

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN
THE ISLAMIC REPUBLIC OF IRAN**



**World Health
Organization**



MINISTRY OF HEALTH AND
MEDICAL EDUCATION
ISLAMIC REPUBLIC OF IRAN

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN THE ISLAMIC REPUBLIC OF IRAN

A report of the assessment of the mental health system in the Islamic Republic of Iran using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

Tehran, the Islamic Republic of Iran

2006



*WHO, Country Office in the Islamic Republic of Iran
WHO, Regional Office for the Eastern Mediterranean
WHO Department of Mental Health and Substance Abuse (MSD)*

This publication has been produced by the WHO, Country Office in the Islamic Republic of Iran, in collaboration with WHO, Regional Office for the Eastern Mediterranean and WHO, Headquarters. At WHO Headquarters this work has been supported by the Evidence and Research Team of the Department of Mental Health and Substance Abuse, Cluster of Noncommunicable Diseases and Mental Health.

For further information and feedback, please contact:

- 1) Emran M. Razzaghi, Ministry of Health and Medical Education,
E-mail: razaghie@sina.tums.ac.ir*
- 2) Mohammad Taghi Yasamy, WHO, Regional Office for the Eastern Mediterranean,
E-mail: yasamym@emro.who.int*
- 3) Shekhar Saxena, WHO Headquarters, E-mail: saxenas@who.int*

(ISBN)

World Health Organization 2006

Suggested citation: WHO-AIMS Report on Mental Health System in The Islamic Republic of Iran, WHO and Ministry of Health and Medical education, Tehran, the Islamic Republic of Iran, 2006.

(Copyright text as per rules of the Country Office)

Acknowledgement

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system of the Islamic Republic of Iran.

The project in the Islamic Republic of Iran was carried out by EM Razzaghi, MT Yasamy, SA Bagheri Yazdi, A Hajebi, A Rahimi Movaghar and from the Mental Health Office and The Bureau of Psychosocial and School Health in the Ministry of Health.

The preparation of this study would not have been possible without the collaboration of all other sectors of the Ministry of Health and the Social Welfare Organization. We are grateful for the support to E Akbari, H Aminloo, Jamshidi, M Vazirian, Samadi, SZ Ghaemmagham Farahani, M Zainali, Sadrifar, Aminesmaili, N Mahdavi, and many other colleagues.

The project was supported by Mubasher Sheikh, Ali Reza Mafi, Parisa Ardam and Roshan Lohrasbpour from WHO office in Tehran, the Islamic Republic of Iran.

The project was also supported by the WHO Regional Office team.

The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

The project received financial assistance and/or seconded personnel from: The National Institute of Mental Health (NIMH) (under the National Institutes of Health) and the Center for Mental Health Services (under the Substance Abuse and Mental Health Services Administration [SAMHSA]) of the United States; The Health Authority of Regione Lombardia, Italy; The Ministry of Public Health of Belgium and The Institute of Neurosciences Mental Health and Addiction, Canadian Institutes of Health Research.

The WHO-AIMS team at WHO Headquarters includes: Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris, Anna Maria Berrino and Grazia Motturi. Additional assistance has been provided by Erik Goldschmidt and Alexandra Isaksson.

The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the Islamic Republic of Iran. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable the Islamic Republic of Iran to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Data collected by WHO-AIMS was helpful in identifying areas of success and areas of need. In terms of the policy and legislative framework for mental health there have been major achievements. During the last 17 years a national policy and plan has been available and recently major amendments have been done to expand and improve the program in urban areas. What has been lacking is that users themselves have not been involved, though to some extent families of the consumers have recently been active and included. One of the positive aspects of the national policy is the availability of a disaster/emergency preparedness plan for mental health which was last revised in 2004. The plan was first drafted in 1998 after a needs assessment following two earthquakes and a pilot study in another earthquake. The last revision occurred after implementation in the Bam earthquake.

The lack of comprehensive and coherent mental health legislation is evident. Although available laws cover some areas like competency, capacity, and guardianship issues for people with mental illness and despite the ratification of some progressive laws in 1997 that provided legislative support for employment, there are still many areas not addressed, for example, involuntary hospitalization. A need for enforcing the laws is apparent. The same holds true for monitoring and training on human rights protection in mental health services.

Taking into account the high burden of mental disorders, the amount of money spent for mental health services should be increased. In the domain of mental health services, there is an authority in the Ministry of Health that provides advice on mental health and it is positive that mental health services are organized in terms of catchments/service areas especially in rural areas. However, more should be done for the urban areas. At the rural level, the multipurpose health workers and the general practitioners are contributing immensely to service provision. In urban areas the health volunteers have not proved as efficient and coverage in the urban areas is also not sufficient.

Outpatients' services are available but there should be more room for children, adolescents and more attention to substance related problems. The number of patients in community residential facilities providing long-term hospitalization and in mental hospitals has been considerable and growing which is not in the acceptable direction. The recently launched mobile services (i.e. home visits initiative) is still at the pilot level and provides a small amount of coverage. Outpatient facilities and community based

psychiatric services based in general hospitals provide better quality service in terms of more comprehensive psychosocial treatments. Lack of medications is not an issue. The number of day treatment facilities is quite small with limited coverage. In terms of equity, the situation has been improving regarding rural coverage but there is a real need for better insurance coverage for urban areas.

Regarding the provision of mental health care through primary care, the training of medical students, nurses and other health workers on mental health is far from satisfactory. The same holds true about refresher courses devoted to mental health. One of the positive aspects of Iranian mental health is involvement of both physician-based primary health care (PHC) and non-physician based PHC clinics in the country. The amount of professional interaction between primary health care staff and other care providers with the mental health professionals has not been satisfactory.

In terms of human resources, the distribution seems to be fair because quite a considerable number of general practitioners are involved, but this holds true mostly for the rural areas. In terms of staffing in mental health facilities, the number of psychiatrists and nurses per bed in community-based psychiatric inpatient units is comparable to that in mental hospitals. While for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), the number of staff per bed in community-based psychiatric inpatient units is one sixth that of mental hospitals.

The distribution of human resources between large urban areas and more peripheral areas is relatively unfair. The national policy has been to fill the gap by training general practitioners in more remote areas and to train the multipurpose health workers (behvarzes) in rural and health volunteers in urban areas.

The amount of refresher courses for different levels of the health system does not look to be sufficient as well. There is no consumer association available in the country but there is a major NGO for families. The mental health office of the MOH has developed a good relationship with the NGO and started some technical and economic support for the family association; and to some extent involved them in the formulation or implementation of mental health policies, plans, or legislation in the past two years.

A great deal of work has been ongoing in the domain of education and public awareness campaigns on mental health organized and coordinated by the mental health office. Government agencies, NGOs, professional associations, private trusts and foundations, international agencies have promoted public education and awareness campaigns, which have targeted the following groups: the general population, children, adolescents, women, trauma survivors and other vulnerable groups. In addition, there have been public education and awareness campaigns targeting professional groups including: health care providers, teachers, social services staff, leaders and politicians, and other professional groups linked to the health sector. Every year the “mental health week” is being celebrated at the national level.

Legislative provisions exist about legal obligation for employers to hire a certain percentage of employees, but are not fully enforced. However, there is a need for the development of an up-to-date mental health act. Such an activity is under way and there is some hope that the new draft will go to the parliament next year. In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for Primary health care/ community health, HIV/AIDS, reproductive health, Child and adolescent health, substance abuse, child protection, education, welfare, the elderly, and other departments/agencies.

