Iran J Psychiatry Behav Sci. 2025 September; 19(3): e160577 https://doi.org/10.5812/ijpbs-160577

Published Online: 2025 August 3 **Research Article**

Challenges and Requirements in Community-Based Care for Severe Mental Illness in Iran: A Qualitative Study

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Received: 16 February, 2025; **Revised:** 25 May, 2025; **Accepted:** 21 July, 2025

Abstract

Background: Severe mental illnesses (SMI) are currently managed through various community-based interventions; however, these initiatives face numerous challenges.

Objectives: The present study seeks to assess the challenges and requirements related to community-based care services in Iran.

Methods: The current study employed a qualitative content analysis based on the approach developed by Elo and Kyngas. The research targeted adults aged 18 to 65 with severe mental illness, along with their families, healthcare providers, health experts, and policymakers. To capture a wide range of perspectives and experiences, purposive sampling utilizing a maximum variation technique was implemented. Data collection involved in-depth semi-structured interviews, with questions designed according to the World Health Organization (WHO)'s conceptual framework. To ensure the study's accuracy and validity, the researcher adhered to the criteria established by Lincoln and Guba. A total of 32 interviews (7 patients, 5 caregivers, 16 healthcare providers, 4 policymakers) were conducted with qualified participants. Following each interview, the recordings were transcribed verbatim, and the data were subsequently analyzed with MAXQDA2020 software.

Results: After analyzing the interview data and extracting the primary codes, we identified a total of 14 main categories and 38 subcategories that align with the eight generic categories of the WHO's conceptual model. The main categories identified include: The development and integration of services; moral and legal support; economic barriers; structural and communication barriers; physical and equipment barriers; treatment and care barriers; the need for financial credit; lack of human resources; the requirements and competencies of the treatment team; the necessity for educational infrastructure; provision of comprehensive care; destigmatization; sources of awareness; and the imperative for research and technology development.

Conclusions: Integrating community mental health care centers into the national health system addresses funding and manpower challenges while enhancing service accessibility. To establish a sustainable community-based care delivery, it is essential to secure reliable funding, maintain adequate staffing levels, and promote ongoing professional development, all while actively addressing the reduction of stigma associated with care services.

Keywords: Community Mental Health Centers, Community Mental Health Services, Health Personnel, Mental Disorders, Social Stigma

1. Background

Severe mental illnesses (SMI), including schizophrenia and bipolar disorder, encompass distinct diagnostic criteria and varying degrees of disability. These conditions may also result in atypical behaviors, such as experiencing hallucinations (1). These disorders can lead to considerable distress not only for the individuals affected but also for their families and those in their social circles over the long term. Until the 1970s, the predominant approach to treating patients with severe mental disorders involved institutional care within health facilities (2). The deinstitutionalization movement arose to downsize and eventually shut down large care facilities. Instead, it aimed to provide community support, driven by these institutions' inadequate performance in effectively caring for individuals (3). Global standards, through a holistic approach, advocate for the enhancement of community-based services (2, 4, 5). In numerous countries, a diverse array of community-based mental health interventions is employed to manage these disorders. These include crisis services, community outreach programs, peer support initiatives, hospital-based services, supported

How to Cite: Mohammadi Z, Zarea K, Jahani S, Rassouli M, Asadizaker M, et al. Challenges and Requirements in Community-Based Care for Severe Mental Illness in Iran: A Qualitative Study. Iran J Psychiatry Behav Sci. 2025; 19 (3): e160577. https://doi.org/10.5812/ijpbs-160577.

living arrangements, and community mental health centers (CMHCs) (6-10). Integrating mental health services at the community level offers numerous advantages, such as enhanced accessibility, cost efficiency, improved treatment adherence, and better clinical outcomes. Furthermore, delivering these services within the community significantly contributes to raising public awareness about mental health, diminishing stigma and discrimination, and fostering the social inclusion of individuals with SMI (10). Different countries have different approaches to their mental health, which are constantly changing and tailored to their existing situations, goals, and policies. In Iran, a crucial approach to community-based mental health services is the incorporation of these services into the national healthcare framework, particularly within the primary healthcare system, to improve accessibility. Although this initiative has shown success in rural regions, it has fallen short of expected results in urban environments (11). The 2011 Iran Mental Health Survey (IranMHS) revealed that 23.6% of adults, approximately one in four, experience psychiatric disorders.

Alarmingly, over two-thirds of these individuals remain unrecognized and untreated. Furthermore, many of the available mental health services are either inadequate or of substandard quality (12). Over the past three decades (1990 - 2019), Iran has experienced a significantly higher burden of mental disorders, recorded at 77%, compared to the global increase of 55%. This disparity is primarily linked to shifts in population size and structure, highlighting an escalating demand for mental health services across primary, secondary, and tertiary care levels (13). To enhance urban mental health, the establishment of community-based mental health centers was proposed and subsequently approved by the mental health department of the Ministry of Health and Medical Education (MOHME). The first of these centers was inaugurated in Tehran in 2010 (14). The primary characteristics of these centers include comprehensive care that encompasses prevention, diagnosis, treatment, and rehabilitation for patients, minimizing the need for psychiatric hospitalization. In 2015, the Ministry of Health incorporated the CMHC service model into the SERAJ program, a comprehensive mental and social health initiative aimed at Iranian communities, recognizing its effectiveness and the high level of patient satisfaction it achieved (12). Consequently, the services provided by CMHC have been enhanced to incorporate rehabilitation programs specifically designed for individuals with SMI (15). The CMHC program is presently being piloted in several cities across the country (16). The CMHC was created to improve rehabilitation services for people with SMI. However, these centers face major challenges, such as not having enough staff and limited funds, which make it hard for them to provide ongoing services (15). In medium and large cities, mental health services are predominantly offered by hospitals and clinics rather than primary care, primarily due to the insufficient number of CMHCs. Additionally, there is a notable lack of coordination among various service providers (14). Studies indicate that the implementation and evaluation of community-based mental health services pose significant challenges for numerous national healthcare systems, primarily due to constraints in resources, including financial and professional limitations (17, 18).

