



Why Iran Needs a National Preventive Mental Health Program for Pre-Hospital Emergency Personnel – A Viewpoint

Milad Ahmadi Marzaleh¹, Jamal Mohammadpoor², Fatemeh Nematollahi^{3*}

¹ Department of Health in Disasters and Emergencies, Health Human Resources Research Center, School of Health Management and Information Sciences, Shiraz University of Medical Sciences, Shiraz, Iran

² Master's student in Nursing, Fasa University of Medical Sciences

³ Student Research Committee, Shiraz University of Medical Sciences, Shiraz, Iran

Keywords: Pre-hospital Emergency Personnel; War-related Anxiety; Psychological Preparedness; National Mental Health Program; Iran

Article History:

Received: 17 May 2026

Accepted: 28 June 2026

Please cite this paper as:

Ahmadi Marzaleh M, Mohammadpoor J, Nematollahi G. Why Iran Needs a National Preventive Mental Health Program for Pre-Hospital Emergency Personnel – A Viewpoint. Health Man & Info Sci. 2026; 13(3): 259-262. doi: 10.30476/jhmi.2026.111783.1392.

*Correspondence to:

Fatemeh Nematollahi,

PhD student, Shiraz University
of Medical Sciences, Shiraz, Iran.

Email: fatemehnematollahi2@gmail.com

Dear Editor

Pre-hospital emergency personnel in Iran are routinely exposed to traumatic events, death, injury, and violence, all of which place them at heightened risk for psychological distress, burnout, and reduced occupational functioning. Currently, mental health support for Iranian EMS personnel is fragmented, reactive, and largely limited to informal peer support or occasional debriefing sessions without standardized protocols or national coordination. No structured preventive program exists at the national level, and access to professional psychological services remains limited due

to stigma, resource constraints, and lack of clear referral pathways. In the current regional context, the added threat of war and the anticipation of mass casualty events may further intensify anxiety and undermine workforce readiness. Protecting the mental health of emergency responders is therefore not only an individual concern but also a critical element of health system resilience (1, 2). The primary objective of this viewpoint is to propose a context-sensitive, evidence-informed national preventive mental health program for Iranian pre-hospital emergency personnel, with a focus on feasibility, cultural

appropriateness, and integration into existing emergency medical structures. International evidence indicates that preventive mental health support for frontline responders can be incorporated into routine organizational practice. Experiences from countries such as Lebanon and Israel suggest that screening, peer support, resilience training, and rapid-access services can be integrated into emergency systems when mental health is treated as an operational priority (3, 4). However, these models cannot be transferred to Iran unchanged. Differences in organizational hierarchy, resource availability, stigma surrounding help-seeking, and regional variation in service delivery require a context-sensitive approach. Accordingly, the proposed program emphasizes feasibility, confidentiality, and alignment with existing emergency medical structures. (1, 5).

Our recommendations were developed through a contextual analysis of the Iranian pre-hospital emergency system and a comparative review of international preventive mental health initiatives. For

the comparative review, we systematically searched PubMed, Scopus, and WHO databases using keywords including "emergency medical services," "mental health," "prevention," "first responders," and "psychological preparedness." We included peer-reviewed articles, WHO reports, and program evaluations published between 2015 and 2025 that described implemented or evaluated preventive mental health interventions for pre-hospital emergency personnel. Studies were selected based on their relevance to the Iranian context, particularly those from conflict-affected or resource-limited settings. The proposed measures were selected using three practical criteria: their relevance to stressors identified in Iranian EMS personnel, their compatibility with organizational culture and workflow, and their likelihood of implementation under current resource constraints, with particular reference to the WHO mental health action plan and the PEREI trial framework. In other words, the framework is not a direct copy of foreign models, but an adapted strategy designed to fit the realities of the Iranian setting.

Proposed Components of the Program

Component	Objectives	Expected Benefits	Implementation Considerations
Continuous confidential mental health monitoring	Biannual voluntary screening using GHQ-12 and PCL-5; provide clear referral pathways	Early identification of at-risk personnel; reduced long-term morbidity	Requires validation of instruments in Iranian EMS staff; ensure data confidentiality and separation from administrative records
Mandatory resilience and coping training	Integrate stress management and psychological first aid into training curricula	Enhanced coping skills; reduced stress-related absenteeism	Needs adaptation of training content to Iranian cultural context; train qualified instructors
Accessible peer and professional support systems	Establish 24/7 hotline and peer support networks	Reduced stigma; timely access to support	Requires trained peer leaders; ongoing supervision and quality assurance
Crisis-specific debriefing protocols	Structured group sessions after critical incidents	Prevention of PTSD; improved team cohesion	Must be non-punitive and voluntary; train facilitators in evidence-based debriefing methods
Cognitive-behavioral interventions against narrative warfare	Media literacy workshops; practical techniques to limit distressing content exposure	Reduced information fatigue	-

A Context-Specific Recommendation for Iran

In addition to these measures, we propose a Peer-Leader Liaison Model tailored to the Iranian organizational context. Because

trust in hierarchical structures is often strong in emergency services, selected station supervisors or shift leaders can be trained as mental health liaisons or "well-being ambassadors." These individuals

would not replace mental health professionals, but they could serve as the first point of contact, normalize help-seeking, reduce stigma, and facilitate timely referral. This model may be particularly effective in settings where personnel are reluctant to approach formal psychiatric services due to cultural or institutional barriers.