In terms of support for child and adolescent health, about one tenth of primary and secondary schools have either a part-time or full-time counsellor and about a quarter of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. The number of prisoners who receive mental health services is small. There is a need for training of judges, lawyers and police officers on mental health.

In terms of evaluation and monitoring, especially in rural areas there is a good system of monitoring with a uniform data collection format and the health department regularly receives such data. However, there still is a real need for improvement in urban areas and inpatient facilities.

A successful initiative in the country has been the activity lead by the Mental Health Research Department of the National Health Research Department which has published scientometric studies on mental health research based on data collected with the assistance of the mental health office. These studies have only partly focused on epidemiological studies in community samples, epidemiological studies in clinical samples, non-epidemiological clinical/questionnaires assessments of mental disorders, services research, policy, programs, financing/economics, psychosocial interventions/psychotherapeutic interventions. The greater emphasis in these studies is on basic science and clinical issues. Based on these findings more emphasis is now paid to community-based mental health research.

WHO-AIMS COUNTRY REPORT FOR THE ISLAMIC REPUBLIC OF IRAN

Introduction

Background

The Islamic Republic of Iran is a large country with an approximate area of 1,648,000 sq. km and a population of 67.478 million, 44.77 million (66%) live in urban and 22.7 (34%) million in rural areas. The country is a lower middle income group country based on World Bank 2004 criteria. The literacy rate is 83.5% for males and 69.9% for females. The life expectancy at birth is 71.4 years on average: 72.8 for females and 69.9 for males. The official language is Persian and almost all Iranians understand it and the majority of the people are Moslems.

Mental Health

A mental health policy and programme was initially formulated in 1986. The main components are advocacy, promotion, prevention, treatment and rehabilitation. The main strategy has been to integrate the mental health program within the Primary Health Care system. From 1988 to 1990 successful pilot studies were implemented in Shahr-e-Kord and Shahreza in central Islamic Republic of Iran, which showed significant increased knowledge of health workers and improved skill in patient screening compared with the control area. The 15 years of expansion of the integration of mental health within PHC has resulted in immense improvements in the provision of mental health services in rural areas.

Evaluation of mental health in the Islamic Republic of Iran

There is a simple information system for mental disorders like psychosis, depression, epilepsy, mental retardation, etc. There is also a mental health reporting system within the health network. Routine monitoring of mental health activities is being carried out through regular report-taking and statistical analysis and periodic visits to the field by responsible professionals in the provinces and headquarters in Teheran. An independent evaluation was carried out by the World Health Organization Regional Office for the Eastern Mediterranean in 1995. The research included field surveys and data collection from 266 multipurpose health workers (behvarz) and health houses, 91 general physicians and rural health centers, and 737 families who lived in the neighborhood of the rural areas where mental health programs were in operation. It also included a study on psychiatric disorders in general medical practice and pathway to treatment. According to the report:

The Iranian experience of mental health reform in the country is multi-faceted. The integration of mental health care within the primary health care system is an impressive achievement. The extent of coverage, particularly in rural areas shows that given the

necessary infrastructure and political will, it is possible to integrate mental health within primary health care. General health personnel are capable of providing basic mental health care, provided they are trained and supervised and are backed by a proper referral system. Once the system was established, mental health professionals have cooperated with it. The success of this program of integration was dependent on the presence of a well-structured health system.

WHO-AIMS authors indicate that the instrument was not intended to establish mental health standards. However, this evaluation could be used to identify areas which have been neglected and need to be targeted more seriously.

Iranian mental health activists had good reasons to implement the evaluation and to contribute to the improvement of WHO-AIMS.

Data was collected in 2005 and is based on the year 2004.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Iran's mental health policy was last revised in 2004 and includes following components: (1) developing community mental health services, (2) building psychiatric wards in general hospitals, (3) developing a mental health component in primary health care, (4) human resources, (5) advocacy and promotion, (6) human rights protection of users, (7) equity of access to mental health services across different groups, (8) financing, (9) quality improvement, and (10) a monitoring system. In addition, a list of essential medicines is present. These medicines include: (1) antipsychotics, (2) anxiolytics, (3) antidepressants, (4) mood stabilizers, and (5) antiepileptic drugs.

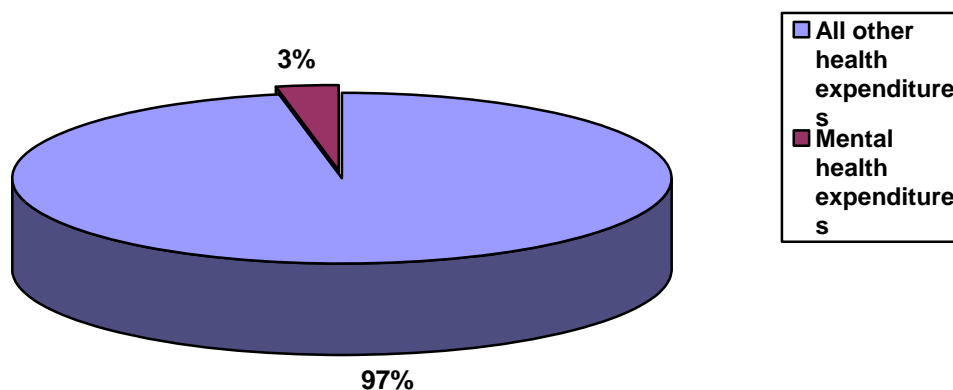
The last revision of the mental health plan was in 2004. This plan contains the same components as the mental health policy. In addition, a budget, a timeframe and specific goals are mentioned in the last mental health plan.

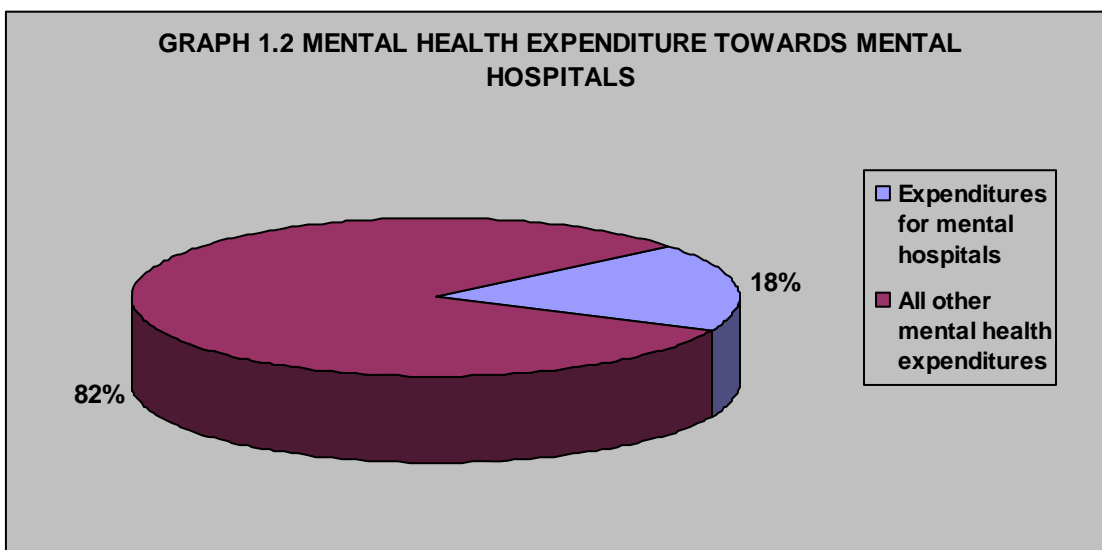
A disaster/emergency preparedness plan for mental health is present and was last revised in 2004. The plan was first drafted in 1998 after a needs assessment in follow-up to two earthquakes. The plan was then studied in a subsequent earthquake. The last revision occurred after its implementation following the Bam earthquake. There is no current mental health legislation.

