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Mental Health Services Integration in Primary Health Care in Iran: A Policy Analysis

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Abstract

Objective: The National Mental Health Services (N-MHSs) in Iran was integrated with Primary Health Care (PHC) in 1988. This study aimeds to analyze the policy of integrating N-MHSs in PHC, focusing on the analysis of the current situation, pathology, and the existing challenge.
Method: This qualitative research was conducted in 2020 using a case study approach. This study used the policy triangle model to analyze the policy. The required data were collected via interviews, literature review, and document analysis. The interviews were conducted with 23 experts, stakeholders across the country who were selected through purposive sampling, and the data were analyzed using the content-analysis method.
Results: The main goals of this policy were to raise mental health literacy among the people and eliminate its stigma in the society, while implementing the referral system for N-MHSs. Twenty weaknesses were extracted in eight areas, including negative views of mental health, weaknesses in human resource training, compensation for the service of psychologists, unfavorable working conditions of the workforce, inappropriate service delivery facilities, lack of meaningful communication between different levels of service delivery, poor inter-sectorial communication, and the challenging nature of mental health care. De-stigmatizing psychological disorders in the society and identifying hidden patients are some of the most significant achievements of this policy.
Conclusion: Despite the successful implementation and significant achievements in integrating N-MHSs in PHC, the results of the present study indicate that there are many challenges in this field that require serious planning and attention from relevant authorities.

Key words: *Integration; Mental Health; Policy Analysis; Primary Health Care*

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The prevalence of mental disorders was estimated to be roughly 25% at all ages and approximately 10% among the adult population. The cause of the significant burden of mental problems is the high prevalence, long-term patient involvement, delay in diagnosis and treatment, and high severity of the disability, resulting in a disability rate of 33% for these disorders. In this regard, mental disorders rank at the top of all diseases and conditions (1, 2). The prevalence of various types of mental illnesses in Iran is 23.6%, which shows that 26.5% of females and 20.8% of males experience at least one psychiatric disorder (3). Studies indicate the rising prevalence of mental disorders in Iran, similar to worldwide trends. Generally, psychiatric disorders rank second after accidents and account for 15% of all illnesses (4, 5). While the prevalence of this group of diseases in the country is increasing, the coverage of mental health services, especially in cities, is insufficient. In 2007, about 97% of the rural residents and 41.4% of the urban residents were covered by the National-Mental Health Services (N-MHSs), while the distribution of human resources, such as psychiatrists and psychiatry nurses, relative to the people covered in large cities is significantly higher than that of other regions of the country (6).

Countries differ in their approaches to improving mental health, and many of them are undergoing changes. Most countries are moving towards community-based services and Primary Health Care (PHC) provision. Each government, considering its condition, goals, and policies, is planning to follow this path (7). Like other countries, many approaches have been developed in Iran to improve mental health status. One of the most important approaches is the Integration of Mental Health in PHC (IMH-PHC), which started in 1988 in collaboration with the countries of the region and with the assistance of the World Health Organization (WHO). The main goal of this project was to prevent mental disorders, detect cases, provide treatment and active follow-up at patients' residences, and promote general education in the community. The dispersion of population settlements in Iran, like many Low and Middle-Income Countries (LMICs), has made it difficult for most areas to access limited mental health facilities. Therefore, much effort has been made to integrate the provision of N-MHSs into the existing PHC (8).

During the last 22 years that this policy has been implemented, several studies have been designed and conducted to assess the achievements and consequences of this policy, such as the studies of Bolhari *et al*. and Tairi *et al*. (8-10). However, the results of these studies show a lack of comprehensive scientific policy analysis that examines all aspects of this policy and provides an appropriate analysis. Furthermore, the health transformation plan in Iran has been implemented by the Ministry of Health and Medical Education (MOHME) that focuses on mental health. Therefore, this study aims to identify and properly introduce the characteristics and nature of each of these measures, analyze and evaluate the performance of programs and activities in this field, and provide valuable documentation for managers and policymakers of the MOHME. Hence, this study intends to investigate the policy of integrating N-MHSs in PHC in Iran by analyzing the current situation, pathology, and the existing challenge.

Materials and Methods

This qualitative inquiry with a case study approach was conducted in 2020 at Tabriz University of Medical Sciences. The policy triangle model, designed by Walt and Gilson in 1944 specifically for health sector policy analysis (11), was used to analyze the policy. In 2008, it was partially modified by Walt *et al*. (12). This model covers four general sections, including content, context, stakeholders/actors, and process (Figure 1).

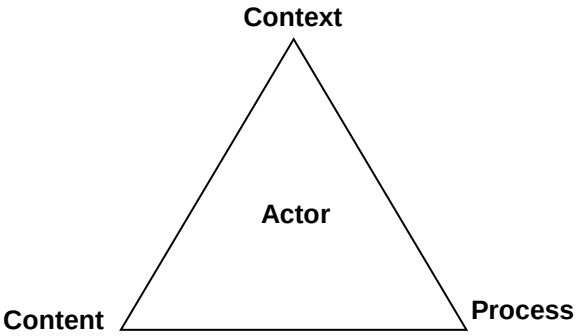

Figure 1. Walt and Gilson Health Policy Triangle Framework

The following information was examined in each component of the policy triangle:

Content: The objectives of IMH-PHC policy in Iran.

