Medical Ethics and Law Research Center
The Bioethics and Health Law Institute
Shaid Beheshti University of Medical Sciences

Bioethics and Health Law Journal
Journal homepage: *https://journals.sbmu.ac.ir/bhl*

Original Article

Inadequate Support for Social Mental Health in Iran's Criminal Policy and Macro-Strategic Policy Documents

Mahdi Khaghani Esfahani[1*]

1. Department of Criminal Law & Criminology in the Institute for Research and Development in the Humanities (SAMT), Tehran, Iran.

Article Information

Article History:

Received: 06 February 2026
Accepted: 23 April 2026
Available online: 09 May 2026

Keywords:

Criminal Policy
Social Mental Health
Public Policy in Iran
Support for Mentally Ill
Social Harms

***Corresponding Author:**
Mahdi Khaghani Esfahani

E-mail:
khaghani@samt.ac.ir

ABSTRACT

Support for social mental health, despite its central role in preventing Social harms and criminal involvement, occupies a marginal and unstable position in Iran's public policymaking. This article critically examines the high-level policy documents of the Islamic Republic of Iran - specifically the General Policies of the Islamic Republic of Iran and Iran's Overall Vision Document for 2024, selected five-year Development Plans adopted from the early 1380s through the late (2000s-2010s) and annual budget laws enacted during the 1390s and early (2010s-early 2020s) - in order to assess the extent and quality of attention devoted to social mental health within Iran's criminal policy framework. The study adopts a qualitative, interdisciplinary analytical approach, focusing on the conceptual and institutional linkages between criminal policy and social mental health as reflected in upstream policy texts and their modes of implementation. The findings demonstrate that references to social mental health in these documents are largely indirect, abstract and non-binding, often subsumed under vague notions such as "social harms", "spiritual health" or limited support for chronic psychiatric patients. This marginalization is further intensified in budgetary legislation within the above period, where mental health is not treated as a rights-based public policy with a defined basic service package and a transparent, independent funding line, but rather as a fragmented, project-based expenditure dependent on annual fiscal conditions. The inconsistency between macro-level policy commitments - particularly the emphasis on prevention and mental health promotion in general health policies - and the treatment-oriented, short-term logic governing budget allocations has weakened social prevention mechanisms and shifted the burden of unmanaged mental health issues onto the criminal justice system. The article concludes that inadequate support for social mental health in high-level policy documents and related budget laws during the examined period represents not merely a shortcoming in public health governance, but a structural deficiency in criminal policy. This configuration reinforces reactive, stigmatizing and security-oriented responses, contributes to the reproduction of crime, increases penal costs and undermines social justice. Repositioning social mental health within upstream policy frameworks and budgetary structures is therefore essential for aligning criminal policy with preventive and health-oriented approaches.

Please cite this article as:

Khaghani Esfahani M. Inadequate Support for Social Mental Health in Iran's Criminal Policy and Macro-Strategic Policy Documents. Bioeth Health Law J. 2026; 6: e1.

https://doi.org/10.22037/bhl.v6i6.51573.

Introduction

Criminal policy has traditionally focused on crime prevention, the regulation of deviant behaviors and punitive responses to violations of legal norms (1), whereas social mental health policy emphasizes social prevention, harm reduction, care, support and the empowerment of vulnerable individuals and groups. In contemporary governance, the interface between these two policy logics is increasingly treated as a shared risk-management and rights-protection domain rather than two isolated silos. In many jurisdictions, this interface has been operationalized through integrated frameworks - such as "Health in All Policies", community-based mental health governance and justice - health coordination models - aimed at preventing the downstream criminalization of distress and reducing avoidable penal contact (2-4). By contrast, in Iran the convergence of criminal policy and social mental health has rarely produced genuine synergy; instead, it has frequently generated conceptual appropriation, the medicalization of structurally produced social problems and the criminalization of psychological distress through both formal criminalization and informal security-oriented responses.

International best practices treat the relationship between justice institutions and mental health not merely as "treatment after punishment", but as a continuum spanning prevention, early identification, diversion and continuity of care. The dominant comparative pattern includes: 1. Upstream prevention via social protection, education, housing and employment policies; 2. Early screening and crisis response mechanisms that reduce unnecessary arrests; 3. Diversion and alternative measures (including mental health courts or diversion panels, prosecution guidelines and conditional non-custodial dispositions); 4. Prison health governed by the principle of equivalence of care and strong clinical independence; 5. Post-release continuity via community mental health and social reintegration services (5-7). These approaches are typically justified through a combined rationale of rights (non-discrimination and dignity), effectiveness (reducing recidivism driven by untreated disorders) and cost (avoiding the "penal substitution" of health services). Against this benchmark, the Iranian policy landscape shows persistent discontinuities: Mental health is often framed as an ancillary concern rather than a cross-cutting determinant of crime prevention and coordination mechanisms remain under-institutionalized.