Ghalichi et al. identify several significant challenges in delivering services in Iran. These include a limited understanding of care needs, insufficient knowledge regarding mental disorders, discrimination, inadequate access to services, and high costs. Tackling these issues is crucial for enhancing the quality of service delivery (13). Addressing this issue in Iran is especially crucial given the significant population that requires this type of service (19, 20). The aforementioned materials emphasize the need to fill research gaps in mental health policies. They highlight the importance of analyzing current policies, allocating resources (financial and human), and training programs for mental health workers, understanding patients' needs and their families, adequacy and satisfaction with existing services and treatments, or the need for unconventional treatments.

2. Objectives

The present study evaluates the challenges and requirements associated with community-based services from the viewpoints of consumers, including patients and families, as well as providers, practitioners, and policymakers in the mental health sector in Iran.

3. Methods

3.1. Design

A directed qualitative content analysis was conducted in the present study. Content analysis aims to

Table 1. World Health Organization's Guidelines for Community Mental Health Services to Promote Person-Centered and Rights-Based Approaches

Dimensions	Definitions
Policy and strategy for mental health	Creating national programs and projects and developing them with the participation of stakeholders
Law reform	Creating equal rights for people with mental disorders with other people
Community-based mental health services and services model	Providing a wide range of services and interventions to meet different needs and support people
Financing	Changes in the types of services and interventions by governments through health insurance plans and funding
Workforce development and training	Changes in the attitude, knowledge, competencies, and skills of service providers
Psycho-social, psychological interventions, and psychotherapeutic drugs	Attention and importance to evidence-based interventions considering their limitations and possible negative effects
Information systems and data	Understanding and control of the existing situation and evaluation of the level of achievement of goals
Civil society, people, and society	Doing basic actions related to changing negative attitudes or mentalities, stigmatization
Research	Need to control and evaluate activities at all levels, determine high centers to conduct research

provide knowledge, insight, and practical guidance for understanding phenomena in context (21). The research draws upon the "Guidelines for Community Mental Health Services" published by the World Health Organization (WHO) in 2021 (5). The purpose of choosing this model is to provide information and guidance to all stakeholders who wish to develop or transform their mental health service delivery system, and the dimensions examined in it (Table 1) are appropriate to the contexts that need to be addressed in Iran (7). In this study, qualitative content analysis was employed to gain insights into the challenges and requirements of delivering community-based care in the Iranian context. The analysis focused on model dimensions from the perspectives of consumers, including patients and families, as well as providers and policymakers involved in the care of individuals with SMI.

3.2. Participants

The study focused on adults with SMI aged 18 to 65, along with their families, healthcare providers, experts, and policymakers. A total of 32 interviews were conducted with qualified participants, as detailed in Table 2. To capture a wide range of perspectives and experiences, purposive sampling utilizing the maximum variation technique was employed. Participants of various genders and ages were recruited from diverse settings, including CMHC, daily rehabilitation facilities, residential rehabilitation centers associated with the Welfare Organization, general and specialized hospitals, the Health Office of the MOHME, and home care centers.

Inclusion criteria were patients needed to be willing to share their experiences, have a confirmed diagnosis of serious mental illness, understand their condition, and communicate effectively. Families had to know the patient's diagnosis and have at least six months of caregiving experience. Care providers needed at least one year of experience in mental health services for adults with SMI. Policymakers were expected to have expertise in mental health management and hold managerial or executive positions in relevant organizations. The exclusion criteria were the absence of inclusion criteria and unwillingness to cooperate.

3.3. Data Collection Method

Data were collected through comprehensive interviews utilizing questions derived from the WHO model. Before the interviews, the researcher carefully selected suitable participants and clarified the study's objectives, subsequently obtaining their written consent. The questions were specifically designed to match the reading levels, professional backgrounds, and experiences of the participants. After obtaining consent, individual interviews were carried out in a calm and peaceful setting. Each interview lasted between 15 and 60 minutes, varying based on the participants' comfort levels and the topics discussed (patients tolerated less time, 15 - 20 minutes, than care providers, 45 - 60 minutes). The information was recorded with the participant's consent. Contact details, including phone numbers and addresses, were collected for follow-up interviews and to verify the accuracy of the notes, while ensuring the confidentiality of the information. Follow-up interviews (two interviews) were conducted to clarify initial ambiguities and address new questions. During these sessions, participants were encouraged to elaborate with prompts like "Can you explain more?" to facilitate deeper exploration. Following each interview,

Table 2. Demographic Characteristics of the Participants [a]

Variables	Female	Male
Gender		
Patients	4 (57.1)	3 (42.8)
Caregivers	5 (100)	0 (0)
Healthcare providers	4 (25)	12 (75)
Policymakers	3 (75)	1 (25)
Age		
Patients	36.57 ± 12.39	-
Caregivers	47.60 ± 10.69	-
Healthcare providers	41.56 ± 10.23	-
Policymakers	49.75 ± 10.99	-
Education		
Patients	Diploma: 3; BS: 3	-
Caregivers	Middle school: 5	-
Health care providers	Social worker: 4 (MS: 1, BS: 3); psychologist: 4 (BS: 4); psychiatrist: 2; occupational therapist: 3 (M.A: 1, B.A: 2); head nurse: 3 (MS: 1, BS: 2); home care manager: 1 (BS: 1)	-
Policymakers	Ph.D.: 1; professional doctorate: 1; MS: 2	-

[a] Values are expressed as No. (%) or mean ± SD.

the interviewer asked whether the participant had any additional comments. Sampling continued until data saturation (not receiving new data) was reached at interview 30, with two more interviews conducted for added assurance. After the interviews, audio recordings were transcribed verbatim in Microsoft Word. Sample questions can be found in Table 3.

3.4. Data Analysis

To analyze the data, the qualitative content analysis approach developed by Elo and Kyngas (2008) was employed. This method encompasses three distinct stages: Preparation, organization, and reporting (21). During the preparation phase, the researcher transcribed the interviews using Microsoft Word and thoroughly reviewed the text to gain a deeper understanding of the participants' feelings and experiences. For enhanced data management, the researcher utilized MAXQDA2020 software. The analysis involved a meticulous line-by-line examination of the interview text, where primary codes were extracted and similar items were grouped into sub-categories and main categories based on their similarities and differences during the organizing stage. Discussions with the research team addressed any discrepancies regarding the codes within their categories. After refining the categories, the researcher documented the findings in the text.