Stakeholder: In this part, stakeholders consisting of influential individuals and organizations were identified and then analyzed. The WHO Stakeholder Analysis Guideline (13), which includes process planning, choosing and defining a policy, recognizing main stakeholders, providing the tools, cumulating and recording the information, completing the stakeholder chart, analyzing the stakeholder chart, and applying the report, was used to run this section.

Context: Political, economic, cultural, and other background conditions were investigated in this section. Licher's method was employed to classify the contextual factors, including conditional, structural, cultural, and international elements (14).

Process: This section has various parts, including agenda-setting, policy development, policy implementation, and policy evaluation. In this study, a multiple streams framework, introduced by John Kingdon (1984), was used for agenda-setting. Kingdon

identified three streams in the political system: problems, politics, and political processes (15). The process and designing method of the policy were analyzed in the policy development section. The way of implementing the policy was examined in the implementation part. The achievements of PPP in PHC were reviewed in the evaluation part, both quantitatively and qualitatively. In the qualitative section, experts' opinions were used for evaluation, while quantitative evaluation was performed using statistics and indicators extracted from studies.

The data were collected through reviewing texts and documents using qualitative methods. Initially, the required information was collected by reviewing published studies, reports, and available documents. Databases, websites, search engines, and organizational reports were used to find documents, related articles, and organizational reports pertaining to IMH-PHC in Iran. PubMed, Scopus, web of knowledge databases and their Persian equivalents in Persian databases, including IranDoc, SID, MagIran, were searched using keywords such as integration, mental health, mental illness, PHC, and Iran in order to extract and find articles. Google was also used as a search engine, using different combinations of keywords. Each time a search was performed with a different keyword combination, records found up to 10 pages were examined. There was no time limit on searches. At first, the titles of all documents were reviewed, and items which were not consistent with the aim of the study were excluded. The abstracts and full texts of articles were studied in the following steps, and the studies that were not relevant to the study's objectives were identified and excluded. The results of reviewing texts and documents were merged with the results obtained from interviews with experts and analyzed.

In the next step, interviews were conducted with stakeholders who played an essential role in integrating mental health care into Iran's PHC policy. Totally, 23 experts and stakeholders were interviewed, including officials and senior managers of the MOHME, the vice chancellor for the health of medical universities and their subdivisions, officials and senior managers of the district health networks, experts, and officials from other departments of the health sector. The purpose-based sampling method was used to select participants. The participants were chosen heterogeneously. This sampling method selects participants who provide the most and richest information (16). Inclusion criteria for participants consisted of having at least five years of management or executive experience in the field of providing PHC services, being a faculty member with a background in understudy policy, holding at least a BS degree in health sciences, having enough experience in PHC, and having the willingness and ability to participate in the research.

A few days prior to each interview session, an information sheet was sent to the interviewees, providing an explanation of the purpose of the study, instructions on how to gather information, and a set of interview questions. At the beginning of each session, the interviewer explained the purpose of the session, how the interview would be conducted, and how the information would be used. Participants could leave the study if they were dissatisfied with the process of the interview and applicability of results. The conversations were recorded and transcribed as soon as possible with the informed consent of the participants. In addition, notes were taken during the interviews. At this stage, the interview guide form was used for the interviews. This guide included a few questions, from general to specific inquiries that required open and interpretive answers. Each session lasted between 40 and 90 minutes.

In this study, four criteria proposed by Goba and Lincoln (17) (including credibility and confirmability, dependability, and transferability) were used to increase the consistency and accuracy of the research. The submergence and review by the research team members, participants, and expert opinions were used to address the credibility and confirmability criteria. For dependability, the data were coded by two individuals. Finally, the experts' opinions and heterogeneous and purposeful sampling were used to meet transferability criteria.

The data were analyzed using content analysis manually. The content extracted from text reviews, document analysis, and expert interviews were integrated. The extracted contents were read many times to understand the themes; subsequently, the data were coded, and finally, the main themes were removed from the primary codes. Two researchers implemented the coding of data.

Results

Context

In the "context" section, ten themes were extracted in four areas from the participants' perspectives (Table 1).

Content

The overall goal of this program/policy is to provide essential mental health services that are easily accessible to all people in the Islamic Republic of Iran with a particular emphasis on the most vulnerable groups, including deprived urban and rural people who have not been provided with services, especially those who live in remote areas. Additionally, some of the goals of this program include creating a model of mental health services compatible with the cultural and social construction of the Iranian society, encouraging community participation in creating mental health services, increasing public awareness and mental health skills in public health services, encouraging people to make greater use of health principles to promote health, social and economic development, and ultimately improve the quality of life.

Process

The study's findings in this part are discussed in the form of four sections, including agenda-setting, policy design, implementation, and evaluation.

Table 1. Contextual Factors of Integrating Mental Health Services in Primary Health Care Policy in Iran