Criminal policy and health policy therefore exhibit numerous explicit and implicit entanglements, yet the necessary institutional interaction between these two critical governance domains is largely absent in Iran. In best-practice settings, the linkage is secured through formal governance tools - inter-ministerial coordination bodies, mandatory health impact assessments for major penal and policing policies, shared data protocols with safeguards, joint budget lines and legally recognized roles for academic and clinical expertise in policy formation (2, 8). In Iran, however, strengthening interdisciplinary research capacities in the spheres of health policy and criminal policy remains more rhetorical than operational. The result is a recurrent pattern: Health system strategies are neglected under conflicting criminal policy approaches, while criminal policymakers only intermittently engage with mental health system programs and the evidence base on prevention and harm reduction.

The necessary laws and regulations to incentivize key research actors and to translate macro-level policies into durable research-and-implementation pipelines are largely absent. In comparative experience, stable policy learning typically depends on: 1. Statutory mandates for evidence use and evaluation; 2. Protected funding for prevention and community mental health; 3. Institutionalized channels that convert research into guidelines, protocols and service packages (3, 4). By contrast, criminal policymaking in Iran - closely linked to harm, victimization and therapeutic needs and whose injurious adjudications and punishments impose a treatment burden on the health system - often proceeds with insufficient regard for medical system resilience. Decisions regarding arrests, detention, punishments, flogging, stigma-related psychological harms affecting offenders and their families, deprivation of social rights and fines that weaken household financial capacity (and thereby reduce the ability to cover health-related expenses) are commonly made without

structured assessment of health-system capacity or long-term social prevention outcomes. Consequently, criminalization, sentencing and the design and implementation of policing and judicial policies occur in relative isolation from public health governance and from internationally recognized standards emphasizing proportionality, non-discrimination and prevention-oriented interventions.

Similarly fragmented, health system policymaking often proceeds without adequate attention to legal consequences. Internationally, a core best-practice requirement is the embedded presence of legal expertise in health policymaking - particularly where regulations affect liberty, confidentiality, involuntary treatment, disability rights and access to essential services - so that normative safeguards and enforceability are built into policy design (3, 9). In Iran, during the drafting of ordinary laws, health regulations and even high-level health policy documents, legal studies working groups have no clearly defined role. In major upstream documents, such as the Comprehensive Scientific Map and the Health System Transformation Map, parallel working groups produce outputs independently, without reliable coordination. Intra- and inter-sectoral coordination in health research policymaking is minimal (10). The resulting situation - neglect of legal integration in health policymaking and friction between criminal and health policies - reflects structural gaps in governance rather than incidental administrative weakness.

These governance gaps are observable in the way "social mental health" is conceptualized and operationalized within criminal policy knowledge production. In best-practice models, "social mental health" is treated as a population-level determinant and a public policy right: It requires a defined basic service package, transparent financing, community-based delivery and measurable prevention outcomes (2, 7). In Iran, manifestations of inadequate criminal policy attention to social mental health suggest that criminal policy knowledge has not reached an interdisciplinary knowledge-management level due to weak linkage between researchers and policymaking institutions in related fields, including health policy. Conversely, the management of social mental health knowledge and its policymakers have not fully integrated with justice-related issues or recognized the necessity of legal support within the capacities of criminal and extrajudicial knowledge and action. As a result, genuine interdisciplinary integration between criminal policy and social mental health policy has yet to emerge and the practical burden is shifted toward reactive criminal justice interventions rather than upstream social prevention and rights-based service provisioning.

The present qualitative study employs an interdisciplinary comparative analysis of criminal policy in juxtaposition with the macro-level policy of social mental health, conceptualized as a health science beyond individual psychology. It seeks to answer the following questions: What are the mechanisms through which the criminal policy-making process influences social mental health and in what ways does this influence occur? Moreover, what are the common factors, manifestations and consequences of the misalignment between criminal policy and social mental health policy within public policymaking in the Islamic Republic of Iran, when contrasted with internationally recognized standards and best-practice governance arrangements?

Within this framework, delineating the semantic system of reciprocal relations between criminal policy and social mental health enables a detailed conceptual mapping of interrelations among the doctrines of "state crime", "public health rights policymaking" and "criminal policy for mental health". This approach also supports analysis of the legislative, judicial, executive and participatory capacities of criminal policy in addressing psychological harms that contribute to both criminality and victimization and in assessing the degree to which these capacities are aligned - or structurally misaligned - with a prevention-oriented, rights-based mental health policy-making process.

Among the limitations of this study are the scarcity of laws and regulations specifically governing mental health and the relative absence of legislation dedicated to social mental health. Additionally, limited access to precise statistics on psychological harms, cognitive and behavioral

disorders, crimes committed by individuals with mental illnesses and crimes affecting victims with mental disorders - as well as data on treatment success rates among incarcerated populations and statistics derived from psychometric monitoring or criminal records (including police, judicial and unreported cases) - constrains the analysis and underscores the importance of transparent, institutionally coordinated data infrastructures in any future governance reform agenda.

1. Research Background

The author's motivation stems from the overlooked issue of the bidirectional relationship between criminal policy and social mental health policy in Iranian social science scholarship. While the following references each address partial preliminary aspects of the present study's research idea, no prior research explicitly examining the relationship between criminal policy and social mental health policy in Iran was identified. To strengthen the theoretical framing and provide a comparative lens, this study also draws on international scholarship that conceptualizes justice institutions not merely as sites of adjudication and punishment, but as actors capable of producing *therapeutic or anti-therapeutic consequences* for mental health and social functioning.

