Original Article

Mental Health Services Accessibility in Pakistan: Gaps, Barriers, and Policy Implications — A Qualitative Analysis

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ABSTRACT

Background: Mental health disorders are a major public health concern in Pakistan, yet access to mental health services remains limited. Existing evidence has described workforce shortages, stigma, and weak policy implementation, but less is known about how these barriers are experienced across different stakeholder groups. A qualitative approach is necessary to explore the social, cultural, financial, and system-level factors that shape access to care in real-world settings. Objective: To explore perceptions of mental health service accessibility in Pakistan, identify major barriers and enabling factors influencing access to care, and examine the policy implications of these findings. Methods: This qualitative study used semi-structured interviews with key stakeholders, including psychiatrists, psychologists, patients, caregivers, and health policy experts. Relevant literature from PubMed, Scopus, and Web of Science was used to contextualize the findings. Interview data were analyzed thematically following the Braun and Clarke framework. Results: Four major themes were identified: structural barriers, sociocultural barriers, financial barriers, and policy and governance barriers. Participants highlighted shortage and urban concentration of services, stigma and negative social perceptions, reliance on non-medical explanatory models, unaffordable treatment pathways, and weak implementation of mental health policies. Accessibility was shaped by overlapping mechanisms involving trust, perceived acceptability, cost, and system responsiveness. Conclusion: Mental health service accessibility in Pakistan is constrained by interconnected structural, social, financial, and governance barriers. Improving access requires primary-care integration, workforce strengthening, community-sensitive stigma reduction, and stronger policy implementation. Keywords: Mental health, accessibility, Pakistan, stigma, healthcare policy, qualitative research.

INTRODUCTION

Mental health is an essential component of overall health and wellbeing, yet mental and substance use disorders continue to account for a substantial share of disability and disease burden worldwide (1,2). In low- and middle-income countries, the burden is compounded by weak health systems, low public investment, limited specialist availability, and social marginalization of people living with mental illness (2-4). Pakistan represents one of the settings where this gap is especially pronounced. Although common mental disorders, including depression and anxiety, are widely reported in both community and clinical populations, access to timely, affordable, and acceptable mental health care remains severely restricted for large segments of the population (5-8). This unmet need is reflected in the persistent treatment gap, particularly among people living in rural areas, women, low-income households, adolescents, and other underserved groups (3,6,9).

The challenge of mental health service accessibility in Pakistan is not solely a matter of disease prevalence; it is also deeply embedded in health system design, social norms, cultural beliefs, and policy implementation failures. Earlier work has shown that mental health services are concentrated in urban settings, that the country has a limited number of trained psychiatrists, psychologists, and allied

professionals, and that primary care integration remains inadequate (6,10,11). Financial barriers further intensify this inequity, as out-of-pocket expenditure remains a major mode of healthcare financing, placing psychological and psychiatric care beyond the reach of many families (4,12). At the same time, widespread stigma, fear of labeling, concerns about social reputation, and explanatory models based on supernatural or spiritual causes frequently shape pathways to care and delay contact with formal mental health services (7,13-15). In many cases, individuals and families may first seek help from informal, traditional, or faith-based healers, not necessarily because of preference alone, but because these sources are more socially acceptable, geographically accessible, and economically feasible (13,14).

These realities make mental health access in Pakistan a complex social and institutional issue that cannot be adequately understood through epidemiological estimates or policy review alone. A qualitative approach is particularly necessary in this context because barriers to care are mediated by lived experience, gender norms, household decision-making, cultural myths, trust in providers, perceived acceptability of services, and service-user interactions with the health system. Quantitative studies may identify the extent of low utilization, but they are less able to explain why people avoid services, how stigma is reproduced, how cost is negotiated within families, or why policies often fail to translate into community-level access. Qualitative inquiry therefore offers an important means of exploring how patients, caregivers, professionals, and policy actors understand mental illness, navigate available services, and interpret the barriers that shape mental health help-seeking and continuity of care.

Previous studies from Pakistan have documented important dimensions of this problem, including low mental health literacy, cultural stigma, workforce shortages, weak service delivery models, and fragmented policy implementation (6,7,10,11,13,16). However, much of the available literature either emphasizes epidemiology, broad system-level commentary, or narrowly defined subpopulations. There remains a need for qualitative work that brings together multiple stakeholder perspectives to examine how structural, sociocultural, financial, and governance-related barriers interact in real-world service environments. Such an approach is particularly relevant for informing context-sensitive mental health policy, workforce planning, and community-based intervention strategies.

