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EDITORIAL:

No Health Without Public Mental Health - A Strategic Roadmap for Pakistan

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ABSTRACT
Pakistan faces a mental health emergency with mental disorders affecting around 24 million individuals. The economic implications are equally devastating. The economic burden of mental illness reached approximately £2.97 billion in 2020, while the allocated mental health budget of 2.4 billion PKR represents merely 0.4% of total health expenditure, covering less than 2% of the actual burden. Current mental health approaches in Pakistan fail because they treat symptoms while ignoring root causes. Traditional biomedical models focus on individual pathology while systematically overlooking the traumatic experiences that drive mental health outcomes across Pakistani society. To address this failure of symptom-focused care, and the mismatch between current approaches and what people actually need, we propose a special initiative as an alternative framework for mental health in Pakistan through an approach that recognizes trauma and adversity as primary drivers of mental health outcomes and structures entire systems around this understanding.

KEYWORDS
Public mental health, Pakistan, Mental health care.

I. The Mental Health Crisis in Pakistan

Pakistan faces a mental health emergency of unprecedented scale. With mental disorders affecting an estimated 10-16% of the population, approximately 24 million individuals, the nation faces a crisis that can no longer be relegated to the margins of public health discourse [1,2,3]. The statistics paint a stark picture: mental disorders are the leading contributor to disability-adjusted life-years among females (51.9%) and the second leading contributor among males (48.1%), yet more than 90% of people with common mental disorders remain untreated [1,4]. Recently, the National Psychiatric Morbidity Survey conducted by the Pakistan Psychiatric Society revealed an alarming 37.91% lifetime prevalence of any psychiatric disorder. What's even more worrisome is the survey was only conducted among individuals above the age of 18. With under 18 making up 47% of the country's population, the survey potentially points to an even higher prevalence.

The economic implications are equally devastating. The economic burden of mental illness reached approximately £2.97 billion in 2020, while the allocated mental health budget of 2.4

billion PKR represents merely 0.4% of total health expenditure, covering less than 2% of the actual burden [5]. This represents a fundamental failure to recognize mental health as important to human development and social progress.

This crisis is amplified by Pakistan's demographic reality as one of the world's youngest countries, with 64% of the population below age 29 [6]. The convergence of youth demographics with grossly inadequate mental health infrastructure creates conditions for a generational catastrophe.

II. Why Trauma-Informed Approaches Are Essential for Pakistan

Current mental health approaches in Pakistan fail because they treat symptoms while ignoring root causes. Traditional biomedical models focus on individual pathology while systematically overlooking the traumatic experiences that drive mental health outcomes across Pakistani society. This represents not merely an incomplete approach, but a fundamentally flawed one that perpetuates cycles of suffering.

Pakistan's social fabric is permeated by traumatic experiences that directly generate mental health problems. Research reveals that up to 80% of women in areas with high domestic violence experience antepartum depression an almost direct causal relationship between trauma and mental illness [7,8]. The substance use epidemic among youth, with 7 million regular users and 700 daily deaths, cannot be understood without examining underlying adverse childhood experiences, family dysfunction, and social adversities that drive young people toward drugs as coping mechanisms [9,10].

Traditional approaches ask "What is wrong with you?" and respond with symptom management i-e., treating depression without addressing domestic violence, managing anxiety without confronting poverty and social exclusion, or attempting addiction treatment without understanding family trauma patterns. This approach explains why treatment gaps remain massive despite decades of mental health awareness campaigns. People don't seek care for "mental illness," but they might engage with services that understand and address what happened to them.

To address this failure of symptom-focused care, and the mismatch between current approaches and what people actually need, we propose a special initiative as a series of interconnected articles in the journal of Pakistan Psychiatric Society, dedicated to *trauma-informed public mental health* as an alternative framework for mental health in Pakistan. This initiative was conceived through a collaboration between leadership of Pakistan Psychiatric Society and international researchers from Harvard Medical School and Harvard T.H. Chan School of Public Health, with the central premise that Pakistan would benefit from a fundamental shift toward trauma-informed public mental health, an approach that recognizes trauma and adversity as primary drivers of mental health outcomes and structures entire systems around this understanding.

Trauma-informed approaches fundamentally reframe the clinical and public health question from "What is wrong with you?" to "What happened to you?" and ultimately to "What is strong with you?" This shift recognizes that most mental health symptoms represent normal responses to abnormal experiences, and that healing occurs not through symptom suppression but

through addressing underlying traumatic experiences while building on individual and community strengths.

