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The dynamics of mental health policy in Iran over the last century

Hashem Rastegar¹, Esmaeil Khedmati Morasae² and Leila Doshmangir^{3,4*}

Abstract

Background Mental disorders represent a significant global health concern, accounting for a substantial proportion of disabilities worldwide. Given its significance, it has consistently been a priority for health policy makers. The aim was to provide a comprehensive assessment of mental disorder-related policy events and related interventions in Iran.

Methods A content analysis of the literature and published and unpublished official documents and local media as well as a comprehensive network analysis of the text taken from the main databases of laws and regulations and the official websites of ministries and institutions related to mental health in Iran from 1907 to 2024 were carried out. A co-occurrence network analysis and degree centrality measures were performed on the collected corpus.

Results A total of 196 documents were identified. Following the removal of duplicate documents and content irrelevant to the topic of mental disorders, 131 documents were extracted. A substantial number of documents pertained to the years 1930–1978, which were concerned primarily with the admission and dispatch of patients to the mental health clinic and psychiatric hospitals and the financial aspects of the care and treatment of patients with mental disorders by the trustee organizations. Following the 1979 revolution, the focus shifted to the expansion of social and insurance support for these patients and their families.

Conclusions The advancements related to severe mental disorders in Iran highlight the critical importance of public interventions in this field. Nevertheless, over the past century, no discernible pattern or coherence has been identified in this area between responsible agencies and ministries. Future policies related to mental disorders should be based on the principles of increasing community-based care, sustainable financing and economic and social support for mental disorders.

Keywords Health policy, Mental disorders, Health system, Mental health

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Introduction

Mental disorders are among the leading causes of disability worldwide, accounting for 13% of the total global burden of disease (GBD) and 32.4% of years of healthy life lost due to disability (YLD) [1]. Mental disorders lower quality of life, depletes personal and family finances, feeds into the cycle of poverty, and has a potentially devastating impact on the global economy. Between 2010 and 2030, this cost \$16 USD trillion in lost economic output—more than the cost associated with cancer, diabetes, and respiratory diseases combined [2].

Patients with mental disorders are considered vulnerable groups [3]. Social and economic challenges related to mental disorders include stigma and discrimination, violence and abuse, restrictions on civil and political rights, deprivation of full participation in society, reduced access to health and social services and emergency services, lack of educational opportunities, deprivation of income and suitable job opportunities and increased disability and premature death [4].

Severe persistent mental illnesses (SPMIs) are those that are prolonged and recurrent, impair activities of daily living, and require long-term treatment. Common diagnoses include schizophrenia, bipolar disorder, and major depression. Schizophrenia is one of the top 25 leading causes of disability worldwide [5]. Despite its low lifetime prevalence (median of 4.0 per 1,000 persons) and health, social, and economic burdens related to schizophrenia have been tremendous, not only for patients but also for families, other caregivers, and the wider society [6]. The treatment and care of patients with a diagnosis of schizophrenia account for between 1.5% and 3% of the total national health expenses in the most developed countries and 22% of the costs associated with mental disorders [7].

A substantial proportion of individuals with mental disorders are unable to recognize the necessity of treatment and their needs and rights due to a lack of insight [8]. The stigma attached to mental disorders presents a significant barrier to employment, housing, and access to treatment services [9]. A number of issues have been identified with respect to the financing and insurance of mental illness, particularly in the context of chronic conditions such as schizophrenia [10]. Individuals with mental disorders are frequently subjected to abuse and violence by others, yet they may also perpetrate violence or inflict harm upon others [11]. Such spillover effects or externalized costs justify some form of public intervention [12]. For example, the municipal financial responsibility Act in Sweden requires municipalities to pay for the care of mental patients who are still under hospital care after three consecutive months and cannot live independently [13]. Additionally, the mental health/substance abuse parity

laws in the United States prohibit any restrictions on the provision of mental health services [14].

The history of mental health reflects the lengthy process of humanity's comprehension and treatment of mental disorders. From antiquity to the present era, diverse cultures across the globe have devised distinctive methodologies for addressing mental health concerns. Each culture possesses a system of values, beliefs, and practices that inform their understanding of and response to mental illness [15].