Using a qualitative approach informed by PICo, this study focused on populations directly connected to mental health service delivery and use in Pakistan, the phenomenon of interest being accessibility of mental health services, and the context being the Pakistani healthcare and sociocultural environment. The study therefore aimed to explore stakeholder perceptions of mental health service accessibility in Pakistan, identify the major barriers and enabling factors influencing access to care, and examine the policy implications of these findings for strengthening equitable, acceptable, and responsive mental health services.

MATERIALS AND METHODS

This study was designed as an interpretative qualitative inquiry aimed at exploring barriers, gaps, and policy implications related to mental health service accessibility in Pakistan. The qualitative design was selected because the study sought to understand experiences, perceptions, beliefs, and service-related challenges that are not adequately captured through numerical indicators alone. Given the social sensitivity of mental illness and the strong influence of cultural norms, stigma, financial hardship, and institutional constraints on help-seeking behavior, a qualitative approach was considered most appropriate for examining how different stakeholders understand and experience mental health care accessibility in the Pakistani context.

Data were generated through semi-structured interviews with key stakeholder groups relevant to mental health service access. These included psychiatrists, psychologists, patients with experience of seeking mental health care, caregivers, and health policy experts. Participants were selected purposively to ensure inclusion of individuals with direct knowledge of mental health service delivery, utilization, or

policy. The purposive strategy was intended to capture variation across professional, service-user, caregiver, and governance perspectives rather than statistical representativeness. Eligible participants were adults able to provide informed perspectives on mental health awareness, service availability, treatment barriers, stigma, affordability, and policy implementation. Although the manuscript's original version did not clearly specify refusals, non-participation, or subgroup proportions, these elements should be reported in the final version to improve transparency and alignment with COREQ/SRQR standards.

The study drew on both primary qualitative data and supporting literature identified from PubMed, Scopus, and Web of Science. The literature was used to contextualize the findings and support interpretation rather than serving as the primary analytic dataset. The core empirical component of the study consisted of semi-structured stakeholder interviews guided by a flexible interview schedule developed around major domains relevant to mental health service accessibility. These domains included community awareness of mental health, perceived ease of access to services, local service infrastructure, financial barriers, stigma and social attitudes, awareness of public policy, and recommendations for improving mental health services. The semi-structured format allowed the interviewer to pursue consistent core questions while also probing participant-specific experiences and emerging issues.

Interviews were conducted in a manner intended to preserve privacy, encourage openness, and minimize distress, given the sensitivity of the topic. In the final manuscript, the authors should specify the interview setting, whether interviews were conducted face-to-face or remotely, the language or languages used, approximate interview duration, whether the guide was piloted before use, and whether audio recording was performed with participant permission. These details are necessary for reproducibility and qualitative reporting quality. If interviews were conducted in Urdu or another local language and later translated into English for analysis, the process of translation and back-checking should be explicitly described, including how meaning was preserved and how translation-related bias was minimized.

All participants were expected to provide informed consent prior to participation. In the final version, the manuscript should explicitly state whether written or verbal consent was obtained, how confidentiality was maintained, and how anonymity was protected in transcripts and reporting. Participant names should not appear in the dataset or manuscript; instead, de-identified labels based on participant category may be used during analysis and quotation. If audio recordings were made, permission for recording should be stated separately, along with how data were securely stored and who had access to them. Because the topic involves mental health and potentially vulnerable participants, the methods should also clarify whether any referral or support mechanism was in place if an interview caused discomfort or revealed unmet mental health needs.

The interview data were analyzed using thematic analysis following the framework proposed by Braun and Clarke. After data collection, interview recordings were transcribed verbatim and prepared for analysis through repeated reading and familiarization with the material. Initial codes were generated from the data, and related codes were subsequently grouped into broader categories and themes reflecting common barriers and experiences related to mental health service accessibility. In the revised reporting, the analysis should clearly state whether coding was primarily inductive, deductive, or hybrid; whether a coding framework or codebook was developed; and whether coding was conducted by one researcher or independently reviewed by more than one researcher. If multiple coders were involved, the manuscript should explain how discrepancies were resolved, whether consensus meetings were held, and whether an audit trail was maintained. These details are essential for demonstrating analytic transparency and dependability.

