Collaborating Centres ANNUAL REPORT

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Name of the University, Hospital, Research Institute, Academy or Ministry

Teheran University of Medical Sciences

Name of the Division, Department, Unit, Section or Area

Teheran Institute of Psychiatry

City	Teheran	**Reference Number**	IRA-22
Title	WHO Collaborating Centre for Mental Health		
Report Year	06-2013 to 06-2014		

1. Please briefly describe the progress made in the implementation of your agreed workplan as WHO collaborating centre during the past 12 months (or the reporting period listed above). Please report on how each workplan activity was implemented, if any outputs have been delivered, if any results have been achieved and if any difficulties have been encountered during this time. If an activity has previously been completed, has not started yet, or been placed on hold, please indicate this.

Activity 1

Title: Providing a model for Urban Mental Health(UMH) of Iran: for cities more than 100000 population
Description: This project has been proposed by Mental Health Bureau of Ministry of Health for developing and updating Urban Mental Health services in big cities. The following items have provided a new situation which UMH program is a serious need for our society:
1. Changes of our demographic feature. Currently, 70% of our population living in the cities than rural area.
2. The high level of stress in living condition in our cities
3. Dramatic changes in the educational level of our population
4. Lack of mental health network in our big cities
In this Updating model seven sections based in new polices and strategies will be included:
1. Principle, introduction
2. Mental health services:
a. Required beds
b. Outreach services
c. Occupation
d. Housing
e. Emergency services
3. Situational analysis
4. Advocacy and legislation
5. Information system
6. Financing
7. Human resources

Description: providing this model, will help the ministry of health to establish and expand the mental health network in urban areas.
Please briefly describe the progress made in the implementation of THE ABOVE SUBJECT.
1. HOW DOES IT IMPLEMENTED?
a. An expert committee were chosen consists of nine members of psychiatrist, general practitionnaire, occupational worker, social medicine specialist (working in ministry of health), specialist in management.
b. The expert committee reviewed the related issues from different sources, review article, best practices, WHO documents, different models, successful experiences from UK, Australia, and Canada.
c. The following principles were considered:

i. Primary health care included General Practitionnaire has the pivotal role in this model
ii. The available facilities in current organizations considered seriously to be promoted for delivering the required services
iii. Collaboration between related organizations: ministry of health (university of medical sciences), welfare organization, police department, charity NGOs, psychiatric association (private stakeholder), municipality, department of housing
d. One expert national expert panel has been hold to review the document

2. IF ANY OUTPUTS HAVE BEEN DELIVERED?
a. English and Persian manuscript provided after 12 months of intensive work.

3. IF ANY RESUTLS HAVE BEEN ACHIEVED?
The ministry of health, mental health bureau approved the document as an official guide and model for Iran Mental Health network for Urban Areas
Executive Summary
The policy makers and mental health officers of Ministry of Health has concluded that to plan a programme for mental health of urban areas. In this document the Urban Mental Health programme (UMHP) has been planned based on General Practitionnaire (GPs), in the PHC frame work.
In the PHC services the role of GPs has been considered as a basic component to provide mental health services to the community. The programme of “Family Physician and Referral System in Urban Area” (FPRSUA) has been implemented as a pilot study in three provinces in the last five years. After piloting and sum up the results, the 2nd draft has been issued in 2012 by Ministry of Health (MoH). Now, it has been officially ordered by the MoH that the FPRSUA has to be launched as a nationwide programme.
The Urban Mental Health will be established in cities with more than 200 thousands population. More probably given the new instruction of MoH on “FPRSUA” it seems that the two programmes will be launched simultaneously in the target city.
The Provided model of UMHP is based on primary health care in which general physician has a pivotal role of its functioning. The current health policy of Iran is going to be rebuilt on Family Physician program, in which the UMH has to be accommodated itself with the new policy of the country.
The UMHP consists of the following steps and services:
PHASE ONE
During the last 12 months, the UMH programme has been developed and it has the following sections:
A. Situational analysis
1. This part will be conducted according to the AIMS instruction of WHO.
B. The role of GPs in the urban mental health programme.
1. Visiting and managing the neurotic cases
2. Visiting and managing the Severe Mentally Ill cases (SMIs) in the remission period
3. Receiving regular supervision from mental health professionals by holding educational meeting, consulting and sharing the cases.
C. Mental health services
1. Providing emergency services by:
I. Hotline
II. Mobile teams
III. Hospital-based emergency
D. Short and long-term hospitalization
1. Twelve acute psychiatric beds for community with 100’000 population
2. Five permanent psychiatric beds for community with 100’000 population
F. Home-visit services
1. It is estimated that 260 SMIs need to be cared by follow-up and aftercare services
2. Two or three mobile team, supporting 80 to 90 patients, by each team will be required for population of 100’000
3. Telephone follow-up will be conducted by the mobile team or outpatient services for the well controlled SMIs
G. Day-center services
1. One hundred SMIs are eligible for day-center services, therefore, two centers are required for a population of 100’000

