, mental health issues are widely attributed to supernatural causes and often considered a form of divine punishment.¹⁹ There is also a cultural propensity to see symptoms and feelings as a test of resilience from God, leading to stigmatization and shame. Additionally, many Pakistanis continue to believe that mental illness is the result of black magic, 'nazar' or jinns, and resort to unscientific practices like going to faith healers and pirs to obtain "spiritual cleansing" for those affected by mental illness.²⁰

The lack of awareness regarding mental health also extends to mental health practitioners. In a cross sectional study from Lahore in 2015, doctors were surveyed to determine the attitudes and beliefs of Pakistani medical practitioners towards depression. 37% of those surveyed felt that supernatural forces were responsible.²¹ This belief was particularly prevalent among doctors who worked in rural settings. Many of the doctors surveyed also reported that depression was "due to a lack of stamina and will-power and was a natural part of growing old."²² The attitudes of medical practitioners towards mental illness are particularly important in a country like Pakistan, due to the prevalence of comorbid mental and physical diseases. Negative attitudes towards mental health prevent medical practitioners from being

¹⁷ Mark Haddad et al., "The Attitudes and Beliefs of Pakistani Medical Practitioners about Depression: A Cross-Sectional Study in Lahore Using the Revised Depression Attitude Questionnaire (R-DAQ)," *BMC Psychiatry* 16, no. 1 (2016), <https://doi.org/10.1186/s12888-016-1069-1>.

¹⁸ Salman Shafiq, "Perceptions of Pakistani Community towards Their Mental Health Problems: A Systematic Review," *Global Psychiatry* 3, no. 1 (January 2020): pp. 34, <https://doi.org/10.2478/gp-2020-0001>.

¹⁹ Tahir Mahmood Ali and Sana Gul, "Community Mental Health Services in Pakistan: Review Study from Muslim World 2000-2015," *Psychology, Community & Health* 7, no. 1 (March 2018): pp. 59, <https://doi.org/10.5964/pch.v7i1.224>.

²⁰ Ahmed Waqas et al., "Public Stigma Associated with Mental Illnesses in Pakistani University Students: A Cross Sectional Survey," *PMC (US National Library of Medicine, December 16, 2014)*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4273937/>.

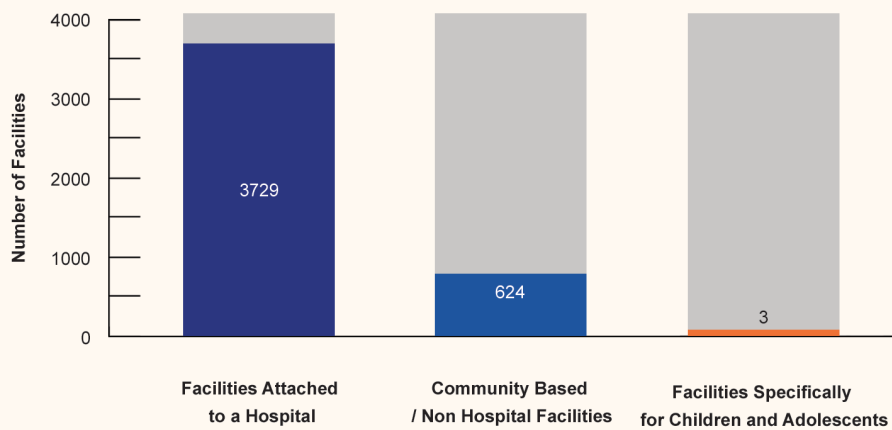
²¹ Mark Haddad et al., "The Attitudes and Beliefs of Pakistani Medical Practitioners about Depression: A Cross-Sectional Study in Lahore Using the Revised Depression Attitude Questionnaire (R-DAQ)."

²² Ibid.

able to accurately diagnose, treat, or advise those that come to them.²³

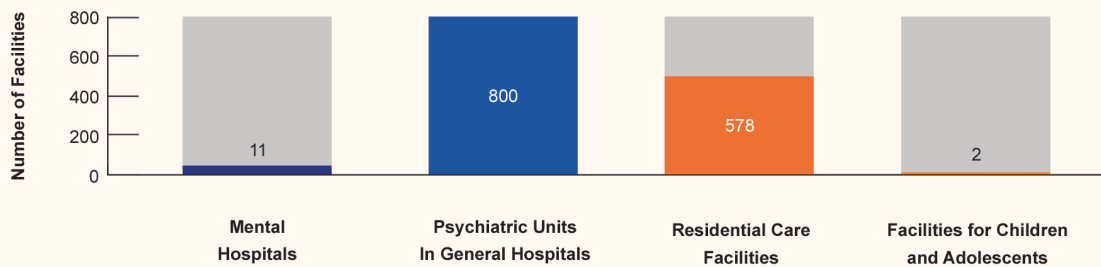
There are only an estimated 400 psychiatrists for a population of 220 million; with one psychiatrist per 550,000 Pakistanis, while the number of allied mental health practitioners (which include non-medical mental health practitioners including psychologists, psychotherapists, counselors, etc.) is not adequately documented.²⁴ In 2017, WHO reported that Pakistan had a total of 4,356 outpatient mental health facilities available for a population of 200 million+ (See Figure 1 for breakdown).²⁵ There were also a total of 1,391 inpatient mental health facilities. (See Figure 2 for breakdown). While the median number of mental health beds per 100,000 population is 50+ in high income countries and 11.3 in the Mediterranean region, it is 1.7 in Pakistan.²⁶

Figure 1: Outpatient Mental Health Facilities in Pakistan



Data by WHO, 2017.

Figure 2: Inpatient Mental Health Facilities in Pakistan



Data by WHO, 2017.

²³ Ibid.

²⁴ Afzal Javed et al., "Mental Healthcare in Pakistan," *Taiwanese Journal of Psychiatry* 34, no. 1 (March 2020): pp. 6-14, https://doi.org/10.4103/TPSY.TPSY_8_20.

²⁵ "Mental Health Atlas 2017: Pakistan" (World Health Organization WHO, 2017),

https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2017-country-profiles/pak.pdf?sfvrsn=9437b8d1_1&download=true.

²⁶ "2021 Monitoring Report: Universal Health Coverage Pakistan" (Ministry of National Health Services, Regulations and Coordination, December 2021), pp 32. <https://phkh.nhsrcc.pk/sites/default/files/2021-12/Universal%20Health%20Coverage%20Monitoring%20Report%20Pakistan%202021.pdf>.

Most of the facilities that do exist are located in urban centers. In addition to limited mental health services and facilities, those that do exist, especially in the private sector, are unaffordable for the vast majority of the population. Experts report that one session with a qualified mental health practitioner in urban centers like Lahore and Karachi can cost up to Rs. 10,000, preventing common people with mental disorders from being able to access medical help. In the public sector, mental health practitioners are overwhelmed by the sheer volume of cases, unable to provide adequate services. At present, Pakistan spends approximately 2.9% of its GDP on health expenditure²⁷ out of which only 0.40 is allocated for mental health.²⁸ Most of this funding is then funneled to mental health and substance abuse hospitals.²⁹ This means that instead of prioritizing prevention and early management, funding is instead channeled towards managing the existing mental health burden at its latest stages. Research shows that the best way to provide mental health support is to focus on prevention and early management.

Although the Constitution of Pakistan does not guarantee the right to health, Article 9 guarantees the right to life, Article 14 refers to the inviolability of dignity of man, and Article 25 enshrines the equality of all citizens before the law.³⁰ From the right to life perspective, we can extrapolate the right to health including mental health; for there is no life without good health. From Articles 14 and 25, we can extrapolate the importance of the rights of those with mental illness or psychosocial disabilities. Pakistan has no comprehensive mental health plan or effective mental health policy. In 2001, the archaic Lunacy Act of 1912 was finally replaced by the Mental Health Ordinance 2001, designed to implement safeguards around mental health services and delivery in Pakistan. However, before it could be fully implemented, the 18th amendment was passed and health, including mental health, was devolved to the provinces.

Sindh passed the Sindh Mental Health Act in 2013, followed by the Punjab Mental Health Act in 2014, the Khyber Pakhtunkhwa Mental Health Act in 2017, and finally, the Balochistan Mental Health Act in 2019. In Islamabad, the 2001 Mental Health Ordinance still applies. However, there is no implementation of this legislation. Service providers and healthcare officials are unaware of its existence. In the provinces, the provincial Mental Health Acts remain unimplemented. Healthcare establishments and facilities providing mental health services, including psychiatric clinics and rehabilitation centers, remain unregulated and unchecked, despite provisions in the law that should prevent this from happening. Mental health service providers like psychologists, therapists, counselors and healers remain unregulated, without any consequences for the misrepresentation of qualifications or offering mental health services without proper training.

A combination of factors, including little to no funding for early prevention or mental health awareness and promotion; limited awareness of mental health resources among the general population; limited availability of qualified mental health practitioners and affordable mental health services; and the lack of regulation of mental health services have put the health and the human rights of millions in jeopardy. As described in Case Study 1, this landscape of mental health has opened up the potential for unchecked abuse of power. The situation as it stands facilitates the violation of the rights of those who suffer from mental health issues and

²⁷ "Health Expenditure Profile: Pakistan." (WHO Global Health Expenditure Database) https://apps.who.int/nha/database/country_profile/Index/en.

²⁸ "Mental Health Atlas 2017: Pakistan" (World Health Organization WHO, 2017)

²⁹ Onaiza Qureshi, et.al. "Country Profile: Pakistan." Taskeen Health Initiative, 2020, pp. 5. <https://taskeen.org/en/wp-content/uploads/2020/11/Pakistan-Country-Profile-final.pdf>

³⁰ Constitution of the Islamic Republic of Pakistan.

denies Pakistanis the right to health, adequate treatment, and dignity.

The National Commission for Human Rights (NCHR) is committed to protecting and promoting the human rights of all Pakistanis, and Taskeen Health Initiative (Taskeen) is committed to ensuring the rights of people with mental illness are upheld. In this report, NCHR and Taskeen aim to identify the gaps in mental health policy, legislation, licensing, qualification, and ethical mental health service delivery in order to highlight the human rights violations and malpractice that people face as a consequence. In addition, policy recommendations are provided to ensure safe, ethical delivery of mental health services to those who need it.