3.5. Trustworthiness

To ensure accuracy and validity, the researcher adhered to the criteria established by Lincoln and Guba (22). In pursuit of credibility, the researcher employed a maximum variation sampling technique. Engaging deeply with the research topic and data, the researcher dedicated six months (from March 4, 2023, to September 6, 2023) to the collection, review, and analysis of the data. Alongside self-monitoring, the researcher implemented peer checking and member checking throughout the data collection and analysis phases to validate interpretations. To enhance dependability, the research team's supervisors, advisors, and colleagues meticulously scrutinized and refined the interview data, addressing any discrepancies through discussion and involving an external observer familiar with the research. To ensure verifiability, comprehensive records were maintained throughout all research stages, especially during data analysis and the creation of detailed classifications. By providing a comprehensive description of the participants' characteristics, experiences, sampling method, and the timing and location of data collection, the researcher enhanced the transferability of the findings for readers' evaluation. To

Table 3. Guide to Interview Questions with Participants

Experts and Policymakers	Care Providers	Patients/Family Caregivers
(1) What role do community-based mental health services play within the broader health system? (2) What policy requirements must be met for effective community-based mental health services? (3) What training and human resource provisions are necessary for community-based mental health services?	(1) Could you describe the existing procedures for delivering care to patients with severe mental illness? (2) What obstacles and difficulties do you encounter in providing care? (3) What deficiencies or limitations exist within the service?	(1) What actions has the health team taken to solve the problems you or your patient experienced since your last visit? (2) How well did the services and care meet the needs of you or your patient? (3) What problems or gaps are there in the service?

ensure accuracy, the researcher made a concerted effort to remain impartial and minimize bias throughout the research process, while also emphasizing the authenticity of the collected information.

4. Results

The analysis of the interview data uncovered a total of 1,704 primary codes. After removing duplicates and consolidating similar codes, alongside the 8 generic categories (framework), we identified 14 main categories, which include 38 subcategories (Table 4). Below, we present a comprehensive overview of these main categories along with their subcategories.

4.1. Mental Health Policy and Strategy

4.1.1. Service Integration and Development

4.1.1.1. Care Continuity

Participants underscored the critical need for continued treatment for patients with mental disorders following their discharge from the hospital. They stressed the importance of establishing support centers for these individuals and advocated for the creation of local psychiatric facilities to ensure ongoing care and facilitate communication with families. One participant, the Head of the Mental Health Department, noted, “While patients who improve may leave the hospital, they often lack someone to monitor their treatment, procure their medications, or consult with a doctor post-discharge. As a result, many experience a relapse or discontinue their medication. It is essential to have a system in place to track their progress” (participant No. 10, head nurse).

4.1.1.2. Accreditation of Community-Oriented Mental Health Services

The participants noted that CMHC in the country is not officially part of the Ministry of Health and functions as a pilot project. To continue services for SMI and expand these centers, policymakers need to recognize and integrate CMHC into the health system, allowing them to operate at medical science universities. "Just for this CMHC to take root to support SMI, one of the most important things is for policymakers to understand the importance of this issue and somehow recognize it so that these centers can be expanded" (participant No. 19, psychiatrist).

4.2. Law Reform

4.2.1. Moral and Legal Support

4.2.1.1. Preservation of Human Dignity

The participants highlighted the importance of prioritizing the rights and dignity of individuals with mental illness. They advocated for enhancing the self-worth of patients and their families through consistent follow-up, creating a supportive and non-judgmental environment, and safeguarding the privacy of patients. “I heard that we have therapeutic attention, a group can be formed to follow up on the patients, even if it’s just a phone call once in a while” (participant No. 16, occupational therapy supervisor).

4.2.1.2. Collaborative Decision-Making

Some participants expressed the view that a disconnect exists between raising awareness and empowering mental health patients with the right to choose. “We think that a chronic patient can no longer think and make decisions, as a result, even our psychiatrists and nurses do not give them the right to choose” (participant No. 21, faculty member and PhD of mental rehabilitation). Many individuals emphasized that patients and their families should have the autonomy to make decisions and engage actively in the treatment planning process. “We give the patients with depression and anxiety, the right to choose what they want to do; that is, we give them this right as far as we can” (participant No. 6, psychiatrist).

Table 4. Generic, Main, and Subcategories Appeared from Analysis

Framework (Generic Category); Main Category	Sub-category
Mental health policy and strategy	
Service integration and development	Care continuity; accreditation of community-oriented mental health services
Law reform	
Ethical and legal support	Preservation of human dignity; collaborative decision-making; informed consent; determining the legal framework
The service model and provision of community-based mental health services	
Economic barriers	Unaffordability; employment problems
Structural and communication barriers	Insufficient access; poor inter-organizational support
Physical barriers and equipment	Lack of proper physical space; lack of proper equipment and facilities
Treatment and care barriers	Shortage of medicine; therapeutic misconceptions; weakness of home care infrastructure; inefficient family care; exhaustion and destruction of the family
Financing	
The need for financing	Lack of funds; income and cost imbalance of psychiatry
Workforce development and training	
Lack of workforce	Factors of job dissatisfaction and leaving service; lack of efficient workforce
Treatment team requirements and competencies	Workforce selection criteria; establishing an effective therapeutic relationship
The necessity of providing educational infrastructure	The need to change the mental health education program in the university; the importance of education and training the workforce
Psychosocial and psychological interventions and psychotherapeutic drugs	
Comprehensive care provision	Adoption and preparation of treatment plan; providing specialized care services; educational/informational support; social support and counseling; welfare and entertainment support
Civil society, people, and society	
Types of stigmata	Destigmatization
Information sources	Advertisement; training
Information systems and data and research	
The necessity of developing research and technology	Weakness of using data in research; exclusive mental health research

4.2.1.3. Informed Consent

Participants raised concerns regarding ethical issues, including the psychiatrist's responsibility to clearly explain treatment procedures, the necessity for staff to provide comprehensive information before procedures, and the importance of communicating effectively with patients, particularly when their insight has not fully returned after symptom improvement. "We explain to the patient that it is the patient's right to know that these procedures have been done for her/him due to the conditions she/he had, for example, the medicine, and we explain all this to her" (participant No. 1, head nurse).