Factor	Description	Quotation of Participants
Conditional Factors	The rapid expansion of technology and access to mass media	Participant No 3: "... Access to mass media has re-identified people's identity, which has raised tensions, frustrations, and psychological damage in society ...".
	The extent of psychological and social harm in the country	"... the psychological damage caused by divorce, violence, addiction, suicide, etc. was a strong stimulus for mental health services be available to the public through the network system ...".
	Increasing life expectancy and community aging	"... Increasing life expectancy and population aging, as well as increasing heart disease and diabetes, also increased mental illness such as depression and Alzheimer ...".
	Problems caused by the Iran-Iraq war	"... the occurrence of the imposed war and eight years of holy defense in the country caused the highlight of these disorders in the society ...".
Structural Factors	Technical issues: Sufficient ability and capacity to provide mental health services	"... The expansion and accessibility to primary health care system for providing this type of services (mental health services) are undeniable...".
	Political issues: High political support for the primary care system	"... there was good political support for the primary care system that provided the right capacity for integration ...".
	Socio-economic issues: The need to expand mental health care in disadvantaged areas	"... Mental health services used to be a luxury service that incidentally is most needed in the poor areas...".
Cultural Factors	Cultural factors: Low level of culture and literacy of the people	"... People should have learned that a person who faints has epilepsy, not possessed by the devil ...".
	Change in people's lifestyles	"... People's lifestyles were changing from large families to living alone or having one child ...".
International or External Factors	The global increase in the number and burden of mental illness	"... After World War II, different countries realized the importance of mental illness and incorporated mental health into their health system's programs ...".

Agenda Setting**:** The most important reasons for IMH-PHC in Iran in the view of study participants are shown in the form of a cause-and-effect diagram (Figure 2).

In this part, based on the John Kingdon (1984) model, the factors causing the setting of this policy as the agenda are presented in the form of policies, politics, and problem streams (Figure 3).

Policy Design: This policy has been designed based on the upstream documents and, according to the participants, is the main factor in developing these protocols. The protocols and guidelines have been developed with a focus on the Mental Health Office of the MOHME and the Network Management Center and with the concurrence of the psychology and psychiatry departments of the country's medical universities. The designed guidelines and protocols were then provided to the Network Management Center for implementation. The design process takes 3-4 years. IMH-PHC, developed by the Mental Health Office of the MOHME, serves as the main program for diagnosing and caring for common psychiatric disorders. Several backup programs are available to run this program, which include life

skills programs, parenting skills, and self-care programs. A suicide prevention program has also been developed as a part of the crisis management program. In the initial integration program, there were four classifications for mental disorders: severe psychiatric disorders, mild psychiatric disorders, epilepsy, and mental retardation. After the health evolution plan, these categories were transformed into other disorders and classifications. For example, mental retardation was replaced by mental disability, and autism spectrum disorders were also added. Figure 4 illustrates the process of designing and preparing the policy.

Implementation: The national program for integrating mental health services in primary health care has been designed by organized teams in the MOHME from 1986 to the present day in the form of national programs and communicated to the relevant sub-levels. Therefore, the country follows a "top-down" approach to implementing the policy. Relying on the success of the pilot projects, senior health officials at the MOHME are committed to pursuing an integrated primary care model for mental health across the country. This involves training General Practitioners (GPs) and psychologists. The expansion of primary care services began by hiring psychologists and re-assigning mental health services to health care providers, health workers, and physicians at the national level. After holding workshops for health workers, physicians and psychologists, the program began.
Currently, mental health services are provided in three dimensions, as shown in Figure 5.

Policy Evaluation: The interviewees' opinions on assessing this policy have been extracted and summarized in two areas: weaknesses and strengths/achievements.

***Weaknesses*:** In this study, based on the perspectives of experts and officials involved in the design and implementation of this policy, 20 weaknesses in eight areas were finally extracted (Table 2).

Strengths: Six primary and general strengths were extracted in terms of strengths and achievements (Table 3).