Iran, with a population of approximately 87 million, is constituted of 31 provinces, exhibiting a considerable range of socio-economic characteristics [16]. Iran's gross domestic product (GDP) per capita exhibited a 2% annual growth rate from 1950 to 2018, reaching a value of \$6,947. However, this indicator is volatile and influenced by oil revenues [17]. Gross domestic product (GDP) exhibited a 5% year-on-year growth rate from April to December 2023 [18]. Iran has seen significant political changes over the past century, including the establishment of the Pahlavi Dynasty in 1925, the Islamic Revolution in 1979, and the subsequent establishment of the Islamic Republic of Iran. These events have had a profound impact on the socio-economic status and mental health of the nation [19]. As with global trends, mental and behavioural disorders represent a significant cause of disability and years lost to life in Iran [20]. The prevalence of mental disorders has increased from 21% in 1999 to 31.7% in 2015 [21, 22]. In 2019, mental and substance use disorders accounted for 1.9% of total DALYs (disability-adjusted life-year). Depression, anxiety disorders, and bipolar disorders were the mental and behavioural disorders that had the greatest impact on the age-standardized DALY rate [23]. Although the observed increase in the burden of mental disorders in Iran (77%) has been higher than the general increase in the world (55%), it has been lower than the WHO Eastern Mediterranean region countries (114%) [20]. In recent years, a number of significant developments have occurred in the realm of mental health policy. Among these, the promotion of mental health indicators, as outlined in the Fifth Economic, Social and Cultural Development Plan of the Islamic Republic of Iran in 2012 and general health policies in 2014, and the inclusion of mental health and substance abuse prevention in the 2014 Health Transformation Plan stand out as particularly noteworthy [24]. The Ministry of Health is responsible for defining, implementing and monitoring mental health programmes [25]. The State Welfare Organization, the main provider of social services in Iran, targets mental health as well. The organization emphasizes the empowerment of individuals and families and improving mental health in communities. The national mental health organizations, Emdad Relief Organization, Prisons and Corrective Measures

Organization, Ministry of Youth and Sports, Ministry of Education, The Police Force and a variety of NGOs provide similar services [26].

Mental health is one of the important components of health, and writing the history of mental health services emphasizes the experiences of psychiatric patients and the social, cultural, political, medical and institutional context of their treatment [27, 28]. A review of historical documents related to mental health reveals the hitherto hidden aspects of some laws and policies and the possible reasons for their approval, as well as the conditions of that time. In light of the aforementioned background information, Iran represents a valuable case study for the review of documents and the identification of policies, laws, and regulations pertaining to mental disorders. This could potentially enhance the policymaking process within the field of mental health. The results of the analysis offer insight into the distribution and concentration of mental disorders, which can be used as a basis for informed decision-making by policymakers.

Methods

Study design

In this study, we conducted a comprehensive review of the literature and published and unpublished official documents and local media and a comprehensive network analysis of the text derived from laws, policies, and regulations concerning mental health in Iran from 1907 to 2024. The selected time period was determined by the age of the available documents, with the oldest among them in the Laws and Regulations Portal of the Islamic Republic of Iran [29] dating back to 1907. To facilitate a detailed temporal analysis, documents were systematically grouped into decade-long intervals, ensuring that each dataset was sufficiently robust for subsequent analyses.

Data collection

First, with a general review, policy databases related to laws, regulations and documents were identified. The Laws and Regulations Portal of the Islamic Republic of Iran, with more than 154,000 documents related to laws and regulations registered since 1907, was recognized as the main base of laws and regulations. A review was conducted of the titles of the documents accessible via this portal, with particular focus on those pertaining to the field of mental health. Subsequently, the content of the identified documents was subjected to a detailed examination. The documents in question referenced a number of institutions, organisations and ministries that were deemed worthy of further examination. This included the following: Iran-Constitution 1979 [30], Development Programs in Pahlavi era [31], The Economic, Social and Cultural Development Programs of the Islamic Republic

of Iran [32], Islamic Parliament Research Center (IPRC) [33], National Library and Archives of Iran [34], Ministry of Health and Medical Education [35], Ministry of Cooperatives, Labour, and Social Welfare [36], Planning and Budget Organization [37], Government of The Islamic Republic of Iran [38] and State Welfare Organization of Iran [39]. In addition, other institutions referenced in the aforementioned databases were also included in the study. The keywords we used included “mental health”, “mental disorders”, “mental patients”, “health insurance” and “mental disorders financial protection”. The data collection period spanned from January 1907, the earliest available document, to April 2023, the time of data collection. Moreover, an examination was conducted of pertinent documents pertaining to the subjects of “health insurance” and “financial protection” within the context of insurance coverage policies for all individuals, with a specific emphasis placed on patients and disabled individuals, utilising the search engine Google. To filter the documents related to mental health patients, the titles of the documents were checked, and if they were related, the contents of the documents were checked, and then duplicate documents were removed. These steps were carried out separately by two of the study’s researchers, and consensus was reached on duplicates and eliminable items. The main steps of our study are explained in Fig. 1.