Within this comparative framework, therapeutic jurisprudence offers a structured vocabulary for analyzing how legal rules, procedures and institutional practices shape mental health outcomes and, ultimately, pathways into or away from criminal justice involvement. Pioneered in mental health law scholarship, therapeutic jurisprudence treats "law" (including criminal procedure, sentencing practices and institutional routines) as a social force whose design can either aggravate distress and stigma or support autonomy, procedural justice and stabilization. This literature has directly informed the rise of "problem-solving justice" mechanisms - particularly mental health courts and diversionary models - aimed at reducing criminalization of psychological distress and improving continuity of care through tailored judicial supervision and service linkage (11, 12). Empirical work in recent years continues to assess diversion and mental health court effects on reoffending and downstream outcomes, reinforcing the policy relevance of a justice - mental health interface that is prevention-oriented rather than purely punitive (13).

Complementing this perspective, forensic social work literature provides an applied institutional bridge between legal systems and mental health - social support infrastructures. In international practice, forensic social work is defined as a specialty operating at the intersection of social work, law and behavioral health, encompassing assessment, case formulation, diversion planning, court liaison, reentry/ aftercare coordination and rights-based advocacy for justice-involved or justice-impacted populations. This body of work clarifies role expectations, standards of practice and ethical constraints in justice settings and it is increasingly framed as a governance mechanism for reducing fragmentation between welfare/ health agencies and criminal justice institutions - precisely the fragmentation at issue in the Iranian context (14; forensic social work practice standards literature; recent handbook syntheses).

Against these international theoretical and applied models, the Iranian literature relevant to mental health and legal policymaking has been more concentrated on normative rights discourse and professional ethics than on the structural interaction between criminal policy and social mental health policy. The two-volume book *Principles of Ethics and Conduct Codes for Psychologists and Psychiatrists* (2024), translated by Tahereh Seqat al-Islam and Mahmoud Abbasi, as well as *The Right to Mental Health: Theoretical Foundations, Normative Order* (15) and *Judicial Practice* by Sediqeh Elhian, Mahmoud Abbasi and Mohammad Jalali (16), represent part of the foundational discourse on mental health and legal policymaking in this domain. However, these works do not develop an explicit analytic model for how criminal policymaking processes (criminalization, policing, prosecutorial priorities, sentencing, custody and collateral consequences) operate as determinants of social mental health - or how social mental health policy design may upstreamly reduce penal contact.

Homayouni et al. (2024), in the article *Documentary Analysis of Health Policy-Making in the Eight Governments of the Islamic Republic of Iran from [1989-2021] with Emphasis on Cabinet Resolutions*, applied qualitative content analysis with an inductive approach and open coding of documentary data, emphasizing cabinet resolutions over the study period. They concluded that none of the governments achieved sufficient balance in the identified policy domains; while policy actions may have been driven by governmental slogans, they were largely short-term and did not follow a unified line to achieve long-term health system objectives. Although this study is useful for diagnosing instability in public policymaking, it does not address the legal dimension, nor does it examine criminal policy mechanisms that translate policy fragmentation into penal outcomes (e.g., over-reliance on arrest/detention, custodial sentencing or stigma-producing collateral sanctions).

Hosseini et al. (17), in *Integrated Criminal Policy toward the Health Domain*, argued that integrated criminal policy regarding technical and specialized crimes in the health sector requires the design of combined reactive and proactive strategies. They concluded that developing a comprehensive, health-oriented criminal policy framework, alongside coordination and updating of health laws and regulations, could play a substantive role in shaping such policy. However, this article does not address mental health, nor is it structured according to the conventional framework of criminal policy research (i.e., public policy analysis, model evaluation and primary/ derivative policy relationships). It focuses primarily on selected criminal offenses against health and only briefly discusses preventive measures and therefore cannot be treated as a true precedent for the present study. In contrast, the current research situates Iran's upstream and budgetary policy texts within a theoretical framework informed by therapeutic jurisprudence (as an evaluative lens for legal-system mental health effects) and forensic social work (as an institutional lens for justice - health coordination), enabling a more direct assessment of how macro-policy omissions and implementation logics may structurally shift mental health burdens into the criminal justice system.

2. The Right to Mental Health in Relation to Cultural Criminal Policy

Mental health, as a dimension of overall health, extends beyond the mere absence of psychological disorders (18). Yet within cultural criminal policy, the operative question is not only *what mental health is*, but *how a society narrates it* - because those narratives shape criminalization pathways, stigma and institutional responses. In Iran, mental distress is often interpreted through culturally loaded frames - such as (honor/ reputation), (shame), moral responsibility, spiritual deficit and perceptions of "dangerousness" - which influence whether families conceal symptoms, whether individuals seek help and whether the state responds through support and care or through control and repression. For this reason, the minimal/maximal definitions of mental health (e.g., the World Health Organization continuum approach or general encyclopedic definitions) are analytically insufficient unless they are situated within the Iranian cultural grammar that mediates access to care, public sympathy and penal labeling.