International research over the past 3 decades has shown that between 70-90% of adults report traumatic event exposures over their lifetime, with multiple trauma types being common [11,12]. Neurobiological research has generated conclusive evidence that trauma can literally alter brain structure and function, particularly in developing children, creating lasting vulnerabilities to mental health problems [13]. Genetic studies further demonstrate how trauma interacts with biological predispositions to increase mental health risks across generations [14,15].

In Pakistan, emerging research has only confirmed these patterns. Studies show direct links between adverse childhood experiences and adult depression among women [8]. Research on maternal mental health demonstrates how traditional protective practices can buffer against trauma's effects, suggesting that trauma-informed approaches can build on existing cultural strengths rather than imposing foreign models[7].
Pakistan's mental health crisis cannot be resolved through more psychiatrists providing more individual therapy. The scale of need calls for approaches that address root causes at population levels. Trauma-informed public mental health offers this possibility by:

- Preventing mental health problems through systematic attention to adverse childhood experiences, and family violence as well as communal violence and the long history of exposure to natural and man-made disasters.
- Making services more acceptable and effective by addressing real-life concerns rather than abstract psychiatric symptoms.
- Building on existing community and cultural strengths rather than pathologizing traditional practices.
- Creating conditions for healing that extend beyond clinical encounters to families, schools, and communities.

III. Trauma: The Hidden Driver of Mental Health Outcomes in Pakistan

Pakistan's maternal mental health crisis exemplifies the trauma-mental health connection. With postpartum depression prevalence ranging from 28% to 63% which is the highest in South Asia and among the highest rates globally, Pakistani mothers experience mental health challenges that cannot be explained by hormonal changes alone [16,17,18]. The evidence reveals a direct trauma pathway: studies show that 80% of women in areas with high domestic violence experience antepartum depression, demonstrating how traumatic experiences directly generate mental health symptoms [7,8]. The additional responsibility of childbearing and psychosocial stressors can only add to the toll it takes on mental health of women in Pakistan. Latest research has shown that this can lead to intergenerational trauma cycles. Depressed mothers struggle to provide secure attachment for infants, creating adverse childhood experiences that increase their children's vulnerability to mental health problems. Traditional approaches treating maternal depression as individual pathology miss this larger pattern by focusing on symptoms while leaving trauma sources intact, and this can result in continued suffering across generations.

Pakistan's substance use epidemic among youth represents trauma-driven coping in plain sight. Current data showing 7 million regular drug users, including alarming heroin use among educated youth, cannot be understood through addiction models alone [9,10]. Research reveals that substance use peaks between ages 16-18, precisely when young people face family pressures, educational stress, economic uncertainty, and social pressures without adequate support systems [19,20]. The 700 daily deaths from drug-related complications represent not just a substance use crisis, but a trauma response crisis [9]. Young people turn to drugs because they lack healthy coping mechanisms for adverse experiences. Family dysfunction, peer pressure, and socioeconomic stressors create conditions where substance use becomes a logical, though ultimately destructive, survival strategy. Traditional addiction treatment that ignores underlying trauma experiences predictably fails, explaining high relapse rates and treatment resistance.

Furthermore, Pakistan's "hidden epidemic" of suicide represents the ultimate failure of trauma-blind mental health approaches. Suicide rates remain systematically underreported, but emerging evidence suggests substantial numbers of individuals, particularly young people and women, reach points where trauma-related suffering becomes unbearable [21]. Traditional suicide prevention focusing on crisis intervention misses the developmental pathway where accumulated adverse experiences overwhelm individual coping capacity.

The current mental health crisis in Pakistan reflects not just individual trauma, but systemic trauma embedded in social structures. Poverty affects 39% of the population, creating chronic stress that activates trauma responses daily [6]. Gender discrimination systematically traumatizes women and girls. Educational and social systems often re-traumatize vulnerable individuals through exclusion, punishment, and stigmatization. Religious and cultural misconceptions about mental illness create additional layers of trauma through shame and social rejection.

These systemic factors explain why individual mental health treatments, even when available, often fail. People return from therapy to the same traumatizing environments that created their symptoms. Without addressing systemic trauma sources, mental health interventions become exercises in symptom management rather than healing.

IV. A Strategic Roadmap for Trauma-Informed Care

This special series of articles has been conceived to employ a strategic, pedagogical approach designed to build the trauma-informed argument progressively in quarterly releases over the next 2-3 years. Rather than presenting scattered research, researchers will offer a carefully sequenced exploration that establishes scientific foundations, examines specific trauma-mental health pathways, contextualizes findings within Pakistani realities, and culminates in evidence-based solutions.

