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Psychiatric practice in Iran and the UK

More than any other area of medicine, psychiatry is influenced greatly by the cultural setting in which it is practised. Iran and the UK have similar-sized populations, but are very different in many other respects. The opportunity arose to compare psychiatric practice in these two countries when one of us (N.H.) spent 3 months visiting mental health services at a UK centre.

Organisation of health services

Whereas patients in the UK are only required to contribute directly to the costs of medication, in Iran, payment takes place at all levels of health care. Patients pay 25% of the fee for a clinic consultation, laboratory investigations or medicines obtained from pharmacies. This includes expensive investigations such as computed tomography and magnetic resonance imaging scans. For hospital in-patient treatments, including investigations and medicines, a payment of 10% is required from the patient. All emergencies, however, are treated immediately without prior payment. Unlike the UK, where children and the elderly are exempt from payments for medication, fees in Iran do not vary across age ranges.

In both Iran and the UK, the private sector exists alongside a much larger public sector. Whereas the National Health Service (NHS) in the UK is mainly funded independently of the private sector, the NHS in Iran is funded partly by government and health insurance and there is also a small charge that is covered by the patient. The private sector in Iran has more autonomy under the Ministry of Health and can accept private patients without health insurance, but it provides a limited range of services and fees are higher. All patients in Iran can therefore choose between the public and private sector and they also have direct access to general practitioners (GPs) and specialists without referral. Clinics can therefore be very busy depending upon the popularity of the doctor. However, there is consequently less coordination, with no organisation of comprehensive services into geographical sectors as in the UK.

The most comprehensive services are concentrated in the large cities, which then act as referral centres for complex cases from the surrounding country; for example, the city of Shiraz in Southern Iran covers three provinces and a population of 10 million. For Iran as a whole, 10% of general hospital beds, i.e. 3000 beds, are allocated to psychiatry. Additionally, there are 7000 beds in special psychiatric hospitals situated in the larger cities. Shiraz has a psychiatric hospital for mainly chronic mental disorders with 400 beds and separate hospitals for acute disorders with 60 beds.

Treating mental illness

There is limited research in Iran on the prevalence of mental illness. Anecdotal evidence suggests that, as in the UK, depressive disorders are common, particularly among women. Although suicide is prohibited strongly by Islam, in a province in Southern Iran with a population of 500 000, the suicide rate was 8.6 per 100 000 and attempted suicide 16.8 per 100 000 (Zadebagheri, 1996). Combined analysis for the causes of both suicide and parasuicide found marital problems in 49%, economic hardship in 17%, psychiatric disorder in 11% and emotional problems in 15%. Methods included burning (48%), overdose and poisoning (46%), gunshot (30%) and hanging (3%). In the UK, suicide is recorded in 10 per 100 000, with hanging and poisoning or overdose the most common methods (Department of Health, 2001). A survey of school pupils and university students in Iran using the Beck Scale found that 1.5–1.7% had major depression, whereas 35.6% had mild to moderate depression (Zadebagheri, 2002*a*).

Somatisation is widespread, possibly as a result of the stigma associated with psychological disorder in Iran. Patients are generally more willing to discuss their mental health problems in the UK. Anxiety states presenting as headaches (tension, migraine and tension–migraine headaches) are commonly seen in psychiatric clinics. The most common condition after affective and anxiety disorders is opiate dependence, followed by schizophrenia, other psychoses, epilepsy and mental retardation. Medications manufactured in Iran are generally more widely available than those that are imported. Thus the tricyclic antidepressants and the older neuroleptics are used routinely. Nevertheless, fluoxetine and clozapine are now manufactured and risperidone, although imported, is available throughout Iran.

In relation to community care, the social context between the two countries is very different. While there is greater social mobility and loosening of family ties in the UK, family bonds constitute the fabric of society in Iran. The family is expected to take responsibility for its members and it is rare for an individual to become isolated. This family cohesion is reinforced by social convention, religion and the law. In matters such as finance, mortgages, employment and hospitalisation, a family member is routinely expected to countersign any documents. Consequently, the attitude towards mental health legislation is very different between the two societies. In the UK, legislation is deemed essential to protect the individual's rights and in practice, families are discouraged from taking responsibility for compulsory treatment; however, in Iran the family is expected to take control. If the police detain a disturbed individual, they are usually taken to the family or if brought to a hospital, relatives are quickly summoned. The family is involved closely in the patient's treatment and takes responsibility for the patient's care after discharge from hospital.