Financing of mental health services

Overall 3% of health care expenditures by the government health department are directed towards mental health (Graph 1.1). Of all the expenditures spent on mental health, 18% is directed towards mental hospitals (Graph 1.2).

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH





About 53% of the population has free access (at least 80%) to essential psychotropic medicines. A new plan for insurance in rural areas is under way in which mental health is included too. For those who pay out of pocket, the cost of antipsychotic medication equals 1500 rials (0.16 dollars) per day and antidepressant medication is 600 rials (0.07 dollars) per day (4% and 2% of the daily minimum wage respectively). All mental disorders are covered in social insurance schemes, but there are limitations for the length of a hospital stay.

Human rights policies

Though there is no separate modern “mental health legislation” in the country, there are articles in various pieces of legislation which address the issue. The most recent articles on mental health legislation (enacted in 1997) focused on the rights of mental health service consumers, competency, capacity, and guardianship issues for people with mental illness and law enforcement and other judicial system issues for people with mental illness. The current legislation is insufficient to address the real needs of the people with mental illness. A draft for mental health legislation has been prepared and will be submitted to the Parliament in 2007.

A national human rights review body does not exist and there are no inspections of human rights protection of patients in mental hospitals, community-based inpatient psychiatric units or community residential facilities. Mental health staff did not receive one day training, meeting or other type of working session on human rights protection in the year of assessment.

Domain 2: Mental Health Services

Organization of mental health services

A national mental health authority exists which provides advice to the government on mental health policies and legislation. The mental health authority also is involved in service planning, service management, coordination and monitoring, and quality assessment of mental health services. Mental health services are organized in terms of catchment/service areas. In rural areas there is a better implementation of the national guidelines compared with large urban areas. Most mental health hospitals and all community-based inpatient units are run by the medical universities and some of them train psychiatry residents. Residential facilities are run by the Social Welfare Organization in the Islamic Republic of Iran.

Mental health outpatient facilities

There are 855 outpatient mental health facilities available in the country, of which 40 are for children and adolescents only. These facilities treat 640,000 users (948 per 100,000) general populations. Of all users treated in mental health outpatient facilities, 60% are female and 25% are children or adolescents. The users treated in outpatient facilities are primarily diagnosed with neurotic, stress related and somatoform disorders (34.2%) and mood/affective disorders (34.1%). The average number of contacts per user is 5.7. About 6.1% of outpatient facilities provide follow-up care in the community, while 1% has mental health mobile teams. The majority (50-80 %) of patients in outpatient facilities receive one or more psychosocial treatments. All mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a nearby pharmacy all year round.

Day treatment facilities

There are 31 day treatment facilities available in the country, of which none is for children and adolescents only. These facilities treat 1,881 users (2.78 per 100,000) general populations. Of all users treated in day treatment facilities, 58% are females and 42% males. On average, users spend 294.5 days per year in day treatment facilities.

Community-based psychiatric inpatient units

There are 46 community-based psychiatric inpatient units providing 1,366 beds (2.02 per 100,000 population). About 3% of these beds in community-based inpatient units are reserved for children and adolescents only. In the year of assessment, there were 22,150 admissions in community based inpatient units, about 27% of which were female and 20% were children/adolescents. Users of community-based psychiatric inpatient were primarily diagnosed with schizophrenia, schizotypal and delusional disorders (24%) and mood/affective disorders (21%). On average patients spend 20 days per discharge. Three quarters of patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. All community-based psychiatric inpatient

units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community residential facilities

There are 75 community residential facilities available in the country for a total of 3,600 beds/places (5.3 per 100,000 populations). About 58% of users treated in community residential facilities are female. No children or adolescents are cared for in these facilities. The number of users in community residential facilities is 4,060 (6 per 100,000 population) and the average number of days spent in community residential facilities is 328. The residential facilities are run by the Social welfare Organization and most wards are small, sheltering less than 100 patients. They are trying to improve the conditions in these facilities and provide more outdoors activities.

Mental hospitals

There are 33 mental hospitals available in the country for a total of 5,350 beds (7.9 per 100,000 populations). All of these facilities are organizationally integrated with mental health outpatient facilities. Only 3.4% of these beds in mental hospitals are reserved for children and adolescents. The number of beds has increased by 7% in the last five years. The patients admitted to mental hospitals are primarily diagnosed with mood/affective disorders (65%) and schizophrenia (17%). The number of patients in mental hospitals is 88,000 (130 per 100,000), of whom 46% are female and 4% are children and adolescents. These facilities have a 93% occupancy rate

Patients spend an average of 20.7 days in mental hospitals. Nearly ninety percent of patients spend less than one year, 5% of patients spend 1-4 years, 2% of patients spend 5-10 years, and 2% of patients spend more than 10 years in mental hospitals. About 75% of patients in mental hospitals received one or more psychosocial interventions in the last year. All mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Forensic and other residential facilities

There is no forensic inpatient unit available in the country. The forensic patients are detained in prison and the psychiatrists visit them there. In addition to beds in mental health facilities, there are 45,400 beds in other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc.

Human rights and equity

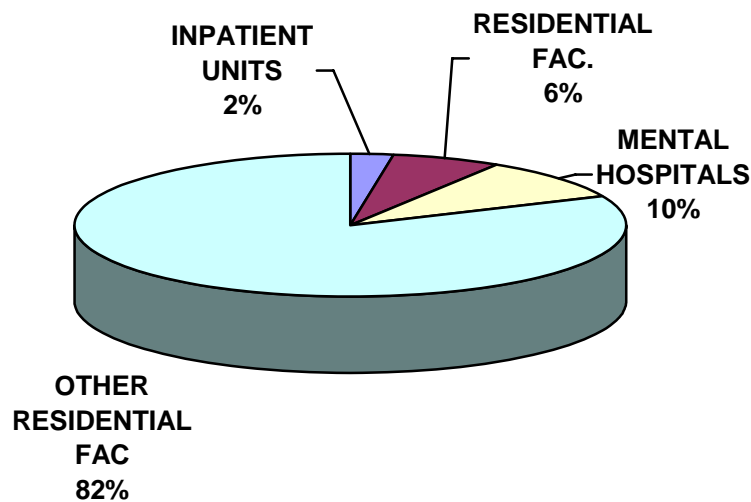
The number of psychiatric beds per capita located in or near the largest city is twice the total number of beds per capita for the whole country. Such a distribution of beds limits access for rural users. Almost all people speak Persian. For this reason inequity of access

to mental health services for minority users is not an issue in the country. Due to the expansive primary health care network nationwide and the integration of mental health into it, rural areas have access to affordable services. The main problem remains in large urban areas where poor people have not utilized services despite the availability of such services.