CHAPTER

2

METHODOLOGY

Methodology

In order to provide a holistic view of the mental health landscape in Pakistan, various methodologies were utilized. These include a background literature review focused on existing legislation and policies, stakeholder interviews, and an online survey of service users.

A literature review was conducted to identify the gaps in mental health service awareness, availability and access, national policies, legislation and regulation. This was supplemented with semi-structured interviews of mental healthcare practitioners, including psychologists, psychiatrists, psychotherapists, and public health professionals, to pinpoint gaps in legislation and policies in Pakistan. Data from the provinces and ICT on the number and type of mental healthcare establishments was requisitioned from the Government of Pakistan. This included, among other information, the number of beds in each institute, and the number of full and part time medical officers employed at these establishments in order to ascertain the type of care being offered to the public.

An online qualitative survey was administered to users of mental health services. Users were able to anonymously and confidentially elaborate on their experiences with malpractice and inappropriate conduct. The survey focused on adult service users and the challenges they experienced with mental health services in Pakistan. It was open to all Pakistanis ages 16 and above and was not limited to a particular type of mental health practitioner.



96 responses were received in this survey. These responses allowed users to self-identify their age groups, document their interactions with mental health service providers and the kind of challenges they experienced. Users were also able to share the changes they would like to see to restore their confidence in mental health services. These responses were charted and a thematic analysis conducted to ascertain common themes of interest. The findings of this report have been structured according to the identified themes.

CHAPTER

3

FINDING AND ANALYSIS

Findings and Analysis

The various methodologies of inquiry have highlighted deficiencies in many areas of the mental health regulation ecosystem in Pakistan. These gaps in mental health legislation, regulation and licensing lead to various issues for both end users and practitioners, and in the management of care.

With an overall lack of knowledge of technical terminology surrounding mental health, most patients are not able to discern between standardized and non-standardized services. The burden of regulating the overall landscape falls on healthcare authorities, who have traditionally struggled with this role. The devolution of health after the 18th amendment sought to change this by decentralizing health regulation to the provinces. As elaborated further in various sections, this has had limited success in tackling mental health. While the provinces have set up basic legislation to address mental health, they have been unable to set up the means to enforce it.

The findings have been divided into six overarching themes. These include the following:

1. Gaps in Mental Health Legislation, Regulation and Licensing
2. Issues with Confidentiality and Privacy
3. Misrepresentation of Credentials and Qualifications
4. Inappropriate or Unethical Provider Behavior
5. Issues in Diagnosis and Treatment
6. Miscellaneous Problems in Care
7. Problems Faced by Women and Girls

Our first case study cuts across most of the themes above, and displays how gaps in regulation, a lack of concern about confidentiality, the misuse of credentials and inappropriate behavior can result in the violation of the human rights of end-users.

Case Study I: NCHR Complaint Regarding Mental Health and Human Rights

On December 1st, 2021, NCHR received a complaint regarding human rights and mental health. Rukhsana ³¹, a 35-year old adult woman, was allegedly detained at a rehabilitation and psychiatric facility in Islamabad, against her will at the behest of her mother. The complaint was filed by Rukhsana's friend, who informed NCHR that Rukhsana had been incarcerated at the clinic for over a week. According to the original complaint, Rukhsana's mother, Saleha Begum ³² allegedly had her daughter forcibly committed to a psychiatric ward under the claim that

³¹ Name changed to protect confidentiality.

³² Name changed to protect confidentiality.

Rukhsana was mentally unstable; however the complainant alleged that the real reason was because Rukhsana refused to get married or move in with her mother, the only two options that her mother gave her.

On December 3rd, an NCHR team composed of two NCHR members, the Complaint Officer, and the Legal Officer visited the facility in question along with the police to ascertain the truth of the situation. There, they discovered that the complaint had indeed been genuine. Rukhsana, despite being an adult of sound mind, was being held against her will at the clinic. The team met with Rukhsana, her doctor, and Saleha Begum. NCHR then acted as a mediator between Rukhsana and her mother, and brokered an agreement by which all parties agreed that Rukhsana should not be incarcerated and should be able to go back home.

However, this case raised genuine questions for NCHR- how was a 35-year-old adult, independent woman employed at a multinational company, with no prior history of psychotic breaks, confined in a psychiatric clinic against her will? NCHR decided to follow up with the District Health Office (DHO) and the Ministry of Health to inquire about the regulations governing psychiatric facilities in order to prevent such a gross violation of human rights again. On December 7th, NCHR exercised its powers of a civil court and issued a notice to the Secretary of the Ministry of National Health Services Regulation and Coordination (NHSR&C), the Inspector General of the Police, the District Health Officer (DHO), Rukhsana and Saleha Begum, demanding that they appear at NCHR for a hearing regarding the case on December 8th. The hearing was attended by Additional District Health Officer, ASI Shahzad Town Police, Rukhsana, and Saleha Begum.

At the hearing, it was established that although Rukhsana had been wrongfully detained, her mother had asked for her to be committed to the clinic in good faith, under the genuine belief that her daughter was mentally unstable and needed help. The DHO explained that there was very little regulation of psychiatric facilities, but private medical facilities do fall under the ambit of the District health Office and the Islamabad Healthcare Regulatory Authority (IHRA). He agreed to submit a detailed report in collaboration with the IHRA within seven days regarding the functioning of the psychiatric clinic and rehabilitation center in question. The IHRA then replied to NCHR's request on December 17th and indicated that it would submit a detailed report on the concerned facility within a week's time. However, no report was submitted, and so another hearing was fixed for January 26th 2022 and notices were sent out to all concerned parties (IG Police, DHO, Secretary IHRA, Rukhsana and Saleha Begum) on January 5th. In response, the DHO sent a letter to NCHR stating that the case did not fall under the administrative jurisdiction of the DHO, and instead fell under the purview of IHRA. Only the DHO attended the NCHR hearing on January 26th, and both the Ministry of National Health Services Regulation and Coordination (NHSR&C) and the IHRA failed to appear.

The Chairperson NCHR then sent a letter to the Secretary of the Ministry of NHSR&C describing the case and asking for information regarding the legal framework applicable for registration, licensing, and regulation of healthcare establishments. Moreover, the NCHR informed the Secretary that no one appeared at the hearing on behalf of the Ministry of NHSR&C and the IHRA, and reminded them that the NCHR Act empowered the commission to summon and enforce attendance, and that all proceedings in front of the commission were official judicial proceedings. Finally, the Chairperson NCHR asked the Secretary to look further into the matter, conduct a surprise inspection of the psychiatric facility where Rukhsana had been detained, and issue directions to the IHRA and the Ministry to cooperate fully with NCHR's investigation.

On March 8th, 2022, the IHRA wrote to the NCHR after receiving a letter from the Ministry of NHSR&C. The IHRA clarified that they provide a regulatory framework to ensure the provision of quality health services and that it was compulsory for healthcare establishments to register with the IHRA and obtain licenses. The IHRA also told NCHR that they had established Quality Healthcare Services Standards (QHSS) for health related services, and routinely made surprise inspections. The IHRA also indicated that they had received no such summons from the NCHR, and that it would cooperate fully. In a show of good faith, the IHRA submitted that it had conducted a surprise inspection of the facility on March 3rd, and found that it was registered with the IHRA and complied with the QHSS. The IHRA also said that Rukhsana was brought to the center "...on proper consent and request of the mother of the said girl which is a compulsory condition for admission of the Psychiatric and drug addict patients." ³³

However, the NCHR submitted a request for information to the IHRA on April 4th 2022, asking for a list of all mental healthcare establishments registered under the IHRA. ***As per the information that the IHRA itself provided, the rehabilitation and psychiatric facility concerned was only registered on December 12, 2021. This is significant because NCHR received the complaint regarding human rights violations at this clinic on December 1st 2021-meaning that the facility was not registered at the time it institutionalized Rukhsana and provided services, unregulated, to countless others.*** Moreover, the facility has 30 inpatient beds, but zero full time psychiatrists.

The NCHR is still following up with this case. How, for example, did the doctor on duty required to conduct an independent psychological assessment of Rukhsana when her mother asked for her to be institutionalized, come to the conclusion that she was mentally unstable enough to be an in-patient at the clinic? During the first meeting with NCHR at the facility, the CEO claimed that they had conducted an independent evaluation before forcibly tying Rukhsana up with rope to bring her to the clinic. When pressed for details by the NCHR team, he said that a survey was conducted and that Rukhsana adopted too many stray

³³ F. No. 2-121/IHRA/2022 (Letter from CEO IHRA to Ministry of NHSR&C + NCHR)

cats, thus rendering her unstable. However, when the NCHR team asked for further explanation, the doctor eventually revealed that the mother had asked the clinic to incarcerate her daughter until she agreed to marry or to move to the US with her. Second, how was this facility functioning prior to being registered? Evidence shows that it has been in service since at least 2019, but was not registered until December 2021. The entire situation is ethically murky at best, and an independent investigation into assessment practices and the functioning of mental health facilities must be conducted.

The findings are discussed thematically below:

1. Gaps in Mental Health Legislation, Regulation and Licensing

Within the current landscape, there are multiple gaps in the legislation, regulation and licensing aspects of mental health in Pakistan.

The issue is threefold: existing legislation is either outdated or insufficient, does not exist at all, or is not implemented. Since the devolution of health, each province has its own Mental Health Act modeled on the 2001 Mental Health Ordinance (MHO 2001) which technically still applies at the federal level in Islamabad. This implies that while the provinces have all enacted legislation within the last 5-8 years, the majority of the Acts are based on a 20 year old act that has itself not been updated during this time frame.

The original 2001 Ordinance was launched with the intent to amend and strengthen the laws regarding treatment and care of people with mental health conditions. It also enacted provisions for the management of legal affairs and defined due process for those suffering from severe mental illness. However, due to lack of implementing bodies and vague language, the Act has mostly failed to make significant headway.

This issue extends to the provinces, where regulatory bodies that the provincial Mental Health Acts created remain dysfunctional or unestablished. In addition to this, the Acts all retain the use of obsolete terminology, vague definitions and a myopic focus towards treatment of serious mental health problems. The Acts do not attempt to address mental health promotion or mental illness prevention, which are the foundation for any public mental health program.