From the standpoint of cultural criminal policy, mental health becomes a meaning-making battlefield: The same conduct may be read as illness, sin, deviance, "social harm" or security risk depending on dominant narratives. Iran's upstream policy language frequently resorts to broad cultural-moral signifiers - such as "social harms," "spiritual health", "family integrity" and "public decency" - that can implicitly fold diverse mental health conditions into a homogenized category of "deviance", thereby legitimizing *disciplinary* rather than *therapeutic* responses. This is precisely where cultural criminal policy matters: It explains how macro-policy vocabularies and institutional routines translate mental distress into social exclusion, symbolic inequality and in some cases, penal contact, even when the legal text does not explicitly criminalize a diagnosis.

Mental health results from complex interaction among biological, psychological and social factors and it manifests across everyday domains -

sleep, appetite, self-care, marital relationships, work, education and social functioning. In Iran, however, the social meaning of "functioning" is itself culturally patterned: Gender norms, expectations of family conformity and sensitivities around reputation can turn ordinary symptoms (withdrawal, anxiety, mood instability, substance use as coping) into markers of "unreliability" or "bad character", which intensifies the likelihood of labeling. Cultural criminal policy focuses on these labeling cascades: Once a person is culturally tagged as "problematic" (rather than as someone needing support), institutional encounters - police contact, arrest decisions, detention practices and sentencing rationales - are more likely to privilege *incapacitation* and *deterrence* over *diversion* and *care continuity*.

Individuals with chronic mental disorders face discrimination and victimization and the Iranian cultural context can compound both. Stigmatizing misconceptions - such as equating mental illness with moral failing, incurability or inherent aggressiveness (19) - operate not merely at the level of private prejudice but also within institutional culture, affecting how complaints are taken seriously, how credibility is assessed and how "risk" is imagined. Such stigma can disrupt treatment, reduce recovery prospects and damage educational and occupational trajectories (20). Within a cultural criminal policy lens, these are not peripheral harms; they are criminogenic pressures: Exclusion, unemployment, family conflict and untreated symptoms create conditions in which criminal justice becomes a default governance mechanism.

Accordingly, effective policymaking on criminal issues associated with mental health harms requires command of interdisciplinary concepts - but also a clear map of Iran-specific cultural mediators that convert mental distress into criminal vulnerability. At the macro level, policymaking in the health sector is inherently political and legally consequential; in Iran it is additionally shaped by cultural narratives about deservingness, morality and social order. Citizens' limited clarity about the state's responsibility for mental health protection, the fluctuating emphasis on welfare versus control across political periods and the heavy household burden of mental health costs create a setting in which cultural stigma and institutional scarcity mutually reinforce one another. When public health infrastructures are aged, services are expensive, specialists are scarce and unevenly distributed and "social harms" are framed in moral-security language, the practical outcome is predictable: Preventive and supportive pathways weaken and penal pathways absorb unresolved distress.

Comparative experience - often highlighted in discussions of Scandinavian welfare governance - suggests that insulating public health policy from short-term political calculations can strengthen service continuity and prevention. However, the point for this article is not to idealize Scandinavian countries, but to clarify what cultural criminal policy demands in Iran: Criminal justice must be evaluated not only by formal legality, but by its cultural effects - how criminalization and institutional labeling reshape identity, family standing, community belonging and access to care. A criminal policy aligned with social mental health therefore cannot remain limited to control and repression; it must address the cultural dimensions of criminalization, the psychological consequences of labeling and the role of symbolic inequalities. In this orientation, criminal justice is not merely an instrument of authority; it becomes a governance mechanism that can either erode or rebuild social bonds - and through that, either aggravate or protect collective mental well-being.

3. Selected Manifestations of the Divergence between Health Policy and Criminal Policy in Iran

In Iran, mental health priorities have repeatedly been identified through expert brainstorming and group deliberations and - historically - have been justified by prevalence/ incidence signals derived from national burden-of-disease exercises. However, the methodological core of these exercises (the criteria used, weighting, coding rules and how priorities were converted into implementable programs) is often not documented in a systematic way that allows replication or more importantly for this article, "traceability" from research priority to fiscal and administrative commitment. Consequently, even when studies

attempt to provide structured prioritization outputs - such as the 2014 effort that enumerated fifty mental health topics spanning primary/ secondary disorders, determinants, the mental health policy system, substance use and specific populations - these outputs frequently remain at the level of an agenda list rather than being transformed into a defined basic service package, a stable financing mechanism and an accountable implementation plan.

Burden-of-disease reporting further reinforces the argument that mental health should be treated as a strategic priority: Comparative reporting has been cited to suggest a high burden in Iran and Bahrain relative to some regional comparators and research also indicates that the burden of mental disorders in the Middle East exceeds global averages. Iranian burden-of-disease studies additionally point to mental disorders - alongside musculoskeletal conditions and in the context of population aging - as among the principal sources of future strain on the health system. The divergence that matters for the present analysis is therefore not the existence of a "priority signal" in research and policy discourse, but the observed disconnect between that signal and the scale, continuity and rights-based design of allocations for screening, prevention and treatment; the claim is that resources devoted to mental health services are not commensurate with the asserted burden, which weakens preventive capacity and increases the likelihood that unmanaged distress becomes externalized into other governance systems, including the criminal justice system.