4.2.1.4. Determining the Legal Framework

Legal criteria included being of legal age, obtaining consent for hospitalization and treatment, obtaining permission from the family or legal guardian for the patient without insight, and involving legal authorities when necessary. It is also important to facilitate the entry of laws into the psychiatric emergency field. "Someone does not have the power to make a decision. This family took him to the doctor. The doctor determines that he should be hospitalized. When he does not have the power to make a decision, the family naturally makes this decision" (participant No. 4, social worker).

4.3. The Service Model and Provision of Community-based Mental Health Services

4.3.1. Economic Barriers

4.3.1.1. Unaffordability

Participants pointed out that individuals with mental illness cannot bear the financial burden of their families and cannot pay for expenses. They requested financial support centers or salaries from specific organizations. "Many times, one is stuck in the expenses,

sometimes, financially, one can have some support, that is good" (participant No. 31, wife of the patient).

4.3.1.2. Employment Problems

Not having a job was a major economic issue for the participants. The reasons included the mistrust of mental patients, challenges in hiring them, and a lack of special employment centers. They suggested that recognizing patients' talents, teaching them skills, and finding job centers could help. "When my husband couldn't work, the social worker told me that there was a center for schizophrenic diseases, and gave them jobs depending on their condition, which was very good" (participant No. 31, wife of the patient).

4.3.2. Structural and Communication Barriers

4.3.2.1. Insufficient Access

Participants faced obstacles in accessing community-based centers due to the lack of service centers, limited coverage areas, insufficient capacity to serve more patients, and difficult locations. "We absolutely cannot send patients from one region to another to receive services. The psychiatrist cannot see a large number of patients from different regions, affecting service quality and accessibility" (participant No. 20, supervisor of the CMHC center).

4.3.2.2. Poor Inter-organizational Support

The existence of problems, including the lack of support from organizations in mental health, great efforts to convince organizations to assist clients, and the weak performance and inactivity of other organizations, such as the Welfare Department, in providing rehabilitation services, showed the need to improve communication between responsible organizations and integrate processes from the perspective of participants. "We have to try hard to persuade the relevant organization to come and help us" (participant No. 9, social worker).

4.3.3. Physical Barriers and Equipment

4.3.3.1. Lack of Proper Physical Space

The participants stated that centers face challenges due to the lack of suitable space for training and occupational therapy. "One of our problems is the lack of space and we have to remove some of our activities against the existing protocol" (participant No. 17, occupational therapist).

4.3.3.2. Lack of Proper Equipment and Facilities

In this case, the existence of minimal facilities, the need for more tools and facilities, the existence of a ceiling for accepting patients in the private sector under welfare supervision, a limited number of beds, prioritization of patients, and long waiting times for admission were noted. "There are one or two private centers. Patients who want to go there have to register because their space is limited to about 40 - 50 beds. They have many referrals and patients stay there for a long time" (participant No. 3, responsible for private home care).

4.3.4. Treatment and Care Barriers

4.3.4.1. Shortage of Medicine

Participants expressed barriers to treatment, including a shortage of medicines, lack of essential drugs, and high costs. "The problem for the patients who are hospitalized here is the lack of medicine. Right now, the antipsychotics we use intermittently are not on the market. We have to change" (participant No. 24, psychiatrist).

4.3.4.2. Therapeutic Misconceptions

The participants mentioned paying more attention to hospitals, treatment-oriented mental health services, and not having a holistic view of patients as barriers to care and treatment. "Our treatment symptom is our dominant view. We say that a person is cured when he/she has no symptoms. As a result, we only give him medicine, which is why we are expanding our hospitals" (participant No. 21, PhD in mental rehabilitation).

4.3.4.3. Weakness of Home Care Infrastructure

Participants noted several obstacles to home care, including poor cooperation between general practitioners (GPs) and psychiatrists, potential violence, limitations on the number of patients, time-consuming visits, patient non-cooperation, and travel expense coordination issues. "In the areas of home visits, however, the coordination, transportation, and expenses are the challenges that we are facing" (participant No. 20, CMHC supervisor).

4.3.4.4. Inefficient Family Care

The main issues identified were the families' lack of cooperation and responsibility after discharge, limited empathy and support for patients, excuses for not continuing treatment, low information levels, unawareness of how to manage patients, and lack of knowledge about non-pharmacological activities. "Well, if they taught me, it would be much easier. Our biggest problem at home is that we don't know what to do" (participant No. 29, mother of the patient).

4.3.4.5. Exhaustion and Destruction of the Family

From the participants' point of view, challenges include families losing hope as clients age, experiencing despair, depression, anger, fatigue, suicidal thoughts, inability to care for patients at home due to old age or having a single parent, and a lack of control over some patients, even with medication. "It seems that as the age of the client increases, the family gives up hope, they don't have the empathy and support the patient needs to continue the treatment" (participant No. 13, psychologist).

4.4. Financing

4.4.1. The Need for Financing

4.4.1.1. Lack of Funds

Participants found that only 3% of health sector funds go to mental health, and CMHC centers receive limited funding from the Ministry of Health, causing financial pressure (providing expert staff and their training) and dependence on charities. One participant said: "The problem of CMHC will not be solved until it is integrated and is included in the budget of the Ministry of Health" (participant No. 19, psychiatrist).

4.4.1.2. Income and Cost Imbalance of Psychiatry

Providing services (day care, welfare, support, and care centers) for mentally ill patients is costly, and investors are reluctant to invest in mental rehabilitation due to its lack of revenue generation. One participant noted, "The cost of providing services such as daily care, welfare, and support for mental health patients is high. Additionally, investment in mental rehabilitation is limited due to insufficient income generation, and the returns from rehabilitation are not substantial, leading to a reluctance to invest" (participant No. 19, psychiatrist).