Additionally, most of the provincial Mental Health Acts focus solely on psychiatrists, and do not regulate or license clinical psychologists, counselors or other allied mental health practitioners. Without clearly defined protocols and regulatory bodies to enforce the Acts, they remain open for misinterpretation and abuse. In addition, no individuals with lived experience were consulted in the development of any of the Acts, creating a further disconnect from understanding the core issues faced by affectees of mental illness. These Acts have also not

been updated since their inception in any way.

Mental Health Authorities

At present, only the Sindh Mental Health Authority (SMHA) is functional after being set up in 2017. However, it remains only partially functional according to its charter.³⁴ No other provincial mental health authority has been set up, although Punjab is in the process of setting up their authority.

Board of Visitors

The Sindh, Punjab and Balochistan provincial Acts retain a provision to constitute a 'Board of Visitors' to inspect psychiatric facilities. This Board is to comprise of 7 members in Sindh and Punjab and 9 members in Balochistan. The inspection is meant to ensure that facilities are operating in an ethical manner and that patients are receiving adequate care. While there is a Board of Visitors appointed in Sindh, there is limited meaningful inspection. Punjab and Balochistan have yet to appoint their board of visitors, and there is no such provision under the Khyber Pakhtunkhwa Mental Health Act.

Conditions for Involuntary Detention

All provincial Mental Health Acts, as well as the MHO 2001, provide provisions for four types of involuntary detention of a patient. These include admission for assessment, which can last 28 days; admission for treatment, which can last up to six months and is renewable; urgent admission for up to 72 hours, and emergency holding in a hospital for up to 24 hours. An application for detention under any of these must be filed by the parent, spouse, or guardian of a patient or by a medical officer. This provision is meant to apply to cases where the patient is "suffering from mental disorder of a nature or degree which warrants the detention of the patient in a psychiatric facility for assessment [or treatment or urgent admission or emergency holding]" and when the patient is deemed to be a health or safety risk to themselves and/or others.³⁵

Involuntary detention is also dependent on the recommendation of two medical practitioners, "one of whom should be a medical officer and one should be a psychiatrist [or a]... medical practitioner with experience in psychiatry."³⁶ The patient, their relative, or guardian can file one appeal against detention to a Court of Protection.

These grounds are vaguely worded and often abused, and patients are kept detained against their will even when these conditions are unfulfilled. These grounds must be updated to reflect international standards of involuntary admission. In the UK, US, and Canada for example, very strict eligibility requirements are implemented. Only those who exhibit dangerous behavior towards themselves or others, or are helpless to care for themselves qualify for involuntary admission.³⁷ Even in these cases mental health practitioners rarely recommend involuntary admission except in extreme cases.

³⁴ Background," Sindh Mental Health Authority, accessed April 21, 2022, <https://smha.sindh.gov.pk/background/>.

³⁵ Mental Health Ordinance, 2001. <http://punjablaws.gov.pk/laws/430a.html>

³⁶ Ibid.

³⁷ "Mental Health Act," NHS (NHS, April 17, 2019), <https://www.nhs.uk/mental-health/social-care-and-your-rights/how-to-access-mental-health-services/>.

As discussed further in Case Study I, relatives of the patient can use this provision for detention for their own personal interest. There are no repercussions for the medical practitioners that agree to the detention of patients. During consultations, mental health professionals in Pakistan described situations in which this provision was misused. This occurs often against women in cases regarding property and inheritance. In many cases, male family members have had female relatives detained at psychiatric facilities under the guise of being mentally ill in order to capture their share of inheritance and property. This is in direct opposition to the Acts that seek for those with serious mental illness to have a guardian manage their financial affairs rather than forgoing inheritance. Thus the vague language of the Acts and lack of implementing bodies allow for a patriarchal and cultural interpretation of their meaning.

“ In inheritance disputes, family members pay a psychiatrist a certain amount to declare a family member (most often a woman), of unsound mind and forcibly institutionalize them at an in-patient facility. They then take over their property. This is very common, and I’ve heard this story many times. ”

- Clinical Psychologist

Emergency Powers

Under all four provincial Mental Health Acts, medical practitioners have emergency powers to administer treatment to ease serious suffering, prevent the loss of life, prevent serious deterioration of the patient’s condition, or to prevent the patient from hurting themselves or others. As in Case Study 1, these powers are misused often in Pakistan, and must be restricted to severe conditions and severe situations. This is not possible without oversight by regulatory bodies.

Rules of Business

The Balochistan, Sindh, and Punjab Mental Health Acts empower the government to make rules to implement the Acts in spirit. One of the powers in the rules is to “prescribe conditions subject to which a psychiatric facility may be licensed.” Since only Sindh has set up a mental health authority, the SMHA developed its Rules of Business, called the Sindh Mental Health Rules 2014. According to a current member of the SMHA, the rules of business were revised in 2019 in consultation with mental health practitioners and sent to the cabinet, where they remain pending. However, although the SMHA is responsible for the licensing and regulation of mental health facilities under its 2014 Rules, it has not implemented this in practice as of June 2022. ³⁸

Chapter IV of the SMHA Rules describes the minimum facilities required for every psychiatric center in order to treat patients. These include one full time Psychiatrist, one Medical Officer or Clinical Psychologist or Medical Social Worker, and one staff nurse on duty

³⁸ SindhMentalHealthRules2014.ChapterIII,License.Pp.6-9.<https://smha.sindh.gov.pk/storage/rulesRegulations/iAMtoxLGe9HaBAMrfxEnjMTnpjsrIyIQFsmYR9T.pdf>

at all times. In consultations with experts, it was discovered that this is not being implemented in Sindh.

Licensing and Regulation of Mental Health Facilities

In all of the provinces and ICT, no regulation of mental health facilities under the Mental Health Act takes place. In the provinces, the health departments currently license all medical facilities, including psychiatric facilities. NCHR requisitioned data on both public and private registered mental health facilities from all provinces and the ICT. The information received was incomplete, but painted a worrying picture (See Table 1) .³⁹

Registered Mental Health Facilities Self-reported by Provincial Health Departments

	Number of facilities	Range of beds in each facility	Facilities that employ at least 1 full time psychiatrist
ICT	10	0-45	0
Punjab	67	0-386	Did not provide information
Sindh	Did not provide information	Did not provide information	Did not provide information
Khyber Pakhtunkhwa	41	0-30	Did not provide information
Balochistan	1	130	24

Table 1⁴⁰

In the data requisition request, NCHR asked for details based on the registration form of each province. This included the date of registration of each facility, the type of ownership (public/private) the number of beds, the number of full time psychiatrists on staff, the number of clinical psychologists on staff, the number of nurses, average number of patients, and the types of disorders treated at the facility.⁴¹ However, as the consolidated table above shows, the data actually received was far less than what was requested. Most problematic is that in ICT, across 10 facilities that had anywhere from 0 to 45 beds each, none employed a full time psychiatrist. All employed exactly one part time psychiatrist, which seems to contradict the MHO 2001. Under the MHO 2001, conditions for assessment, admission, and discharge of patients require the recommendation of a psychiatrist. Punjab and Khyber Pakhtunkhwa provided only the names of mental health facilities and some numbers for beds. Sindh did not submit any data until the time of publishing. Balochistan provided all of the information requested for one facility, the Balochistan Institute of Psychiatry and Behavioral Sciences, Quetta.

³⁹ See Annex for detailed report

⁴⁰ Annex D for the responses received to the data requisition request.

⁴¹ Please refer to Annex C for the Data Provision Request that was sent to all provinces and the ICT

Licensing and Regulation of Non-medical Mental Health Practitioners

The Balochistan Mental Health Act goes one step further than the other three Acts, and declares that non-doctors or any doctor not licensed by the Pakistan Medical Commission cannot prescribe medication to patients, and if found guilty, is subject to the law. The Khyber Pakhtunkhwa Mental Health Act, in contrast, does not have any provisions for licensure or regulation of mental health facilities.

The licensure and regulation of mental health practitioners, including psychologists and psychotherapists, is not addressed by any of the Acts. Currently, only psychiatrists are required to be licensed and registered under the Pakistan Medical Commission (PMC). There are also no definitions for who can call themselves a psychologist, a psychotherapist, a counselor, etc. There are numerous cases in Pakistan in which unqualified people provide mental health services under one of these terms.

Patients and clients can file complaints against psychiatrists with the PMC, however, a similar body does not exist for allied mental health practitioners. Under the SMHA Rules 2014, in Sindh complaints against psychiatrists can be filed with the SMHA. However, there are no defined procedures for filing complaints against psychologists, psychotherapists, counselors, etc. This represents a huge gap where provincial regulatory bodies that remain functional do not cover all practitioners within their scope.

*“ We need basic ethical standards in the industry that include confidentiality.”
- Psychotherapist*

Ethical Standards

None of the provincial Mental Health Acts, nor do their rules of business, recommend or enforce a code of ethics that practitioners must abide by. This means, in essence, there is no endorsed code of ethics or healthcare standards that exists neither at a federal or provincial level.

The Allied Health Professionals Council Act, 2022

The Allied Health Professionals Council Act, 2022, introduced by the previous government, aimed to address this gap and introduce licensing requirements for non-medical health practitioners (including allied mental health practitioners) to practice within Pakistan. Article 10J of the Act cites the creation of a code of ethics and standards for practitioners as one of its many regulatory roles.⁴² The Act was passed by parliament but the regulatory council it proposed remains to be set up. This means many of the improvements that the Act

⁴² Allied Health Professionals Council Act, 2022, ACT NO. IX OF 2022, Government of Pakistan, 05 March 2022.
[http://www.pcp.gov.pk/SiteImage/Downloads/7412\(22\)Ex%20Gaz-I%20Senate.pdf](http://www.pcp.gov.pk/SiteImage/Downloads/7412(22)Ex%20Gaz-I%20Senate.pdf)

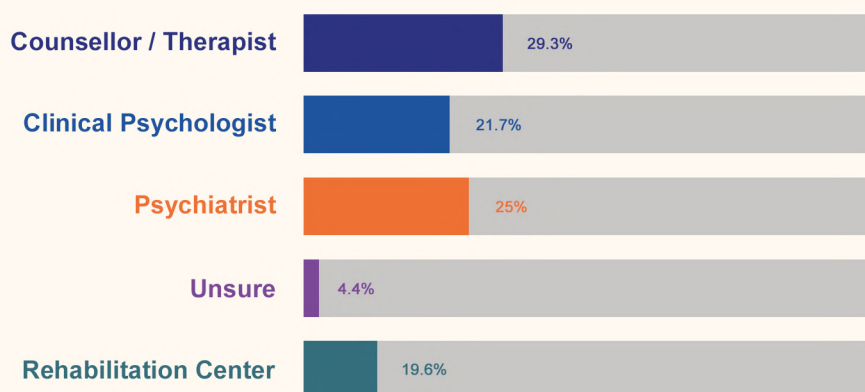
brought to to the mental health landscape remain applicable only on paper. Since no regulatory body under the Allied Health Professionals Council Act, 2022 has been set up yet, there is no recourse for complaints or malpractice allegations against allied mental health practitioners.