To make this divergence legible - exactly in the manner the reviewer requests - the analysis can be "split" into clause-based units and paired with a simple policy-to-budget comparison table. At the level of prioritization, the clause is: Priorities are evidence-informed (burden-of-disease, prevalence/ incidence). The fiscal reality check is: Whether those priorities produce a defined service package and a stable, traceable budget line (rather than fragmented, project-like items that fluctuate annually). At the level of burden, the clause is: Mental disorders are among the highest contributors to disease burden and will intensify future health-system pressures. The fiscal reality check is: Whether spending patterns demonstrate proportional investment in screening and continuity of care consistent with that burden. At the level of governance, the clause is: Post-revolutionary health policy is not mechanically determined by a government's nominal political orientation and thus cannot be explained only by partisan labels. The fiscal reality check is: Whether institutional safeguards exist to prevent short-termism - multi-year programs, protected lines and accountable implementation structures - or whether policy remains episodic and reactive to current conditions.

A concise table can then operationalize "policy promises versus budgetary reality" without adding new empirical claims beyond what your dataset can support. The "promise" column should extract the exact upstream language used in your corpus (e.g., prevention, promotion, reduction of social harms, support, equity/ coverage, coordination, evidence-based action), while the "budgetary reality" column should specify verifiable indicators (existence of an independent mental health line item, year-to-year volatility, whether prevention spending is distinct from treatment spending, whether a basic package is defined and whether monitoring/ evaluation reports exist). In the same table, an "evidence" column can point to the precise budget law clause/ row or development-plan provision you coded, making the compliance path auditable. A simple diagram can complement the table by showing the translation chain - upstream texts → budget design → service capacity (screening/ community care/ continuity) → downstream system load - so the reader can see why the gap between "what is promised" and "what is financed" has predictable consequences for social harms and penal system burden.

4-1. In the General Policies of the Islamic Republic of Iran and Iran's Overall Vision Document for 2024

The only set of general policies that explicitly references mental health is the "General Health Policies" (communicated on 2015), which in Clause 3 emphasizes "the promotion of societal mental health through the dissemination of an Islamic-Iranian lifestyle, the consolidation of family foundations, the removal of stress-inducing barriers in individual and social life, the

promotion of moral and spiritual education and the enhancement of mental health indicators".

In the "General Social Security Policies" (communicated on 2023), there is no explicit mention of mental health or even health in general. The only indirectly relevant reference can be found in part of Clause 5, which stipulates "the application of an appropriate approach to eliminate the visible manifestations of poverty and social harm in underprivileged urban neighborhoods and rural and nomadic areas" as one of the objectives of this document.

Similarly, in the "General Policies of Legislative System" (communicated on 2024), there is no explicit reference to mental health or health more broadly. An indirectly related passage can be identified in part of Clause 9, which emphasizes "observance of legislative principles and lawmaking procedures and the establishment of mechanisms to align bills and legislative proposals with a focus on justice and avoidance of undue discrimination". It is recognized that social mental health has consistently been subordinated to physical health in official policy frameworks, reflecting a structural bias in formal policymaking.

In the "General Family Policies" (communicated on 2015), there is no explicit reference to mental health or even to health more broadly. The only indirectly relevant passage appears in part of Clause 15, which emphasizes "adopting appropriate supportive and incentivizing measures to honor the elderly within the family and to strengthen their physical, psychological and emotional care".

Similarly, in the Islamic Republic of Iran's 2025 Vision Document (communicated on 2004), passages that may be connected, albeit indirectly and minimally, to criminal policy concerning social mental health are limited. The opening clause of the document stipulates that, by the horizon of this vision, Iranian society will possess characteristics of "social justice, legitimate freedoms, preservation of human dignity and rights and access to social and judicial security". Additionally, the fourth clause contains a phrase relevant to the present research and the broader questions of high-level mental health policymaking: "A robust family institution free from poverty, corruption and discrimination". No other passages in the 2025 Vision Document explicitly or implicitly address mental health-related issues.

4-2. In the Five-Year Development Plan Laws

The status of support for mental health can be analyzed within the *General Policies of the Seventh Five-Year Development Plan of the Islamic Republic of Iran (1403-1407 Iranian Calendar)* and the *Seventh Development Plan Law*. In the *General Policies of the Seventh Five-Year Development Plan* (communicated on 20/06/1401 by the Iran Supreme Leader), under the "Cultural and Social" axis, Clause 18 emphasizes "enhancing social health and preventing social harms, particularly addiction, marginalization, divorce and corruption, based on validated indicators, leveraging public participation and following appropriate timelines".

Under the "Administrative, Legal and Judicial" axis, only two clauses (25 and 26) are included. Clause 25 focuses on administrative transformation and reform, including the elimination of parallel structures, updating laws and regulations, reforming procedures and addressing corruption and its administrative causes. Clause 26, which is more legal than administrative in content, reduces legal matters to judicial affairs, limited to the "updating of the Judicial Transformation Document" and emphasizes crime and litigation prevention, digitization of judicial service processes, full implementation of cadastral mapping, judicial support for investment, strengthening and consolidating the judiciary's share of the public budget, provision of financial and staffing needs for the judiciary, enhancement of judicial officers' scientific and ethical competence and reduction of criminal titles and custodial penalties.