Statistical analysis

First, the content pertaining to mental disorders in each document was translated into English and placed in a separate word file for each decade. Then, spaCy and NetworkX libraries in Python [see Additional file 1] were used to perform the text network analyses on the corpus. Employing co-occurrence network analysis, we constructed network graphs for each decade’s corpus, enabling us to visualize and quantify the interrelations between various terms and concepts. A key component of our analysis involved the use of degree centrality measures, which quantitatively assess the importance of a node within the network on the basis of the number of connections it has with other nodes. This measure effectively highlights terms that are most frequently associated with others, providing insights into the central themes and topics within each document set [40, 41]. By identifying the most pivotal words and topics through degree centrality, we were able to trace the evolution of mental health policies over the last century, highlighting how key issues and focuses have shifted in response to changing societal, medical, and political contexts. The resulting networks elucidate the dynamic landscape of mental health discourse in Iran, offering a unique longitudinal perspective on the development and transformation of mental health policies. Gephi software was later used on Python outputs to visualize the produced networks.

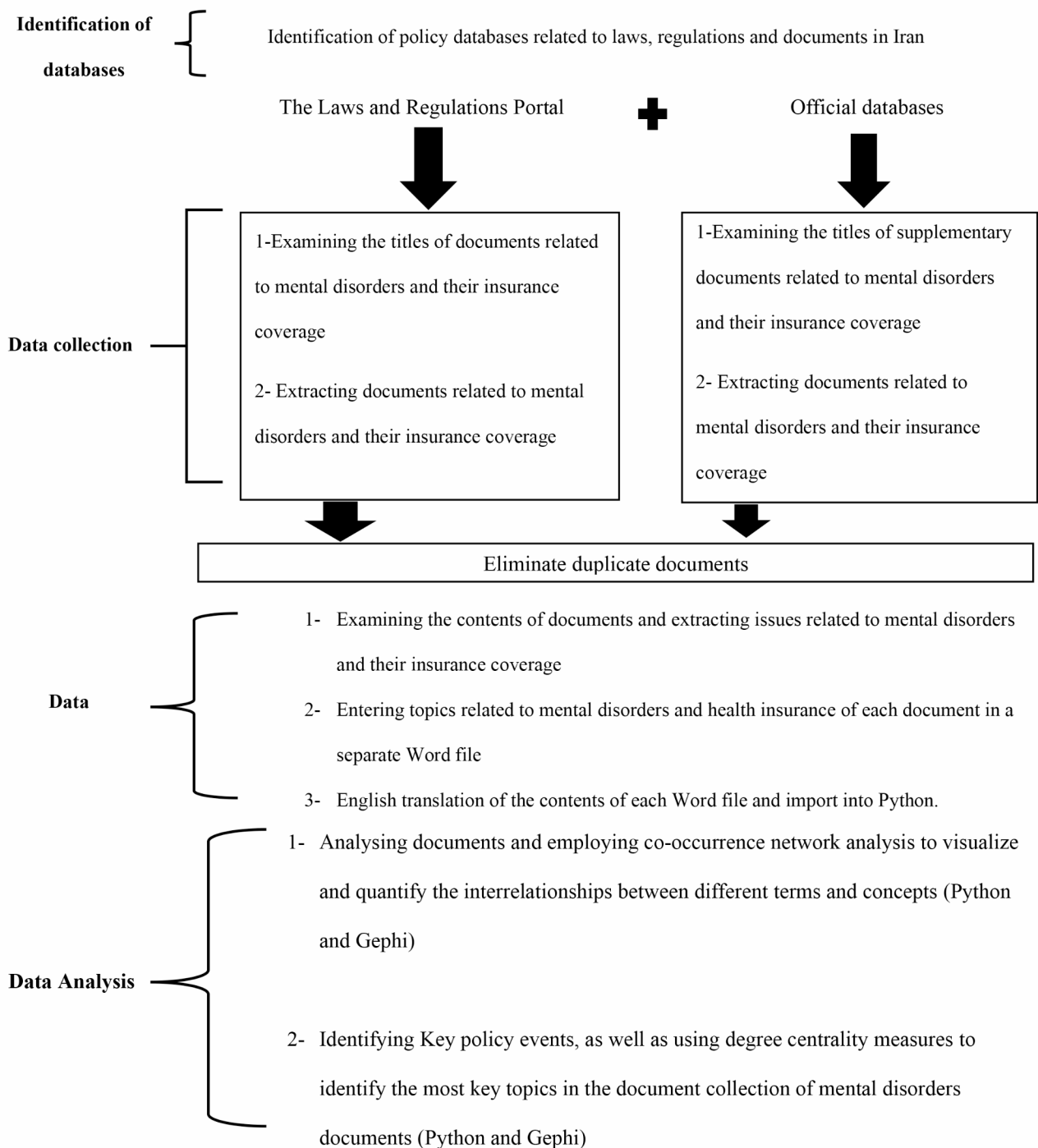


Fig. 1 Study framework

Results

A total of 196 documents were identified (see Table 1). A total of 12 documents were found to lack any content related to mental disorders. These documents include some upstream documents and preliminary versions of standards for hospital accreditation that were missing content regarding mental disorders. After eliminating

duplicate documents, 131 documents were extracted. Ninety documents (69%) were directly related to mental disorders, and 41 documents (31%) indirectly included mental disorders, which were related mainly to insurance coverage.