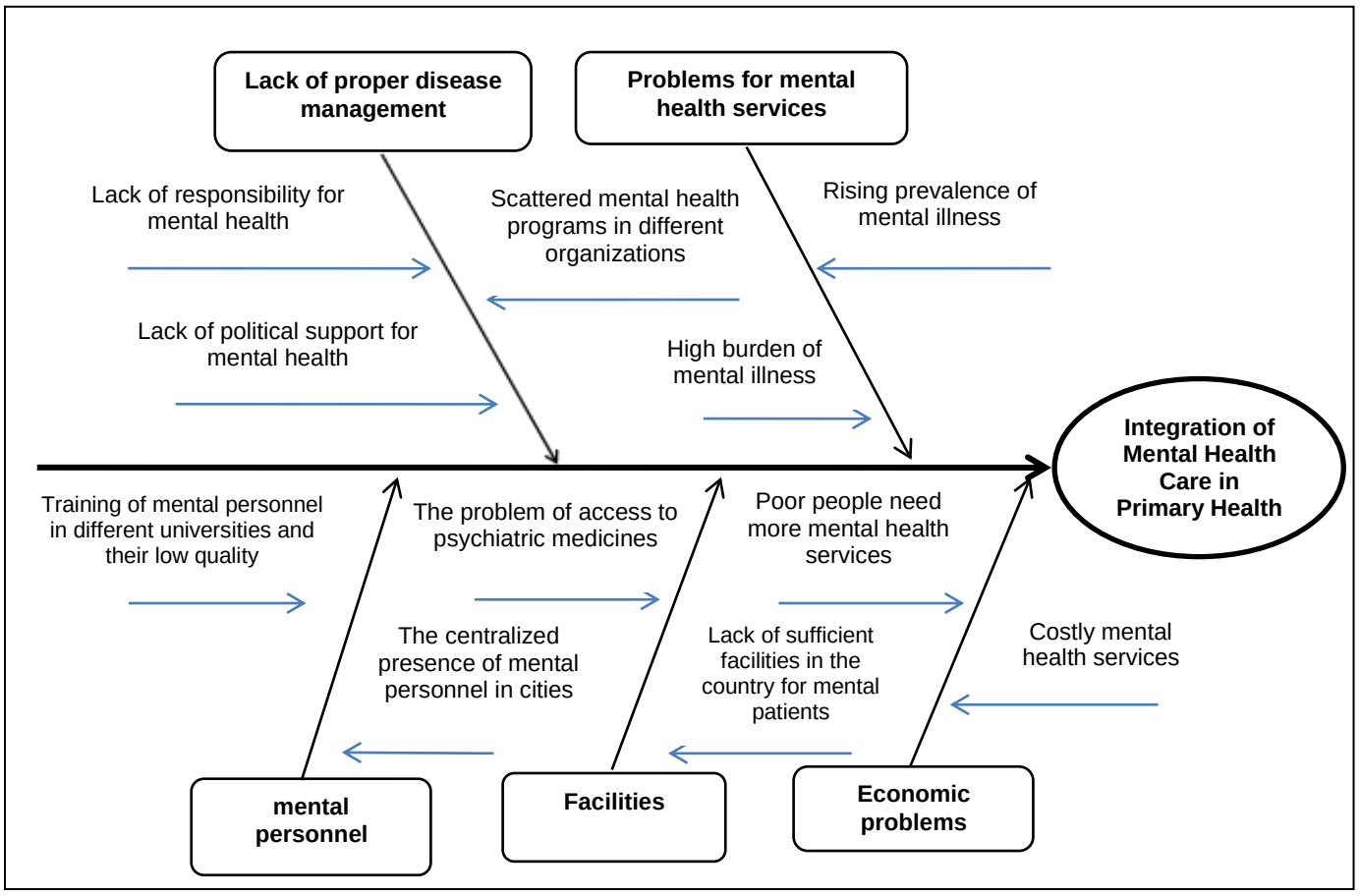

Figure 2. Fishbone Chart of Reasons for the Integration of Mental Health Care in Primary Health Care

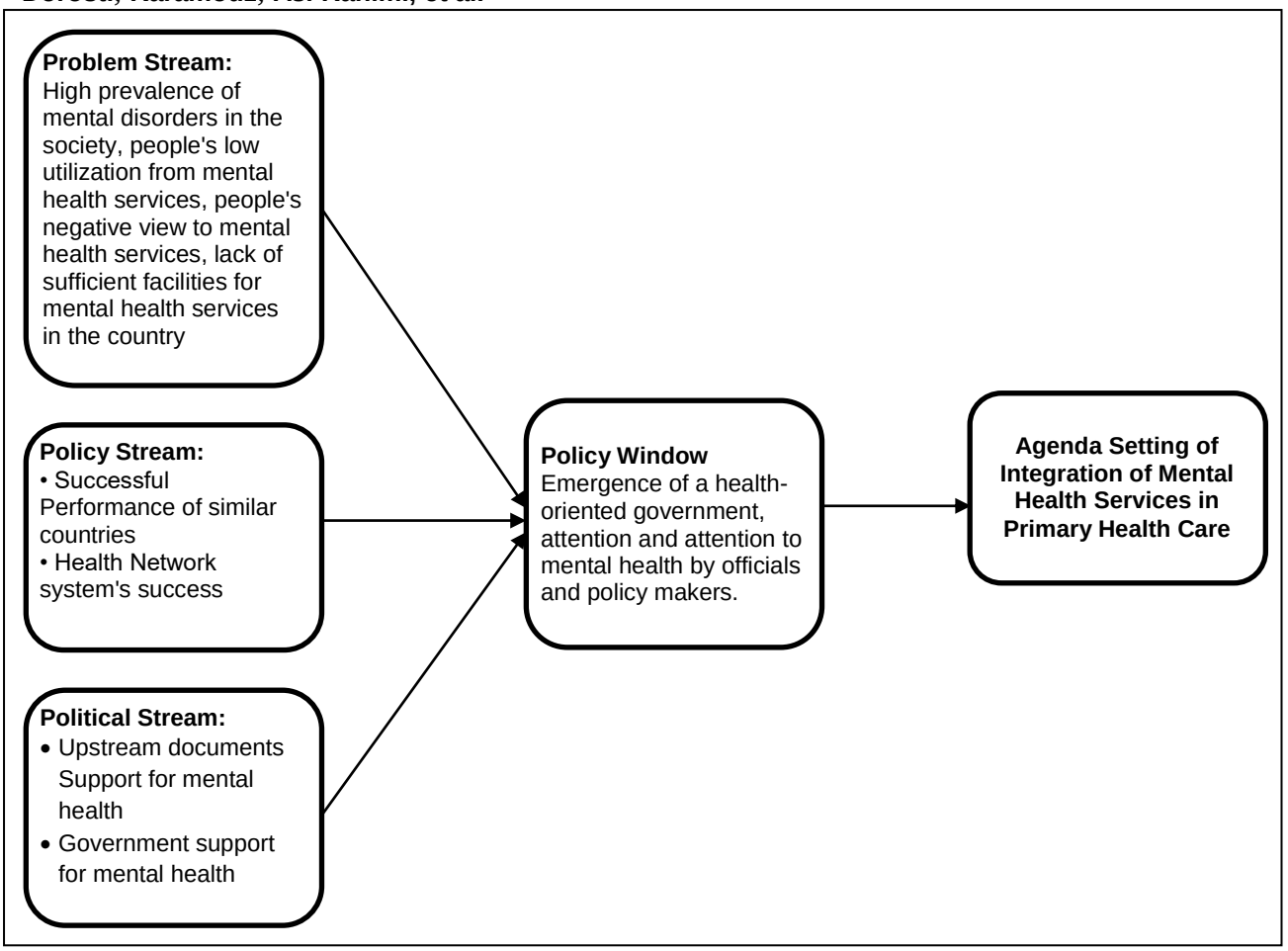

Figure 3. The Multiple Streams Flow of the Agenda Setting of Integration of Mental Health Services in Primary Health Care Policy in Iran