H. Housing services
1. It is estimated that in a city with 100'000 population, 16 SMIs will be in need of housing to prevent homeless individuals.
2. Four apartment with 80 square meter will be suitable for the above mentioned SMIs
3. The cultural and extension of families will influence greatly this estimation
I. Legislation and advocacy
1. Stakeholder analysis has been provided in this programme. This will evaluate the role of every organization in the implementing of the UMH
2. The supportive legislation has been provided in the programme
J. Monitoring and evaluation
1. It has been planned according to the WHO instruction. It consist of :
I. Monitor and evaluation of policies
II. Monitor and evolution of plan
K. Information registration
1. It has been conducted according to the electronic documents of "FPRSP" of MoH.
Phase Two
In this phase, the planned programme in phase one will be reviewed by the experts of AUMS and representatives of stakeholder organizations by providing their comments and suggestions in order to make it more appropriate and consistent with the cultural and social situational of the target city. It has been predicted that implementing the phase two requires twelve months which will be tailored by the steering committee and executive team of AUMS. With the assumption of the following detail, the Gantt chart has been suggested.
By providing this model, the main objective of this project, which was provide practical and scientific (based on best practices) has been achieved. This document provided a practical model which is capable to implement.
To provide this model the following issues have been considered:
1. The current available mental health services in different organizations
2. The principle of collaboration of related organization to provide UMH
3. To avoid providing parallel services in different organizations
4. Using the national policy of Family Physician program to implement the UMHP
To achieve the main goal of phase two of this program, is depends on the AUMS which the MoH, the mental health bureau is responsible to assign the cities which this program has to be piloted. To implement the mode in pilot areas the following has been performed:
1. The detail executive instruction has been provided elsewhere
2. The paper work has been done by MoH/mental health bureau to invite an international expertise to supervise the implementing of the program in AUMS

4. ANY DIFFICULTIES ENCOUTERED SO FAR?
a. Tried to join officially with some international organization as a shared work ( ) or having international supervisor for close supervision however it was not available for this project
5. IF ANY ACTIVITIIES HAVE NOT BEEN STARTED YET?
a. The project has been completed but to follow and implement the project:
b. After approving the document, the MOH/mental health bureau has decided to pilot this project in two middle size cities and has done some negotiation with the deans of universities of medical sciences. It has not been launched so far and needs more collaboration.
c. An international expert is needed to supervise technically the implementation of project.

6. IF ANY ACTIVITIES HAVE BEEN HOLD?
a. no
7. HAVE YOU HAD ANY COLLABORATION WITH WHO ON THIS PROJECT? HAVE YOU HAD ANY PROBLEM IN COMMUNICATION?
a. Yes, the WHO/IRAN has partly supported this project financially
b. YES, Prof. Rachel Jenkins, WHO senior consultant provided a mission report and feedback from mental health services of Iran, including the Urban Mental Health program, different mental health services in Ministry of Health, Tehran Municipality health services, Welfare organization and other related services, 24 NOV- 6 DEC, 2013. A comprehensive report has been provided.
c. Currently waiting for final decision of Mental Health Bureau, ministry of health for implementing the program in suitable city as pilot study, including the feasible point of Prof. Jenkins. Recently, the "Family Physician

Program (FPP)" of Iran is being under revision which has crucial impact on "Urban Mental Health Program" of Iran. The pilot implementation of UMH has to be postponed until final version of FPP.

Activity 2

Title: Revision of "National Integration of Mental Health Program in Primary Care System"
Description: Iran mental health program in primary care is running for about 25 ys and successful program evaluation showed same shortages and a need to revision of program.

Description: Iran mental health program in primary health care is running for about 25 yrs and successful program evaluation showed same shortages and a need to revision of program.
1. HOW DOES IT IMPLEMENTED?
• From three decades ago, mental health program has been integrated into primary care, in Iran. During this period and after different evaluations, revision of the program was essential. This study has been done by an active collaboration of a committee, which included 22 professional mental health experts and supervised by the director of Tehran Psychiatric Institute (TPI). During the processes of current program, outcomes of past evaluations, demographic information, prevalence & incidence data, our mental health documents and publications of the other countries, extensively have been discussed by the team. The committee revised goals and strategies of the program based on WHO & national policies of mental health and primary health care, .
• Five task-force work groups have worked on the revision of Iran national mental health program, each of them engaged in different part of the project, such as primary, secondary, tertiary prevention, education, evaluation, monitoring and promotion and up grading the care.
2. IF ANY OUTPUTS HAVE BEEN DELIVERED?
• Final comprehensive report of the project has been developed in April / May of 2013. The revised project defined seven strategies, which delineate a practical framework:
o 1: service strategies,
o 2: educational strategies
o 3: strategies of informational system & evaluation,
o 4: strategies of increasing collaboration,
o 5: strategies of providing essential drugs,
o 6: strategies of promoting quality,
o 7: financial strategies.
3. IF ANY RESUTLS HAVE BEEN ACHIEVED?
• Yes, the project completely revised by the committee. The final report included two parts:
Part one; review on literature and the goals of program
Part two; revised national mental health program, which included five chapters:
- Chapter one; developing the principle and strategies of primary prevention programs
- Chapter two; developing the principle and strategies of secondary & tertiary prevention programs
- Chapter three; developing the new practical manual of mental health education for primary health staff
- Chapter four; developing the evaluative and informational system of mental health program
- Chapter five; developing principles and general structures of mental health program

4. ANY DIFFICULTIES ENCOUTERED SO FAR?
• Yes, after delivering the final report to ministry of health, implementation of the revised program needs more support and attention from national and regional systems.
5. IF ANY ACTIVITIIES HAVE NOT BEEN STARTED YET?
• Based on the project, no activities have been left.
6. IF ANY ACTIVITIES HAVE BEEN HOLD?
There were no activities which have been hold, but the Ministry of Health hold another expert committee to approve and implement the revised program. Our center provided three pilot programs in different area of the country.
7. HAVE YOU HAD ANY COLLABORATION WITH WHO ON THIS PROJECT? HAVE YOU HAD ANY PROBLEM IN COMMUNICATION?
No, we had no active & effective collaboration with WHO.