Table 1 The number and source of extracted documents

Raw	Institution, official websites	Number of documents	Document field
1	The Constitution	1	Articles 3, 29 and 43 of the Constitution
2	Development Programs in Pahlavi era	5	The upstream documents
3	The Economic, Social and Cultural Development Programs of the Islamic Republic of Iran	6	The upstream documents
4	Islamic Parliament Research Center (IPRC)	31	Rules and regulation
5	The Laws and Regulations Portal	38	Rules and regulation
6	National library and Archives of IRAN	72	Historical documents
7	Ministry of Health and Medical Education	2	Rules and regulation
8	Ministry of Cooperatives, Labour, and Social Welfare	5	Rules and regulation
9	Planning and Budget Organization	10	Rules and regulation
10	Government of The Islamic Republic of IRAN	2	Rules and regulation
11	State Welfare Organization of Iran	2	Rules and regulation
12	Medical Affairs Organization	0	Rules and regulation
13	Nursing Organization of Islamic Republic of Iran	0	Rules and regulation
14	Psychology and Counselling Organization Islamic Republic of Iran	0	Rules and regulation
15	Support Association for Schizophrenia Patients	0	Rules and regulation
16	Hospital accreditation standards(First to fifth round) and Google search	19	Rules and regulation
17	Other institutions and official websites	3	Rules and regulation
	Total documents	196	

Policies related to people with severe mental disorders over the first 50 years: the first decade (1920–1929): identifying the presence of traces of patients with mental disorders

The first documents available (which were from unpublished documents) relate to the Prime Minister's and the municipalities' handling of the request for free care for psychiatric patients, the so-called "the insane", in Tehran (capital city of Iran) psychiatric hospital, the so-called "madhouse", in 1927 and 1928 [42]. The transfer of the administration of psychiatric hospital affairs to the municipality in 1924 constituted a pivotal historical event in the context of mental disorders during this decade. Following this transfer, psychiatric hospital affairs were conducted under the guidance and supervision of the Tehran Municipality [43].

The second decade (1930–1939): the initial efforts to address mental disorders

The developments of this decade represent a continuation of those of the preceding decade with respect to the management of affairs at psychiatric hospitals under the supervision of municipalities [34].

The third decade (1940–1949): the establishment of a defined procedure for the treatment and associated costs

In response to a written request from the families of patients with severe mental disorders regarding their inability to pay for their patients, the government authorities initiated correspondence with municipalities to provide free admission and care for patients with severe

mental illness. Municipalities were responsible for the cost of care and treatment of mentally ill patients, which had to be paid to psychiatric hospitals for mentally ill patients. For each day of care and for each number of psychiatric patients, payments were made to the account of the psychiatric hospitals by the municipality concerned [44]. The establishment of the first psychiatric hospital in 1946 and the subsequent expansion of psychiatric facilities in provincial centers represent significant milestones in psychiatric care during this period [45].

Fourth decade (1950–1959): establishing legal procedures

The designation of a legal guardian to safeguard the interests of mentally ill patients who are unable to make their own decisions represents one of the most significant developments in this field over this decade. The role of the guardian is to oversee the patient's current affairs and to take measures to prevent any adverse consequences in the future [46]. In the current decade, regulations have been approved that stipulate that the financial burden associated with the care and treatment of patients with severe mental illnesses should be borne by the municipality of their residence [47].

The fifth decade (1960–1969): approval of national laws and regulations on mental disorders

The process of the financial responsibility of the municipality for the care of individuals with severe mental patients, in formal law, as outlined in Article 42 of the Law of Municipalities, continued throughout this decade. In this context, there was correspondence between

municipalities, governorates and psychiatric hospitals regarding the financing of care for severe mental health patients and the importance of providing it despite the municipalities' budget problems. The decade also saw discussions regarding the handover of management of psychiatric hospitals to the Ministry of Labour and Social Affairs and the introduction of a new directive (approved in 1969) outlining the allocation of costs for the care of mental patients between the health associations of cities and municipalities. The health associations of the cities were approved in 1958, and all the funds related to the health affairs of the cities were used with the approval and supervision of the said association [48].