2. Issues with Confidentiality and Privacy

“ During my initial assessment, porters kept walking in and out of the room interrupting the session, flow, and my privacy. ”

- End User, 20-30, Female, Karachi

Figure 3: Type of Mental Health Practitioner Respondent Went To



“ The only instance in which confidentiality can be broken is if you believe they are going to harm themselves or others. But here there are so many issues with confidentiality ”

- Clinical Psychologist

Respondents to the online questionnaire have reported widespread disregard for confidentiality and privacy while availing mental health services in Pakistan. Figure 3 depicts the type of mental health respondents went to, showing that the problems span across different types of practitioners.

Respondents noted that many practitioners did not understand the concept of privacy and would take sessions in noisy environments or environments where the clients could be overheard. This violated the client's right to privacy and led to tremendous discomfort during the consultation. This complaint highlights the overall lack of understanding of privacy and confidentiality requirements within the healthcare and mental health realm.

One end user related how her therapy sessions in her late teens were all divulged in detail to her parents in a blatant violation of confidentiality and ethics. This not only caused her anguish but also eroded her trust in her practitioner as well as the entire care process.

End users reported feeling that notes, conversations and prescriptions were inadequately being taken care of by healthcare providers. Presently, while laws exist to support confidentiality of patient information, they are not prescriptive in what that confidentiality entails. There is no clear guidance on the management of confidential healthcare information.

To further complicate issues, national standards for healthcare data management do not exist at the federal or provincial level. This means that no specific requirements exist for providers to comply with except for an overall adherence to ensuring patient confidentiality. The vagueness and lack of defined procedures create loopholes that dilute the enforcement of basic tenets of healthcare.

As identified earlier, for end users going to non-doctor mental health practitioners, there is no clear guidance on how to report these measures. In the absence of clearly defined guidance by mental health authorities or regulatory bodies, rules for confidentiality and privacy are taken from provincial health regulatory authorities. However, these are difficult to enforce when there is no provision for the licensing of allied mental health practitioners or regulatory bodies specifically for mental health.

3. Misrepresentation of Credentials and Qualifications

“ Banners outside read ‘child psychologist’, somewhere else on the internet he claims to be a psychiatrist and during the session it was revealed he was a palmist.”

-End User, 20-30, Female, Karachi

As identified above, Pakistan does not have any legislation or regulation regarding the licensing and qualifications of allied mental health practitioners. Psychiatrists, due to regulation by the Pakistan Medical Commission, are required to validate their license and update their qualifications with a governing body. However, this does not extend to psychologists or mental health counselors, who are able to practice without licensure or registration with a centralized body.

The Allied Health Professionals Council Act, 2022 aimed to restrict this loophole by identifying governing bodies for psychologists as well as minimum requirements for attainment of licensure and practice. However, it has not been set up.

Due to the largely disconnected structure of professional regulation, many practitioners at present are able to practice without any checks and balances. The lack of licensure allows both professionals with valid mental health backgrounds and quacks to

practice within the field alike. Without a significant legal basis or existing regulatory bodies enforcing their mandate, many of the “quacks” in the field are able to label themselves as mental health practitioners.

Mental health practitioners with valid degrees and experience have no licensure requirements and no requirements to keep themselves up to date to changes in diagnosis and management. Only informal professional bodies, such as the Pakistan Psychiatric Society and Pakistan Psychological Association fulfill this gap. However, as private bodies with no regulatory, licensure or government mandated authority, they cannot enforce these requirements. There is also limited professional oversight of these without individual governing bodies.

Meanwhile, non-professionals or “quacks” are freely able to label themselves as mental health practitioners and enter the field with little or no oversight. They are able to play the role of caregiver and exploit already vulnerable clients. In essence, they are able to scam end users and carry on abuse etc. without oversight.

This abuse can be psychological, social or sexual, as delineated by end user responses in the survey. Preying on those with mental health issues is inexcusable and one of the most glaring consequences of the lack of regulation is that these “quacks” openly exploit and abuse those with mental health conditions and face few repercussions. See Case Study II, which serves to highlight the intersection of poor mental health, non-standardized services and patriarchal norms in which gender based violence is normalized.

Case Study II: TherapyWorks and the Misrepresentation of Credentials and Qualifications

TherapyWorks has offices in Karachi, Lahore, Islamabad, and Multan. They offer private inpatient and outpatient services, and counseling diploma services. Until July 2021, their website claimed that “Therapy Works is a counseling and psychotherapy center affiliated with the Counseling and Psychotherapy Central Awarding Body (CPCAB) in the United Kingdom and is a member of the British Association for Counseling and Psychotherapy (BACP).”⁴³ However, a gruesome murder committed in Islamabad by a former TherapyWorks Employee resulted in the discovery that the BACP had no affiliation with the center at all.

On 20th July 2021, 27 year old Noor Mukadam was held hostage, tortured, and decapitated brutally by Zahir Jaffer, a man with a history of schizophrenia and violent outbursts. At the time, Zahir Jaffer was offering therapy services to clients through TherapyWorks and providing mental health counseling services to schools.⁴⁴ After the murder, Zahir called his parents, who called TherapyWorks

⁴³ Faizan. “They’re also mentioned on their website.” Jul 22, 2021, 11:34 PM, Twitter <https://twitter.com/thoraoffbeat/status/1418278241987661831/photo/1>

⁴⁴ Nutellastaan, July 21 2021, Twitter. <https://twitter.com/Nutellastaan/status/1417900465522683907/photo/1>

instead of the police. TherapyWorks personnel found Zahir with the murder weapon and tied him up before the police came to arrest him hours later. After the murder, many called into question the credibility of TherapyWorks if they accredited someone with a reported history of violence on their rostrum of therapists. On social media, users tagged the BACP and the CPCAB in the UK, asking for an investigation into the practices of places they had allegedly licensed. The BACP issued a clarification via their twitter account stating “Thanks for bringing issued a clarification via their twitter account stating “Thanks for bringing this to our attention. We can confirm that this organization is not a member of BACP, and we’ve contacted them to ask they remove the BACP logo from their website and other advertising materials.”⁴⁵ The CPCAB announced that they were launching an investigation into the allegations as the awarding organization.⁴⁶ After this incident, multiple stories surfaced on social media indicting TherapyWorks, making it clear that the organization had been training and certifying ‘therapists’ without requisite background checks or qualifications, leading to more harm than good.

End users are not able to fully appreciate the differences between qualified and nonqualified mental health practitioners, as there are no credentialing mechanisms or regulatory bodies in mental health. These mechanisms are designed as barriers to practice before the credentials of practitioners are validated. From the patient point of view, it becomes very difficult to discern between valid credentials, embellished ones and those that are falsified. Many respondents were frustrated at their inability to trust provider credentials and felt that they were unable to differentiate between credible providers, which led to unfortunate interactions.

4. Inappropriate or Unethical Behavior

“ He asked me to come in weekly, and in those sessions would touch me without consent, as well as vape in his office. ”

- End User, 20-30, Female, Islamabad

Respondents in the surveys complained of a range of problematic behaviors by mental health providers in the field. These include patient harassment, inappropriate remarks, sexual harassment and patient detention as the most egregious examples.

One end user reported that her brother, who struggled substance abuse problems, was kept as an inpatient in a rehabilitation center. The client was given the substances he requested to keep him pacified, while the family members were misled about the client’s state.

⁴⁵ BACP, July 21, 2021 5:58 PM, Twitter. <https://twitter.com/bacp/status/1418193855787188229?lang=en>

⁴⁶ CPCAB, July 22, 2021, 4:19pm, Twitter. <https://twitter.com/cpcab/status/1418168878463602689>

The center, essentially, prolonged and supported the his substance abuse problems.

Others reported harassment at the hands of service providers who would often conduct interactions outside of the clinic setting or pass inappropriate sexual remarks during sessions. One respondent reported inappropriate touching and feeling sexualized by the provider, creating a hostile environment. In another documented case, one client was taken for “treatment” by her family and kept in detention until a friend reported her missing to NCHR (See Case Study I).

These examples highlight an overall disregard of ethics in patient care brought about by the lack of accountability. Without regulatory oversight, it can be argued that these setups have become a way for incompetent providers to prey on those in vulnerable states.

The overall lack of ethics displayed is egregious enough to warrant a hard look at some upstream causes such as lack of ethics courses in training programs, institutes and clinical apprenticeships, where the focus on what constitutes ethical practice may need to be strengthened. Additionally, without the requirement for practitioners to engage in clinical attachments or review prior to licensure, the transition to patient care occurs without oversight or supervision. This can lead to even practitioners with valid credentials bypassing the necessary clinical training and supervision, leading to compromised ethical practices.

Since there are no functioning regulatory processes in place to check the behavior of practitioners and no repercussions exist for those flaunting these practices, there is no requirement for ethical practice. The onus, therefore, falls on the patients/clients to protect themselves from these situations and from harassment- which itself is quite problematic. With no barriers to entry for practitioners without valid credentials, the landscape becomes rife with quacks who exploit those suffering from ill mental health.

The lack of overall regulation, therefore, facilitates unethical practices within the mental health sphere. Without any governing bodies, respondents reported often feeling powerless as there was no one they could reach out to for complaints regarding incidences of unethical practice and abuse. Since no clinical review or processing was possible without a governing body, they felt that inappropriate and unethical practitioners could not be held accountable. Not only is the lack of accountability problematic on its own, but respondents also elaborated that it added to their trauma and suffering.