Activity 3

Title: Consolidating the prevention of domestic violence program in PHC.
Description: policy paper and pilot project on domestic violence in the PHC has been done in recent years in Iran. In this project we will develop the existing manuals and model of intervention based on policy paper

Title: National Policy of Safety Promotion and Prevention of Domestic Violence (DV) in IR Iran
Description: Policy paper of domestic violence prevention (DV) as well as primary pilot projects for this program has been done in Iran during past years. In this project with technical and final support from WHO, different manuals for DV reviewed, the model of intervention in rural and urban areas upgraded, a national advocacy plan with duties and responsibility of each agency and organization prepared, and finally a new pilot program implemented in Tehran.
How this implemented does: First of all, we held a national technical committee for domestic violence prevention, a scientific committee, and work committee for pilot project. In the next step previous draft of policy paper and model, responsibilities and duties, as well as the manuals for DV in primary health care discussed and upgraded by scientific committee. In the step 3 after approving these steps by national committee, in step 4 an advocacy plan and pilot project for implemented in Tehran.
If any outputs have been delivered? Yes, a Persian and an English version of reports included policy paper, advocacy plan, responsibilities and duties of agencies and organizations in Iran, pilot program proposal and its primary result of implementation have been delivered to Ministry of Health and WHO Office in Tehran.
If any results have been achieved? The importance of implementing many practical activities on domestic violence prevention in Iran by leadership of health sector and cooperation of other sectors at national level, and by a national willing is the main result. Other result is upgrading a new health and comprehensive collaborative model for future implementation in country, an in other EMRO countries.
Any difficulties encountered so far? No
If any activities have not been started yet? No
If any activities have been hold? No
Have you had any collaboration with WHO on this project? Have you had any problem in communication? This project has been done with JPRM budget of WHO and financially support from Ministry of Health. We had no problem in communication.

Activity 4

Title: Community mental health center (CMHC)in a catchment area of Tehran University of Medical new Science.
Description: The aim of this project is developing a network for urban mental health services in a crowded big city. In this project 20 general practitioners will be connected to mental health services and supervised by psychiatrist after participating in workshops.

This is the third year of activity.
Description: This is the third community of mental health care center in Tehran. The goal of this project is integration of mental health services in community. This project has two divisions:
1. Collaborative care and aftercare. Collaborative care includes the treatment of neurotic patients that are visited by trained general practitioners under psychiatrists' supervision. The aim of this division is detection and treatment of mental disorders such as anxiety disorders and depression on these patients.
2. Aftercare program covers chronic and disabled psychiatric patients.
HOW DOES IT IMPLEMENTED? This project has started from 2012 June.
1. second and 6th district area of Tehran, the capital, has been determined as catchment area of this study.
2. Due to losing the GPs to collaborate with this project, the field of trial has been expanded to 2nd district
3. We invite General practitioners that practice around our catchment area and presented our project to initiate collaboration with CMHC.
4. We carry out conferences and workshops in order to enhance the quantity and quality of these GPs.
5. Aftercare program goes by selection of chronic psychiatric patients by our criteria to enter the program. The sources of referral cases are psychiatric hospitals, private offices of psychiatrists and some of NGOs.
IF ANY OUTPUTS HAVE BEEN DELIVERED?
1. 16 general practitioners have cooperated with CMHC until to now
2. They have identified 730 neurotic patients that are currently in the progress of treatment. In these patients the most common disorders are depression and anxiety.
3. Ninety eight clients using telephone follow up and 15 using home visit services
IF ANY RESUTLS HAVE BEEN ACHIEVED?
1. Most of the clients (around 70%) are female
2. The most common disorders are depression and the second identified one is anxiety;
3. The highest number of patients belongs to the age group of 30-39.
4. The educational level of most of the patients is a high-school diploma degree.
ANY DIFFICULTIES ENCOUTERED SO FAR?
1. Most of physicians have several difficulties to participate because of some limitations;
a. Their problems are limited time for visiting patients based on psychiatric interviews
b. The insurance services, especially the financial issue.
c. Furthermore, some problems in entering the CMHC data by the physicians and receiving the completed data
d. Having GPs to collaborate in this project. Most of them has changed their major activities to skin care for financial reasons
e. Some of the neurotic patients need some kind of consultation services which has not been provided in this service. Currently, GPs are not qualified to provide such services. These clients refer to other centers to receive consultation services
IF ANY ACTIVITIES HAVE NOT BEEN STARTED YET?
• No
IF ANY ACTIVITIES HAVE BEEN HOLD?
Yes, we are in needs of more corporations of the general physician in our catchment area and in this regard we have been trying some new ways.
HAVE YOU HAD ANY COLLABORATION WITH W.H.O. ON THIS PROJECT?
No, this project was founded by the Ministry of Health.
HAVE YOU HAD ANY PROBLEM IN COMMUNICATION?
• NO

Activity 5

Title: Setting up a regional parliamentarians forum for mental health in EMRO
Description: A large gap exists in the treatment of mental disorders in the region. It is well known that stigma of mental disorders is an important factor in preventing the affected people to seek help and increases or maintains the treatment gap. Furthermore, the rights of the patients with mental disorder are not respected in many countries. Among some of the EMR members, the mental health programs have the lowest priority among general health programs. One of the key elements to success the scaling up the mental health plans is Political commitment at high level.
Mutual contribution of Parliaments and national mental health committee can play an important role in relieving some of the main obstacles to improve mental health of the people by allocating the necessary resources and development of policies, strategies and legislations infrastructure. This could result in enhancing the political commitments of the different stakeholders.
In this regard, a project has been proposed by the WHO Regional officer for EMRO in Mental health and substance abuse, to set up a standing forum of regional mental health officers and parliamentarians for mental health.