4.5. Workforce Development and Training

4.5.1. Lack of Workforce

4.5.1.1. Factors of Job Dissatisfaction and Leaving Service

The factors contributing to workforce attrition included the contractual nature of employment, low fixed salaries, lack of benefits, disappointment, and job dissatisfaction. "We are facing a lack of manpower, and the lack of support makes a person unhappy and upset, leading them to be unwilling to continue working" (participant No. 13, psychologist).

4.5.1.2. Lack of Efficient Workforce

The participants mentioned other reasons for the staff shortage, including the absence of a main instructor for training, few trained personnel available as centers grow, no scientific group for support, and a lack of trained occupational therapists in SMI. A psychiatrist said: "Currently, the number of centers is increasing, and there is a shortage of trainers who can teach all of these. Regarding occupational therapy and rehabilitation, we practically lack someone who works in the field of psychology to come and provide supervision or hold training workshops for them" (participant No. 19, psychiatrist).

4.5.2. Treatment Team Requirements and Competencies

4.5.2.1. Workforce Selection Criteria

The main criteria for workforce selection included experience, interest, consideration of physical and mental health, and personnel needs. A nurse said: "Someone interested can serve more, that is, the psychological characteristics of people can influence their choices" (participant No. 16, head nurse).

4.5.2.2. Establishing an Effective Therapeutic Relationship

Effective therapeutic communication involves proper communication between the therapist, staff, and client, understanding the patient, creating peace and security, and avoiding fear in the patient. "But if there is no shouting, I think it will be better to tell the patient calmly, she is not stubborn, she feels relaxed and safe" (participant No. 28, companion of the patient).

4.5.3. The Necessity of Providing Educational Infrastructure

4.5.3.1. The Need to Change the Mental Health Education Program in the University

Participants emphasized the need to start education at universities, shape perspectives on SMI, and train relevant professionals (psychologists, occupational therapists, and social workers). "I think the first step is to train occupational therapists. Occupational therapists in the university are not in their psychological field and they are not given much proper training" (participant No. 14, occupational therapist).

4.5.3.2. The Importance of Education and Training the Workforce

This subcategory focuses on training the therapeutic team and promoting a professional, interdisciplinary perspective for mental rehabilitation. "I think the first thing is to look interdisciplinary; it means that a team that interacts and can discuss with each other and has a clear process is very important and that the team must have received training and the right attitude has been created in them and they understand the meaning of psychological rehabilitation" (participant No. 21, PhD in rehabilitation).

4.6. Psychosocial and Psychological Interventions and Psychotherapeutic Drugs

4.6.1. Comprehensive Care Provision

4.6.1.1. Adoption and Preparation of Treatment Plan

Creating a treatment plan involves careful thought and planning to achieve good results. It requires understanding the person's needs, likes, and situation, and then developing a personalized approach to meet specific goals and challenges. One of the participants said: "We first evaluate them here, after that, we have a treatment team, nurses, assistants, psychologists, and occupational therapists, they are all present, the patient's evaluation is read and a service is assigned according to the disease, the family conditions and problems he may have" (participant No. 15, head nurse of the Rehabilitation Center).

4.6.1.2. Providing Specialized Care Services

Specialized care services are designed to meet the unique needs of individuals, ensuring they receive tailored support and attention. These services focus on delivering high-quality care that addresses specific health conditions, personal preferences, and lifestyle requirements, ultimately enhancing the overall well-being of those served. "First we played sports, then we talked with the coaches, then we played group and individual games, it was an intellectual game, it was a concentration game, it was a creativity game, and we made boxes like this" (participant No. 10, a patient of the Rehabilitation Center).

4.6.1.3. Educational/Informational Support

Educational and informational support plays a crucial role in enhancing learning experiences and facilitating knowledge acquisition. By providing structured guidance and relevant materials, educational support fosters a deeper understanding of subjects and promotes critical thinking skills. "Here we have educational groups, patient education, family education, anger management, life skills, social skills, and I think I said it all" (participant No. 15, head nurse of the Rehabilitation Center).

4.6.1.4. Social Support and Counseling

Social support and counseling play a crucial role in enhancing individual well-being. Effective counseling can guide individuals through challenges, offering a safe space for expression and growth. By cultivating strong social networks, individuals can experience increased feelings of belonging and reduced stress, ultimately leading to improved mental health outcomes. One of our participants said: "I myself think that 100% of families need counseling. When the counselor talks to the family, they turn from one side to the other, especially because they do not know the treatment after discharge and do not know its importance. Counselors should teach these to families, and this is a very important task for counselors" (participant No. 1, head nurse).

4.6.1.5. Welfare and Entertainment Support

Results showed that support for welfare and entertainment is essential in improving the quality of life for participants. It includes a range of programs and initiatives aimed at providing assistance and promoting well-being, while also facilitating recreational opportunities that encourage social interaction and personal growth. Regarding this subcategory, one patient said: "We have occupational therapy here, we

have embroidery, we have sewing, and we have theater sessions, we have music. I sew, I sew the children's clothes, the children play football in the afternoons; we have a restaurant. It's a good place here, a very good place" (participant No. 25, a patient of the welfare center).

4.7. Civil Society, People, and Society

4.7.1. Types of Stigmata

4.7.1.1. Destigmatization

In the present study, four categories of stigma were identified: "General stigma towards the workforce", "general stigma towards the disease", "patient stigma towards their own disease", and "family stigma towards the patient". General stigma towards the workforce prevented the workforce from being recruited into psychiatric units. The stigma of the general public, due to their lack of knowledge and awareness of mental illness, also prevented the patient and family from disclosing the illness and seeking treatment. Additionally, the patient's general attitude towards their illness and the idea of being labeled prevented them from seeking treatment and receiving care, and families blamed their patients for their illness and laziness. One participant stated about the patient's stigma towards his illness: "We hospitalized my son; now he says take me to the asylum, you labeled me, no one will marry me" (participant No. 30, a mother of a patient).

4.7.2. Information Sources

4.7.2.1. Advertisement

Participants suggested using advertisements on various media, including movies, lectures, and social media, to raise awareness about mental health and CMHC centers. They also proposed involving prominent figures such as governors and Friday prayer leaders to improve awareness and access to services. "Another thing is that there should be publicity about this matter, for example, key informants who exist in the communities, for example, the mayor, the governor, or the Imam of that region, such things can play a key role in spreading things, or the media, which now has an important role in the society" (participant No. 19, psychiatrist).