The sixth decade (1970–1979): the transfer of responsibility for patients with mental disorders to psychiatric hospitals

One of the most notable developments of this decade has been the impact of the municipal budget deficit and the associated costs of caring for mental patients on the provision of services in psychiatric hospitals. During this period, the health associations were responsible for covering the cost of the first two months of hospitalization and care, whereas municipalities were responsible for covering costs exceeding this period. Irregular and late payments for the care of psychiatric patients by the municipalities due to frequent budget deficits and the lack of proper coordination to send psychiatric patients to psychiatric hospital in Tehran and other important cities were among the common problems in this period. In response to these challenges, there have been significant changes in the way these institutions are managed. Consequently, the responsibility for psychiatric hospitals and the associated costs of treating mental patients has been transferred to the Ministry of Labour and Social Affairs (established in 1962). This transfer was ultimately completed in 1974 [49].

Policies related to people with severe mental disorders over the second 50 years

Seventh decade (1980–1989): a new approach to mental disorders

Over the course of this decade, the constitution placed an emphasis on the right to access healthcare funded by public revenues and revenues generated by public participation. After the 1979 revolution, the measures taken in the field of health were based on principles 3, 29 and 43 of the Constitution. These principles emphasize the satisfaction of basic health and treatment needs, the enjoyment of social security benefits, the creation of welfare, the elimination of all forms of health deprivation, and the extension of insurance [30]. The state welfare organization of Iran was established in 1980, and one of its principal objectives was to provide support and rehabilitation

services for individuals afflicted with chronic mental illness (which were from law) [39]. Remuneration was also given to the activities of mental patients in production workshops under the supervision of the State Welfare Organization [29, 33, 34].

Eighth decade (1990–1999): expanding insurance coverage for mental disorders

The expansion of social insurance benefits vulnerable populations (special patients, families with disabled individuals and without guardians), the enactment of a universal health insurance law, and the expansion of universal insurance coverage represent some of the most significant developments of this. The Universal Health Insurance Law was one of the most significant pieces of legislation enacted in Iran in 1994, providing coverage for individuals lacking health insurance (which were from law) [29, 32, 33].

The ninth decade (2000–2009): Organizing patients with chronic mental disorders

In this decade, the organization and rehabilitation of patients with chronic mental disorders was included in the Law of the Third Program of Economic, Social and Cultural Development of the Islamic Republic of Iran (approved in 2000) and subsequent programs [32]. The comprehensive legislation protecting the disabled was enacted in May 2004, setting out the minimum amount of subsidies for nongovernmental rehabilitation centres for individuals with chronic mental health conditions [29, 33]. Furthermore, laws have been introduced to offer free insurance for vulnerable populations in the event of hospitalization, establish a comprehensive welfare and social security system, and regulate the welfare safety net [29, 32, 33, 39].

The last decade (2010–2019): comprehensive approach to supporting individuals with mental disorders

During this decade, the organization and rehabilitation of patients with chronic mental disorders were pursued [32]. The enactment of the subsidy-targeting legislation led to an expansion in health insurance coverage and an increase in the utilization of services [29, 33, 39]. At the macro level, the Law on the Protection of the Rights of the Disabled, which was enacted in March 2018, was replaced by the Comprehensive Law on the Protection of the Disabled. In accordance with this legislation, the amount of subsidies allocated to nongovernmental institutions for the care of patients with severe mental disorders or the families of these patients for their care is determined and publicly announced on an annual basis. The State Welfare Organization is responsible for paying these subsidies to the families of patients in the case of taking care of them or to nonprofit institutions taking

care of severe mental patients [29]. Furthermore, mental health issues were incorporated into general health policies [29, 33]. In addition, the executive regulations pertaining to the care and treatment of individuals with mental illness, as well as the instructions for the financial protection program for patients with incurable, special and needy conditions, were also approved during this same decade [29, 35].

The period between 2020 and 2023: the provision of financial protection through insurance

In September 2022, a new support measure was introduced in the form of a special fund for individuals with severe mental illness and other special and incurable diseases. This fund has been implemented by health insurance and social security organizations, and individuals with basic insurance and those with special and incurable medical conditions are eligible to receive benefits. To

financially protect chronic mental patients, as one of the main beneficiaries of this fund, fundamental steps were taken. These patients were exempted from paying the deductible during hospitalization in a psychiatric hospital [29]. Additionally, the national accreditation standards for Iranian hospitals incorporated considerations related to financial assistance. To further enhance support, the Iran Ministry of Health and Medical Education approved instructions for economic assistance for patients in medical centers and supporting individuals with special, rare, and incurable diseases [35].

The specifics of developments pertaining to policies concerning patients with severe mental illness are outlined in Table 2.