Based on your last year information in the checklist of annual reports, this project has been aborted by WHO.

Activity 6

Title: Suicide prevention program
Description: in order to improve the PHC network services, the following activities have been performed:
1.To train the health workers including the GPs, health technician, Behvarz (rural health worker) to identify and management of depressive disorder
2.The improved and reorganize the referral system
3.To improve the registration forms and data registration system
4.To provide 5-session consultation for suicide attempters and follow the patients by telephone contact
5.To provide a screening tool to identify the depressed and at risk individuals for suicide behaviours
6.Active screening the general population by Behvarzes in rural setting periodically and users the outpatient clinics by health clinics in urban setting.

Description: to test the national program of suicide prevention. In this strategy the general practitionnaire has the pivotal role to identify and manage the depressed and at risk individuals.In this strategy the capability of primary health care network will be evaluated for integration of suicide prevention program into PHC.

Please briefly describe the progress made in the implementation of THE ABOVE SUBJECT.
1. HOW DOES IT IMPLEMENTED?
a. Capacity buildings in the PHC network of the study regions
i. Creating screening questionnaire to identify depressed and at risk individuals to suicide.
ii. To provide a screening tool, the following steps were taken: 1) providing primary checklist for depressive symptoms comprising 41 items drawn from DSM-IV criteria, 20 (26) (2002), 2) content validity was approved by two psychiatrists and two psychologists working in the mental health services, 3) completing the checklist by a psychologist for 70 subjects , 35 cases with major depression (according to DSM-IV criteria) and 35 without mental disorders.
iii. The available training manuals on suicide behaviours compiled and edited by Ministry of Health/ Mental Health Bureau for health staffs included Behvarz, GPs, and health technicians (HTs) were revised. In these material the subjects of description, etiology, clinical characteristics, sign & symptoms, screening, depressive disorders, management, pharmacotherapy algorithm, follow-up in PHC network, referrals and related forms, emergent cases, interview sample, evaluation of suicide tendency according to needs of different staff were included.. In this pyramid-like model, the consultant psychiatrist trains the mental health officer and GPs, the GP trains the HTs and the HT trains the Behvarz of his/her district.
iv. Referral pathways between different levels of health services were organized for identified cases in this study for the first time including health house (level 1), rural/urban health center (level 2), psychiatric outpatient clinic/emergency department (level 3) and psychiatric hospital (level 4) and the data collection forms were prepared for each level.
v. A charge-free “suicide prevention consultation office” (SPCO) was established in both cities for referred suicide attempted cases, depressed patients and any individuals who were at risk of suicide. A trained psychologist with BS degree was in charge of this office. The main tasks were to make an immediate contact

with suicide attempters at Emergency Department and to provide five-consecutive-consultation sessions and providing educational brochures to the victims and their family
vi. Given that this study has been carried in the community and the whole population of the urban and rural areas of the assigned counties has to be covered, two-day educational workshop was held for the 50 out of 90 GPs of private sector for those people who prefer to receive medical services from private section. General Practitionnaire in private sector are not included in PHC network.
vii. Holding the educational one-day seminar for different groups of the population in order to raise and sensitize the public awareness on depression and suicide.
b. Staff-tasks definitions
i. Behvarzes in level one of PHC (Health Houses, HHs of PHC):
ii. 1) active screening of the rural inhabitants for depressive disorder and risk for suicide behaviours, 2) registering data on determined forms, 3) referring the positive cases to the GP in the health center (level 2), 4) follow the treatment of the patients by regular home visits, 5) refer the attempted cases to Emergency Department (ED) of hospital
iii. Health Technician (HTs) in Rural/Urban Health Centers, HCs (level two of PHC):
iv. General Practitionnaire in Rural/Urban Health Centers (level two of PHC): general practitioners had the pivotal role in this study: 1) visiting and re-evaluating the referral cases from HHs and HTs for major depression or presence of any risks for suicide, 2) Prescribing medicine, according to the provided algorithm, for the depressed cases and manage the at risk of suicide cases (not serious suicide ideation).
v. Psychiatrist in hospital (level three of PHC). Visit the referral cases, drug prescription, or hospitalization, or referral to level four (psychiatric hospital), admitted the attempted cases in emergency department.
vi. Psychologist in SPCO: visit the referred suicide attempters and depressed cases from GPs or psychiatrist, provide initial rapport with the clients and their families, holding free of charge 5-session of consultation by providing educational brochures. Follow the registered cases by telephone in case of missing any appointment, register the required data. This service was more available to the settlers in urban areas due to accessibility.
c. INTERVENTION
i. Screening the population of rural areas.
ii. In urban areas the screening was performed among the referrals in HCs every day and the suspected cases were referred to GPs in the same center for any management.
iii. The referred cases were re-evaluated by GPs. The confirmed cases for depression had been treated according to provided algorithm.
iv. In private sector, the suspected patients were treated by the GPs. the data could not be registered in their office and there is not registered data
v. In hospital setting, the referred suicidal cases were registered in their medical documents. They were visited by the psychiatrist and any other specialist in case.
vi. Public education performed via providing 15 educational brochures and distribution in rural and urban health centers, private offices of medical doctors, exhibiting educational stands and posters in health centers and outpatients clinics in rural and urban areas, and holding educational one-day seminar for different group of people and organization to raise the public awareness and sensitivity on depression and suicide, holding 2 session of TV program at the beginning of the study on depressive disorders. Nurses and GPs working in the emergency department: 1) to register the diagnosis of referred cases with suicide attempt, 2) refer the suicide attempters to SPCO after stabilizing the medical condition.
vii. Visiting the attempted cases in ED by psychiatrist and proscribing required inpatient or outpatient management, refer the severe cases to the mental hospital in center of the province.
d. Intervention program process monitoring
i. The implementation of the program has been supervised by the main investigators and the deputy of health of TUMS and HUMS through regular field visiting. The monitoring had being done every month by the investigator team and deputy of health of the two universities.
e. Data collection
i. The pathway of flowing data in this study has been shown in figure one. After categorizing and omitting the duplication data, the refinement file had being sent to the university, mental health Bureau, the end point of data collection of this study (figure one).