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Treating addictions

The use of alcohol is prohibited by both religion and legislation in Iran. Consequently, alcohol-related disorders are rarely seen. Tobacco is used widely, particularly by men. A survey in Fars province, which has a population of 7 million, found the prevalence of cigarette smoking to be 11.4% and for smoking through waterpipes 9.8% (Mirahmadizadeh *et al*, 1999). Surveys in England show that the prevalence for cigarette smoking is 28% (Office for National Statistics, 2000). A survey of medical students at Yasuj University found that 15–20% smoked cigarettes despite their social status and their role model in society (Hashemi, 2002).

Although illegal in Iran, the use of opiates is not prohibited by Islam. The country also sits astride the trade route for illegal opiates from Afghanistan to Europe. Opium is most common and is usually smoked, often by men. A survey of 3750 people aged between 20 and 50 years found that 2% were addicted, and that the majority smoked opium using an opium-smoker's pipe or a waterpipe (Zadebagheri, 2002*b*). In England and Wales, the lifetime use of opiates across a similar age range is 1.1% (DrugScope, 2000). Heroin is also available and generally smoked on its own or with tobacco or, less commonly, is injected intravenously. Needles and syringes can be bought from pharmacies and hospitals, but sharing and recycling used equipment is a recognised health hazard.

The treatment of opiate dependence in Iran is hampered by limited options. Methadone tablets, available for cancer pain, were only sanctioned for the treatment of addiction by the Ministry of Health in 2002. N.H. found that within the first 6 months, almost 200 patients attended his clinic. For opium addiction, a dose of methadone between 20 and 30 mg usually proved effective, whereas heroin addicts usually required 30–60 mg. The dose of methadone was reduced over a few weeks and compliance was generally good. Other than methadone, treatment is usually symptomatic using combinations of benzodiazepines, non-steroidal anti-inflammatories, hyoscine, diphenoxylate, metaclopramide and clonidine. These are used in both the out-patient and ward settings. Although naltrexone has now been sanctioned for use by the Ministry of Health, it remains difficult to obtain and is rarely used.

Patients rarely present to psychiatric clinics with other types of substance misuse and little information is available on cannabis and stimulant use in Iran. Unlike in the UK, comorbid mental illness and substance misuse is not seen as a major problem. It often depends on the relationship between the patient and the doctor whether the mental illness and opiate dependence are treated simultaneously.

Psychiatric training

In Iran, all doctors undergo 7 years' training, during which they will have 2 months' practical exposure to psychiatry. Subsequent specialisation takes 3 years, including 3 months' experience in neurology. This postgraduate psychiatry training is offered at 12 university centres across the country. The only recognised sub-speciality is child psychiatry. The majority of textbooks used are from the USA and, to a lesser extent, Europe. Thus, the approach relies mainly on models of psychiatry from the USA. There are 750 trained psychiatrists working across Iran. The university centres also train other professionals such as clinical psychologists, social workers, mental health nurses, family, drama and occupational therapists. There are 250 clinical psychologists and a further 40 who have completed their PhD. Most of these professionals work at universities or health services in the major cities.

Conclusion

Psychiatrists practising in Iran and the UK encounter differences in the range of disorders they treat. Suicide is notably lower in Iran, but the greatest contrast is seen in the addiction disorders. Opiate dependence is twice as common in Iran, while alcohol misuse is rare. Tobacco consumption is higher in the UK, but Iran could yet witness a rise in nicotine addiction without a clear, well-planned strategy of prevention. Psychiatrists also work within different social contexts. Stronger family ties, religious beliefs and community networks in Iran offer much of the support that health and social services provide in the UK. However, we should also be aware of the many similarities in psychiatric practice between these two countries.

Declaration of interest

None.

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