4.7.2.2. Training

The data showed that the application of training in the initial stages for clients, starting from the basic centers for the screening of clients and then continuing the training process during the provision of specialized services, holding individual or group face-to-face classes, and self-study can be useful. "I feel that training should be given in the initial stages, then it reaches the specialized level. This means that the education of that awareness is much more important than creating a specialized platform first" (participant No. 5, treatment coordinator).

4.8. Information Systems and Data and Research

4.8.1. The Necessity of Developing Research and Technology

4.8.1.1. Weakness of Using Data in Research

The participants stated that owing to the lack of electronic data registration in the centers and the lack of access to all the data at once, the data of the centers are usually not used in research. "The reality is that as far as I know, the data is not used much in research, one of the reasons is that the data is not uniform, and because the data collection is in the file and not electronically, it is more difficult to collect it for research work" (participant No. 19, psychiatrist).

4.8.1.2. Exclusive Mental Health Research

Some participants noted that if the mental health office needed to conduct research, most national studies would be conducted at the National Mental Health Center or by academic staff colleagues. "For research programs in the field of mental health, mainly his office, based on the necessity, sometimes a program is considered to evaluate mental health which is often entrusted to faculty colleagues or to the national health center, where many national researches should be conducted there" (participant No. 32, policymaker).

4.8.1.3. The Necessity of Providing Electronic Registration System

The participants recognized the need for an electronic registration system because of issues with manual data entry in the CMHC centers. Challenges include difficulty in monitoring paper data, separate systems for basic and specialized centers, and limited access to information on specialty services performed by GPs. "Currently, CMHC record systems are manual and not electronic, and this is one of the problems with

patient referrals, meaning that whether a patient goes from CMHC to the base center or from the base center to CMHC, no one knows what actions have been taken for the patient because the two systems are separate from each other" (participant No. 19, psychiatrist).

5. Discussion

The present research assesses the challenges of providing community-based mental health services to SMI patients in Iran. Development and integration of services, moral and legal support, barriers to accessing services (economic, structural, communication, physical and equipment, treatment and care), financing, lack of human resources, destigmatization and public awareness, and the development of research and technology were among the most important factors mentioned by the participants.

5.1. Development and Integration of Services

Participants emphasized the importance of continuity of care and the accreditation of community-based mental health services. Studies suggest that continuity of care for SMI can reduce mortality, prevent suicide, and improve overall quality of life and adherence to treatment (23, 24). Continuity of care has several dimensions, including the continuity of relationships with providers, throughout services, during care transitions, and in response to changing patient needs (25). Therefore, it is suggested that the existing health services in the continuum of care be evaluated and improved. This could include developing regulations and providing adequate financial and other resources to support local access to effective continuity of care models.

On the other hand, the participants emphasized that the complete integration of community-oriented mental health centers into the national health system of Iran is crucial for addressing issues related to sustainable funding, human resources, and overcoming other challenges. This integration is important because it helps stabilize these centers as official providers of specialized community-based services. Similarly, other studies have also recommended the integration of community-based programs to reduce challenges in providing care (15).

5.2. Ethical and Legal Support

Community-based services for SMI patients require legal and moral support to preserve dignity, involve patients and families in decision-making, obtain informed consent, and establish legal frameworks. In this context, Kelly argues that dignity is a fundamental human right for all individuals with mental disorders (26), while studies have shown that mental health patients face a lack of respect, rights violations, not being heard, and devaluation of their insights (27). A similar study in Iran showed that healthcare providers do not adequately consider the dignity of psychiatric patients during hospitalization (28). Therefore, understanding the dignity and respect of healthcare providers is essential for protecting patient rights and improving the quality of life for mental health patients.

Additionally, involving patients and their families in decision-making is a key aspect of ethical and legal support. Studies have shown that patients with SMI tend to participate in their care planning. However, in the clinical field, obstacles such as patient factors (low literacy, fear, lack of trust), staff-related factors (attitudes), and systemic issues (lack of counseling time) prevent the realization of expectations (29). It seems that in our study, all factors, especially those related to clinical staff, contribute to the patient's lack of involvement in decisions. The study by Shojaei et al. also confirms these results (28). On the other hand, studies show that involving people with serious mental illness in treatment decisions leads to reduced symptoms, increased self-confidence, better adherence to treatment, and greater satisfaction (29). In this study, the reasons for the patient's participation in treatment planning have not been investigated, and it seems that more research is needed in this area.

In addition, from the perspective of the participants, obtaining informed consent from patients is important for their moral and legal support. In confirmation of the above results, studies show that these patients should receive information about the necessity of hospitalization, treatment, diagnosis, benefits, and related risks in simple language appropriate to their educational level (30). It was also found in this study that SMI patients may not be able to make collaborative decisions and give informed consent in many cases. Participants stressed the need for new laws for alternative decision-making, homeless individuals, and legal support in psychiatric emergencies. It is necessary to formulate mental health law and provide legal solutions to preserve the dignity and human and civil rights of this category of patients (31).

The successful experiences of countries such as Italy and Peru in the field of legislation for people with

mental disorders and their support confirm the results obtained in this study (32). In addition, a study by Nasr Esfahani and Attari Moghadam found that Iran has addressed mental patient rights in various laws but lacks independent mental health legislation (31). Therefore, law reform in mental healthcare is essential to improve access and rights for people with mental disorders, considering cultural and social aspects.

5.3. Economic Barriers

The results of our study also showed that many community-based service centers, including CMHC and rehabilitation centers, face challenges in providing services due to economic, structural, communication, physical, and treatment obstacles. Patients' unemployment and lack of income were significant economic barriers in this study. Some studies show barriers to employment for people with mental disorders include interference of symptoms, side effects of drugs, lack of skills, stigma, reduced job opportunities, and weak support (33). Having a job, in addition to building self-esteem and having financial benefits, also helps with recovery (34). Therefore, promoting individual strengths, creating a suitable work environment and social support, professional rehabilitation, motivation for work, vocational college support, educational programs, and external support (family, friends, and others) can help in obtaining and maintaining a suitable job (33). Also, the individual placement and support (IPS) model is the best approach for helping people with mental health issues find work. It offers personalized support, considers individual strengths, and encourages teamwork for better job placement (35). A review found that supported employment is effective for helping people with severe mental disorders find jobs for at least 2 years (36). So, policymakers should tackle barriers to supported employment for people with severe mental disorders everywhere, regardless of income.