f. PRIMARY OUTCOME
i. Number of committed suicides

ii. Suicide data were collected from the end point, at the end of March 2011 from mental health office of Hamedan and Tehran University of Medical Sciences. The data had been reported every month.
iii. THE SECONDARY OUTCOMES
iv. Number of identified at risk individuals for suicidal behaviours The secondary outcomes were the number of individuals with major depressive disorder and identified at risk cases by active screening, which had been conducted by Behvarzes in rural areas and HTs in urban areas. Secondly, the number of referrals in SPCO office who were individual of attempted suicide or depression.

2. IF ANY OUTPUTS HAVE BEEN DELIVERED?
a. Providing executive instruction to implement the program in other cities and areas
b. Providing the executive program at the level of province
3. IF ANY RESUTLS HAVE BEEN ACHIEVED?
a. To evaluate the knowledge of mental health workers after training course in both cities, The t-student test revealed significant increase in post test scores (P. < 0.02)
b. Commit suicide. 17 subjects committed suicide in both cities (9 deaths in Nahavand and 8 deaths in Savojbolagh). Regarding to the population size in Nahavand (180’658) and in Savojbolagh (238’081) the rate of suicide after intervention became 4.98 and 3.36 per 100’000 population
c. The most common methods of committed suicide were respectively drug-intoxication followed by hanging and self-immolation.
d. The rate of commit suicide has reduced from 16 in 2009 (in the year of before intervention, HUMS, statistic office) to 5 per 100’000 population in 2010 (in the intervention period). This rate is close to the average rate of committed suicide in the country (7). However, in savojbolagh the program was not successful and the rate of suicide rose from 1.6 (in the year of before intervention, TUMS, statistic office) to 3.4 per 100’000 population (in the intervention period) in the correspondence period.
e. Suicide attempt. One thousands and forty four (1044) subjects attempted suicide in both cities (Nahavand = 655, Savojbolagh = 389).
f. The most prevalent methods of attempt were drug poisoning, agricultural poisoning, and using sharp objects

4. ANY DIFFICULTIES ENCOUTERED SO FAR?
a. Not suitable cooperation of local officials
b. The high burnout of Behvarzes
c. Enough sources (budget, human) to build the capacities

5. IF ANY ACTIVITIIES HAVE NOT BEEN STARTED YET?
a. no
6. IF ANY ACTIVITIES HAVE BEEN HOLD?
a. No
b. The following activities have been performed in 2013-2014
c. Provide the final report to Ministry of Health
d. Provided an article for publication and to WHO/EMRO as an new experience in one of the members
e. Founding a national association for suicide prevention: Iranian Scientific Society for Suicide prevention. www.irssp.iums.ac.ir
f. Establishing a suicide study office at Tehran Psychiatric Institute.
g. Collaboration with International Association for Suicide Prevention on public awareness and research
h. Holding annual national meeting on suicide prevention program collaboration with other universitiies, welfare organization and Teheran municipality
7. HAVE YOU HAD ANY COLLABORATION WITH WHO ON THIS PROJECT? HAVE YOU HAD ANY PROBLEM IN COMMUNICATION?
a. no

Activity 7

Title: Clinical Case-management for Patients with SMIs (Severe Mental Illness) In Iran: A randomized Study of the Clinical Outcomes of Mental Health Workers as Case Managers and telephone follow-up
Description: in order to improve the Urban Mental Health network services, this study is being currently carrying out. Its feature is the following:
1.Qualifying the health workers (nurses, General practitionnaire) to provide home-care services for SMIs by visiting them monthly
2.To educate the patients and their families on severe mental disorders
3.To provide limited education of social skill by assigning the monthly tasks
4.To provide required regular treatment facility such as injection of anti-psychotics depot prescription
5.To provide emergency psychiatry visit for the patients in case of exacerbation of the symptoms
6.To provide educational intervention particularly for High Expressed Emotion families.

Description: the aim of this research work was to provide and test a new model of home visit services for SMIs in social and economic setting of Iran. This model is innovative research activity which could introduce a new model of community based services for the SMIs.