5. Issues in Diagnosis and Treatment

“ Kept giving me the wrong medications by convincing me constantly that I’m “psychotic” every time I would bring it up. Kept insisting I indulge in prayers to feel better even though I already did pray in the first place. Misdiagnosed for 2 years as well. ”

-End User, 20-30, Female, Karachi

Most end users were informed of a diagnosis without any explanation of what it entailed and how it affected their lives. Others, however, elaborated that providers tried to reduce self and societal stigma by not assigning a diagnosis at all. The lack of counseling by mental health providers or their staff meant that patients were not educated about their conditions. Patients remained uninformed about their mental illness and its impact on their lives. Respondents cited this as a reason for overall dissatisfaction with their providers.

In case medications were prescribed, patients complained that options were not discussed in detail and they were unsure of what they were taking. Without informed consent to treatment, patients lose their autonomy in decision making by not being involved in their own care process. This is a flagrant violation of accepted patient rights and represents how patients are expected to trust their providers blindly, even if those providers may be faking or embellishing their credentials as highlighted earlier. Without the establishment of trust, many patients remained skeptical and did not feel that the medications prescribed would be beneficial to them. This lowered their compliance with therapy as well as reduced their overall follow ups for care.

There can be significant upstream causes for these provider behaviors, which include poor training for legitimate providers, or lack of training for providers who have been able to access the field due to lack of regulation. It also demonstrates an overall lack of understanding of patient care requirements by both providers and training institutes, where cultural norms have not kept up with globally changing attitudes. Patients who are aware of their rights find trusting such providers difficult, and this erodes trust in an already poorly regulated ecosystem.

Oversight and regulation can enforce better standards of care and address upstream causes by ensuring that patient care and hands on clinical experience are part of the process of for licensure to practice etc. The lack of awareness both in providers and patients exacerbates these issues. Without any set requirements and oversight, providers may not feel obligated to spend the necessary time with patients and involve them in their care, while only informed patients feel like they can ask questions.

Since governing bodies for mental healthcare do not exist, there are no locally established and enforced standards of care. This leaves room for misdiagnosis, poor management of cases and lack of standardization in practices. These are most obvious in inpatient care, where those with mental illness are detained for unnecessarily long stays in the absence of clearly defined discharge criteria.

6. Miscellaneous Problems

“ He moved to Islamabad without informing me or giving me a referral in the year of 2016. He was my first proper therapist and we were working on my abandonment issues and then he triggered the same issue. I also had recently confided to him something really important and he disappeared right after it.”

- End User, 20-30, Female, Hyderabad

In addition to the problem areas identified above, other miscellaneous problems exist. One area of concern by respondents is the overall lack of coordinated care delivery. Surveyed end users complained about various issues outside of ethical practice. These included noisy environments for sessions and no clear guidance on documentation or use of information provided by patients. Many end users felt that no clear follow up mechanisms existed.

Lack of availability of caregivers is a consistent theme for inpatient settings. NCHR surveyed rehabilitation centers in Islamabad after the incident of inpatient incarceration and found that the majority of centers did not have full time psychiatrists (See Table 1). This incarceration type care is emblematic of a complete lack of regulation of these centers, where there are documented cases of individuals being placed in care as a means of extricating them from society or admitted for personal vendettas. Other respondents have reported poor facilities and amenities, often leading to worsening of the patient's condition while undergoing treatment.

This overall lack of standardization of care as per established international protocols and healthcare quality paradigms includes care set ups with poorly standardized practices, lack of basic necessities for patients including clean linen, sanitary items etc. These are part of an overall unhygienic atmosphere of caregiving. Many of the surveyed facilities have no standardized protocols in writing, allowing for interpersonal interpretation of patient management by staff. This introduces variations in patient care that may be detrimental to overall care goals.

The most egregious examples of these are lack of suicide prevention protocols in inpatient centres, lack of patient restraining protocols (in case a patient under care is to be restrained), or a lack isolation protocols limiting the amount of time an individual can be held in isolation. Without clear guidance, there is no structure to how these cases are managed and there remains a large potential for abuses that patients can undergo at these facilities. In addition to this, the lack of clear suicide prevention protocols mean that self-harm cannot be adequately prevented.

With an overall lack of documentation and processing protocols at these sites, abuse is often unreported and undocumented. Patient's complaints and protests can be easily negated or underplayed in such environments, leading to a toxic atmosphere rather than one conducive to healing.

“ The lady listened to my case history, then said my depression was directly a punishment from Allah as a response to my mother committing the “sin” of taking a stand against my father’s physical and psychological abuse and his infidelity. ”

- End User, 30 - 39, Female, Lahore

While these examples are egregious on their own, another factor that contributes to this abuse is the lack of discharge planning requirements for inpatient psychiatric facilities. No

regulatory bodies require discharge planning for patients once admitted. This results in a general lack of ownership of patient discharge and a reluctance to manage patients outside inpatient settings. This allows for the focus to remain on keeping patients admitted rather than to rehabilitate them and move them to outpatient management. Not only does this perpetuate the incarceration type inpatient care but also increases costs to patients and the overall expense of care.

These incidents not only point to an overall lack of standardization of practices that is encouraged by the lack of regulation, but also towards a lack of training. They contribute to a culture of abuse and human rights violations, as cited by the case studies and testimonies of end users. Especially in inpatient settings, these practices have become normalized and create an adverse environment for those already suffering with mental illness.

Functional regulatory bodies would address these by providing standards of care, enforcing these standards, ensuring that facilities are inspected and surveyed against these standards, closing facilities engaged in malpractice, reviewing complaints, and allowing for the clinical review of cases and complaints. Without these structures, mental health care systems remain unanswerable for their practices.

7. Problems Faced by Women and Girls

One common theme identified throughout the review of literature, stakeholder interviews, and the survey results, is that women and girls are disproportionately affected by malpractice and unethical conduct in mental health. Because of the prevalence of patriarchal attitudes, women and girls are most at risk for patriarchal violence and resulting mental distress. Studies reveal that twice as many women as men seek psychiatric care.⁴⁷ Surveys of psychiatric outpatients show that approximately 70% of the women under care were victims of gender based violence and over 80% suffered from marital or family problems.⁴⁸ Societal attitudes and treatment, the lack of public spaces and bodily autonomy, early marriages and the social set up of Pakistan places undue burden of mental illness on women and girls.

Moreover, during interviews with mental health practitioners, a recurring theme was that of women falling prey to instances of forced detention in psychiatric facilities over family disagreements and property disputes. Women also faced the greatest barriers to accessing mental health services in the first place.

Over 77% of respondents to the survey on malpractice in mental health were female. Women are more likely to be told by both their families and by mental health practitioners that the solution to their mental health problems was to either get married or have a child. Most women are first taken to faith and spiritual healers, or are told their behavioural problems are a result of 'nazar' and black magic. Women also often exhibit psychosomatic symptoms such as fatigue, exhaustion, and aches and pains, that are often misdiagnosed by traditional doctors.

Female respondents to the survey reported that there had been instances of inappropriate behaviour by service providers, including instances of abuse and misconduct.

⁴⁷ Unaiza, Niaz, "Women's Mental Health in Pakistan." *World Psychiatry* 3(1) (2004): <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414670/>

⁴⁸ Ibid.

Moreover, respondents complained about the lack of confidentiality of service providers, in which sessions with women were often discussed with their husbands, parents, or in-laws. Others reported that their concerns were not taken seriously by practitioners.

Women and girls with mental health illness, already vulnerable, face particularly severe risks when it comes to unregulated mental health services and practitioners. The lack of documentation, evidence based practice, and inadequate explanation of mental health diagnoses results in greater harm than good. It is easier for practitioners to negate the concerns of women and girls. Findings on women and girls cut across the different themes identified in this report. Women and girls are disproportionately affected by the regulatory and licensing gaps in mental health, the issues with confidentiality and privacy, the misrepresentation of credentials and qualifications, inappropriate or unethical provider behaviour, issues in diagnosis and treatment, and other miscellaneous problems. Regulation of mental health services and practitioners in Pakistan would resolve many of these issues, and simultaneously raising awareness to reduce the stigma around mental health is integral.



CHAPTER

4

POLICY
RECOMMENDATIONS

Policy Recommendations

These recommendations were made in consultation with psychiatrists, psychologists, psychotherapists, counselors, and public health professionals. They are also based on the concerns of those with lived experience, who have suffered from mental health issues and have sought help for mental illness in Pakistan. Recommendations include:

1. Public Awareness

- a. Develop and launch mental health awareness and stigma reduction campaigns.
- b. Conduct educational campaigns to help people get help from legitimate mental health practitioners.

2. Legislative Actions

- a. Decriminalize suicide immediately via repeal of Section 325 of the Pakistan Penal Code.
- b. Develop and pass a Federal Mental Health Act as an update to the Mental Health Ordinance 2001.
- c. Amend and update the provincial Mental Health Acts and incorporate input from psychiatrists, psychologists, psychotherapists, and those with lived experience of mental health problems, in line with the Mental Health and Human Rights Report by the United Nations High Commissioner for Human Rights.
- d. Prioritize enforcement of existing Provincial and Federal Acts through engagement with the provincial and federal health ministries. This includes updating the Acts based on the Federal Mental Health Act to limit loopholes in implementation and eliminate vague language.

3. Mental Health Licensing Bodies

- a. Implement relevant legislation to establish a body to license allied mental health practitioners, including psychologists, psychotherapists, community mental health workers, and counselors. This body should function similarly to medical license regulatory bodies such that beneficiaries must go through examinations for licensure and require further training for specialization, and there must be a process for renewing licenses periodically. This body should ensure that only those that comply to minimum standards of qualification are able to call themselves psychologists, psychotherapists, and counselors and ensure fines or penalties for misrepresentation or for offering services without requisite qualifications.
- b. Establish a mechanism for licensing bodies to regularly review the curriculum and requirements for mental health practitioners to ensure that ethical conduct, clinical care and supervised clinical hours are in line with best practices worldwide.

- c. Develop best practices for mental health practitioners to define key roles and titles for them. These definitions should delineate the differences between psychologists, psychotherapists, etc. and describe what service they are ethically allowed to provide.
- d. Develop and enforce a Professional Ethics and Code of Conduct and a means of measuring and enforcing compliance to ensure ethical practice and procedures under mental health.