5.3.1. Structural Barriers

According to the participants' experiences, inadequate access due to the location of the centers, distance, and poor inter-organizational support were cited as structural and communication barriers. In this regard, Whittle et al. considered physical and logistical issues (such as travel, distance, and location) as general barriers to accessing mental health care and stated that adopting innovative methods of providing services and using alternative models such as remote psychiatry can be helpful (32). Our results also suggest that the use of applications and the formation of educational groups on social media such as WhatsApp can be helpful.

5.3.2. Communication Barriers

Participants also reported insufficient support from relevant institutions in providing mental health services. In studies, poor communication and lack of service coherence, joint work, and conflict between services were highlighted as barriers to accessing mental health services (32). Practical strategies such as preparing agreements and protocols for sharing information and signing memorandums of understanding (MOU) between agencies and bodies or strengthening existing MOU to increase interagency cooperation, as well as developing joint evaluation protocols, can help (6).

5.3.3. Physical Barriers

Participants in the study cited lack of space, equipment, and facilities as barriers to specialized, supportive education services. In the same direction, Taban et al. found that providing physical space is a major challenge for implementing community mental health plans (16). Setting up centers requires infrastructure and location planning, as well as adequate space and funding. Therefore, proper preparation is crucial before implementing the plan.

5.3.4. Treatment Barriers

Key informants confirmed that barriers to treatment and care include a lack of medicine, medical misconceptions, poor infrastructure for home care, and family burnout. According to our results, drug access barriers include high cost, shortage, lack of insurance coverage, and insufficient supply by manufacturers in the market. In this regard, another study found that high costs, including medical and therapeutic services, are common barriers to accessing mental health care. Lack of insurance, incomplete coverage, and unaffordable premiums are key reasons. However, improving health insurance and government subsidies can reduce psychiatric drug costs (37).

Additionally, the participants' experiences revealed a treatment-oriented view of mental disorders, leading to increased hospital admissions and beds. In this case, the study by Dehbozorgi et al. reported similar results (36). Drawing policymakers' attention to change mental

health policies to eliminate mental hospitals and focus on prioritizing community services can be helpful (5).

Among other approaches used by CMHC for qualified people (people without cooperation for face-to-face visits, elderly people, or people without guardians or single guardians) is the use of home care services, which caused the centers to face problems due to the lack of necessary infrastructure. Appointing a psychiatrist as a technical manager, using psychiatrist assistants instead of GPs, ensuring a mix of male and female staff for safety, and allocating a budget for travel can help. Weekly staff meetings and training courses for team members are also suggested (38).

Ineffective family caregiving was another barrier to treatment and caregiving expressed by participants. According to the experience of the participants, the lack of necessary knowledge and awareness was the main focus of the families' non-cooperation to follow up on the treatment and how to deal with or act appropriately in the face of their patients. The reasons for this are the non-uniformity of the learning level, the lack of a support system for the patient other than the family, the lack of relationships between the family and mental health professionals to receive the necessary information due to the high volume of work, and the lack of family involvement in treatment planning (39). Establishing respectful communication and active listening, collaboration with patients and families, and increasing mental health professional knowledge and awareness to provide support and interventions for families and caregivers can be beneficial (40, 41).

Among other treatment and care obstacles, the experience of the participants showed that families experience exhaustion and feelings of frustration, sadness, depression, and fatigue in caring for their patients. The findings of Akbari et al. also confirm this. They emphasized the necessity of supporting the family caregivers of people suffering from mental disorders from custodian organizations such as welfare (42).

Based on the experiences of the participants, a very small percentage of the total budget allocated to the health sector is dedicated to mental health services. Due to the wide range of services in this area, the allocated financial credits are far from the amount required to cover the programs and their implementation. On the other hand, the specialized services provided in these centers (CMHC) are completely free and are managed with financial resources allocated by the Ministry of Health. Although this strategy has been implemented to eliminate inequalities in access to services and help the poor, it should also be kept in mind that the lack of funding and delays in payments lead to challenges in providing resources (financial and human) and uncertainty about the continuation of programs in providing specialized, social, and support services, as well as reducing the expansion or closing of existing centers.

Additionally, similar studies in low or middle-income countries show low resource allocation for mental health services, leading to gaps in access and coverage of effective services. To address financial constraints in mental health, strategies include boosting budgets, prioritizing community-based services, integrating care in primary settings, and including mental health in insurance plans (43).

Furthermore, due to the lack of financial incentives, little investment is made in mental health rehabilitation services, which has led to less desire for psychiatric specialists for mental rehabilitation. The lack of policy focus on mental health rehabilitation in recent years is due to significant economic limitations of health systems because providing long-term rehabilitation services (outpatient and residential) is expensive (44). On the other hand, many studies show the effectiveness of mental health rehabilitation services (45). Currently, the UK and Australia are backing the advancement of specialized mental health rehabilitation services, with specialized rehabilitation psychiatry now approved by the Australian and New Zealand College of Psychiatry (46). These cases show that specialized mental health rehabilitation services for SMI are politically, economically, and clinically necessary and need the attention of policymakers and leaders.

5.4. Lack of Human Resources

The study found that the lack of human resources is a major issue affecting mental health care. This is due to factors such as poor job satisfaction, low wages, and lack of insurance, leading to staff leaving and reducing the quality of care. Job satisfaction depends on working conditions, benefits, and relationships with colleagues (47). Improving mental health care requires addressing workforce issues such as funding, salaries, fair distribution, education, career advancement, staff participation in program development, supportive work environments, and access to support services (9). By addressing these factors, mental health organizations can improve the stability of the workforce and the quality of care.