1. HOW DOES IT IMPLEMENTED?
a. Design of the study was a double blind, multi center, Randomized Controlled Trial (RCT).
b. Two hundred and forty one patients with severe mental illness were recruited from four psychiatric centers (80 subjects from Razi center, in South of the city, 83 subjects from EmamHosein center, located East of the city, 39 subjects from Taleghani center, located in North, and 39 subjects from Rasool center, in middle part of the city, Tehran the capital). Sixty five percent (119 subjects) had bipolar mood disorder diagnosis and 35 percent (63 subjects) with spectrum diagnosis of Schizophrenia. We defined severe mental illness as schizophrenia, schizoaffective and bipolar mood disorder (BMD).
c. We measured baseline variables at the beginning of the study. These variables were measured again after 12 months follow up period.
d. The study subjects were allocated randomly between three groups of home-visit, telephone follow up and control.
e. Out of ten, after interview and evaluation, four persons were selected to provide case-management (CM) services to the patients.
f. Home visit group. The patients in this group had a one face-to-face session per month by case manager. For every 60 study sample, three case managers had been assigned. Each session- time was an average of 45 minutes. The case manager completed the symptoms and drug side effects check lists and sending the list to the patient's psychiatrist in case of necessity. Educating the patient and their family members by providing brochures and being in touch with the patient or the family in case of an emergency situation were another interventions in this group. The patient or their families were allowed to contact their case-manager in the emergency situation.
g. Telephone follow up. Each study subject in this group were contacted by phone as a reminder of their appointment and in case of missing an appointment they were contacted again and questioned about the reason of their absence and if necessary were encouraged to meet her/his psychiatrist. A trained nurse conducted the telephone contact.
h. Control group (as usual). This group received "as usual treatment". It is a type of care in which patients receive the services by request and presenting him/her selves in outpatient clinic. As routine the psychiatrists prescribe useful medicine for them. The patients are being cared by their families and attend to the clinics whenever she/he needs any help or services.
i. The following measures were used in this study:
j. Kohlman Evaluation of Living Skills. Knowledge questionnaire for caregivers. Family Experience Interview Schedule (FEIS). Persian version of General Health Questionnaire-28 (GHQ-28). Client Questionnaire Satisfaction (CQS). Positive and Negative Symptoms Scale (Kay, 1987). Young Mania Rating Scale: To evaluate the severity of symptoms of BMD. Short Form of Health Survey-36.
k. Monitoring program. Collecting receipt from the patient's caregiver for every home-visit done by the case managers, registering the telephone contact in a particular sheet every months, and Making telephone contact with the consumers or their caregivers every 2 to 3 months to trace the activities being done by case managers were measures we used to monitor the study.
l. Statistical analyses. To compare demographic and clinical variables between three groups of intervention we used chi-square for nominal data and analysis of variance for numeric variables. Analysis of variance (ANOVA) was used for comparing the mean score of questionnaires between groups too. We calculated two

by two comparison of groups by Scheffe as a post- Hoc test. Paired sample t-test was used to compare mean score of questionnaires before and after interventions among each group. Odds ratio with 95% confidence interval was calculated for independent effect of each intervention on recurrence rate using logistic regression.

2. IF ANY OUTPUTS HAVE BEEN DELIVERED?
a. Among the results of other correspondence studies, the results have the results have been used for translation knowledge in order to make a brief report for policy makers in welfare organization and the health committee of the national parliament.
3. IF ANY RESUTLS HAVE BEEN ACHIEVED?
a. The mean duration of illness for total 182 subjects was 13 years and the mean of hospitalized frequency was 4.5 times lifetime. In other words, frequency of hospitalization was once per three years for every patient with severe mental illness.
b. After 12 months follow up all psychological aspects were better than baseline measures significantly (P <0.05), but for YOUNG. Using Scheffe as a post- Hoc test, we showed PANSS, Knowledge on BMD, and CSQ were different just between home visit and as usual (control) group significantly.
c. The recurrence rate was 24.6%, 33.3%, and 55% for home visit, telephone, and as usual treatment respectively.
d. The risk of rehospitalization in telephone and as-usual groups is 1.53 (CI95%: 0.68-3.44) to 2.5 (CI95%: 1.14-5.53) times more than home visit group.
e. There was no significant differences across groups neither before nor after intervention onany domain of SF-36 questionnaire.
f. Comparing the cost-effective

Title	HOME-VISIT	Tel. G	Control
Sample number	80	81	81
Average expenses per person	288, 0227	2,173,875	2,628,074
Days of hospitalization/yr	1131	849	1031

Lost years for disabilities of disease

Title	Home-visit	Tel. G	Control G.
Before study	115,769	96,669	1,042,375
After study	86,956	8,695	139,556
YLD	28,813	9,719	-353,185

4. ANY DIFFICULTIES ENCOUTERED SO FAR?
a. no
5. IF ANY ACTIVITIES HAVE NOT BEEN STARTED YET?
a. no
6. IF ANY ACTIVITIES HAVE BEEN HOLD?
a. no
7. HAVE YOU HAD ANY COLLABORATION WITH WHO ON THIS PROJECT? HAVE YOU HAD ANY PROBLEM IN COMMUNICATION?
a. No
8. The provide article has been provided for publication
9. KNOWLEDGE TRANSLATION AND EXCHANGE MEETING?
a. The result of this program along with other similar projects which has been performed in Iran introduced in a meeting participated delegates from medias, banks, other organization in order to introduce the results of the projects as best practices about community services for SMIs. In the meeting, fascilated by the public affair of Iran University of Medical Sciences has been hold in last week of OCT, 2013.
b. The results has been reviewed
c. Provided a message for public

d. Provided a policy brief for the delegates of organizations
e. Provided a policy brief for “health commission of the Parliament”. The titles were:
i. Description, benefits, hazards, cost, cost-benefit ratio, implementation strategies, impediment of performing these strategies of provided services listed below:
1. Telephone follow-up
2. Home-visit service by nurse
3. Home –visit service by GP
4. As usual treatment, outpatient and hospitalization after relapse

2. Please briefly describe your collaboration with WHO in regards to the activities of the WHO collaborating centre during the past 12 months (e.g. means of communication, frequency of contact, visits to or from WHO). Please feel free to mention any difficulties encountered (if any) and to provide suggestions for increased or improved communication (if applicable).