We also recommend introducing mental health leave of 2–3 paid days per year, separate from sick leave, to reduce stigma and support recovery. This benefit should be framed as an occupational protection measure rather than as evidence of illness.

To ensure data confidentiality, we emphasize that all mental health screening results and counseling records must be stored in a separate, non-administrative database, accessible only to designated health professionals, with no linkage to performance evaluation or disciplinary files.

Implementation Roadmap and Pilot Phasing

A phased implementation approach is advisable. We propose the following timeline:

Phase 1 (Months 1–6): Pilot program in two provinces – Khuzestan (due to its proximity to conflict zones and high operational stress) and Tehran (as the largest EMS hub with diverse case exposure). This phase includes validation of screening tools, training of peer leaders, and establishment of hotline services.

Phase 2 (Months 7–12): Program refinement based on pilot feedback, expansion to four additional provinces, and integration of debriefing protocols.

Phase 3 (Months 13–24): National rollout, accompanied by continuous monitoring and evaluation.

Economic Justification

Although initial investment is required, the program is likely to yield substantial cost savings. Preventing even a modest reduction in burnout-related absenteeism, turnover, and medical errors can offset implementation costs within 18–24 months. International estimates suggest that every US dollar invested in workplace

mental health interventions returns between \$2 and \$4 in improved productivity and reduced sick leave. In the Iranian context, where EMS turnover rates are already high, such returns may be even more pronounced.

Monitoring and Evaluation Mechanism

Program success will be measured through:

Process indicators: Coverage rate of screening, training attendance, hotline utilization.

Outcome indicators: Changes in GHQ-12 and PCL-5 scores at 6- and 12-month intervals, reduction in sick leave days, and self-reported job satisfaction.

Qualitative feedback: Semi-structured interviews with personnel and peer leaders after each phase.

Evaluation will be conducted by an independent research team affiliated with the Ministry of Health to ensure objectivity.

Implementation Challenges and Mitigation Strategies

Stigma remains the most significant barrier. To address this, we recommend confidential services, awareness campaigns normalizing help-seeking, and framing mental health support as a professional strength rather than a sign of weakness. Financial constraints can be mitigated through phased implementation, international partnerships, and reallocation of existing health budgets. The hierarchical organizational culture can be leveraged positively by training trusted supervisors as peer leaders and well-being ambassadors. Finally, lack of built-in evaluation mechanisms will be addressed through the independent monitoring framework proposed above, with clear benchmarks and regular reporting to the Ministry of Health.

Conclusion

The threat of war is not hypothetical for Iran's pre-hospital emergency personnel. Without a national preventive mental health program, the system risks losing the workforce on which disaster response depends. International evidence offers a useful roadmap, but local adaptation is essential. We strongly emphasize the need

for pilot implementation in selected provinces, accompanied by rigorous formal evaluation, before nationwide adoption of the proposed program. Delaying action will only deepen an already serious crisis and weaken psychological preparedness at the point of care.

Declarations:

Acknowledgments: None.

Authors' contributions: All authors contributed equally to the conception, drafting, and revision of this manuscript.

Funds: None declared.

Ethics approval and consent for publication: Not applicable.

Competing interests: The authors declare no competing interests.

References

1. Khazaei A, Afshari A, Salimi R, Fattahi A, Imani B, Torabi M. Exploring stress management strategies among emergency medical service providers in Iran: a qualitative content analysis. *BMC Emerg Med.* 2024;24(1):106. doi:10.1186/s12873-024-01026-6.
2. Van Puyvelde M, Van Herck J, Van den Bossche J, Goethals F, Gijbels D, Detaille F, et al. Walk the line: a systemic perspective on stress experienced by emergency medical personnel by comparing military and civilian prehospital settings. *Front Public Health.* 2023;11:1136090. doi:10.3389/fpubh.2023.1136090.
3. World Health Organization Regional Office for the Eastern Mediterranean. Equipping hospital staff in Lebanon with the skills to cope with growing mental health needs. Cairo: WHO Regional Office for the Eastern Mediterranean; 2025. Available from: <https://www.emro.who.int/media/news/equipping-hospital-staff-in-lebanon-with-the-skills-to-cope-with-growing-mental-health-needs.html>
4. Jaffe E, Abramowitz MZ, Daniels Vermus S, Abramowitz M, Herbst R, Knobler HY. [Preventing secondary traumatization in Magen David Adom first responders during the Iron Swords War: an interim report]. *Harefuah.* 2024;163(8):528-32. Hebrew.
5. Nixon RDV, Elizabeth M, Fassnacht DB, van Agteren J, Edney LC, Wild J. Protecting emergency responders with evidence-based interventions (PEREI): protocol for a randomized controlled trial for early career emergency responders, significant others, and supervisors. *Eur J Psychotraumatol.* 2024;15(1):2420459. doi:10.1080/20008066.2024.2420459.