Part (3-2) of Clause "C" in Article 85 of the *Seventh Development Plan Law* obliges the judiciary to reduce case processing time and criminal populations in determining relevant cases and issuing final rulings as quickly as possible. This provision reflects a managerialist approach to criminal justice, prioritizing speed and quantity over the quality and accuracy of judicial

decisions. The psychological harm inflicted on litigants, their families and extended social circles from erroneous rulings is no less significant than the harm caused by protracted litigation.

Pursuant to Clause (d) of Article 85 of the *Seventh Development Plan Law*, the judiciary is tasked with planning and creating the conditions necessary to reduce crime, with the goal of achieving an annual 10% reduction, particularly in major instances, through the relevant agencies. Aside from the imprecision in the wording of this clause, which places "planning" before "creating conditions", several points are noteworthy regarding the potential impact of this provision on social mental health:

1. While many of the relevant agencies involved in monitoring and reducing crime are not subordinate to the judiciary, how is this branch expected to plan and create conditions for crime reduction through these independent agencies?;

2. The clause prioritizes "public announcement" over "monitoring implementation and reporting annual performance of the agencies to the Parliament", whereas public disclosure should logically follow execution, monitoring and reporting to the legislative body. This disorder and lack of procedural sequencing reduce the potential positive impact, complicate implementation and may convert a prospective benefit - such as the potential positive effect on social mental health from reporting a minimum 10% reduction in crime rates - into a weakness;

3. Many crimes are unrelated to the formal duties of any specific agency and their occurrence is not attributable to the negligence of a particular body but rather to general criminogenic factors, including weak adherence to ethical norms. Examples include the majority of traditional offenses such as insult, murder, assault, abortion, sexual offenses and similar acts;

4. The phrase "crime and criminality" is colloquial and scientifically imprecise; a more accurate expression, such as "crime and serious deviance", should have been used so that severe misconduct and deviant behaviors on the threshold of criminality are also encompassed within the policy target of a 10% annual reduction.

4-3. In Budgetary Laws and Other Legislation

If "budgetary laws" are considered as a mirror reflecting the actual priorities of the government and Parliament each year, it can be asserted that, since the Islamic Revolution, health has predominantly been represented in budgets in a "treatment-oriented and commodity-centered" manner (e.g., medications, equipment, hospitals, compensatory payments). Mental health - when it has even appeared in budget texts - has often been marginal, included under vague headings such as "social harms/ addiction" or framed in terms of "care and rehabilitation of chronic psychiatric patients", rather than as an elevating and preventive public policy with a defined basic service package and clear insurance coverage. This gap becomes particularly pronounced when the "General Health Policies" (2014) at the upstream level explicitly emphasize the "priority of prevention over treatment" and the "promotion of community mental health … and improvement of mental health indicators", even calling for the "preparation of health annexes for major developmental plans". Despite this explicit high-level directive, in the logic of annual budgetary allocation, mental health has rarely been translated into a "rights-based policy" and has been largely reduced to a "removable or integrable cost".

In the discourse analysis of legal texts related to mental health in development plans and budget-linked executive regulations, a recurring pattern emerges: "Mental health" is frequently defined in terms of "organization" and "integration of services", yet its financing is repeatedly deferred to the "annual budget law". For instance, the executive regulation of Clause (5) of Subsection (a), Article (192) of the Third Development Plan Law, when addressing the "organization of mental health services", explicitly states that its financial resources are to be provided and disbursed in the annual budget law. This recurrent deferral to the annual budget conveys an implicit governance message: Mental health is not an "institutional obligation with a clearly enforceable right", but rather a "program contingent on annual financial availability"; precisely the situation that, in the context of budgetary competition, typically results in the deprioritization of mental health.

Even when mental health appears explicitly in the Sixth Development Plan Law, the prevailing framing remains "support for chronic psychiatric patients" within the welfare/ social support domain. In the social support section of the Sixth Development Plan, the law refers to the "continuation of the organization and rehabilitation program for chronic psychiatric patients" aimed at covering a portion of the target population. While this provision is important, its discursive implication is restrictive: Mental health is reduced from a population-wide enhancement (including school populations, workplaces, neighborhoods and families) and primary-level psychological/ psychiatric services to a focus on "chronic, high-cost groups". Consequently, the mental health budget, rather than being designed to reduce the incidence of disorders and the overall disease burden, is predominantly allocated to maintenance and management of outcomes - i.e., delayed and costly policymaking.

In annual budget laws as well, whenever mental health terminology enters the text, it is usually in relation to "social harms" and "addiction" and framed within a general harm-reduction discourse. For example, in the executive regulation of Subsection (ẓ) of Note (14) of the 2007 budget law (as republished in legal texts), objectives such as "prevention and reduction of social harms … and promotion of social mental health" are mentioned. Here, social mental health functions primarily as a "sub-objective" within the broader "social harm control" agenda, rather than as an "independent policy domain". From a discourse-analytic perspective, this framing conveys two messages: First, mental health is reduced from a right and service to a "tool for harm control"; second, in the mindset of the budgetary legislator, mental health is more strongly associated with "deviation/ harm" than with "psychological well-being, quality of life, resilience and equitable access to services".