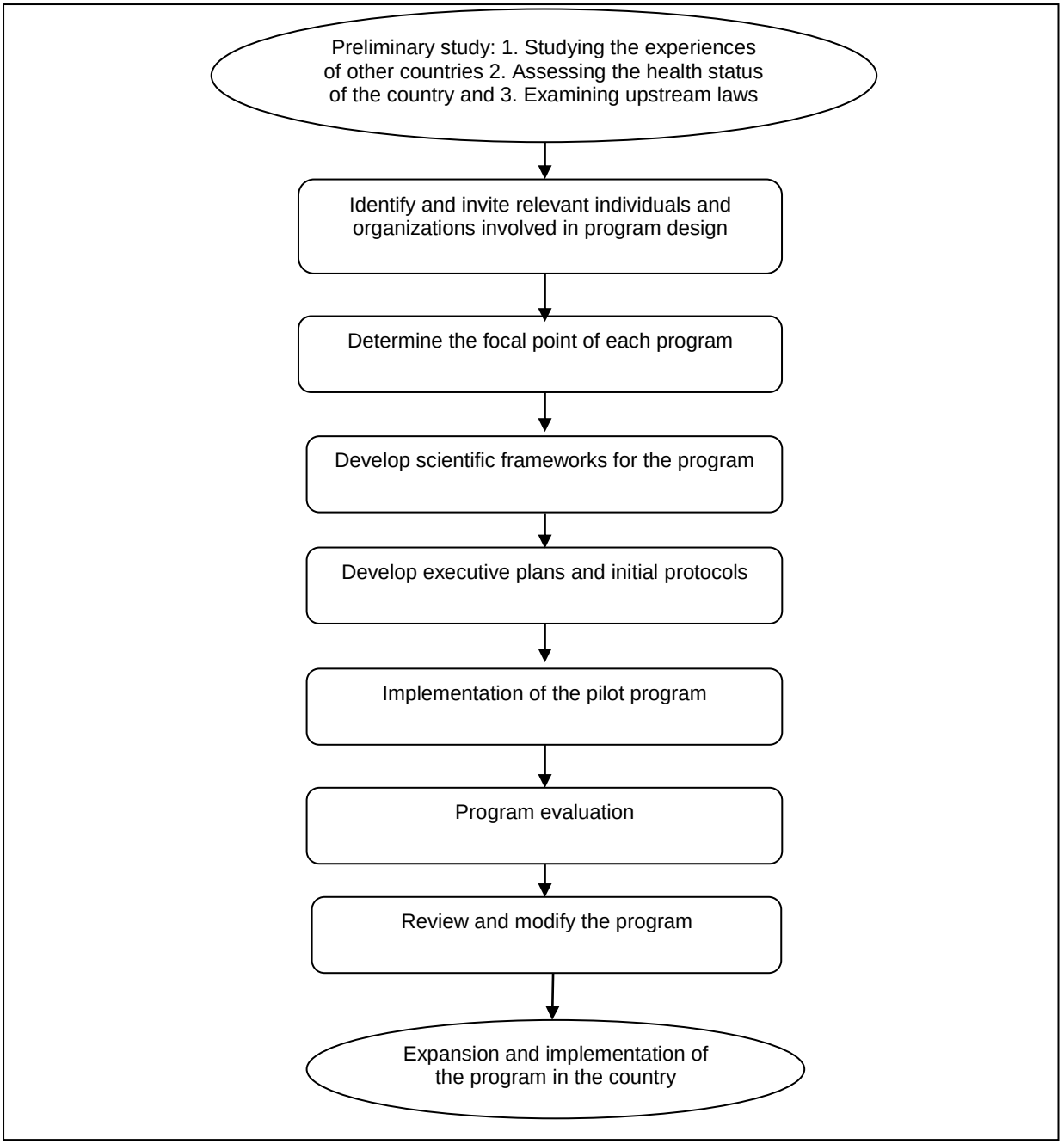

Figure 4. The Process of Designing the Policy of Integrating Mental Health Services in Primary Health Care in Iran