4. Mental Health Regulatory Authorities

- a. Ensure the creation of Mental Health Authorities in all provinces and in ICT.
- b. Develop the Rules of Business for the Mental Health Acts of Punjab, Khyber Pakhtunkhwa, Balochistan, and ICT. Update the Rules of Business for the Sindh Mental Health Authority
- c. Appoint a Board of Visitors in all provinces for inspection of psychiatric facilities and ensure they are given the support and resources needed for them to carry out their work.
- d. Regulate involuntary admission of those with mental health issues into psychiatric facilities and ensure that informed consent is taken in all cases. Only extreme cases should result in involuntary admission, in which the patient is in danger of harming themselves or others, or in case the patient is unable to care for themselves. Ensure rigorous and standardized assessment practices in line with best practices.
- e. Implement the licensing and regulation of all facilities that provide mental health services, including but not limited to: psychiatric hospitals, psychiatric nursing homes, psych wards in hospitals, community mental health centers, patient rehabilitation centers, residential mental health treatment facilities, psychiatric clinics, drug treatment centers and rehabilitation centers, and any other mental health-related facilities. These facilities must all abide by minimum standards as prescribed in the Rules of Business.
- f. The Mental Health Authorities must keep a publicly available registry of licensed and registered mental health practitioners and facilities with transparency regarding their qualifications
- g. Provide a complaint mechanism at the Mental Health Authorities to ensure that non-doctors face penalties for malpractice, unethical conduct, or misrepresentation
- h. Regulate the charges of mental health practitioners or mandate provision of subsidized treatment in order to make mental health accessible for all.

5. Other Recommendations

- a. Ensure integration of mental health in universal healthcare by implementing mental health programs in primary care settings to increase access for underserved populations especially from non-urban areas.
- b. Legislate to ensure that mental health is covered in insurance packages.
- c. Invest in promotion of mental health and prevention of mental illness to reduce the burden of severe mental illnesses.

- d. Ensure that HEC only certifies and recognizes those psychology programs that fulfill baseline requirements regarding ethical conduct, supervised clinical training hours, culturally relevant diagnosis tools, etc., as outlined by the mental health licensing bodies recommended above.
- e. Establish and launch a national mental health helpline that is integrated with tertiary care institutions.
- f. Increase spending on mental health from 0.4% of the health budget to 2%-4% of the health budget.

ANNEX

A

**INTERNATIONAL
HUMAN RIGHTS
INSTRUMENTS THAT
GUARANTEE MENTAL HEALTH
AS A HUMAN RIGHT**

International Human Rights Instruments that Guarantee Mental Health as a Human Right

In 2017, the United Nations Office of the High Commissioner for Human Rights submitted a report on Mental Health and Human Rights to the general assembly that affirmed “the right to the highest attainable standard of physical and mental health is a fundamental human right indispensable for the exercise of other human rights.”⁴⁹ The WHO further affirms that mental health is more than just the absence of a mental disorder; it is instead “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.”⁵⁰ Under the UN Sustainable Development Goals 2030, Goal 3, “ensuring healthy lives and promoting well-being for all at all ages, and its specific and interlinked targets” includes the promotion of mental health in Target 3.4⁵¹ International human rights norms have moved to enshrine mental health as an essential component of health. The right to health, correspondingly, is recognized under:

The International Covenant on Economic, Social and Cultural Rights Article 12

The Convention on the Rights of Persons with Disabilities Article 25

Convention on the Rights of the Child Article 24

Convention on the Elimination of All Forms of Discrimination against Women Articles 10 (h), 11(1)(2)(f), 12, and 14(2)(b).⁵²

Pakistan has ratified all four of these conventions.⁵³ Pakistan has also committed to Universal Healthcare Coverage (UHC) under UN SDG 3.

The right to mental health is also reflected in the general principles of the Convention on the Rights of Persons with Disabilities, including the respect for “inherent dignity, individual autonomy and independence, non-discrimination, and full and effective participation and inclusion in society.”⁵⁴ This convention also

⁴⁹ “Mental Health and Human Rights Report of the United Nations High Commissioner for Human Rights” (OHCHR and UN General Assembly, January 31, 2017), pp.3. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/021/32/pdf/G1702132.pdf?OpenElement>.

⁵⁰ “Mental Health Fact Sheet,” World Health Organization (World Health Organization, March 30, 2018)

⁵¹ “SDG Goal 3 | Ensure Healthy Lives and Promote Well-Being for All at All Ages,” UN Department of Economic and Social Affairs (United Nations), accessed April 21, 2022, <https://sdgs.un.org/goals/goal3>.

⁵² “Mental Health and Human Rights Report of the United Nations High Commissioner for Human Rights” (OHCHR and UN General Assembly, January 31, 2017), pp. 4.

⁵³ Pakistan declared that its accession to CEDAW is subject to the Constitution of Pakistan. https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-8&chapter=4&clang=_en

offers a framework to ensure the rights of people with psychosocial disabilities, “including the exercise of legal capacity, free and informed consent, the right to live and be included in the community and the right to liberty and security, without discrimination.” Involuntary treatment too violates the Convention on the Rights of Persons with Disabilities.

Moreover, the UN Office of the High Commissioner for Human Rights declared in 2020 that “the highest attainable standard of health was fundamental to human dignity, and that there was no health without mental health.”⁵⁵ International Human rights norms have moved to emphasize the adoption of a rights-based approach towards mental health and the inclusion of people with psychosocial disabilities in designing frameworks and policies to promote mental health. The UN recognizes that those who suffer from ill mental health face barriers in accessing housing, employment, social protection, and the right to political participation, which are rights enshrined in most international human rights and national legal frameworks.⁵⁶ The UN has also recognized human rights abuses due to ill mental health, including discrimination, stigma, overmedicalization, and the use of force, and reiterates that persons using mental health services and persons with psychosocial disabilities should be involved in any discussion about their rights.⁵⁷

Furthermore, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has condemned unlawful forced detention or institutionalization based on ill mental health as tantamount to torture.⁵⁸ They also mentioned how the removal of agency and legal capacity of those who suffer from ill mental health is a violation of their human rights to equal recognition before the law.

International human rights law and norms have all embraced mental health as an integral part of health and well being, and Pakistan must incorporate this into its outlook towards mental health and well being.

⁵⁴ “Resolution adopted by the Human Rights Council,” (OHCHR and UN General Assembly, July 19 2020), pp. 2. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G20/159/02/pdf/G2015902.pdf?OpenElement>

⁵⁵ “Mental Health and Human Rights Report of the United Nations High Commissioner for Human Rights 2018” (OHCHR and UN General Assembly, July 24, 2018), pp.4. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G18/232/93/pdf/G1823293.pdf?OpenElement>

⁵⁶ *Ibid.*, 3.

⁵⁷ *Ibid.*, 5.

⁵⁸ *Ibid.*



ANNEX

B

**LIST OF
STAKEHOLDERS
CONSULTED**

List of Stakeholders Consulted:

	Name	Categorization	Affiliation
1	Dr. Salma Siddiqui	Psychologist	Clinical Psychologist, Previous HoD Department of Psychology and current Dean of School of Social Sciences and Humanities NUST
2	Dr. Rubeena Kidwai	Psychologist	Clinical Psychologist, Member of Sindh Mental Health Authority
3	Dr. Muneera Rasheed	Psychologist	Paediatric Psychologist, Technical Consultant, Research Scientist
4	Dr. Sumara Masood	Psychologist	Clinical Psychologist, Assistant Professor Department of Behavioural Sciences NUST
5	Muneera Rasheed	Psychologist	Paediatric Psychologist; Former research faculty at Agha Khan University
6	Dr. Ali Madeeh Hashmi	Psychiatrist	Psychiatrist, Professor of Psychiatry King Edward Medical University
7	Dr. Asma Humayun	Psychiatrist	Consultant Psychiatrist, National Technical Advisor for Mental Health, Ministry of Planning Development and Special Initiatives
8	Dr. Mowadat Rana	Psychiatrist	Consultant Psychiatrist, Motivational Speaker, Professor
9	Dr. Karim Ahmed Khawaja	Psychiatrist, Former Senator	Chairperson of the Sindh Mental Health Authority
10	Fatima Hussain	Psychotherapist	BACP Registered Psychotherapist; Pakistan Psychotherapy and Counseling Association
11	Nauman Qureshi	Psychotherapist	Retired Psychotherapist
12	Tooba Fatima	Psychotherapist	The Safe Space; Pakistan Psychotherapy and Counseling Association
13	Ayamma Mohsin	Psychotherapist	Private practice; Pakistan Psychotherapy and Counseling Association
14	Meera Afzal	Psychotherapist	Concern for Mental Health; Pakistan Psychotherapy and Counseling Association
15	Maryam Suheyl	Psychotherapist	Marriage and Family Therapist; Pakistan Psychotherapy and Counseling Association
16	Ali Ilyas	Psychotherapist	Private practice, Consultant therapist

	Name	Categorization	Affiliation
17	Katherine Usman	Counselor	BACP registered counselor; Lecturer in the Department of Behavioral Sciences, NUST
18	Kate Robertson	UK Psychotherapist	Chair, Association of Child Psychotherapists (ACP) UK
19	Dr. Nick Waggett	UK Psychotherapist	Chief Executive, ACP UK
20	Francesca Calvocoressi	UK Psychotherapist	Director Professional Standards, ACP UK
21	Louise Odwyer	UK Psychotherapist	Registrar and Deputy Director of Professional Standards, ACP UK

ANNEX



**NCHR DATA REQUISITION
REQUEST SENT TO THE
PROVINCES AND ICT**



GOVERNMENT OF PAKISTAN
NATIONAL COMMISSION FOR HUMAN RIGHTS
5th Floor Evacuee Trust Complex, F-5/1,
Agha Khan Road, Islamabad.



No. 2(7)2022-Legal (NCHR)

Islamabad, the 4th April, 2022

To,

The Chief Executive Officer,
Islamabad Healthcare Regulatory Authority,
Government of Pakistan,
Islamabad.

Subject: - REQUEST FOR THE PROVISION OF DATA/INFORMATION

Dear Sir,

The National Commission of Human Rights (NCHR) was established under the National Commission for Human Rights Act, 2012. The NCHR Act, 2012 stipulates a broad mandate for the promotion, protection and fulfillment of fundamental human rights as provided in the Constitution of Pakistan and international Human Rights treaties. Besides this, the Commission also provides input to ensure compliance on commitments made under Generalized Scheme of Preferences (GSP+) Status which facilitates Pakistan's exports to the EU and the SDGs. The effective functioning of the Commission serves as link between international and regional Human Rights machinery within the national context pursuant to Paris Principles of 1993.