Title: service package of mental health for GPs
Description: This manual has been developed for mental health GPs working in Primary Health Care System
1. HOW DOES IT IMPLEMENTED?
a. A professional team included eight persons assigned to provide this manual
b. It took 12 months to finalize the program
c. The manual has been sent for Ministry of Health and some parts of it are currently implemented in the training manuals that are used in PHC for mental health workers.
2. IF ANY OUTPUTS HAVE BEEN DELIVERED?
a. The manual with 194 pages in 6 chapters has been provided for Mental Health Bureau, Ministry of Health
3. IF ANY RESUTLS HAVE BEEN ACHIEVED?
a. Currently it is used in primary health care
4. ANY DIFFICULTIES ENCOUTERED SO FAR?
a. The manual has not yet been publicly published and is not available for everyone.
5. IF ANY ACTIVITIIES HAVE NOT BEEN STARTED YET?
a. NO
6. IF ANY ACTIVITIES HAVE BEEN HOLD?
a. NO
7. HAVE YOU HAD ANY COLLABORATION WITH WHO ON THIS PROJECT? HAVE YOU HAD ANY PROBLEM IN COMMUNICATION?
a. NO

Title: service package of mental health for Behvarzes (Iranian multiple health workers)
Description: This manual has been developed for Behvarzes who are working in Primary Health Care System at health houses
1. HOW DOES IT IMPLEMENTED?
a. Establish a team professional included 10 person
b. Compiled the material according to the needs of MoH
c. The target group was Behvarzes working in PHC, at health houses
d. It took around 18 months to finalize the program
e. Waiting for new version of national mental health program and its integration into PHC
2. IF ANY OUTPUTS HAVE BEEN DELIVERED?
a. A manual in 10 chapters has been provided commissioned by the Mental Health Bureau, Ministry of Health.

b. It has been finalized in 2013-2014.
c. This manual provided for Behvarzes working in primary health care currently
3. IF ANY RESUTLS HAVE BEEN ACHIEVED?
a. Currently it is used in primary health care system
4. ANY DIFFICULTIES ENCOUTERED SO FAR?
a. The manual has not yet been publicly published and is not available for everyone.
5. IF ANY ACTIVITIIES HAVE NOT BEEN STARTED YET?
a. NO
6. IF ANY ACTIVITIES HAVE BEEN HOLD?
a. NO
7. HAVE YOU HAD ANY COLLABORATION WITH WHO ON THIS PROJECT? HAVE YOU HAD ANY PROBLEM IN COMMUNICATION?
a. NO

3. Please briefly describe any interactions or collaborations with other WHO collaborating centres in the context of the implementation of the above activities (if any). If you are part of a network of WHO collaborating centres, please also mention the name of the network, and describe any involvement in the network during the last 12 months.

Title: Effect of Preventive Interventions of " Social Emergency of Welfare Organization (123 services)" and "Telephone Follow-up" Services on Suicidal Behaviors
1. Description: The new strategy selected in current study is based on the existing social emergency services,

called 1-2-3 services and new telephone follow-up services which is supposed to be established in this study. Considering the limited intervention studies in Iran, this study was designed according to the principles of the WHO strategies:
o Based on the World Health Organization strategies
o New and innovative
o Applicable
o Based on existing services in the society
o Without so much financial burden

The main objective of the project:
The main objective of the project is to determine:
• the effectiveness of preventive interventions of "Social Emergency" called 1-2-3 services (provided by social welfare organization)
• "Telephone follow-up services" on suicidal behaviors in Loghman Hakim Hospital, Tehran, 2013-2014.

1. HOW DOES IT IMPLEMENTED?
This study is a randomized controlled clinical trial, prevention trial type.
In this study, all suicide attempters who had referred to Loghman Hakim Hospital and had the criteria for inclusion in the study constitute the study population.
This study is conducted on people referred to Loghman Hakim Hospital in Tehran; and all patients who reside in Tehran will be included in it.

In this study, three main following tools are used :
a. SUPREMISS series of questionnaires, short form
b. Structured clinical interview based on DSM-IV (SCID)
c. MCMI-III questionnaire
d. Questionnaire of data collection periodically

Considering the attrition rate of 30% for one year (the result of SUPREMISS study in Iran), Thus, 300 patients were assigned to each group.
Initial sample of the study are selected from among patients referred to the Loghman Hakim Hospital using simple non-randomized sampling within the specified time, based on the inclusion and exclusion criteria. Participants will be randomly assigned to two groups and balance blocked randomization method is used for this purpose.

Execution method:
a. On the morning of the day of project commencement, interviewers refer to the hospital admission desk and after taking a hit of the patients referred to the hospital, they go to visit the patients according to their place of hospitalization (with respect to their inclusion time).
a. After learning about the plan, patients sign knowingly a consent form (if they would like to do so). SCID 1 questionnaire and SUPREMISS are filled out by the interviewer.
b. MCMI-III questionnaire is given to the patients to be filled out by them. The patient is requested to fill out the questionnaire calmly and he/she was told that there is no time limitation to fill the questionnaire. The patient can ask any question about the questionnaire. This questioner’s explanation comforts the patient; and given the time spent in the previous interview, the patient has the opportunity to fill out and to deliver it to the questioner.
c. Patients randomly assigned to the test and control groups based on the balance blocked randomization procedure.
d. The questionnaires are filled out by the patients in both groups.
e. The package of interventions will be used only in the test group. Package of interventions are divided into both hospital interventions and interventions after follow-up and discharging. These measures are as follows:

INTERVENTION PACKAGE
A – Medical (Hospital) interventions:
Interventions in the hospital (before discharge) as follow:
1-a) giving information to the patient, including defining suicidal behavior, suicide rates and suicide attempts,

protective factors and factors that lead individual to the suicide or attempting suicide, actions that can be performed in time of danger, and factors ready to help resolve the crisis. Patients are provided with educational brochures at this stage.
2-a) Introducing service of "Social Emergency of Welfare Organization (1-2-3)" and encouraging them to use these services in critical situations (with providing brochures about this service).This study will not intervene in the procedure and quality of services provided by “1-2-3” and will only collect data related to the samples of this project. These interventions are done face to face for one hour at the first earliest possible time after filling out questionnaire or before patient discharge in the experimental group.
3-a) After the end of meeting, the first appointment for the first follow-up meeting will be made with the patient and his/her close family member, living in the same house.

B – Telephone follow-up interventions:
1-b) After patient discharge from the hospital, follow-up intervention will be started through telephone follow-up
2 - b) These follow-ups are done at weeks 1, 2 and 4, and then every month for a period of one year (totally 14 times). These are pre-determined and in each contact, the time of the next meeting is coordinated.

C – FOLLOW UP. the follow-up questionnaire which includes 6 questions with following topics will be completed periodically according to study design:
1. Checking the patient for being sure of his/her being alive or dead
2. Checking re-suicidal behaviors
3. Checking current general health of the patient
4. Number and manner of suicide attempt, in case
5. using of 1-2-3 social emergency services and type of received services, in case
During telephone contact, skills of motivational interviewing will be used to continue interview and to have patient’s cooperation with the interviewer and in case he/she has not used mental health services, efforts will be made to provide incentives for the use of these services. When patient is not at home during the phone call, but he will come back home by the end of the day, the time to reconnect with be coordinated with the person answering the phone, and he will be contacted again or her/his cell phone. If necessary, it is coordinated to contact with him/her (by telephone) during the next day. Telephone follow-up intervention is designed and conducted in this project. Currently, there is no such services in the country.

Control group
In the control group, intervention is not done in the hospital and this group will only receive hospital standard therapies. They will be recruited after filling the informed consent form.
At 4, 8 and 12 months after discharge of patients from hospital, the study samples in the control group will be contacted by telephone and follow-up questionnaire will be filled out.
During filling out of the questionnaires, if it is diagnosed that the situation of the patient is critical, so that there is the instantaneous probability of suicide or attempting suicide, the patient should be introduced to the crisis centers based on moral principles, while developing effective communication and doing motivational interventions to help the patient resolve the crisis and from that time onwards, the patient is excluded from the control group. In this case, intention-to-treat method is used in the statistical methods. At the end of this project, all the information, advices and education related to the experimental group are referred to the control group. In order to comply with the ethical issues, immediate after stoppage of psychiatric diagnoses and getting the approval of the project supervisor, study samples in both groups will be informed of these diagnoses via .

Method of data analysis
Descriptive statistics are used to describe data. Primary comparison of qualitative data, such as clinical diagnoses between the two groups is performed by chi-square test. Quantitative variables in both groups are compared by Student's T test. Among the target variables, suicide reattempts and deaths by suicide were compared between the two groups using chi-square test. As it is predicted that the frequencies of suicide attempts in the groups do not follow a normal distribution, Mann - Whitney nonparametric test is used to compare these variables between the two groups at the end of the study. To find factors associated with the suicide reattempts or deaths by suicide, the Kaplan - Meyer test is used. Depending on circumstances, analysis of covariance or regression tests may be used to find relevant factors or to study the effect of

confounding factors. In all cases, the initial alpha error is considered as 0.05. If necessary, the Bonferroni correction will be used to do multiple analyzes.

2. IF ANY OUTPUTS HAVE BEEN DELIVERED?
• Not yet
3. IF ANY RESUTLS HAVE BEEN ACHIEVED?
• Not yet
4. ANY DIFFICULTIES ENCOUTERED SO FAR?
• Changing the hospital to enroll the study subjects due to noncompliance of local authorities
5. IF ANY ACTIVITIIES HAVE NOT BEEN STARTED YET?
• The project has been launched July 2013
6. IF ANY ACTIVITIES HAVE BEEN Holds?
• no
7. HAVE YOU HAD ANY COLLABORATION WITH WHO ON THIS PROJECT? HAVE YOU HAD ANY PROBLEM IN COMMUNICATION?
• Consult with Dr. Khalid Saeed on methodology, Regional Advisor , Mental health and substance abuse, WHO/EMRO;Cairo, Egypt

• consult with Prof. Diego De Leo AO, DSc, MD, PhD, FRANZCP
Professor of Psychiatry | Griffith University |
Director, Australian Institute for Suicide Research and Prevention

4. Please briefly describe any type of technical, programmatic, advisory or other support received from WHO during the past 12 months for the implementation of the agreed activities listed above (if any).

We strongly believe that communication & collaboration between 4 WHOccs in WHO/EMRO should be facilitated to conduct shared project based on ToRs or to negotiate about the process and outcomes of their projects.
We received technical support from Dr. Khald Saeed, the director of WHO/EMRO, for providing a model of Urban Mental Health for Iran.
We believe that implementation and development of all projects needs more support from WHO as well as Iran Health Ministry. We think that maintenance and development of the project is more important and more difficult than the establishment of them.