Summary charts

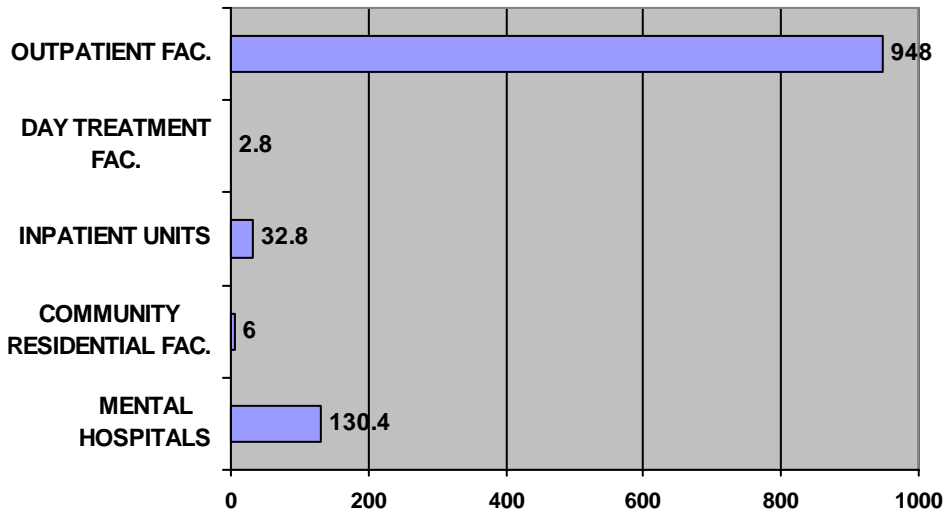
Most mental hospitals and all community based inpatient units are run by the medical universities and some train psychiatry residents. Residential facilities are run by the Social Welfare Organization. Most psychiatric beds in the country are in other residential facilities. These beds in residential facilities are for people with mental retardation and for people with substance abuse problems (e.g. detoxification inpatient facilities), (Graph 2.1).

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



The majority of the users are treated in outpatient facilities and in mental hospitals, while the rate of users treated in inpatient units, day treatment facilities and residential facilities is lower (Graph 2.2).

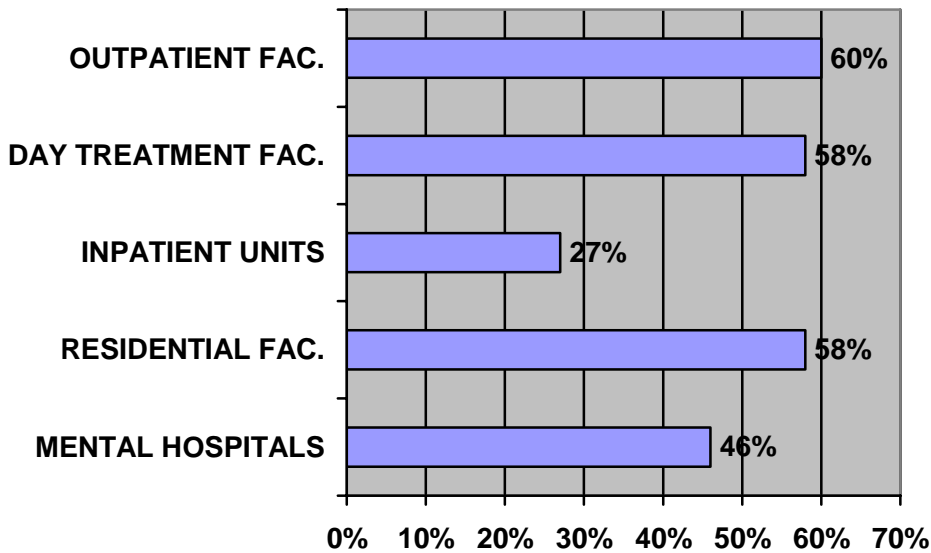
GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES
 (rate per 100.000 population)



Note: In this graph the rate of admissions in inpatient units is used as proxy of the rate of users treated in the units.

The proportion of female users is highest in outpatient facilities and lowest in inpatient units (Graph 2.3).

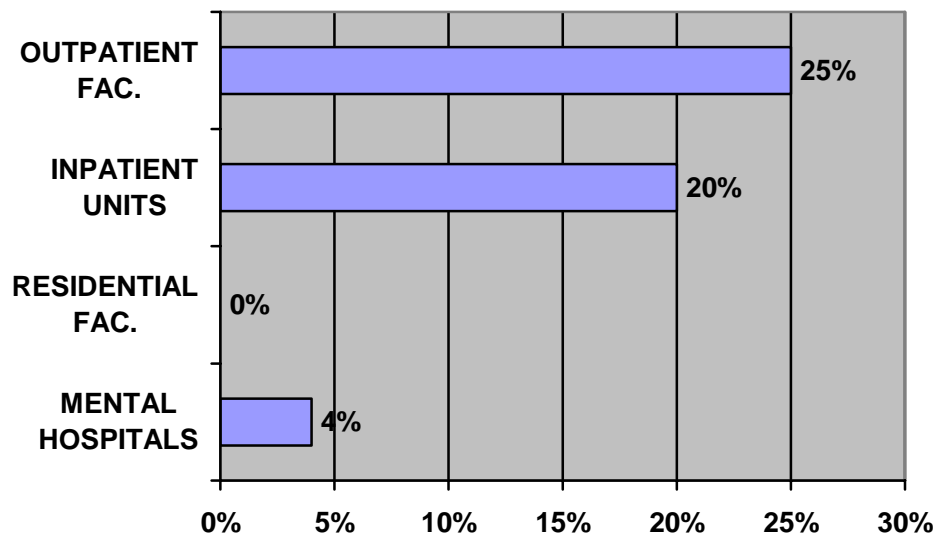
GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



Note: In this graph the percentage of female users' admissions in inpatient units is used as proxy of the percentage of women treated in the units

The percentage of users that are children or adolescents varies substantially from facility to facility. The proportion of child/adolescent users is highest in outpatient facilities and lowest in mental hospitals and residential facilities (Graph 2.4).

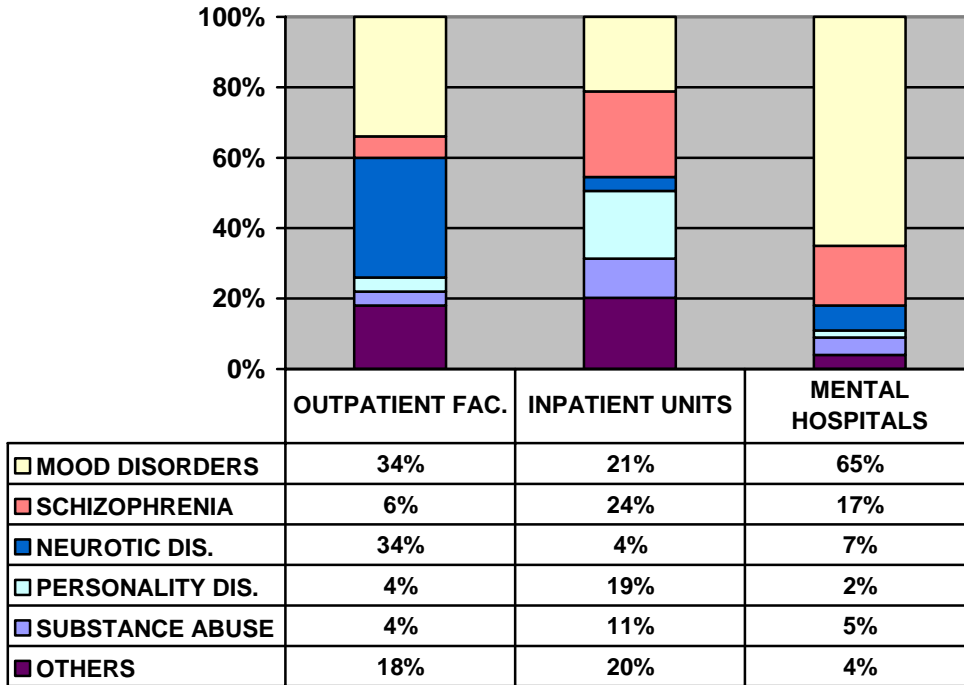
GRAPH 2.4 - PERCENTAGES OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES



Note: In this graph the percentage of children and adolescents' admissions in inpatient units is used as proxy of the percentage of children and adolescents admitted in the units

The distribution of diagnoses varies across facilities: in outpatients facilities neurotic disorders and mood disorders are most prevalent, within inpatient units schizophrenia and mood disorders diagnoses are most common, and in mental hospitals mood disorders and schizophrenia diagnoses are most frequent (Graph 2.5).