2. Within its powers as a civil court, the Commission can call for public records and review safeguards provided under the Constitution and laws of Pakistan and recommend the adoption and/or amendment of laws and policies. By virtue of section 9(c) of the NCHR Act, 2012, the Commission is empowered to visit any jail, place of detention or any other institution or place under the control of the Government or its agencies where convicts, under trial prisoners, detainees or other persons are detained.

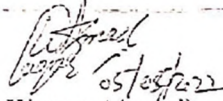
3. The National Commission for Human Rights received a complaint regarding mental health and human rights. Upon investigation/inquiry, other questions regarding the

provision of adequate and ethical mental health services have arisen. In this interest, the NCHR is writing a report on how to improve access to mental health services in Pakistan. To do this, we must collect data on how many mental healthcare establishments are registered and/or licensed and active in Pakistan, and what the features of those establishments are.

4. Aforementioned in view, you are requested to please provide information/data as per attached Performa please.

5. This issued with the approval of the honourable Chairperson.

Yours Sincerely,


(Mian Waqar Ahmed)
Law Officer (NCHR)

Copy for information to:

- The Secretary, Ministry of NHR&C, Islamabad
- PS to Chairperson (NCHR).

No.	Name of Mental Health Establishment	Type of owner Govt., Private, Public, NGO, Trust	Date of Registration	No of beds	No. of full time Psychiatrists employed	No. of full time clinical psychologists employed	No. of medical officers employed	No. of nurses employed	Average No. of patients per month	Types of disorders being treated at this facility (anxiety, depression, schizophrenia, drug addiction, etc.)



ANNEX

D

**DATA RESPONSES
RECEIVED FROM THE
PROVINCES AND ICT**

Annex D



GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY
AUTHORITY (IHRA)



F.No. IHRA/3-116/RC/CEO/21-22

Islamabad, the 11th April, 2022

To,

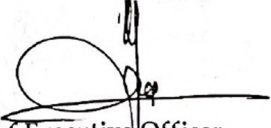
Mr. Mian Waqar Ahmed
Law Officer
National Commission for Human Rights
5th floor Evacuee Trust Complex, F-5/1,
Agha Khan Road, Islamabad

Subject: RE: REQUEST FOR THE PROVISION OF DATA/INFORMATION

Dear Sir,

- Reference to your letter no. 2(7) 2022-Legal (NCHR) dated 4th April, 2022 on the subject cited above. Please find attached list of Registered Rehabilitation Centres of ICT at Islamabad Healthcare Regulatory Authority.
- For the information regarding provinces, provincial Regulatory bodies like Punjab Healthcare Commission, Khyber Pakhtunkhwa Healthcare Commission, Sindh Healthcare Commission may kindly be approached.

IHRA Dy. No. 422
Dated: 11/4/22


Chief Executive Officer
Islamabad Healthcare Regulatory Authority

DISTRIBUTION:

CC:

- PS to Chief Executive Officer (IHRA).
- Personal File

Sr. No.	Name of Mental/Rehabilitation Centre	Type of Ownership	Date Registered	No. of Beds	No of full time Psychiatrists employed	No of part time Psychiatrists employed	No of medical officers employed	Type of disorders being treated at this facility (Anxiety, Depression, Schizophrenia, Drug Addiction, etc.)
1	The Silver Lining Rehabilitation Centre Islamabad	Private	23rd April, 2021	12	Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction
2	Wada Clinic	Private	26th May, 2021	20	Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction
3	Fresh Start	Private	3rd November, 2022	20	Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction
4	Therapy Works Pvt Ltd.	Private	7th July, 2021		Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction
5	Islamabad Psychiatric Clinic & Rehabilitation Centre	Private	12th December, 2021	30	Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction
6	Islamabad Psychiatric Clinic & Rehabilitation Centre	Private	12th December, 2021	30	Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction
7	Hayat Rehab Clinic	Private	9th August, 2021	30	Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction
8	Islamabad Rehab Clinic (IRC) Pvt Ltd	Private	9th August, 2021	30	Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction
9	The Real Health	Private	25th November, 2021	3	Nil	1	2	Anxiety, Depression, Schizophrenia, Drug Addiction

10	Shifa Caring Centre	Private	25th March, 2022	45	Nil	1	2 Anxiety, Depression, Schizophrenia, Drug Addiction
----	---------------------	---------	------------------	----	-----	---	--



Punjab Healthcare Commission

PHC/L&A/41550

Dated: 27th April, 2022

Atlan Waqar Ahmed
Law Officer (NCHR)
8th Floor Evacuee Trust Complex F-5/1
Agha Khan Road, Islamabad

Subject: REQUEST FOR THE PROVISION OF DATA/INFORMATION

Reference to your letter No. 2(7)2022-Legal (NCHR) dated on 19.04.2022 on the subject cited above.

2. The Punjab Healthcare Commission (PHC), established under the Punjab Healthcare Commission Act 2010, has been mandated to regulate the quality of healthcare service delivery in the province. In this regard, the Commission Registers Healthcare Establishments (HCEs), sets Minimum Service Delivery Standards (MSDS) and issues licenses to HCEs on the basis of implementation of these standards.

3. The information available requested through above referred letter is attached herewith.


Director
Licensing & Accreditation

Cc:

- o The Secretary, Primary & Secondary Healthcare Department, Secretariat Punjab, Lahore
- o PS to Chairperson (NCHR)

Address: 125-Armed Block, Garden Town, Lahore, Pakistan
Telephone: 042-99333161-68 Fax: 042-99333169 www.phc.org.pk

 **Helpline: TOLL FREE 0800 00 742**

List of Addiction Treatment Center

Sr.#	Organization Name	Address	District	Bed Strength
1	Young Nation Rehabilitation Centre	Park Avenue Society Bypass Road, Bahawalnagar	Bahawalnagar	0
2	Amnan House (Addiction Treatment Center), Bhuan Road, Chakwal	Amnan House Mohalla Shaheen Abad, Bhuan Road, Chakwal	Chakwal	0
3	Silver Lining	323 Faisal Town Sheikhupura Road, Faisalabad	Faisalabad	30
4	Rehab Home, Samundari Road, Faisalabad	413-P Sehgal City Samundari Road, Faisalabad	Faisalabad	20
5	Ehssas e Zindegi Bahali Centre	311-C, Gulfishan Colony, ABC Road, Jinnah Town, Faisalabad	Faisalabad	49
6	Talha Tark E Munshiat And Nafsiat Centre, Peoples Colony Faisalabad	659-B Peoples Colony No 1, Opp Chinit Pakwan Salimi Chowk Faisalabad	Faisalabad	15
7	Faisalabad Drugs Addiction Treatment Centre	Dann pur Kashtur Road Ghulam Muhammadabad Faisalabad	Faisalabad	45
8	Hayat-e-Nou Centre	38/B, Millat Town, Faisalabad	Faisalabad	15
9	Mian Afzal Trust Hospital	Aroop Morr, Stalkot Road, Gujranwala	Gujranwala	145
10	Freedom Treatment & Rehab, Pindi Bypass Road Gujranwala	Opp Garden Town Phase 3, Pindi Bypass Road Gujranwala	Gujranwala	20
11	Roshni Hospital	Chandhary Colony, Main Street, Gojra Road, Jhang	Jhang	15
12	Rahat Clinic, Jada, Jhelum	Peer Jada Road Near Jada Chungi Stop, Jhelum	Jhelum	15
13	Exclusive Management for Addiction of Alcohol & Narcotics (EMAAAN) Clinic	262-L Johar Town Near Emporium Mall, Lahore	Lahore	33
14	Lahore Psychiatric Hospital	158 Scheme Street Near Bus Stop Sodhiwal Multan Road, Lahore	Lahore	40
15	Willing Ways (Pvt) Ltd, 71-A Jail Road, Lahore	71-A Jail Road, Lahore	Lahore	30
16	Islamic Addiction Treatment Center	88-C-2 Punjab Government Society, Near Wapda Town, Lahore	Lahore	47
17	Umeed Clinic & Rehab Centre	Sultan Ahmed Road, Rehman Pura, Lahore	Lahore	47
18	Shaaf Rehabilitation Centre, Allama Iqbal Town, Lahore	H # 5-Umar Block Allama Iqbal Town, Lahore	Lahore	30
19	Focus On Life Clinic	58-Harman Homes, Yateem Khana Chowk, Band Road, Lahore	Lahore	30
20	Bridge Rehab & Psychiatric Services	1-D1D1A, Block D, New Muslim Town, Lahore	Lahore	25
21	Pak Clinic (Rehabilitation Centre)	28-B New Muslim Town, Bank Stop, Lahore	Lahore	10
22	Addiction Recovery Center, Allama Iqbal Town, Lahore	173-Badar Block, Allama Iqbal Town, Lahore	Lahore	29
23	Blessing Psychiatry Centre	House No 50 Tipu Block Garden Town, Lahore	Lahore	13
24	Nidaa Clinic, Thoker Lahore	99. Westwood Colony Thoker Lahore	Lahore	13
25	Rah-e-Niyat Clinic, Canal Bank Society, Lahore	Canal Bank Society, Faqir Gah, Near Mukhtara Rafiq Hospital, Lahore	Lahore	15
26	Safe And Sound Rehab Center, Rewaz Garden, Lahore	358 Rewaz Garden, Lahore	Lahore	10
27	Health Republic Addiction Treatment Centre.	102 A, Commercial, Phase 6, DHA, Lahore	Lahore	15
28	Ehssas Clinic	21-A Link Wabesha Road Lahore	Lahore	14
29	Ehssas Clinic, 01-G, Gulberg-III Lahore	1-G, Opp. Central Point, Gulberg-III, Lahore	Lahore	49
30	Arshad Rehabilitation Centre, Lahore	Plot # 233 Block C, PIA Road Near Al Janat Fort, Johar Town, Lahore	Lahore	30
31	Innovative Zone Rehabilitation (SMC) Pvt. Ltd	Raja Kamla Estate, Canal Rank, Gulberg II, Lahore	Lahore	30
32	Koshish Clinic	45-C OPF Society, Raiwind Road, Lahore	Lahore	15
33	Bright Way Psychiatric And Addiction Clinic	53-Street 5, Sultan Town, Raiwind Road, Lahore	Lahore	20
34	Ghamkol Decent Rehab Center	House No 2 Block No 3 Sector A-II, Town Ship, Lahore	Lahore	15
35	Focus Life Rehab	House No 39, H Block, Johar Town, Lahore	Lahore	15
36	Al Shifa Addiction & Psychiatric Clinic	184-P Gulberg III Near Gulab Davi Hospital, Lahore	Lahore	30
37	AAS Rehabilitation Centre	House No 847, Block-F, Jubilee Town, Lahore	Lahore	15
38	Women Care Centre	Plot No.3, Block No.B, Barki Road, Lahore Cantt. Lahore	Lahore	30
39	Psy Care Hospital	580-Q-Block, Johar Town, Lahore	Lahore	15
40	Shining Ways Clinic	217/E-Block, Nawab Town, Raiwind Road, Lahore	Lahore	15
41	Lahore Mental Health Association (Fountain House)	37 - Lower Mall, Lahore	Lahore	30
42	Nijat Centre, Near Daewoo Terminal, Multan	Nijat Centre Khanewal Road Near Daewoo Terminal, Multan	Lahore	386
43	Arrahma Hospital For Mental Health	Shokshah Road Nadirabad Phatak Industrial Estate Arca Road, District Multan	Multan	30
44	Nai Zindagi Hospital	Scheme Mor, Nawabpur Road, Multan	Multan	25
45	Nisshan Rehab Hospital, Bossan Road, Multan	86-A, Gulshan-e-Mahar Colony, Chungi No 6, Bossan Road, Multan	Multan	49
46	The Life Care Hospital, Kekar Stop, Multan	30-X, Near Shah Rukn-e-Alam, Metro Station, Kekar Stop, Multan	Multan	15