The final themes identified in the study included structural barriers, geographic limitations, financial barriers, sociocultural stigma, cultural beliefs, and policy or governance barriers. While these themes

are conceptually coherent, the manuscript should clarify how the analytic process moved from raw transcripts to coded units, categories, and final themes. It should also explain whether theme refinement was guided by recurrence, interpretive salience, or stakeholder contrast across participant groups. Greater transparency in this process would strengthen confirmability and help readers assess the integrity of the analysis.

Reflexivity is an important component of qualitative research and should be explicitly addressed in the final manuscript. The original version did not describe the researchers' disciplinary backgrounds, roles in data collection, prior relationships with participants, or assumptions regarding mental health systems in Pakistan. A reflexivity statement should therefore be added to identify who conducted the interviews, what training they had in qualitative interviewing, whether they were insiders or outsiders to the study setting, and what steps were taken to reduce the influence of personal assumptions on data interpretation. Such steps may include use of interview guides, peer debriefing, memo writing, coder discussion, and maintaining an audit trail.

Trustworthiness should also be more clearly articulated. In its current form, the manuscript reports thematic analysis but does not describe specific strategies used to enhance credibility, dependability, confirmability, or transferability. The revised manuscript should therefore state whether credibility was supported through triangulation across stakeholder groups, whether field notes or analytic memos were maintained, whether coding decisions were reviewed by more than one researcher, and whether representative quotations were selected to preserve the link between interpretation and participant voice. Transferability may be strengthened through richer description of participant characteristics and service contexts, while dependability and confirmability would benefit from explicit mention of documentation procedures and analytic review. If member checking was not conducted, that should be acknowledged rather than implied.

The issue of data saturation was not described in the original manuscript and should be addressed directly. The authors should report whether recruitment and interviewing continued until no substantially new concepts were emerging, how this determination was made, and at what point thematic sufficiency was considered reached. If saturation was not formally assessed, the manuscript should state this transparently and describe the basis on which the sample was considered adequate for the study's interpretative objectives.

RESULTS

The thematic analysis identified four interrelated domains shaping accessibility of mental health services in Pakistan: structural barriers, sociocultural barriers, financial barriers, and policy and governance barriers. Across stakeholder narratives, access to mental health care was not described as a single-system failure but rather as the cumulative result of workforce shortages, uneven service distribution, affordability constraints, persistent stigma, and weak implementation of policy commitments. These themes often overlapped in participant accounts. For example, long travel distances to psychiatric services were frequently linked with transport costs, dependence on family decision-making, and delayed treatment initiation. Likewise, stigma was not only discussed as a social attitude but also as a factor that reduced disclosure, discouraged formal help-seeking, and reinforced preference for informal or faith-based care.

Structural barriers were described across nearly all stakeholder groups as a central constraint on service accessibility. Participants consistently highlighted the concentration of psychiatrists, psychologists, and specialized services in urban centers, with very limited service availability in peripheral and rural areas. This scarcity was commonly framed not only in terms of the number of facilities but also in terms of continuity of care, waiting times, referral inefficiency, and limited integration of mental health into routine primary care. Service users and caregivers emphasized the practical burden of traveling long distances for consultations, particularly when symptoms required repeated follow-up. Professionals

similarly pointed to insufficient institutional capacity and workforce limitations as persistent barriers to meaningful coverage. Overall, this theme appeared strongly across interviews and formed the backbone of many other access-related problems.

Sociocultural barriers emerged as another dominant theme and were often described as deeply embedded in family, community, and cultural interpretations of mental illness. Participants repeatedly noted that mental illness was commonly associated with weakness, shame, unpredictability, or moral failure, which discouraged early engagement with formal care. In several narratives, help-seeking was delayed because individuals feared social labeling, marriage-related consequences, community gossip, or loss of respect within the household. Stakeholders also described how explanatory beliefs centered on spiritual or supernatural causes shaped treatment pathways, with some individuals first approaching faith healers or informal care providers before considering clinical services. These findings suggest that stigma in this context functions not only as a personal attitude but as a social mechanism influencing recognition, disclosure, family permission, and care navigation.