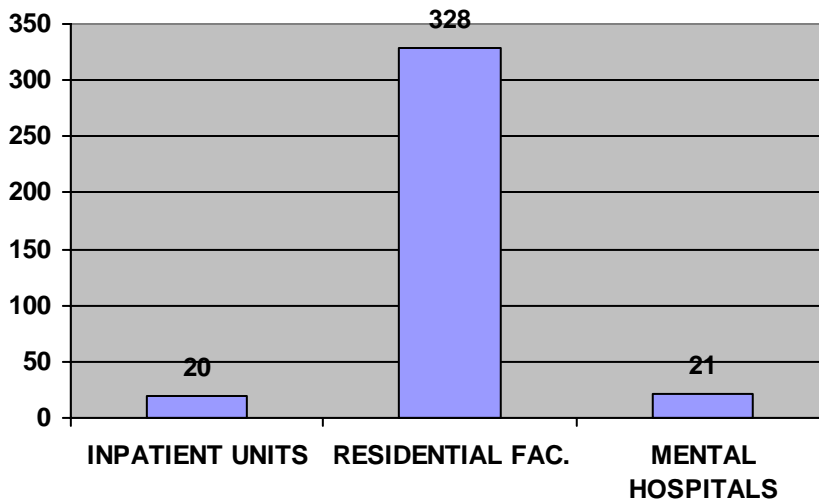
GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



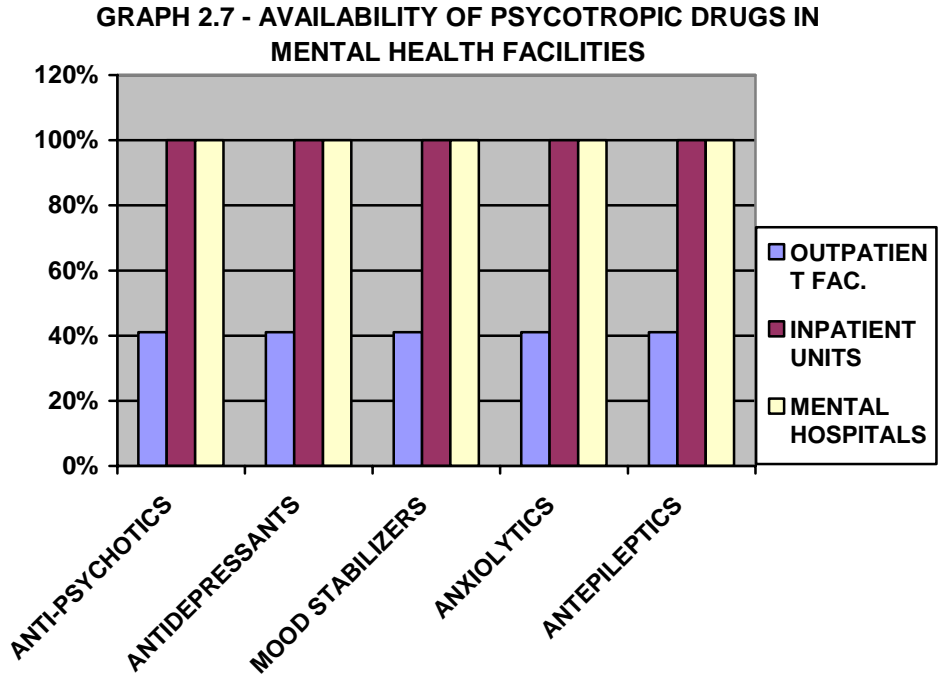
Note: In this graph the percentage of admissions in inpatient units by diagnosis is used as proxy of the percentage of users admitted in the units

The longest length of stay for users is in community residential facilities, followed by mental hospitals and then community-based psychiatric inpatient units (Graph 2.5).

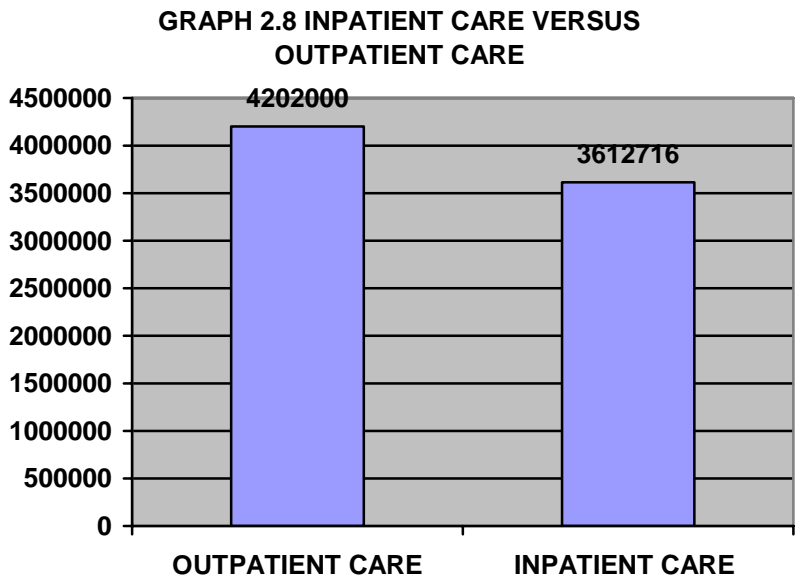
**GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES
(days per year)**



Psychotropic drugs are most widely available in mental hospitals, followed by inpatient units, and then outpatient mental health facilities (Graph 2.7).



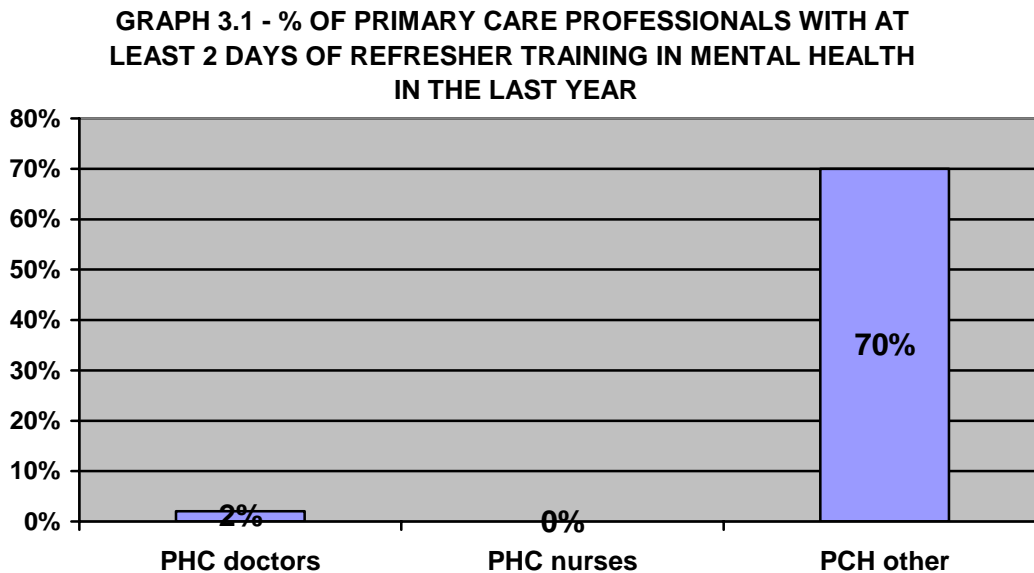
The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals, residential facilities and general hospital units) is an indicator of extent of community care: in this country the ratio is 1.16:1 (Graph 2.8).



Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

About 3% of the training for medical doctors is devoted to mental health, in comparison to 2% nurses and 3% non-doctor/non-nurse primary health care workers. In terms of refresher training, 2% of primary health care doctors have received at least two days of refresher training in mental health, while 0% of nurses and 70% of non-doctor/non-nurse primary health care workers have received such training (Graph 3.1).



Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based PHC clinics, all or almost all (81-100%) have assessment and treatment protocols available for key mental health conditions; the same percent is true for non-physician-based PHC clinics. All or almost all (81-100%) physician-based PHC clinics make an average at least one referral to a mental health professional. About 81-100% of non-physician based PHC clinics make a referral to a higher level of care. As for professional interaction between PHC staff and other care providers, the majority (51-80%) of primary care doctors have interacted with a mental health professional at least once in the last year. None of the physician-based PHC facilities, non-physician-based PHC clinics, or mental health facilities has had interactions with complimentary/alternative/traditional practitioners (Graph 3.2).

Prescription in primary health care

Nurses and non-doctor/non-nurse primary care workers are not allowed to prescribe psychotropic medications in any circumstance. Primary health care doctors are allowed to prescribe without restrictions. As for availability of psychotropic medicines, 81-100% of

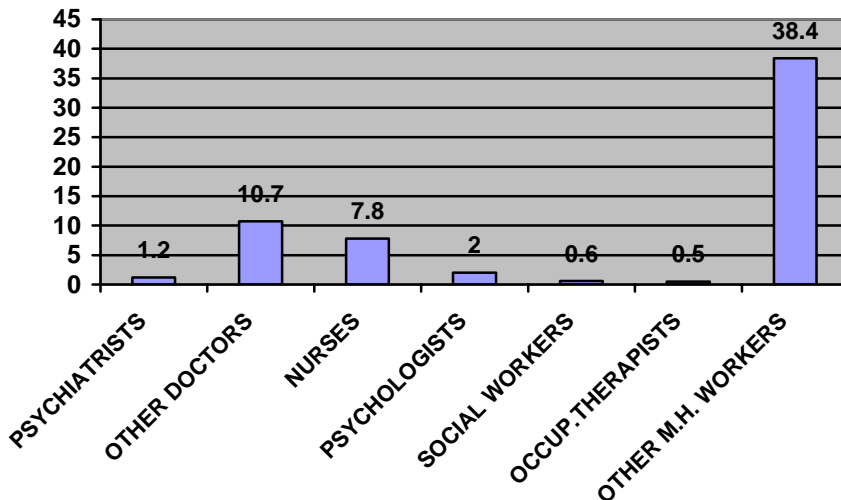
physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) in comparison to 81-100%.

Domain 4: Human Resources

Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 populations is 61.2. The breakdown according to profession is as follows: 800 psychiatrists (1.2 per 100,000), 7,250 other medical doctors, not specialized in psychiatry (10.7 per 100,000), 5,280 nurses (7.8 per 100,000), 1,340 psychologists (2 per 100,000), 402 social workers (0.6 per 100,000), 325 occupational therapists (0.5 per 100,000), and 25,900 other health or mental health workers (38.4 per 100,000), including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors (Graph 4.1).

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)

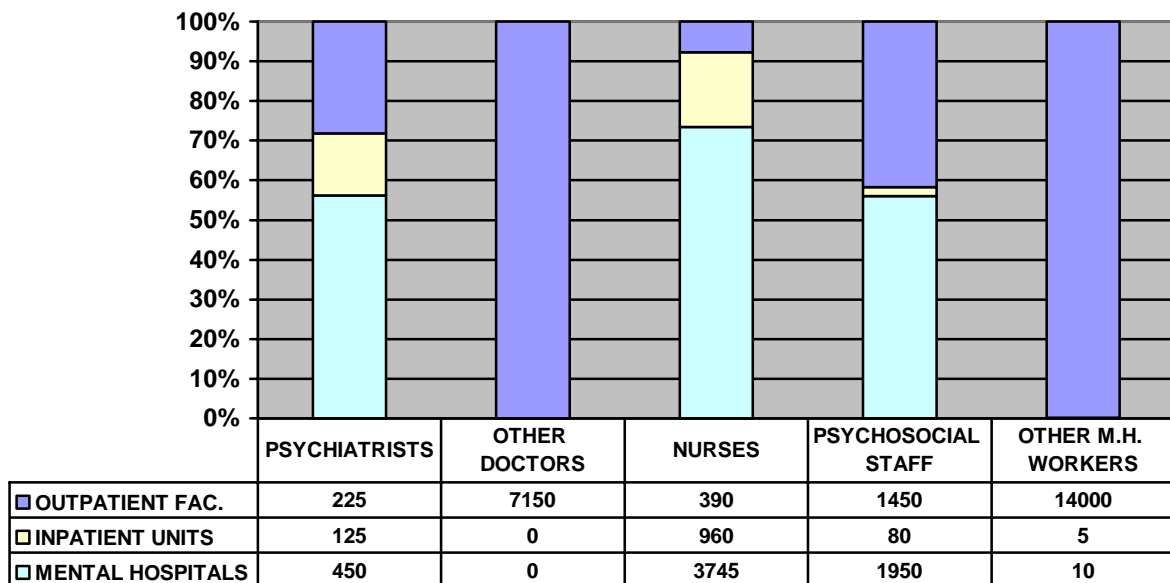


About 6% of psychiatrists work only for government administered mental health facilities, and 23% work only for NGOs, for-profit mental health facilities and private practice, while 71% work for both sectors. About 71% of psychologists, social workers, nurses and occupational therapists work only for government administered mental health

facilities, 9% work only for NGOs, for profit mental health facilities and private practice, while 20% work for both the sectors.