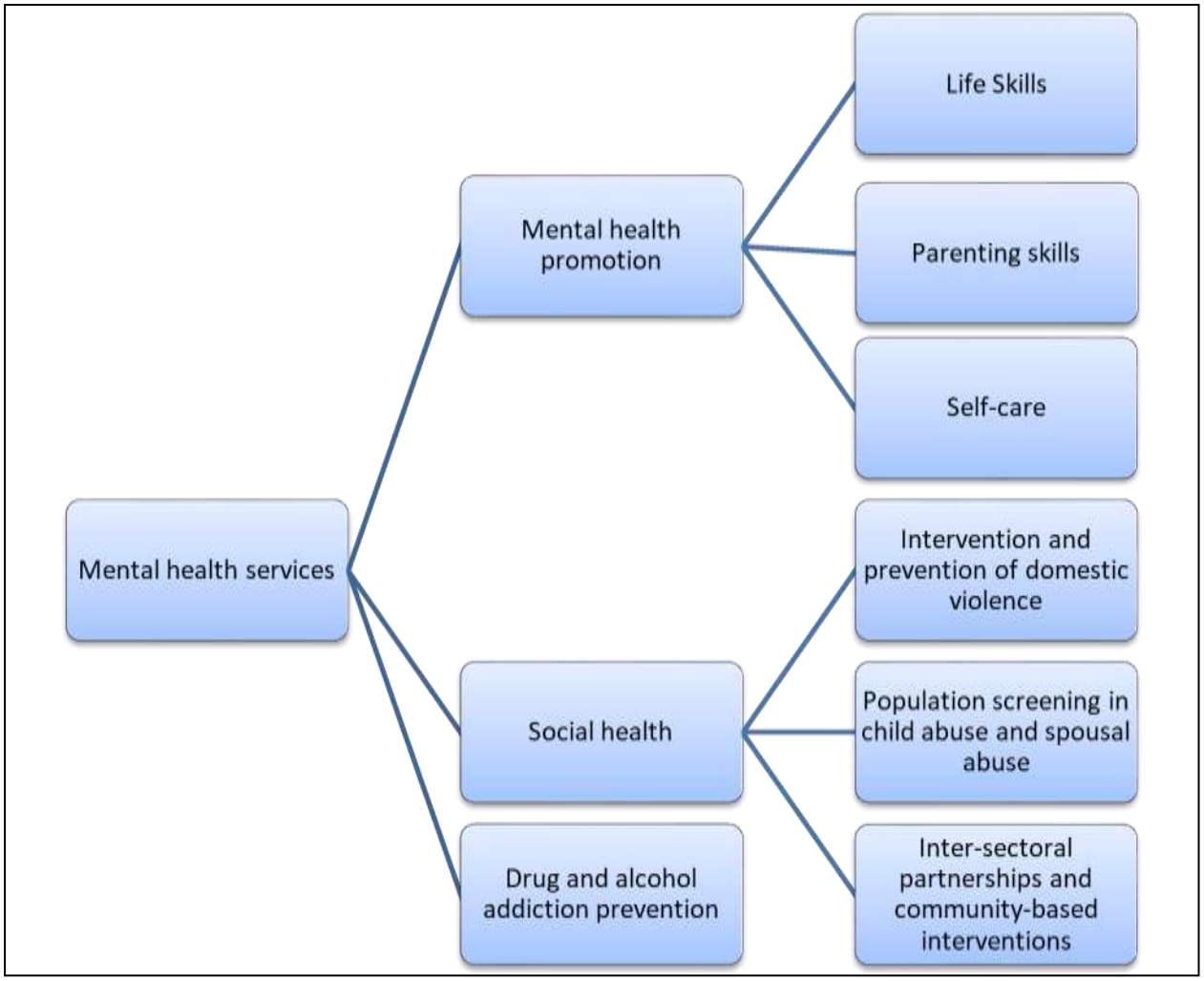

Figure 5. The Process of Implementing the Policy of Integrating Mental Health Services in Iran's Primary Healthcare

Table 2. Weaknesses of the Policy of Integrating Mental Health Services in Primary Health Care in Iran

Main Theme	Sub-Theme	Quote of Participants
Negative View to Mental Health	Social stigma	"... Despite many efforts, several people are still reluctant to receive mental health services and are afraid of (their disorder) being exposed, especially to their families ..."
	Mother and child perspective	"... The view of mother and child still prevails in the system and among the people, and many consider the health system only for mother and child ..."
	The view of health authorities	"... Health policymakers and trustees still do not have a clear view on the impact of health services ..."
	Lack of funds	"... When there is not enough knowledge and good vision of mental services, there is a lack of budget and insufficient funding ..."

Weaknesses in Human Resource Training	Insufficient training of physicians	"... physicians at the university pass only one month of psychiatry training, which is very short and insufficient ..."
	Insufficient training of psychologists	Participant No. 4 noted: "... Some psychologists unrealistically treat patients..."
Compensation for the Service of Psychologists	Contracts' conditions and payment	"... The contract model and the payment of psychologists' salaries are not fair and do not fit with the work they do ...."
	Organizational Structure	"... The mental health structure of the health network system has not yet been operationalized, and the job lines and organizational structure have not yet been communicated so that they (health network system) can attract psychologists ..."
Unfavorable Working Conditions for the Workforce	High workload of psychologists	"... The population covered by psychologists is too high; 30,000 to 40,000 people is too much for a psychologist; the maximum population for a psychologist should be 5,000 ..."
	Hostile confrontation between physicians and psychiatrists, and psychologists	"... Negative confrontation between them (physicians and psychiatrists and psychologists) lowers the quality of their work output while they should decide as a team ..."
	Imposition of various types of services on the health network's workforce	"... imposing new services on network employees will cause them dissatisfaction and burnout ..."
Inappropriate Service Delivery Facilities	Inappropriate building to provide services	"... The construction of health centers and the presence of several service providers in one room lead to a lack of privacy, and makes people not want to recount their mental problems ..."
	Access to medicines	Participant No. 4 stated: "... many people do not accept domestically produced (mental health) medicine, and demand foreign drugs ..."
	Censorship of information by people	"... The provision of (mental) health services is based on the self-expression of people and patients. However, self-censorship is widespread..., especially by men ..."
Lack of Meaningful Communication between Different Levels of Service Delivery	Failure to comply with the referral system	"... The services provided in the network system are not linked to more specialized services at higher levels, and the referred person will be lost in the system..."
	Problems with the electronic system	"... Many referral system processes are performed orally between the health team's members, and referral through the referral system is problematic ..."
Poor Inter-Sectorial Communication	Improper structure of authority	"... part of the authority in the mental health field is in the Ministry of Health and part in the State Welfare Organization of Iran ... all of these should be concentrated in the country's mental health policy committee ..."
	Poor communication with State Welfare Organization and Relief Foundation	"... there is no logical and defined connection with organizations such as the State Welfare Organization of Iran and the Imam Khomeini Relief Foundation..."
	Poor communication with social emergency	"... Poor communication with organizations such as social emergency causes the loss of several service recipients ..."