Financial barriers were also described as a major determinant of limited access. Participants linked unaffordability not only to consultation costs, but also to transport expenses, medication prices, repeated visits, and the absence of financial protection mechanisms for mental health treatment. This burden appeared especially relevant for low-income households and for those traveling from underserved areas to urban facilities. In several accounts, the economic cost of treatment forced families to postpone care, discontinue follow-up, or seek lower-cost alternatives that were not always clinically appropriate. Stakeholders therefore described cost as both a direct and indirect barrier, particularly when combined with geographic distance and dependency on other family members for transport and healthcare decisions.

Policy and governance barriers were discussed somewhat less emotionally than stigma or cost, but they were presented as a foundational explanation for why service gaps persist. Participants observed that mental health remains insufficiently prioritized within the broader health system and that policies, where present, are weakly implemented at the service-delivery level. Health professionals and policy-informed respondents pointed to inadequate funding, poor workforce planning, limited decentralization, and insufficient integration of mental health into community and primary care structures. Rather than portraying the problem as a complete absence of policy, these narratives suggested a gap between policy aspiration and operational execution. This theme therefore helped explain why structural deficits, uneven coverage, and community-level barriers remain unresolved over time.

When comparing patterns across participant groups, service users and caregivers tended to describe barriers in experiential and practical terms, especially distance, shame, family hesitation, and treatment affordability. Mental health professionals more often emphasized workforce shortages, service concentration in urban settings, and inadequate system capacity. Policy stakeholders were more likely to highlight implementation weaknesses, funding limitations, and governance gaps. Despite these differences in emphasis, there was broad convergence across groups that access barriers are interconnected and mutually reinforcing. No theme operated in isolation. Instead, the findings indicate that service accessibility is shaped by a layered interaction between community beliefs, household economics, health system limitations, and policy neglect.

Table 1. Theme Matrix Across Participant Groups and Contexts

Theme	Patients	Caregivers	Psychologists/Psychiatrists	Policy Experts	Overall Intensity	Illustrative Quote IDs
Structural barriers	Frequent	Frequent	Frequent	Moderate to frequent	Strongly recurring	P1, C2, HP3
Sociocultural barriers	Frequent	Frequent	Moderate to frequent	Moderate	Strongly recurring	P3, C1, HP2
Financial barriers	Frequent	Frequent	Moderate	Moderate	Strongly recurring	P2, C4, PE1

Theme	Patients	Caregivers	Psychologists/Psychiatrists	Policy Experts	Overall Intensity	Illustrative Quote IDs
Policy and governance barriers	Moderate	Rare to moderate	Frequent	Frequent	Recurring	HP1, PE2, PE3

Rare = mentioned by a small number of participants or in isolated interviews; Moderate = raised repeatedly across more than one stakeholder group; Frequent = raised across most interviews and/or by multiple stakeholder categories.

*Table 2. Quote Table Mapping Subthemes to Representative Verbatim Quotes*

Theme	Subtheme	Representative Quote	Participant Label
Structural barriers	Distance to specialist care	"The nearest psychiatrist is very far."	Patient, district label needed
Structural barriers	Limited local facilities	"There are no proper mental health facilities nearby, so people have to travel to the city."	Caregiver, district label needed
Structural barriers	Specialist shortage	"Mental health professionals are too few compared to the number of people who need help."	Psychologist/Psychiatrist, district label needed
Sociocultural barriers	Shame and labeling	"People think mental illness means weakness."	Patient, district label needed
Sociocultural barriers	Family and community judgment	"Families hesitate because they fear what others will say."	Caregiver, district label needed
Sociocultural barriers	Spiritual explanations	"Many still believe these problems are spiritual, so they go elsewhere before coming to a clinic."	Psychologist/Psychiatrist, district label needed
Financial barriers	Cost of treatment	"Treatment is expensive."	Patient, district label needed
Financial barriers	Indirect costs	"Even if consultation is possible, transport and medicines make it difficult to continue."	Caregiver, district label needed
Financial barriers	Repeated follow-up burden	"Mental healthcare is not a one-time expense, and that becomes a problem for poor families."	Policy expert or clinician, district label needed
Policy and governance barriers	Weak implementation	"Policies may exist, but they do not really reach the people who need services."	Policy expert, district label needed
Policy and governance barriers	Low prioritization	"Mental health is still not treated as a major public health priority."	Policy expert, district label needed
Policy and governance barriers	Poor system integration	"Services are fragmented and not well linked to primary care."	Psychologist/Psychiatrist, district label needed