Table 2 Chronological view of the key policies on mental disorders in Iran

Decade	Polices
1920–1939	<ul style="list-style-type: none"> • The transfer of the administration of the madhouse affairs to the municipality in 1924 • Follow-up of the admission and treatment of severe mental patients in Tehran(Capital city of Iran) madhouse by state and local government officials
1940–1949	<ul style="list-style-type: none"> • Demand for free care of severe mental patients by government authorities • The establishment of the first psychiatric hospital in 1946 • The expansion of psychiatric hospitals
1950–1959	<ul style="list-style-type: none"> • Appointment of a guardian for severe mental patients • caring and dispatching severe mental patients, financed by the municipalities where the patients live
1960–1969	<ul style="list-style-type: none"> • Payment of care costs for severe mental patients by the municipality according to Article 42 of the Law on Municipalities. • Municipalities' correspondence with relevant organizations concerning care of severe mental patients • The transfer of the administration of mental hospitals from the Ministry of Health to the Ministry of Labour and Social Affairs in 1969. • The new directive and sharing the cost of caring the mental patients between the Health Association and the Municipality, 1969
1970–1979	<ul style="list-style-type: none"> • Problems related to municipal budget deficits and paying for caring the mental patients. • Providing credits related to the cost of caring mental patients and developing mental illness treatment services. • The complete transfer of psychiatric hospitals and the cost of treating the mentally ill to the Ministry of Labour and Social Affairs since 1974.
1980–1989	<ul style="list-style-type: none"> • The Constitution guarantees individuals the right to access healthcare services and insurance. • The remuneration of mental patients in rehabilitation workshops to meet their needs. • The bill to establish State Welfare Organization of Iran
1990–1999	<ul style="list-style-type: none"> • The extension of social insurance benefits to vulnerable populations. • Public health insurance law (1994/10/25) and expansion of public insurance.
2000–2009	<ul style="list-style-type: none"> • The organization and rehabilitation of patients with chronic mental disorders. • The comprehensive law for the protection of the disabled. • Determining the minimum amount of subsidies to nongovernmental rehabilitation centers for chronic mental patients. • Free insurance for vulnerable groups in case of hospitalization. • The Law on the Structure of the Comprehensive Welfare and Social Security System • Regulation of social welfare safety umbrella
2010–2019	<ul style="list-style-type: none"> • Law targeting subsidies to increase health insurance coverage • National Accreditation Standards of Iranian Hospitals, 4th edition • Continuation of the organization and rehabilitation of patients with chronic mental disorders. • The Law for the Protection of the Rights of the Disabled replaces the comprehensive law for the protection of the disabled. • General health policies • Executive regulations on how to keep and treat insane people • Instructions for the financial protection program for incurable, special and needy patients
2020–2024	<ul style="list-style-type: none"> • The special and incurable diseases fund • National Accreditation Standards of Iranian Hospitals, 5th edition • Instructions for economic support for needy patients in medical centers • Instructions for supporting special, rare and incurable patients

Comprehensive network analysis of policy documents concerning mental health care

Figures 2 and 3 illustrate the historical evolution of policies pertaining to individuals with severe mental disorders over the past century. This analysis employs comprehensive network analysis. Figure 2 illustrates the developments that occurred over the initial 50-year period. In the period between 1920 and 1939, the majority of documents pertaining to the care of individuals with severe mental illness were housed within psychiatric hospital, the so-called “madhouse” (Darul-Majanin in Persian) as described by unpublished documents, of Tehran. In the period between 1940 and 1949, the majority of the documents pertained to requests for free care and treatment of mental patients in psychiatric hospitals that were overseen by the municipality. The documents show that between 1950 and 1969, the trend of the last decade continued. The period between 1970 and 1979 saw a widening of the organizations and institutions involved in issues related to the payment of care and treatment of patients with severe mental illness. Figure 3 illustrates the developments that occurred over the second 50-year period. The period between 1980 and 1989 included developments related to mental patients at the beginning of the 1979 revolution, according to the principles of the constitution. The period between 1990 and 1999 saw significant developments in the provision of health and social insurance for patients with mental illness. Social and health insurance for patients, the provision of services and support by the law and the government were the outstanding features of the period from 2000 to 2009. In the period between 2010 and 2019, the provision of support programs offering services to patients through organizations and government bodies, which were covered by health insurance and social security insurance, underwent significant expansion. Finally, instructions for the provision of medical services and support programs for patients between 2020 and 2023 have been approved.