47	Shahbaz Life Care Drug Addiction Rehabilitation Centre	Amerc Colony Street No.06 Near Makkazi Chore Shah gabrision, Okara	Okara	15
48	Okara Mental & General Hospital	Benzair Road Jahaz Chowk, Jinnah Park, Okara	Okara	10
49	First Fouze Life Rehab	House No.229 Near Al-Younis Pharmacy G.T Road, Okara	Okara	15
50	Wapsi Drug Treatment & Rehabilitation, Mithkar Janyua Road, Rawalpindi	168/8 Sarwar Road, Rawalpindi	Rawalpindi	15
51	Wada Clinic	House No.4, Sector 1 Service Road Near CDA Stop Khayaban Sir Syed, Rawalpindi	Rawalpindi	15
52	Devotion Rehab Center, Chaklala Scheme No 3, Rawalpindi	St No 12, Lane No 2, Chaklala Scheme No 3, Rawalpindi	Rawalpindi	30
53	Curelink HealthCare, Said Pur Road Rawalpindi	Annol Plaza, P-1059, Said Pur Road Near Asghar Mal Chowk Rawalpindi	Rawalpindi	16
54	Sadaqat Clinic, Murree Rawalpindi	Don Leith Cart Road, Murree, Rawalpindi	Rawalpindi	30
55	Aman Hospital	Mimhas Plaza 13-C First Floor Main Road Kavaban e Sir Syed, Rawalpindi	Rawalpindi	27
56	Rawal Rehabilitation Center	House No. 35, Block No. 19, Shah Faisal Colony, Rawalpindi	Rawalpindi	4
57	Vision Rehab	Plaza 551/552 Railway Housing Scheme 9 Rawalpindi	Rawalpindi	30
58	Healing House	House No 331 Saidpur Road Scheme No 1 Rawalpindi	Rawalpindi	0
59	Day Break Society	Street # 9, Muslim Bin Aqel Colony, Satiwal	Satiwal	8
60	AZM Rehabilitation Centre, Satellite Town, Sargodha	438-A, Civil Lines, Satellite Town, Opposite Ibrahim Hospital, Sargodha	Sargodha	30
61	Fountain House, Sargodha	Near Nawaz Sharif Degree College Jhang Bypass Road, Sargodha	Sargodha	50
62	Hussain Shifakhana, Ferozwaia Sheikhpura	Al Hamad Garden Sagian Bypass Ferozwaia sheikhpura	Sheikhpura	0
63	Life Care Drug Rehabilitation Center	Faisal Park New Railway Crossing Faisalabad Road, Sheikhpura	Sheikhpura	30
64	Lahore Mental Health Association (Fountain House Farooqabad)	Near Sucha Sodha Village, Farooqabad, Sheikhpura	Sheikhpura	50
65	M.A Jinnah Foundation New Life Rehabilitation Centre	Near General Bus Stand, Stalkot	Stalkot	45
66	Life Care Rehabilitation Centre	Pul Aik Daska Road, Daburgi Mallian, Post Office, Fatch Garh, Stalkot	Stalkot	15
67	Umced-E-Nau Hospital	Bank Wali Gali, Ban Parak Kingra Road, Stalkot	Stalkot	30



No.1-2/Admin:/BIPBS/2021-22/15231-233
**BALOCHISTAN INSTITUTE OF SYCHIATRY
AND BEHAVIOURAL SCIENCES, QUETTA.**
SAY NO TO CORRUPTION

Dated Quetta the 14th May, 2022.

To, ✓
The Secretary,
Govt of Balochistan,
Health Department, Quetta.

Attention: The Chief Planning Officer,
Government of Balochistan,
Health Department, Quetta.

Subject: - **RE: REQUEST FOR PROVISION OF DATA/INFORMATION.**

Kindly refer to Govt of Balochistan, Health Department letter
No.PC(H)/BIPBS/D4HS/2022/2419-23 dated 12th May 2022, wherein
data/information of this institute has been asked as per prescribed Performa.

The requisite information/data on prescribed Performa is hereby
attached and forwarded to Health Department for further necessary action please.

CPO
[Signature]

[Signature]
Executive Director
Balochistan Institute of Psychiatry
and Behavioral Sciences, Quetta.

- Copy to:- *17/5/22*
1. The PS to Chairperson, NHCR.
 2. Master File.

Assisua
[Signature]
Pl. put up

554 17-5-2022

[Signature]
19.5.22

Name of mental healthcare establishment	Type of ownership (Government, public, private, non-profit, corporation, trust)	Dated registered	No. of beds	No. of full time psychiatrists employed	No. of part time psychiatrists employed	No. of full time clinical psychologists employed	No. of Medical Officers	No. of nurses employed	Average No. of patients per month	Types of disorders being treated at the facility (anxiety, depression, schizophrenia drug addiction etc.)
Balochistan Institute of Psychiatry and Behavioral Sciences, Quetta	Government	13-12-2015	130	24	Nil	03	20	18	1200	<ul style="list-style-type: none"> • Mood disorder • Schizophrenia • Drug Addiction • Personality disorder • Sexual & somatoform disorder • Dementia • Organic Psychiatry disorder • Child & Adolescent Psychiatry • Psychiatric illness (Autism, ADHD, Stress, Mental retardation) • Psychiatric patients in Jail (Forensic services) • Tele-Medicine Services • Psychotherapies

Executive Director
Balochistan Institute of Psychiatry and Behavioral Sciences, Quetta.



1 Jan, 2000 12:41PM P2

FRX NO. :

FROM : PLANNING CEL



No. HCC/L&R/333
Date: 19-04-2022

To

Mian Waqar Ahmed,
Law Officer (NCHR),
Agha Khan Road, Islamabad.

SUBJECT: REQUEST FOR THE PROVISION OF DATA / INFORMATION.

Reference to your office letter No.2(7)2022-Legal (NCHR) Dated 04-04-2022, The requisite information is enclosed for your information.


Director L&R
KP-Health Care Commission

Endst: Even date & No:
Copy to:

1. PS to Chief Executive Officer, KP-Health Care Commission.

Director L&R
KP-Health Care Commission


No	Name Of Mental Healthcare Establishment	Type of ownership	Date of Registration	No. of Beds	No. of full time psychiatric employed	No. of part time psychiatric employed	No. of full-time clinical psychologists employed	No. of Medical officer employed	No. of Nurses employed	Average No. of patients per month	Type of disorders treated at this facility (Anxiety, Depression etc.)
1	Munir Specialist Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	Dr. Imran Khan Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	Dr. Mian Mukhtar Ull Haq Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	Dr. Mian Nizam Ali Specialist Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	Khuwaja Psychiatric Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	Neuro Psychiatry & Psychogeriatrics Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7	Jamil Medical Clinic Psychiatry Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	New Al-Shifa Health Trust Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9	Dr. Asif Kamal Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10	Dr. Hasnain Ali Psychiatry Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
11	Roshan Specialized Hospital	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
12	Abdullah Khattak Medical Center	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
13	Dr. Naveed Irfan Memorial Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	Syed Psychiatric Hospital	Private	N/A	16	N/A	N/A	N/A	N/A	N/A	N/A	N/A
15	Wellfare Medical Laboratory	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16	City Psychiatry Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	Khuwaja Younus Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
18	Paracha Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
19	Psychiatry Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
20											
21											


23	Khawaja Younas Welfare Organization & Research Center	Private	N/A	30	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
24	Shafiqe Psychiatric Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	Haripur Psychiatric Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
26	Specialist Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	Iskhat Hospital	Private	N/A	15	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
28	Dr. Fayaz Psychiatric Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
29	Dr. Allah Alam Clinic & Epilepsy Diagnostic Center	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
30	Specialist Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
31	Center For Psychotherapy & Psychiatry	Private	N/A	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
32	Dr. Sibhan Anwar Neuro Psychiatric Hospital	Private	N/A	24	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
33	Dr. Samina Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
34	Psychiatric Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
35	Bashir Psychiatric Hospital	Private	N/A	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
36	Iftikhar Psychiatric Hospital	Private	N/A	23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
37	Irfan Neuro Psychiatric Hospital	Private	N/A	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
38	Specialist Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
39	Dr. Zahid Nazir Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
40	Gornal Social Welfare & Rehab Center	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
41	Dr. Zahid Nazir Clinic	Private	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

TASKEEN 
SEHATMAND PAKISTAN




**British Asian
Trust**

 051 9216771

 5th Floor Evacuee Trust Complex, Agha Khan Road, Islamabad

 www.nchr.gov.pk