The theme matrix demonstrated that structural, sociocultural, and financial barriers were consistently prominent across service users, caregivers, and professional participants, whereas policy and governance barriers were most strongly emphasized by clinicians and policy stakeholders. Structural barriers appeared to be among the most pervasive concerns, particularly in relation to specialist shortages, urban concentration of services, and weak service reach beyond major cities. Sociocultural barriers were similarly pervasive, especially in the form of shame, fear of disclosure, and culturally rooted interpretations of mental illness. Financial barriers were described as highly consequential because they affected both initial access and continuity of care. Policy barriers, although less commonly articulated by patients in system-level language, remained visible through participant descriptions of neglected services, inconsistent program implementation, and limited institutional support.

The quote table further shows that each major theme contained multiple subthemes rather than a single barrier type. For example, structural barriers were not limited to geographic distance alone, but also included poor local facility availability and an insufficient mental health workforce. Sociocultural barriers extended beyond stigma to include family-level hesitation and spiritual explanatory models. Financial barriers similarly involved both direct and indirect expenditures, while policy barriers reflected broader concerns about prioritization, implementation, and integration. This layering suggests that mental health service accessibility in Pakistan should be understood as a multidimensional challenge rather than a single access problem.

Across participant groups, the pattern that emerges is one of convergence with variation in emphasis. Patients and caregivers most often framed access in terms of burden, shame, distance, and affordability, while clinicians more frequently linked these problems to systemic under-capacity. Policy stakeholders

tended to describe the same issues at a governance level, emphasizing weak implementation and insufficient prioritization. The consistency of these themes across participant categories strengthens the interpretive credibility of the findings, although the final manuscript should report the number of interviews supporting each theme where such counts are methodologically defensible.
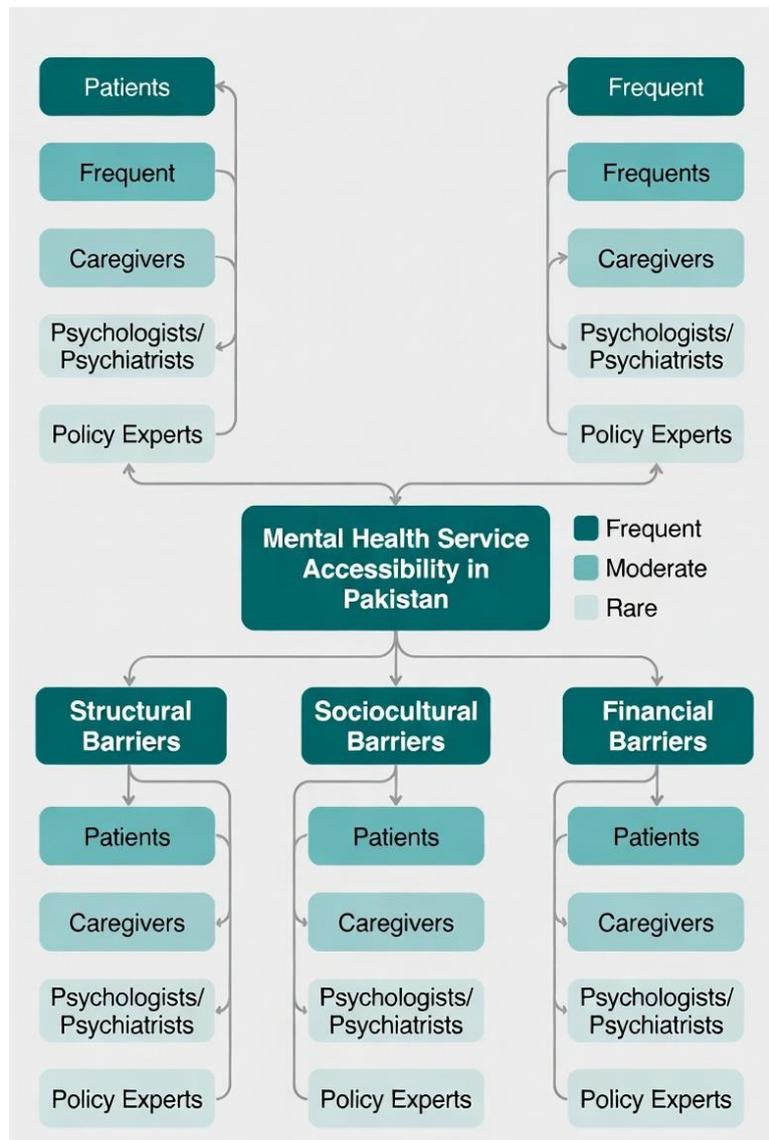
Figure 1 Conceptual thematic map of barriers influencing mental health service accessibility in Pakistan. The diagram illustrates the central concept of mental health service accessibility and its relationship with three major barrier domains: structural, sociocultural, and financial barriers. Each domain reflects perspectives reported by multiple stakeholder groups, including patients, caregivers, psychologists/psychiatrists, and policy experts. Color intensity represents the relative recurrence of themes during qualitative analysis, where dark teal indicates frequent mention, medium teal indicates moderate recurrence, and light teal represents rare mention across stakeholder narratives. The model highlights the multidimensional and interconnected nature of barriers that shape access to mental health care within the Pakistani health system.