The Challenging Nature of Mental Health Care	Long-term treatment of these diseases	"... The long course of treatment of these diseases and the effect of medicine, in the long run, make patients and providers reluctant to receive and provide these services ..."

Table 3. Strengths of Mental Health Integration in Primary Health Care Policy in Iran

Strengths	Quote of Participants
Attracting people to the health system	"... IMH-PHC has attracted people to the health system and has increased people's desire to use health (primary health care) services ..."
Making expensive mental health services affordable to the majority of people	"... The visit of a psychologist with an MSc degree is expensive for people, but the health networks have made it available to the public for free ..."
Providing services in different situations	"... This integration has led to the provision of mental care in critical situations, such as mental health care in floods ..."
De-stigmatization of mental disorders in society	"... Mental health (program) is currently in the process and has not reached the output and outcome. However, it is a great success that it has been able to improve people's culture and vision of mental health services and reduce its social stigma."
Identification of hidden patients	"... With this program, we can identify hidden patients or people on the verge of illness ... especially people with suicidal ideation."
Other organizations welcome mental health services	"... this integration has led even police departments and the judiciary to refer the criminals to a psychologist before making a decision."

Discussion

In Iran, as in many countries worldwide, mental health has received less attention compared to medical priorities, such as infectious and contagious diseases. Consequently, the social and spiritual dimensions of mental health are often overlooked. In this country, mental disorders account for 14% of the total burden of diseases, and rank as the second most common disease after accidents, along with cardiovascular disease. Depression is the first cause of illness among women, while addiction stands as the third leading cause of illness among men (5, 18). While the prevalence and the burden of this group of diseases are increasing in the country, the coverage of mental health services, especially in cities, remains insufficient. In 2007, about 97% of the rural population and 4.41% of the urban population were covered by mental health programs, while the distribution of human resources (psychiatrists and psychiatric nurses) relative to the population covered in large cities and surrounding areas was significantly higher than other parts of the country (6). Studies in the country show that most patients receive outpatient mental health services. Although this may indicate the relative sociability of services, in this country, it may be due to a lack of hospital beds for mental disorders (19).

WHO, in a report on Iran's mental health system in 2014, noted that Iran has an independent mental health policy or program. According to the report, the total number of hospitalized care staff is 8816; the total number of outpatient care staff is 4815, and the total number of mental health staff per 100,000 people is 16.6. Additionally, Iran has 41 mental hospitals, 148 psychiatric wards in public hospitals, 93 patient care centers, 1119 outpatient mental health centers. Furthermore, the number of daily mental health treatment centers is 11. In general, the report declared the overall situation in Iran to be above average (20).

Efforts should be made to strengthen the mental health care system to create a structure to support patients with chronic and severe disorders, as well as their caregivers. For this purpose, collecting more vital information and improving patient identification, as well as providing talented human resources and participation of organizations, providers, and recipients of services should be considered. The satisfaction of service recipients should also be taken into account to improve the quality of care.

However, despite the prevalence of mental health issues in societies, many patients do not receive the required services (6). Similar to many developing countries, the scattered population settlements in Iran have made it difficult for most areas to access limited mental health facilities. Therefore, many efforts have been made to integrate the provision of mental health services into the existing primary health care network. Taking into account the geographical situation of Iran, considerable distances between cities and villages, limited communication facilities, scarce human and financial resources and other health facilities, it becomes obvious that the success of primary health networks across the country highlights the importance of this method in expanding the provision of mental health services.

Most countries are moving towards community-based services and the provision of primary health care. Each country, considering its condition, its primary goals, and policies, is planning to follow this path. For example, Australia regards it as an approach that facilitates prevention and early identification of patients; it also ensures access for all people to appropriate and effective treatment, recovery, and social support, empowering them to participate fully in the society (21). Relying on cheap and humanitarian community-based services, Italy initially opened the doors of psychiatric hospitals to the public. However, in order to develop services in the community, Italy then shifted services from psychiatric hospitals to community-based services (22). The University of Toronto in Ontario has integrated addiction and mental health care into PHC and family medicine to become a global model (23). South Korea has introduced a mental health program to change the mental health system to a community-based approach (24). Providing health services in Brazil is currently national, and a change in direction for providing community-based care is essential. The number of psychiatric beds in Brazil is decreasing, while the volume of new community-based psycho-social centers is rising (25).