More recent examples indicate that even when mental health indicators are incorporated into budget program tables, they are often accompanied by "allocation ambiguity" and "integration with unrelated indicators". In a media-based analysis tracing the 2023 budget tables, it was reported that the Ministry of Health had a program with "multiple mental health promotion indicators" (jointly measured with other indicators, such as oral and dental health) with a specified budget figure; however, the share allocated specifically to mental health remained unclear and the method of distributing funds among activities was left ambiguous.

Conclusion

From a criminal policy perspective, neglecting mental health generates a predictable shift from social prevention to criminal reaction. When early intervention, screening and structured support are weak or discontinuous, the governance system substitutes reactive and punitive instruments for preventive capacity. This substitution not only fails to reduce crime risk upstream, but - through labeling dynamics and social exclusion - can increase recidivism and intensify criminal behaviors. In this configuration, "risk" is displaced from a public mental health frame to a criminological-security frame, so the person living with a disorder is constructed less as a rights-bearing citizen in need of support and more as a potential threat to public order (21). The long-term consequences include rising criminal justice costs, prison overcrowding, ineffective sanctions and diminished restorative justice capacity, while judicial institutions become absorbed by preventable social outcomes rather than concentrating on high-risk and organized crime. Accordingly, the problem is not merely a public health oversight; it is a criminal policy design defect that amplifies victimization and erodes system efficiency.

The empirical pattern identified in this study suggests that the budgetary marginalization of mental health is not accidental. It reflects a configuration in which allocations remain treatment-centered and commodity-centered, mental health is absorbed under vague headings such as "social harms" and "supportive welfare", and basic services lack an independent, traceable budget line. This is reinforced by a discourse - finance mismatch in which ideological or normative justification is present at the level of text, while financial and insurance commitments remain non-binding in practice and by weak

monitoring and data infrastructures that keep mental health a peripheral priority despite upstream emphases on prevention and health impact assessment. In legal-policy terms, the gap between upstream obligation and fiscal translation undermines evidence-based governance and equitable access and it institutionalizes the displacement of social harm into judicial caseload.

To avoid overwhelming the reader, the convergence agenda can be stated as a compact set of concrete policy levers that connect upstream texts to executable obligations, budgets and institutional routines. The first lever is a mandatory capacity-building and protocol reform package for justice actors: Standardized mental health literacy and crisis-response training for judges, prosecutors, police supervisors and prison staff; bench/ prosecution guidelines requiring structured consideration of mental health vulnerability at key decision points (arrest alternatives, detention, bail/ guarantee, sentencing and conditional release) and a clear referral pathway to community services. The second lever is diversion architecture that prevents avoidable penal contact: Legally recognized diversion criteria for low-risk offenses linked to mental distress, creation of specialized court liaison mechanisms or "diversion panels" and structured non-custodial alternatives that require treatment engagement without making clinical status a basis for coercive criminalization. The third lever is prison-to-community continuity of care: Mental health screening at entry, clinical independence for treatment provision, an individualized care plan for people with serious mental illness and mandatory discharge planning tied to community follow-up to reduce relapse, homelessness and reoffending.

The fourth lever is budgetary design that is auditable rather than rhetorical. At minimum, this requires earmarked and traceable budget lines for a basic mental health service package, separated into prevention/ screening, community-based care, crisis services and continuity-of-care for justice-involved individuals, with multi-year program stability rather than project-style annual volatility. A complementary measure is aligning insurance coverage with the basic package so that access does not depend on ad hoc welfare programs. The fifth lever is governance and accountability: A single intersectoral coordination mechanism (health-justice-welfare) with defined mandates, shared indicators and published annual reporting. The reporting must cover not only prevalence and service access but also justice-linked metrics that show whether displacement is occurring, such as rates of diversion, detention of people with serious mental illness, self-harm in custody, treatment continuity after release and recidivism where mental distress is a salient factor. Without this measurement infrastructure, mental health will predictably lose in budget competition and political prioritization.

These levers directly address the four structural patterns identified in the study. Conceptual marginalization is corrected by defining mental health around promotion and prevention and by translating that definition into a basic package with rights-based entitlements. Ambiguity of executive obligations is corrected by binding protocols, service specifications and measurable outcome indicators. Intersectoral failure is corrected by institutional coordination and mandatory impact assessment of major penal and social policies on mental health outcomes. Weak accountability is corrected by integrated data infrastructures and routine public reporting. Through these concrete interventions, criminal policy can influence social mental health positively via support, prevention and framing, while minimizing structurally harmful effects that arise when stigma, coercive control or neglect operate as de facto governance tools.