Discussion

One hundred years have elapsed since the inception of facilities intended for the long-term care of patients afflicted with severe mental illness. A content analysis of the documents revealed a series of notable alterations in the policies governing patients with these conditions over the course of this century. This is while the hospitals and psychiatric wards in large cities, including Baghdad, Cairo, and Damascus, are of an older construction. In the 18th and 19th centuries, with the advent of modern medicine, psychiatric hospitals were established in the Middle East based on European models [50]. The provision of mental health services in Iran following the 1979 revolution, like that in other Middle Eastern countries, is situated within the public health system. This system tends to

prioritise the delivery of psychiatric services, which may consequently be subjected to neglect or underfunding [51]. In recent years, there have been concerted attempts to enhance the allocation of resources for mental health by incorporating mental health considerations into overarching health policies and social, economic, and cultural development programmes. The facilitation and expansion of insurance coverage has resulted in enhanced accessibility to mental health services in Iran, while patients with diagnosed mental health disorders will have access to government hospitals, university hospitals, and primary care centres if their condition is covered by the social health insurance scheme in Turkey. Nevertheless, the Turkish social security system's provision of chronic disease reporting, which offers discounts on medication costs and regular monthly financial support to families with mental disabilities [52], bears resemblance to the financial support programmes for patients with incurable, special, and needy conditions that have been implemented in Iran in recent years.

The developments related to mental health care in Iran illustrate the significance of public interventions with regard to the external effects of mental disorders. These effects include victimisation, abuse and violence by others, violence or harm to others, lower insurance coverage, reduced demand for mental health services and stigma [12]. The responsibility of municipalities in financing the care of severe mental patients represents an example of public intervention in the first half of the 20th century. Similarly, the 1995 mental health care reforms in Sweden demonstrated that the financial responsibilities associated with the care of patients who are hospitalized for prolonged periods in psychiatric facilities and are unable to live independently are incumbent in municipalities [13]. Similarly, we may cite the proposal of a comprehensive insurance system for severe mental disorders by the American National Social Welfare Conference in 1975 [53]. In recent decades, policy interventions in the United States have evolved in accordance with the enactment of parity laws, and it is evident that discrimination against mental disorders and physical illnesses is being eliminated [54–57]. Furthermore, the incorporation of mental health into national health insurance reforms in Ethiopia, India, Nepal, Nigeria, South Africa and Uganda represents another instance of public intervention [58–60]. In line with the policies of other countries, the evolution of policies related to mental health care in Iran in the last century highlights the importance of mental disorders in macro-level policies, and certain institutions have been responsible for each stage of the historical transition (Figs. 2 and 3). With the inclusion of severe mental disorders in upstream policies and intersectoral support, this process has evolved (Table 2). The integration of mental health services into primary care in Iran in 1988 was