Today, providing essential mental health services through IMH-PHC has attracted the attention of many countries worldwide. These countries have achieved significant results by relying on decentralization and IMH-PHC. The plan for IMH-PHC in Hashtgerd was implemented during 1993-1995, and its results indicated that the education effectively changed the attitude of rural Behvarzes (health workers) and villagers in the experimental group. Moreover, Behvarzes were able to identify 44% of patients with mental disorders in the villages and refer them to specialized levels (8). Based on the result of a systematic review of published studies on IMH-PHC in Iran, by the end of 2007, 95.2% of the rural population, 36.6% of the urban population, and 54.6% of the country's total population were covered by the IMH-PHC program (26). Additionally, in 2007, out of 2191 urban health centers, 1387 urban health posts, 2612 rural health centers, and 16994 rural health houses, 1021 (36.6%), 761 (54.9%), 2497 (95.6%), and 16718 (98.4%) were covered by the plan (26), respectively. Evaluations conducted in Iran have demonstrated that implementing IMH-PHC, due to the existence of a strong human force (Behvarzes), has been associated with significant success in rural areas. However, the implementation of the experimental program of health volunteers, though gradually expanding in small towns, does not adequately serve the population of large cities and has been associated with many problems, such as people's distrust of healthy volunteers. There appear to be a significant difference in the awareness and attitude of the covered and uncovered populations, indicating one of the consequences of training health workers and general practitioners working in urban health centers (27, 28).

In a study by Bolhari *et al*., it was found that 97.1% of general practitioners underwent psychiatric training during an internship, 42.9% received mental health training at the beginning of employment, and 25.7% received mental health in-service training. This finding suggests that the effort of the officials to make physicians commit to a course in psychiatric practice has had a positive result, with almost all physicians working in primary health care centers having passed the official psychiatric course (9). However, some studies have shown that physicians are unaware of the diagnosis and unable to treat certain mental disorders, which can be attributed to the lack of ongoing in-service training and the failure to access specific treatment and diagnostic guidelines (29). Studies on mental health assessment have highlighted shortcomings in information and evaluation system and pointed out the irregular evaluation schedule. Strengthening this system and using research to collect the required data to improve the mental health system (with an emphasis on applied research) have been considered (6). The lack of referral feedback forms can be attributed to the weakness of the referral system, lack of access to psychiatrists in some cities, and lack of cooperation with the PHC system (9). Supporting patients and caregivers, especially those with chronic mental health problems who need long-term and costly care, is challenging. Some of these challenges include providing support for these patients and their caregivers, facilitating rehabilitation and job creation, and offering financial support. Service recipients are sent from one institution to another without any responsibility for the care or coordination of services, resulting in apparent discrepancies between the various departments of mental health service management (30). There are numerous challenges in providing human resources. Furthermore, expanding the program without a sufficient number of capable human resources can lead to reduced program efficiency and quality. In addition to the provision of necessary human resources, their training and empowerment should also be considered for implementing programs. Previous evaluations have indicated that in some areas of service delivery,

including diagnosis and treatment, primary care staff faces problems that can be solved by training and following appropriate guidelines (6). A Lack or shortage of essential medicines is observed in rural centers, which can be attributed to physicians' poor performance and supervision of mental health activities, as well as the failure to use psychiatric medications when prescribing to patients.

According to the WHO report, Iranians' experience in improving mental health in the country is multifaceted. Integrating mental health care into the primary health care system is a significant achievement. The coverage, especially in rural areas, demonstrate that mental health can be integrated into primary health care, given the necessary infrastructure and political will. Public health personnel can deliver primary mental health care, with proper monitoring and support through an appropriate referral system. After the establishment of this system, mental health professionals cooperated with it. The success of this integration program depended on the presence of a well-structured health system. The report also highlights that IMH-PHC has been more successful in primary care in rural areas than in urban areas. In urban areas, the private health sector is more robust, and there is no weak public-private partnership. Moreover, cities do not have Behvarzes, which is the main factor contributing to the program's success in rural areas. The government has implemented measures to improve mental health care in urban areas, such as recruiting health care volunteers and establishing community-based mental health centers; however, the coverage has been low so far, and its impact has not been officially assessed (19).

According to the findings of the present study, IMH-PHC is still a fundamental health priority of Iranian society. Thus, it is expected that planners and officials consider this issue as a health priority. Other proposed measures include reconsidering the national health program, developing specific guidelines, conducting in-service training, and reviewing and developing new educational resources for staff that provide services at different levels. Formative evaluation by internal experts every five years and external experts every ten years is an essential requirement, necessitating a comprehensive and continuous planning for its implementation.

Limitation

Utilizing the results of scientific research and the experience of researchers, the present study analyzed, for the first time, the policy of IMH-PHC in Iran by applying a scientific and systematic framework. However, there were some limitations to the present study, the most important of which was the lack of access to certain influential individuals and experts involved in this policy, either due to their death or unavailability to researchers due to the passage of time.

In this study, we also encountered other limitations, such as the lack of access to some influential people in integrating mental health care into primary health care for interviews and the unavailability of some old relevant documents.

Conclusion

The results of this study demonstrate that the policy of integrating N-MHSs in PHC in Iran is suitable and effective. Additionally, in recent years, with changes in the content of this policy, its implementation, and increased support, its effectiveness has improved. However, there are many problems and challenges in implementing this policy, which require principled and timely planning and decisions. Therefore, given the breadth and importance of the problems in the field of mental health in Iran, it is expected that the officials and senior policymakers of the health system and other sectors devote increased attention and support to this policy. Although the present study provided extensive and practical information about the various dimensions of this policy for policymakers, it is recommended that officials and policymakers conduct further assessment of this policy from different standpoints based on their specific needs.

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Conflict of Interest

None.

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