The study found that a lack of a capable workforce was a significant issue. To meet current needs, it is important to improve skills, provide leadership, and training for supervisors (48). In this regard, Thornicroft et al.'s suggestions can be helpful: Training of trainers by employees of other regions or countries, supervisor training, long-term and continuous programs, continuous training and supervision of employees, and the use of rewards to improve the quality of training (47).

Regarding the requirements and competencies of the treatment team, in addition to having clinical skills, motivation and interest in work and communication skills should also be considered in the selection of human resources. Taban et al. found that selecting interested and committed human resources is effective for community mental health goals (16). Also, studies show that effective therapeutic communication is linked to positive outcomes like symptom reduction, fewer hospitalizations, and improved treatment adherence (49). Since the goal of therapeutic communication is to help patients recover and improve their quality of life, employees must improve their skills in this field.

In addition, the study found a need to improve educational infrastructure for mental health services. Caregiver and provider attitudes can influence the quality of care, so the curriculum should align with goals and tasks so that the individual can play his effective role (50). For this purpose, to promote mental health education, universities and institutions should reform their curriculum and assign study units for SMI. Also, the results showed that interdisciplinary cooperation and interaction play a crucial role in providing care for patients with SMI because they need multidisciplinary care to meet their biological, psychological, and social needs (51). In general, it can be said that quality treatment and care for people with severe mental illness require the recruitment of an interested workforce, extensive training, and continuous supervision of personnel. Allocating resources for workforce development (training and supervision) is important to ensure sustainability.

5.5. Providing Comprehensive Care

Participants' experiences indicate that comprehensive care can be achieved through a variety of approaches, including treatment planning, specialized services, education, social support, and recreation. The American Psychiatric Association suggests using both medication and non-medication methods, such as cognitive-behavioral therapy (CBT), family intervention, psychoeducation, and life skills training to assist patients in self-care (52). The emphasis of the WHO is on choosing evidence-based interventions with the least negative effects and considering the patient's advantages (5). In Iran, Sharifi et al. also showed that different types of interventions are offered in CMHC, which are based on evidence, and their effectiveness and use have been measured (15). The results of a study by Fakhari et al. were also in line with the results of the present study (51). However, challenges such as a lack of family cooperation and patient acceptance hinder the effectiveness of these interventions. The study by Dehbozorgi et al. shows a similar result (36). Since these services are provided to improve the health, quality of life, and satisfaction of patients with care, periodic educational programs are needed to increase self-care in patients and improve participation.

5.6. Destigmatization

Creating community-based mental health services for patients with SMI requires public education to reduce the stigma against mental illness, patients, families, and health workers. The results of Subu et al. confirm the above content (52). Using advertisements, mass media, social media, awareness campaigns, face-to-face training, and online methods can be effective in achieving this. Maiorano et al. and Farsi et al. confirm the obtained data (53, 54).

5.7. The Necessity of Research and Technology Development

The study suggests advancing mental health services through electronic registration systems, utilizing data from mental health service centers, and increasing research activities in related areas. It notes that specialized centers lack these systems and that psychiatrists are often unaware of procedures in basic centers. This communication gap is due to a poorly designed system that does not support creating electronic health records and is related to weak internet infrastructure. Jafari et al. suggested creating electronic referral and administrative automation conditions to connect basic centers with higher levels and facilitate feedback to resolve these issues (55).

Due to poor data registration in community mental health service centers, their information is often not used in research. This creates a gap between available

services and the development of better services in research centers. Research can help find effective interventions that match local needs and culture. Suggestions include using government funds for quality research, identifying gaps in mental health service knowledge, promoting research on social factors affecting mental health, and improving collaboration and infrastructure for applying research findings (56).

5.8. Conclusions

The study explores the challenges of providing community-based mental health services to patients with SMI in Iran. Our findings indicate that integrating community-based mental health services into the national healthcare system, along with increasing their sustainability and connecting them with other community-based centers like day rehabilitation centers and home care centers, leads to continuity of care for patients and families. This integration reduces the burden of care in the health system and decreases new or repeated hospitalizations.

Additionally, legal and ethical support is vital for community-based services, ensuring patients' dignity is upheld, involving them in decision-making processes, and securing informed consent. We identified that community-level services face challenges such as economic, structural, communication, physical, equipment, and treatment barriers, which should be prioritized for improvement. Our results highlight the need for financial resources, skilled personnel, and a holistic approach to community care that includes treatment, education, social support, stigma reduction, and the development of home care clinics.

Furthermore, advancing research and technology in mental health services is essential, which includes implementing electronic registration systems, leveraging data from all centers, and expanding research efforts in related fields.

5.9. Limitations

This study had limitations, including withholding some information by participants, especially care providers, due to fear or distrust of the researcher, which affected the clarity of the data. The researcher also faced limitations in selecting patients for interviews, as only those selected by the facility (only the Welfare Organization residential center, not other facilities) were considered, potentially leading to bias. The study reached data saturation but had a limited number of participants in each subgroup, which is a limitation.

5.10. Suggestions

It is recommended to conduct qualitative studies separately in each subgroup with more participants for better insights. Other models, such as the National Consensus Project (57), can help understand the care needs of SMI patients in different dimensions and can be applied in clinical settings. This study did not focus much on culture. Given the geographical spread and the presence of different ethnicities in Iran, it is suggested to investigate how culture and ethnicity affect the treatment and care of patients with serious mental illnesses.

Footnotes

Authors' Contribution: Z. M., K. Z., and S. J. designed and conceived the study. Z. M. collected the data. S. J., M. A., M. R., S. B., and K. Z. contributed to data analysis/interpretation, drafting of the manuscript, and critical revisions for important intellectual content. Z. M., K. Z., M. A., M. R., and S. M. made the final revision. All authors read and approved the final manuscript.

Conflict of Interests Statement: The authors declare no conflict of interests.

Data Availability: The dataset presented in the study is available on request from the corresponding author during submission or after publication.

Ethical Approval: The Ethics Committee of Jundishapur University of Medical Sciences of Ahvaz approved this study (IR.AJUMS.REC.1400.505).

Funding/Support: The present study was financially supported by Jundishapur University of Medical Sciences, Ahvaz, Iran.

Informed Consent: Written informed consent was obtained from the participants.

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