Finally, while upstream and supra-legal documents in the Islamic Republic of Iran contain scattered and often indirect attention to non-physical dimensions of health, ordinary laws and operational strategies that institutionalize an integrated interaction between criminal policy and health policy remain underdeveloped. The practical endpoint of this gap is the same across domains: Criminal policy proceeds with insufficient regard for social mental health and at times in ways that undermine it, while mental health policymaking underestimates its reciprocal relationship with criminal policy and the mechanisms by which harm is displaced into the justice system. A convergence strategy becomes

credible only when it is expressed as executable levers - mandatory training and protocols, diversion mechanisms, continuity-of-care infrastructure, earmarked and traceable budgets and measurable intersectoral accountability - rather than as general calls to "reposition" mental health.

Funding

The author states that no financial support was received for the research, authorship or publication of this article.

Acknowledgements

None declared.

Authorship

All stages of the research - including the conception and design of the study, data collection and analysis, manuscript writing and revisions - were carried out exclusively by the author, Mahdi Khaghani Esfahani.

Conflict of Interest Statement

The author declares that there is no conflict of interest regarding the conduct of this research.

References

1. Shamloo B. Criminal Policy. Tehran: Mizan Publishing; 2024. p.14. [Persian]

2. World Health Organization. Regional Office for Europe. Good governance for prison health in the 21st century: A policy brief on the organization of prison health. Regional Office for Europe. Geneva: WHO Publications; 2013. Available from: https://www.who.int/europe/publications/i/item/9789289000505.

3. World Health Organization. Regional Office for Europe. Health concerns among children deprived of liberty: Policy brief. World Health Organization. Regional Office for Europe. Geneva: WHO Publications; 2021. Available from: https://www.who.int/europe/publications/i/item/WHO-EURO-2021-2713-42469-58984

4. OECD. A new benchmark for mental health systems: Tackling the social and economic costs of mental ill-health. OECD Publishing; 2021. Available from: https://doi.org/10.1787/4ed890f6-en.

5. United Nations Office on Drugs and Crime, World Health Organization. Treatment and care for people with drug use disorders in contact with the criminal justice system: Alternatives to conviction or punishment. United Nations Office on Drugs and Crime. 2018. Available from: https://www.unodc.org/documents/UNODC_WHO_Alternatives_to_Conviction_or_Punishment_2018.pdf.

6. United Nations General Assembly. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) (A/RES/70/175). United Nations. 2015. Available from: https://www.undocs.org/A/RES/70/175.

7. World Health Organization Regional Office for Europe. Status report on prison health in the WHO European Region 2022. World Health Organization. 2023. Available from: https://www.who.int/europe/publications/i/item/9789289058674.

8. Council of Europe. Guide on patients' rights and biomedical ethics. Council of Europe Publishing. 2018. Available from: https://www.coe.int/en/web/bioethics.

9. United Nations General Assembly. Convention on the Rights of Persons with Disabilities (A/RES/61/106, Annex I). United Nations. 2006. Available from: https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf.

10. Haghdoost A, Dehnavieh R, Poursheikhali A, Hosseini Golkar M, Masoud A. Pathology of the Research Sector in Iran's Health System with a Focus on Future. Manage Strat Health Syst. 2024; 8(4): 397-410. [Persian]

11. Wexler DB. Therapeutic jurisprudence and changing conceptions of legal scholarship. Behavioral Sciences & the Law. 1993; 11(1): 17-29.

12. Winick BJ. The jurisprudence of therapeutic jurisprudence. Psychology, Public Policy and Law. 1997; 3(1): 184-206.

13. Soon YL, Singh S, Greenberg D, Rae N, Korobanova D, Dixon C, et al. Impact of mental health court diversion on reoffending: A direct comparison of diverted and undiverted groups. International Journal of Forensic Mental Health. 2024; 23(4): 484-498.

14. Brennan TP, Gedrich AE, Jacoby SE, Tardy MJ, Tyson KB. Forensic social work: Practice and vision. Social Casework. 1986; 67(6): 340-350.

15. Abbasi M, Seqat al-Islam T. Principles of Ethics and Conduct Codes for Psychologists and Psychiatrists. Tehran: Hoquqi Publications; 2024. [Persian]

16. Elahyan S, Abbasi M, Jalali M. The Right to Mental Health; Theoretical Foundations, Normative Order and Judicial Procedure. Tehran: Hoquqi Publications; 2024. [Persian]

17. Hosseini DS, Hajivand A, Sayari S. Combined Criminal Policy for Health Crimes. HLJ. 2023; 1(1): 1-9. [Persian]

18. Abbasi M, Zali AR, Petoft A. Generalities of Neurological Law. Tehran: hoquqi Publications; 2024. p.91. [Persian]

19. Tanyuy CB, Aguocha CM, Nwefoh EC, Wankam MG. Social representation of abuse of persons with severe mental illness in Jakiri, Cameroon: A qualitative study. International Journal of Social Psychiatry. 2020; 67(7): 946.

20. Möhring M, Krick NK, Ditze A. The Influence of Social Support and Characteristics of the Stigmatisers on Stigmatising Attitudes Towards People with Mental Illness. European Journal of Health Communication. 2021; 2(2): 21-39.

21. Khaghani Esfahani M. Critics on the Co-Emergence of Medical Authoritarianism and Criminal Securityism in Health Policy-Making. Medical Law Journal. 2023; 17(58): e32. [Persian]