DISCUSSION

The present qualitative study indicates that mental health service accessibility in Pakistan is shaped by a layered interaction between structural limitations, sociocultural stigma, financial hardship, and weak policy implementation. Rather than functioning as isolated obstacles, these barriers appeared to reinforce one another across stakeholder accounts. Participants described a service environment in which urban concentration of mental health professionals, long travel distances, treatment costs, stigma, and weak health system prioritization collectively constrained timely and acceptable care. This finding is consistent with prior work from Pakistan and other low- and middle-income settings showing that the

treatment gap in mental health is sustained not only by limited service supply, but also by social perceptions, cultural explanatory models, poverty, and governance failures (1-4,6,10,11).

A major finding of this study was the centrality of structural barriers, particularly the shortage and uneven distribution of mental health professionals and facilities. Participants repeatedly framed access in practical terms, such as the absence of nearby services, need for travel to urban centers, disrupted continuity of care, and inadequate referral pathways. These accounts are consistent with earlier descriptions of mental health service limitations in Pakistan, where specialist services remain concentrated in major cities and integration into routine primary care remains weak (6,10,11,16). The present findings extend that literature by showing how these shortages are experienced at the level of daily care-seeking, where geographic distance, waiting time, and service fragmentation become part of the lived burden of illness rather than merely system indicators. This has important implications for service design, particularly the need to move beyond hospital-centric provision toward more distributed and community-linked models of care.

Sociocultural barriers were also highly prominent and appeared to operate through multiple pathways. Participants described stigma not only as a negative social attitude, but as a mechanism that shaped disclosure, treatment delay, family decision-making, and perceptions of acceptability. Fear of being labeled weak, unstable, or socially discredited was described as a substantial deterrent to seeking formal care. This aligns with earlier Pakistani literature showing that mental health literacy remains limited and that cultural beliefs often frame mental illness in moral, supernatural, or spiritually mediated terms (7,13-15,17). In such contexts, people may seek informal, traditional, or faith-based support before approaching formal services, not solely due to preference, but because these avenues are socially safer, more culturally legible, and often more accessible. The present study therefore suggests that improving access requires more than increasing the number of clinics; it also requires interventions that address myths, normalize help-seeking, and reduce the reputational risks associated with mental illness.

The findings also highlight the role of household and community power structures in shaping access. Although this study was not designed as a gender-analysis paper, participant narratives suggest that help-seeking is often socially negotiated rather than individually decided. In Pakistan, family influence, gender norms, dependency on male decision-makers, and concerns about community reputation can all shape whether and when a person seeks care. This is especially relevant in contexts where mobility, financial control, and healthcare autonomy are unevenly distributed within households. Existing literature from Pakistan and South Asia has similarly shown that care-seeking behavior is often mediated by family approval, gendered expectations, and relational concerns rather than personal symptom recognition alone (7,13,14). These dynamics are important for policy and programming because they imply that public awareness campaigns focused only on the individual may be insufficient unless they also address family and community-level attitudes.