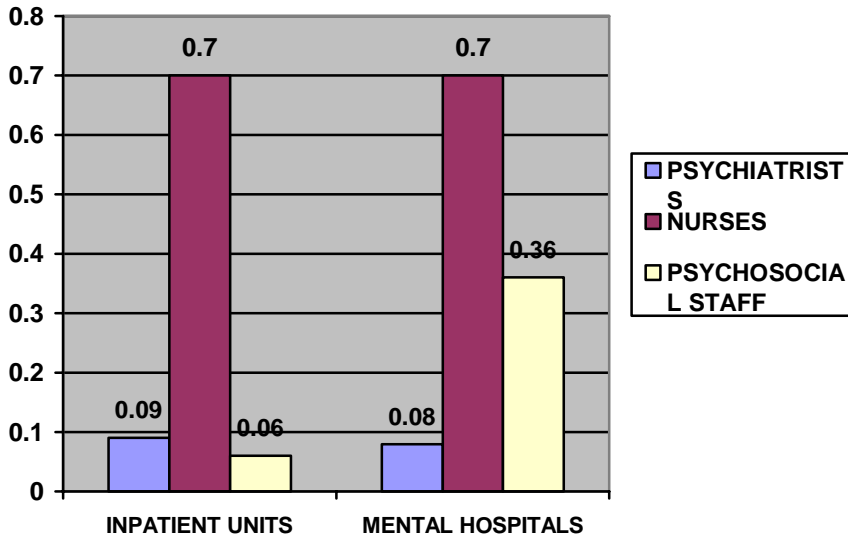
Regarding the workplace, 800 psychiatrists work in mental hospitals, outpatient and inpatient facilities. 125 psychiatrists work in community-based psychiatric inpatient units, 450 in mental hospitals (520 out of 575 psychiatrists work in both outpatient clinics and inpatient facilities), and 225 work only in outpatient facilities. 7150 other medical doctors, not specialized in mental health, work in outpatient facilities. As far as nurses, 390 work in outpatient facilities, 960 in community-based psychiatric inpatient units and 3745 in mental hospitals. 1450 psychologists, social workers and occupational therapists in outpatient facilities, 80 in community-based psychiatric inpatient units and 1950 in mental hospitals. As regards other health or mental health workers 14000 work in outpatient facilities, 5 in community-based psychiatric inpatient units and 10 in mental hospitals.

GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



In terms of staffing in mental health facilities, there are 0.09 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.08 psychiatrists per bed in mental hospitals. As for nurses, there are 0.7 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.7 per bed in mental hospitals. There are 0.06 per bed for community-based psychiatric inpatient units, and 0.36 per bed in mental hospitals (Graph 4.3).

GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS

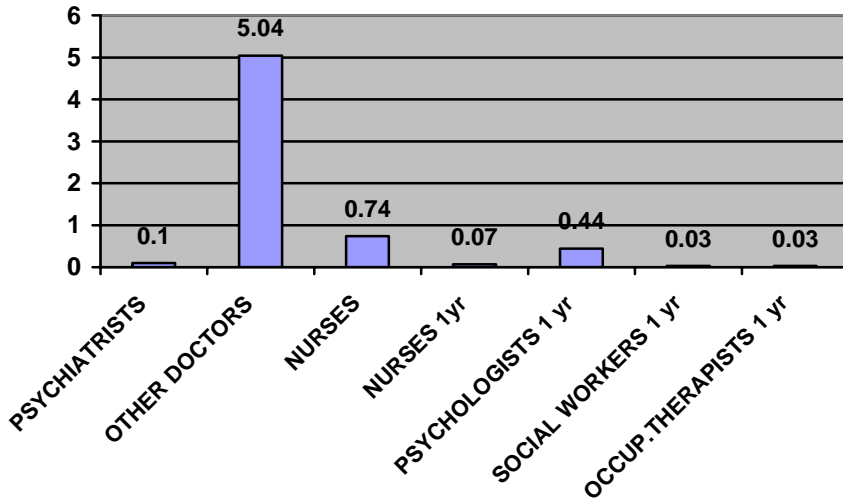


The distribution of human resources between urban and rural areas is relatively disproportionate: The number of psychiatrists per capita is over twice as high in the largest urban area compared to the country as a whole; the number of nurses per capita in or near the largest city is almost twice the rate for the entire country. The national policy has been to fill the gap by training general practitioners in more remote areas, and to train the multipurpose health workers (behvarzes) in rural and health volunteers in urban areas.

Training professionals in mental health

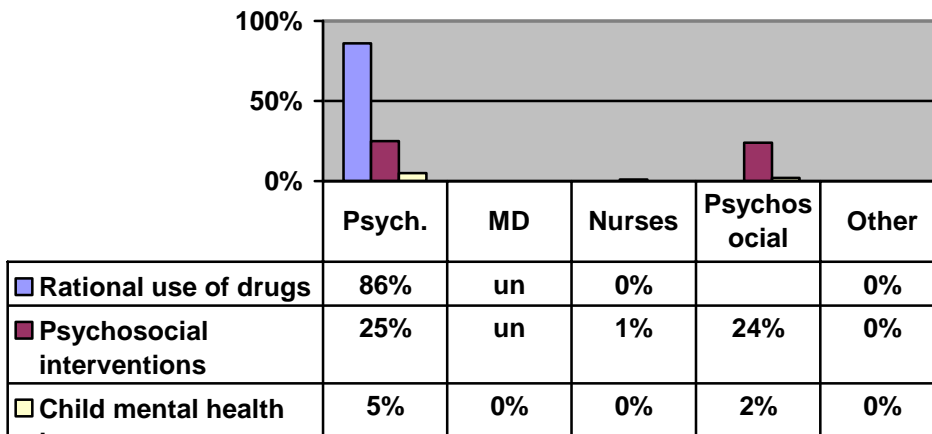
The number of professionals graduated last year in academic and educational institutions is as follows: 68 psychiatrists (0.1 per 100,000), 3,400 other medical doctors (5.04 per 100,000), 500 nurses (0.74 per 100,000), 50 nurses (0.07 per 100,000) with at least 1 year training in mental health care, 300 psychologists (0.44 per 100,000) with at least 1 year training in mental health care, 20 social workers (0.03 per 100,00) with at least 1 year training in mental health care, 20 occupational therapists (0.03 per 100,000) with at least 1 year training in mental health care(Graph 4.4).

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



Only a small number of psychiatrists immigrate to other countries within five years of the completion of their training. Graph 4.5 shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



Psych = psychiatrists; MD = other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers, and occupational therapists. Others = other health and mental health workers

Consumer and family associations

There is one family association of mental disorders in country with 500 family members. The government provides some economic support for family association. Family associations have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. A few of mental health facilities have been interacting with family associations.

Domain 5: Public Education and Links with Other Sectors

Public education and awareness campaigns on mental health

There is a coordinating body to oversee education and public awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations, private trusts and foundations, international agencies have promoted education and public awareness campaigns in the last five years. These campaigns have targeted the following groups: the general population, children, adolescents, women, trauma survivors and other vulnerable or minority groups. In addition, there have been education and public awareness campaigns targeting professional groups including: health care providers, teachers, social services staff, leaders and politicians, and other professional groups linked to the health sector. Since 1985, the last week in October has been designated Mental Health Week and it is celebrated throughout the country. During this week, efforts have been made to increase knowledge and improve the public attitude towards mental health by conducting training sessions, meetings and broadcasting different programmes on national radio, television and other media.

Legislative and financial provisions for persons with mental disorders

The legislative provisions exist concerning the legal obligation for employers to hire a certain percentage of employees, but they are not fully enforced. No legislative provisions exist concerning protection from discrimination (i.e., dismissal, lower wages) solely on account of a severe mental disorder.

Links with other sectors

In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for primary health care/community health, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection, education, welfare, the elderly, and other departments/agencies. In terms of support for child and adolescent health, 11% of primary and secondary schools have either a part-time or full-time mental health professional. Some (21-50%) primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. A few (less than 20%) prisons have at least one prisoner per month in

treatment contact with a mental health professional. As for training, less than 20% of police officers (but no judges and lawyers) have participated in educational activities on mental health in the last five years. In terms of financial support for users, less than 20% of mental health facilities have access to programs outside the mental health facility that provide employment for users with severe mental disorders.

