Urban Mental Health in Iran: Challenges and Future Directions

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In a period of less than five decades, the urban residence has dramatically increased in Iran. Currently more than two thirds of the population live in city dwellings. This rapid urbanization has considerable impact on people's mental health and psychiatric care. The main strategy of Iran's National Program of Mental Health has been the integration of mental health into the primary health care (PHC) system. Since 1986, expansion of the integration has resulted in great improvements in the provision of mental health services in rural areas but there is some evidence showing that the integration did not reach its objectives in urban areas where most of the country's population reside. Recently, some initiatives have been made to face the challenge, for example, home care, aftercare services, and community mental health centers. In any future revision of the national program, mental health care in urban areas should take priority and rethinking the strategies to achieve the goals is necessary.

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Introduction

Urbanization is probably the world's single most important demographic shift over the past century (1). In the early nineteenth century a mere 5% of the world's population was urban; nowadays, half of the world's population live in urban areas and about 70 percent will be city dwellers by 2050 (2). This massive growth, often chaotic and unregulated, is particularly evident in developing countries, such as Iran.

In a period of less than five decades, the proportion of urban residence in Iran has increased from 33% in 1960 to over 68% in 2007 (3). As cities try to adjust to this immense growth, several environmental, socio-economic, and infrastructural problems are having a serious impact on health and mental health of their dwellers. The service delivery of our National Mental Health Program, started since 1986, is mainly focused in rural areas. At the present time, mental health programs need a shift in attention towards urban areas. In this paper, I briefly review the effects of urbanization on mental health. In this context, I discuss the current situation of mental health care delivery in urban areas and some recent initiatives. In conclusion, I make some suggestions for any development in the service delivery in our urban areas.

Urbanicity and mental health

The effect of urbanization on mental health is complex. People experience, the consequences of increased stressors, and adverse events such as overcrowding, pollution, poverty, slums, rising levels of violence, changes in social structure, inequality, poor social support, etc. (4). Special problems like increasing suicide rates, alcohol and drug abuse are challenges to mental health professionals in the urban area (5). There are conflicting reports of increased rates of mental disorders in urban compared with rural areas across the globe (6,7). Among consistent and robust evidence are the research showing that urban birth or upbringing increases schizophrenia risk (8,9). It is not clear, what accounts for this urban-rural difference. Hypotheses include: among others, infections, diet, toxic exposures, social class, and immigration (8).

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A national study in Iran found the prevalence of mental disorders higher in urban areas (10). However, another national study (11) and a systematic review on prevalence of mental disorders in Iran (12) failed to find differences in rate of mental illnesses between residents of rural and urban places. Some authors [for example, (13)] have warned of increasing trend of mental disorders in urban areas. Moreover, in a community study of a densely populated area in Tehran it was evident that economic and social stressors are highly prevalent and distressful (14).

Recognizing the need to enhance its understanding of the relationship between urban living and mental health, the World Psychiatric Association has established the Scientific Section on Urban Mental Health. In addition, World Health Organization has launched the Healthy City Project strategy, that advocates intersectoral approach to health development that focuses on the environmental, social and economic determinants of health and aims to put health issues into urban agenda and mental health is on its top priorities (15,16).

Taken together, urbanization may affect mental health of the people in variety of ways that is not yet clear. Whatever the consequences of urbanicity on mental health, it is obvious that the delivery of mental health services in cities poses intricate problems due to the variety of environmental, psychosocial, cultural and economic issues involved.

Mental health services in urban areas in Iran

Integration of mental health into the primary health care (PHC) system has been the main strategy of Iran's National Program of Mental Health. Since 1986, expansion of the integration has resulted in major improvements in the provision of mental health services (17,18). The aim was to establish a hierarchical, pyramid-like referral system. At the base of the pyramid there are health workers (health volunteers in cities) who are mainly local residents of each primary healthcare area; they are trained to recognise, refer and follow psychiatric cases to the higher level (19) and to educate people in mental health issues. The program was reported to be a very successful endeavour in rural areas, but the achievement was much less in urban areas where most of the countries population reside (20). There is some evidence showing that the integration did not reach its objectives in urban areas. For example, it was shown that case detection is very poor (21). In addition, urban coverage by the program is much less in urban compared with rural areas (21.7% and 82.8%, respectively in 2004) (19).

Some factors have resulted in unfavorable impact of integration of mental health into PHC in cities (20). The most important of which seems to be weakness of PHC in cities (20). Urban residents usually do not seek health care from public primary care professionals. Other factors include limited budget allocation, ever-increasing population especially in suburbs, resistance from traditional hospital-based attitude, barriers in access to care, inadequate community participation, and preference of specialized and tertiary services by the people [see also (22)] Despite the fact that the majority of mental health professionals, including all psychiatrists currently live in cities, service delivery is very poor and disorganized where public and private sectors provide care in an uncoordinated manner and services are manly hospital- and office-based. In addition, with a very few exceptions, community-based programs for patients with severe mental illnesses are nonexistent, and service disengagement and the revolving door phenomenon of discharges, and readmissions is incredibly frequent. The situation should be analyzed in a context where psychiatric beds are almost 100% occupied. The shortage in psychiatric beds is great and insufficient provision of community based services has increased the magnitude of the problem.