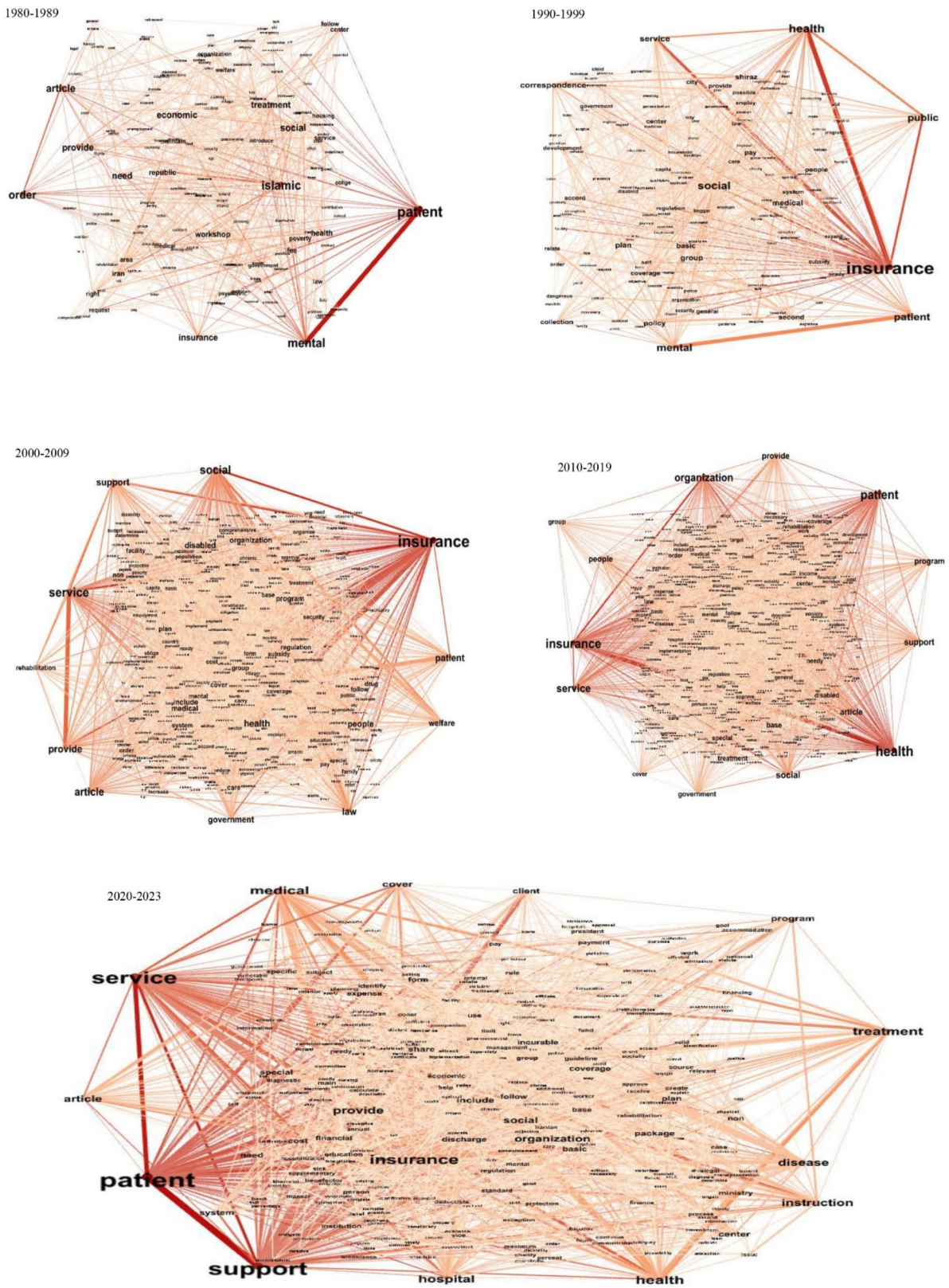


Fig. 3 Policies related to people with severe mental disorders during the second 50 years

designed to enhance mental health literacy and combat social stigma. The presence of a robust human resource, in the form of the Behvarzes, has contributed to notable success in rural areas [61]. Nevertheless, more measures are needed in the field of mental health care in Iran. It is crucial to ensure that individuals with mental health problems have access to appropriate care and support to increase their quality of life. The provision of mental health services, encompassing medical, psychological and social support, has been demonstrated to enhance health-related outcomes, including treatment adherence, remission, quality of life, and personal and social functioning. Furthermore, it has been shown to facilitate social outcomes, such as reduced social stigma, increased housing stability, vocational rehabilitation and community participation [62–67]. The enactment of legislation that safeguards the rights of vulnerable citizens is an indicator of a society that demonstrates respect and care for its people. The implementation of policies and plans that are aligned with internationally accepted human rights standards and best practices can serve as an effective instrument for facilitating access to mental healthcare and for advancing the rights of individuals with mental health conditions [12]. It is thus imperative that these cases be given due consideration by policymakers and health planners.

Study strengths, limitations and policy impact

The primary strength of our study lies in its status as the first to analyze mental health care policies in Iran over the past century using comprehensive network analysis. Additionally, the integration of content analysis with a detailed network analysis of documents enhanced the depth and richness of our findings. However, a limitation of this study is its reliance solely on existing documents. These documents were reviewed based on their availability on the National Portal of Laws and Regulations, as well as references to them in other institutions and organizations. As a result, it is possible that documents from earlier periods, particularly from the first few decades of the 20th century, were unavailable and thus excluded from the analysis. Furthermore, the study's limited focus on the significance of mental health in health policy-making and its role in public policy-making may serve as a valuable reference point for future research in this field.

Conclusion

The present study provides valuable insights into the process of policy change related to mental disorders in Iran, which may prove useful for policymakers and mental health researchers. One of the key findings of our study is that, by the end of the century, significantly more attention was given to social issues and insurance coverage for individuals with mental disorders compared to the

early decades of the century. In the initial decades, the responsibility for caring for patients with severe mental health conditions fell on municipalities. However, by the end of the century, this responsibility had become integrated into the structure of the health system, and mental health services are now part of Iran's primary health care system.

Our findings also reveal that mental disorders have consistently been a concern for government officials. However, there has been no clear pattern or coherence in addressing this issue. Future policies related to mental disorders should prioritize increasing community-based care, reducing reliance on hospitalization in psychiatric hospitals, and implementing sustainable financing mechanisms alongside economic and social support for individuals with mental disorders.

Abbreviations

GBD	global burden of disease
YLD	life lost due to disability
USD	United States Dollar
SPMI	Severe persistent mental illnesses
IPRC	Islamic Parliament Research Center

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s40359-025-02384-x>.

Supplementary Material 1

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Author contributions

LD&HR conceived the study, participated in data collection and data analysis, as well as preparation of the manuscript. EkhM participated in data analysis, writing and editing of the manuscript. All authors read and approved the final manuscript.

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Data availability

All data are available upon reasonable request from the corresponding author.

Declarations

Ethics approval and consent to participate

Not applicable.

The study received ethical approval from Tabriz University of Medical Sciences (Ethical No: IRTBZMED.REC.1402.305).

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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