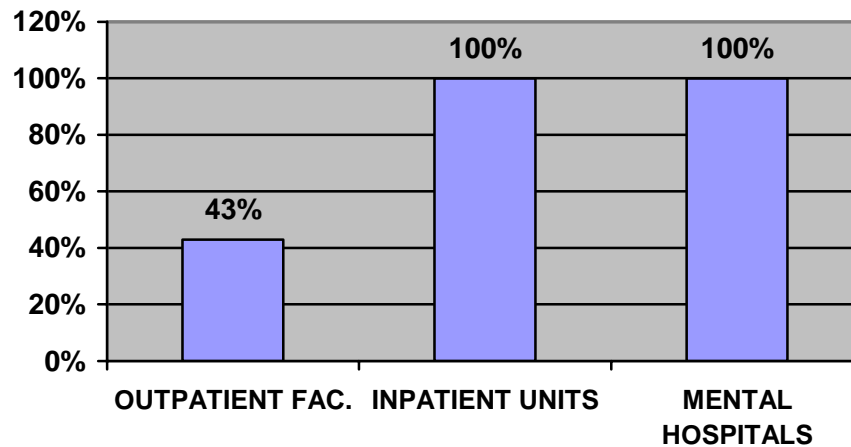
Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. As shown in Table 5.1, the extent of data collection is consistent among mental health facilities. The government health department received data from 43% of mental health outpatient facilities, 100% of community-based psychiatric inpatient units, and 100% of mental hospitals (Graph 6.1). Based on this data, one report was published which included comments on the data.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FACILITIES
N° of beds	100%	100%	-----
N° inpatient admissions/users treated in outpatient facilities.	100%	100%	43%
N° of days spent/user contacts in outpatient facilities.	100%	100%	43%
N° of involuntary admissions	0	0	-----
N° of users restrained	0	0	-----
Diagnoses	100%	100%	43%

GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT



In terms of research, 4% of all health publications in the country were on mental health. The Mental Health Research Department of the National Health Research Department has published scientometric studies on mental health research based on data collected with the assistance of the Mental Health Department. The Mental Health Department reports that the research has only partly focused on epidemiological studies in community samples, epidemiological studies in clinical samples, non-epidemiological clinical/questionnaires assessments of mental disorders, services research, biology and genetics, policy, programs, financing/ economics, psychosocial interventions/psychotherapeutic interventions, and has placed a greater emphasis on basic science and clinical issues. Based on these findings there is now more of an emphasis on community-based mental health research.

Strengths and weaknesses of the mental health system in the Islamic Republic of Iran

Strengths

- Availability of a national programme on mental health and appropriate amendments over time.
- High coverage of the rural population by the mental health system –about 28 million people-according to which the multi-purpose health workers provide both active screening and active follow up of the patients.
- Predominance of outpatient care compared with inpatient care. However this could be regarded as a lack of sufficient inpatient facilities.
- Promoting equity of access for the rural population.

- Availability of essential psychotropic medications in all facilities.
- Availability of an information system that works well in rural areas.
- Involvement of primary care staff with mental health and their interaction with mental health professionals especially in rural areas.
- Availability of a disaster mental health program and capacity building at the national level.

Weaknesses

- Lack of practical mechanisms to protect the human rights of patients (e.g., legislation, review/inspection boards)?
- Although there are efforts to promote equity of access and utilization of mental health services in rural areas, there are problems of service use for the urban poor.
- Only a small proportion of all health resources are spent on mental health.
- Training provided to mental health and primary care staff is not enough.
- Consumers' associations are needed in the country.
- The high number of chronic patients do not receive enough attention

The integration of mental health within the primary health network has provided a good opportunity for further developments in mental health in the country. In recent years steps have been taken to improve the conditions in terms of access and service utilization in urban areas. Coverage in urban areas through the involvement of health volunteers has increased to more than double. Home visits programs have been initiated in 6 university catchments areas and the NGO of families of patients with schizophrenia. A check list has been prepared to monitor the quality of service and rights of the patients in inpatient settings. A new mental health act has been drafted and there is some hope that it will go to the parliament in 2007. Advocacy for increasing the mental health budget last year resulted in a ten fold increase of the Mental Health Department budget in the MOH. Mental health promotion and prevention has been on the agenda and national level capacity building for life skills training and parenting skills training has been accomplished. The national mental health program includes capacity building and contingency management for all parts of the country even remote provinces.

The next steps to be taken are ratifying the mental health act, ratifying the new national “comprehensive policy on mental health “, increasing the mental health budget, improving the quality of services for the inpatients and providing a monitoring system for national mental health programs.

DISSEMINATION

This report needs to be translated into Persian and disseminated to the following departments and sectors:

Bureau for Accreditation and Auditing of Treatment
Continued Medical Education Office
Headquarters for Development of Health Network
Headquarters for Supporting Chronic Mentally Ill
National Management and Planning Organization
Undersecretary for Education, Ministry of Health
Undersecretary for Logistics, Ministry of Health
Association for Supporting Neuropsychiatry Patients
Association for Supporting Schizophrenia Patients
Iranian Clinical Psychology Association
Tehran Institute of Psychiatry
Iranian Occupational Therapy Association
Iranian Psychiatric Association
Iranian Social Workers Association

Planning workshop

Participants from the above mentioned sectors should be invited by the Mental Health Department of the Ministry of Health to review the results of the WHO-AIMS and to agree on a plan of action to improve the mental health system. The workshop may be organized for 2006, after the new Iranian fiscal year has come into effect.

Ideas for planning

Conducting a workshop on improving the urban mental health system and inpatient services with support of WHO is suggested. A short-term action could be to provide the Mental Health Office with technical support during the coming 6 months through sending guidelines and checklists and a medium-term action could be to launch pilot projects on the same during the coming 2 years.

Iran is a large country with a population of 67.478 millions, 66% live in urban and 34% in rural areas. A mental health policy and programme was initially formulated in 1986 and last revised in 2004. The main strategy has been to integrate the mental health program within the primary health care system. The 15 years expansion of the integration of mental health within PHC has resulted in immense improvements in the provision of mental health services in rural areas.

Overall 3% of health care expenditures by the government health department are directed towards mental health. Of all the expenditures spent on mental health, 18% are directed towards mental hospitals. A draft for mental health legislation has been prepared and will be submitted to the parliament in 2007. There are 33 mental hospitals available in the country for a total of 7.9 beds per 100,000 populations. The average number of days patients spent in mental hospitals is 20.7. The rates for human resources working in mental health facilities or private practice per 100,000 populations is as follows: 1.2 psychiatrists, 10.7 doctors, 2 psychologists, 7.8 nurses, 0.6 social workers, 0.5 occupational therapists and 38.4 other health workers. The total number of psychiatrists working in outpatient and inpatient settings is 800. Most of them work in large cities. There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. In terms of research, 4% of all health publications in the country were on mental health. In recent years steps have been taken to improve access and service utilization in urban areas. Mental health promotion and prevention has been on the agenda. National level capacity building for life skills training and parenting skills training has been accomplished. Coverage in urban areas through involvement of health volunteers has increased more than double. The NGO for families of patients with schizophrenia has initiated Home Visiting Programs in 6 university catchments areas. A disaster preparedness plan for mental health is present. The last revision of this program occurred in 2004, after its implementation following the Bam earthquake. Based on the results of this project, MH office is going to revise the national mental health programs in the country.