The series shall begin by establishing scientific foundations through three interconnected papers examining the epidemiological landscape of mental health in lower-middle income countries, genetic mechanisms of trauma vulnerability across generations, and neurobiological research showing how trauma reshapes brain structure and function. These foundational papers will demonstrate that trauma-informed approaches rest on robust biological and epidemiological

evidence.

Building on this foundation, the series will examine trauma-mental health pathways in vulnerable populations. Papers will explore maternal mental health across LMICs and within Pakistani communities, youth psychotherapy interventions, and child and adolescent mental health patterns specific to Pakistan. Field trials from Pakistani settings will demonstrate how trauma-informed interventions build on existing cultural strengths while addressing trauma sources that current approaches ignore.

The series will then transition to solutions, examining Pakistan's severe psychiatric burden through a trauma-informed lens, presenting practical service delivery models for low-resource community settings, outlining institutional reforms necessary to transform mental health systems, and exploring innovative treatments such as low-cost neuromodulation. This approach will ensure we build comprehensive understanding of trauma mechanisms before presenting practical, culturally appropriate solutions for Pakistani communities.

V. Policy Imperatives: Anchoring Reform in Trauma-Informed Principles

Pakistan's mental health system faces twin crises: severe resource constraints and fundamentally misguided approaches. The current mental health budget covers less than 2% of the economic burden, workforce capacity remains critically inadequate, and over 90% of those needing care receive none. Yet channeling scarce resources into symptom-focused interventions while ignoring trauma as the primary driver ensures that even increased investment will fail to reduce prevalence or suffering.

Policy transformation must address both resource allocation and strategic framework. Mental health budget requires substantial increases, but funds should start getting directed toward trauma-informed prevention and community-based interventions rather than expanding tertiary psychiatric facilities. Workforce development through task-shifting must prioritize training in trauma-informed approaches, not merely service delivery protocols. Integration of mental health into primary healthcare, educational systems, and social services must be designed around trauma-aware screening, referral and intervention pathways.

Further, prevention policy must target trauma exposure itself. This requires legislative and programmatic action on adverse childhood experiences, domestic violence, and social determinants of mental health, by treating these as primary mental health interventions rather than peripheral social issues. Health system evaluation frameworks must assess trauma-informed implementation fidelity, not simply service coverage metrics. Accountability mechanisms must ensure that expanded services address root causes rather than scale symptom management.

Without anchoring policy reform in trauma-informed principles, resource increases will expand inadequate approaches, workforce development will train practitioners in failed models, and integration will relocate rather than transform care.

VI. The Need for Informed Innovation

Despite overwhelming challenges, Pakistan has begun implementing innovative interventions that provide hope and practical models for scaling evidence-based approaches. Pakistan is piloting the WHO's Early Adolescent Skills for Emotions (EASE) program, designed for delivery by non-specialists to address the 25% prevalence of psychosocial distress among school-going adolescents [22]. The President's Programme implemented by the Ministry of Health represents a systematic effort to transform schools into platforms for mental health promotion.

Given severe workforce shortages, Pakistan could benefit from task-shifting approaches. Research demonstrates effectiveness of interventions delivered through existing health systems, particularly for maternal mental health where psychosocial interventions can be delivered by non-specialists or peers [23,16,25]. The Thinking Healthy Programme, developed in Pakistan, has shown significant effectiveness and has been scaled internationally [16,24]. Emerging research on traditional practices demonstrates how culturally embedded practices can provide protection against postpartum depression, suggesting opportunities for interventions that build on existing community strengths [7].

These emerging innovations prove that transformation is possible even within severe resource constraints. However, while these examples offer genuine hope, they also reveal a critical juncture. Pakistan can either scale these innovations through a trauma-informed lens, addressing root causes and achieving sustainable impact, or risk expanding well-intentioned programs that perpetuate symptom management at larger scale.

VII. The Path Forward

Therefore, by providing both scientific rationale and a practical roadmap, this special initiative will seek to inform how Pakistan's demonstrated capacity for innovation can be channeled toward interventions that address trauma's root causes, build on cultural strengths, and create sustainable change at population scale.

The choice facing Pakistan is stark: either continue approaches that have demonstrably failed, leaving millions in preventable suffering, or embrace systematic change grounded in trauma-informed principles. The evidence is clear, the framework exists, and Pakistan possesses the capacity for transformation. Yet every day of delay represents thousands of Pakistani mothers, children, youth and families suffering endlessly.

The time of incremental change has passed. Pakistan's mental health crisis calls for bold, systematic, evidence-based action. Implementation would benefit from political will, resource commitment, and collective action from all stakeholders. The journey will not be easy, but it is both necessary and achievable. The alternative of continued trauma-blind approaches is morally unacceptable and economically unsustainable.

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