Recent initiatives

There is an increasing need to address the mental health problems in urban settings, considering the fact that the integration into PHC in cities is less than satisfactory. A suggestion has been to develop alternate pilot projects in cities and if successful to expand their implementation (23). Since 2004, supported by the Mental Health Office at the Ministry of

Health, home aftercare services were developed in several centers across the country to deliver a community-based service to the patients with severe mental illnesses (24,25). The service uses a multidisciplinary approach to care for patients with severe mental illnesses. The goals of the service are prevention of relapse and rehospitalization, decreasing medication adverse effects, increasing treatment compliance, improving quality of life, and increasing patient and family satisfaction of the services. Studies on the service in several countries have indicated that it is more conducive to the maintenance of better health and functioning in patients and it is more economical (26-29). A recent randomized trial of the service in Tehran has shown its effectiveness in reduction of rehospitalisation and improved functioning (30).

Recently, a community-based protocol was developed and approved by the Mental Health Office to provide outpatient services to patients with severe mental disorders (31). In this package, services such as home care, telephone follow-up, family education, and rehabilitation and crisis services have been proposed. Now, three centers in Tehran and Isfahan have started its implementation and investigation of its effectiveness.

An alternative to the integration into PHC is the establishment of Community Mental Health Centers (CMHCs). The main characteristic of the centers is the introduction of comprehensive services for prevention of mental illnesses and also diagnosis, treatment and rehabilitation of the patients, without reliance on large psychiatric hospitals. There are successful examples of CMHCs in the United States and Italy. These centers are not necessarily an integral part of the general health and could deliver their services to the people residing in a catchment area within cities. The initial aim was to replace hospitals with CMHCs (32).

In Iran, some efforts were undertaken to establish CMHCs in Isfahan and Shiraz. Recently, supported by the Mental Health Office at the Ministry of Health, a community mental health center was designed to provide services in a catchment area in Tehran (33). The service planning was based on the current evidence and experience. In addition to community-based care for severe mental disorders, a protocol was designed to improve early recognition and management of mental disorders in primary care, whether in public or private sectors.

Another improvement has been the establishment of psychiatric wards and outpatient clinics in general hospitals. These services are provided by specialist mental health professionals such as psychiatrists and psychologists. Clearly, such services require adequate numbers of trained specialist staff and adequate training facilities for them. Despite the regulation to allocate up to 10% of the general hospital beds to psychiatric beds, the expansion is still facing resistance from other medical disciplines and partly because of that, their ability to provide care to patients with severe mental disorders is limited. Among factors influencing the resistance, we could point out the financial problems of running a psychiatric ward and the stigma of mental illness.

Other forms of community mental health services exist but do not work in an organized system of care. There are a few day centers, community-based rehabilitation services, residential services, and community-based services for special populations such as trauma victims, children, and adolescents that are run by public and private sectors. These services require some staff with a high level of skills and training, although many functions can be delivered by general health workers with some training in mental health (34).

Challenges and future directions

In any future revision of the national program, mental health care in urban areas should take a priority and rethinking the strategies to achieve the goals is necessary. Although attempts have been made to strengthen the integration in PHC, but it is reasonable to expect that the desired outcome will not be achieved until the PHC itself improves in urban areas (23), and the prospect for the latter is not bright in our country. In addition, the newly developed system of "family physicians" may take precedence in the country and its relationship with the existing system of PHC

and mental health care delivery is not yet clear. Integration of mental health into PHC seems to be an ideal (35), however, reaching its objectives in urban areas may be far from reality. As Yasamy has pointed out, "still more evidence is needed to be generated and systematically reviewed on how integration can be implemented in the most cost-effective way." Until strong primary care systems are in place, community-based interventions should be considered as possible alternatives" (23).

Funding mental health care has always been a challenge. Community mental health services of good quality, providing a wide range of services to meet diverse clinical needs, are demanding in terms of cost and personnel and reductions in costs relative to those of mental hospitals are likely to take many years to materialize (34). However, scant resources should be gradually diverted to the community-base services which are cost-effective and have reasonably good outcomes and benefit increased proportions of populations.

Another problem is the absence of a single authority for mental health policy making and strategic planning. Ministry of Health, Welfare Society, National Youth Organization and other public sectors have their own budget, planning and service delivery systems and there is a diffusion of responsibility with poor intersectoral collaboration. Health care could be delivered by different sectors; however, their services should be supervised by the Ministry of Health. Even public and academic mental hospitals do not desire and may not be able to take responsibility for the care in the community and psychiatric academia is not interested in planning and investigating mental health service delivery systems. Unfortunately, we have recently witnessed a decline in mental health services research (36). Attempts to overcome these challenges are yet to be successful.

Often the biggest challenge in beginning a process of reform is that it is difficult to imagine how the mental health system could possibly be different (37). Based on the evidence coming from pilot projects in recent years a system of urban care should be organized in which mental health care in all three levels of prevention are taken into account. Community-based services should be highlighted and a balanced care through of outpatient and inpatient services should be provided (38). A way forward is the establishment of CMHCs to deliver care to defined catchment areas in cities. These centers may not be a part of main public health system and could be run by private sector under supervision by the Ministry of Health. Private sector is quite powerful in our country and has a significant share of health care and mental health is not an exception. Strategies for involvement of private sector and encouraging their participation in programs should be taken into account.

A single model of care might not be possible and the exact form of service organization and delivery ultimately depends on a country's social, cultural, political, and economic context (34). Especially in large cities we could expect that mental health service delivery would be much more heterogeneous and this should be accepted. However, we need an urban mental health program that follows its defined goals through directing, coordinating and giving differential momentum to these diverse activities (20). Research findings and the experience in our country may point towards some of the key ingredients of successful service delivery models to implement it in our urban areas. And finally we should acknowledge that robust service changes take time to ensure that improvements will happen and last. Therefore any wait and see strategy is not justified and the process of change should be started right now.

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