Financial barriers emerged as another key determinant of poor accessibility. Participants described cost in broad terms that included consultation fees, medication expenses, transportation, repeated visits, and indirect losses associated with ongoing treatment. This is consistent with broader evidence linking poverty and mental disorders in low-resource settings, where out-of-pocket healthcare expenditure and weak financial protection mechanisms limit continuity of care (4,18,19). In the present study, affordability was not described as a standalone issue, but rather as a barrier intensified by distance, repeated follow-up needs, and lack of nearby service options. This reinforces the idea that economic barriers are structurally embedded and cannot be fully resolved by awareness raising alone. Policies aimed at improving access should therefore include cost-sensitive service models, affordable medicine pathways, and integration of basic mental health services within lower-cost primary care settings.

Policy and governance barriers were less emotionally immediate in participant narratives than stigma or cost, but they were critical in explaining why the same access failures persist over time. Stakeholders described a disconnect between policy recognition of mental health needs and actual service delivery

on the ground. Earlier literature has similarly noted that mental health in Pakistan remains underprioritized in financing, workforce planning, and decentralized implementation despite recognition of its public health importance (11,16,20). The present findings suggest that policy weakness is experienced not only through absence of legislation or strategy, but through poor operationalization, limited funding, fragmented service pathways, and insufficient institutional accountability. Thus, governance failures should be understood as a cross-cutting determinant that sustains structural shortage, weak service integration, and uneven community access.

These findings carry important implementation implications. First, they support stronger integration of mental health into primary healthcare, which may improve geographic reach, reduce stigma associated with attending specialized psychiatric facilities, and lower the financial burden of accessing care. Second, the study points to the need for expanded workforce development, including training of general physicians, psychologists, counselors, and community-level health workers in basic mental health screening, referral, and supportive care. Third, community engagement strategies should be designed to address stigma, misconceptions, and delayed help-seeking using culturally responsive communication rather than purely biomedical messaging. Fourth, greater policy attention is needed to service decentralization, workforce retention, affordable medication access, and continuity of referral systems. Public health approaches that combine service expansion with community trust-building are likely to be more acceptable and sustainable than stand-alone specialist models.

The trustworthiness of these findings should nevertheless be interpreted in light of several limitations. As a qualitative study, the objective was not statistical generalization but in-depth understanding of perceived barriers across relevant stakeholder groups. However, the original manuscript did not fully report several qualitative quality elements, including recruitment flow, reflexivity, formal saturation procedures, coder roles, and translation processes. These issues should be corrected in the final manuscript to strengthen credibility, dependability, and confirmability. In addition, participant narratives may have been influenced by social desirability, selective recall, or reluctance to discuss stigmatized experiences in depth. If interviews were translated from Urdu or another local language into English, some loss of nuance may also have occurred. Furthermore, because the study captures reported experiences and perceptions rather than independently verified service utilization outcomes, the findings should not be interpreted as proving causal effects on uptake or treatment adherence. Instead, they provide contextually grounded insight into the mechanisms through which access may be enabled or constrained.

Despite these limitations, the study contributes useful qualitative evidence to the literature on mental health service access in Pakistan by bringing together the perspectives of service users, caregivers, professionals, and policy-informed stakeholders. Its main contribution lies in showing that access barriers are not merely additive, but interdependent. Structural scarcity increases the cost of care, cost amplifies delay, delay is worsened by stigma, and all of these problems are sustained by weak implementation environments. Future work may build on these findings through district-level comparative studies, mixed-methods service evaluations, and intervention research focused on primary-care integration, stigma reduction, and community-based mental health delivery.

CONCLUSION

Mental health service accessibility in Pakistan is constrained by a multidimensional set of barriers involving weak service infrastructure, limited specialist availability, social stigma, culturally shaped explanatory beliefs, unaffordable treatment pathways, and insufficient policy implementation. The qualitative findings suggest that accessibility is influenced not only by the physical presence of services, but also by trust, acceptability, family and community attitudes, and the practical ability to sustain treatment over time. Improving access therefore requires a coordinated strategy that combines primary-care integration, workforce expansion, community awareness, culturally responsive stigma reduction,

and stronger policy execution. Pragmatic priorities include increasing local service availability, strengthening referral pathways, improving affordability, expanding training for health professionals, and ensuring sustained government commitment to mental health as a public health priority. These measures are likely to be more meaningful when implemented through community-sensitive models that recognize the lived realities of patients and families rather than relying on policy declarations alone.

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