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ARAŞTIRMA | RESEARCH

Protective and Preventive Community Mental Health Services in Turkey: A Qualitative Research about Experiences of Social Workers and Patients

Türkiye'de Koruyucu ve Önleyici Ruh Sağlığı Uygulamaları: Sosyal Hizmet Uzmanları ve Hastaların Deneyimlerine Dair Nitel Bir Araştırma

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Abstract

The aim of this research is to evaluate protective and preventive mental health services with a holistic perspective through the experiences of social workers working in Community Mental Health Centers (CMHC) and the patients receiving services from these centers. This research has designed as a qualitative research to expose the participants' experiences and evaluations about the protective and preventive dimension of community based mental health services. Descriptive analysis of the data has made. Six social workers and thirteen patients were interviewed. Semi-structured interview form, created by the researchers, has used. The most important finding of the research is that CMHCs provide an alternative to long-term inpatient treatment by providing continuity of treatment and follow-up, decreases the frequency of hospitalization, and contributes to the increase of social functionality, communication skills and self-confidence of patients. It is also that the society hasn't adequate information of mental illness, and this ignorance brings stigma and discrimination. Based on the research findings, it has been proposed to reorganize the social policies in line with the needs.

Keywords: Mental health, community mental health, preventive mental health, social work

Öz

Bu araştırmanın amacı, Toplum Ruh Sağlığı Merkezlerinde (TRSM) sunulan koruyucu ve önleyici ruh sağlığı hizmetlerinin bu merkezlerde çalışan sosyal hizmet uzmanları ve merkezlerden hizmet alan hastaların deneyimleri üzerinden değerlendirilmesidir. Bu araştırma hizmet veren ve hizmet alanların deneyim ve değerlendirmelerini ortaya koyarak bütüncül bir değerlendirme yapmak amacıyla nitel olarak tasarlanmıştır. Veriler betimsel analize tabi tutulmuştur. Araştırma kapsamında altı sosyal hizmet uzmanı ve on üç hasta ile görüşülmüştür. Araştırmada veri toplama aracı olarak araştırmacılar tarafından oluşturulan yarı yapılandırılmış görüşme formu kullanılmıştır. Araştırmanın en önemli bulgusu TRSM'lerin tedavi ve takibin sürekliliğini sağlayarak uzun süreli yataklı tedaviye bir alternatif oluşturduğu, yatış sıklıklarının azaltılmasını sağladığı, hastaların sosyal işlevselliklerinin, iletişim becerilerinin ve buna bağlı olarak da özgüvenlerinin artmasına katkı sağladığıdır. Ayrıca toplumun ruhsal hastalıklar konusunda bilgisiz olduğu, bu bilgisizliğin damgalanma ve ayrımcılığı beraberinde getirdiği ortaya çıkmıştır. Araştırma bulguları sosyal politikaların ihtiyaçlar doğrultusunda yeniden düzenlenmesi gerektiğini göstermektedir.

Anahtar sözcükler: Ruh sağlığı, toplum ruh sağlığı, önleyici ruh sağlığı, sosyal hizmet

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WORLDWIDE research put forth that mental health is related to both genetic and biological elements, as well as the influence of social environment, economic stability, education, physical health, low income, housing conditions, migration, frequent school change, limited access to quality health services, unsafe and stressful environments, and malnutrition on cognitive, emotional and behavioural health (APHSA 2013). These studies also reveal that mental health services are not merely about treating the condition, but aim to improve patients' living standards through enhancing their social functionality; and to ensure that they live in harmony with the society as a productive individual, which can be achieved through ensuring family support during hospitalization. In the WHO report dated 2004, which is based on the theme of "lifelong mental health", the policies aimed at improving mental health and reducing the risk of mental illness are discussed under the following topics: "interventions during pregnancy","parenting interventions", "interventions for children and adolescents", "work life interventions", "interventions at retirement and old age" (Jané-Llopis and Anderson 2007). These policies aim at providing protective and preventive services within the scope of community-based mental health practices, thereby reducing the resources allocated to treat mental health conditions by improving and enhancing mental health services. Another WHO (2011) paper that reports the latest global developments in the field of mental health, the following are emphasized: community-based mental health, continuity of care, the availability of wide-ranging services that respond to different needs of the population, the integration of services in primary care, and the development of protective and preventive services.

In this context, community-based mental health services is emerging in Turkey (T.R. Ministry of Health 2011). Protective and preventive mental health services are being delivered through TRSMs that are designed as primary care health institutions. To ensure successful practice in the field of mental health, evidence-based practice shall be conducted, and practices shall be standardised by taking into account different regional cultural characteristics. Our literature review revealed that there is no qualitative study assessing the protective and preventive services provided by TRSM from service providers' and receivers' perspective, in Turkey. Therefore, the purpose of this research is to deal with protective and preventive services offered at TRSMs with a holistic perspective in the context of the experiences of the social workers working in these centers and the patients receiving services from these centers, thus, contributing to filling the practice, policy and information gaps. In this respect, namely, the protective and preventive mental health services, the community mental health transition process, and the services provided in TRSMs will be mentioned, in this order. Experiences and evaluations of the participants will be discussed in light of this information.

It is possible to analyse recent worldwide mental health services in three eras: (1) asylum (warehouse-type mental hospitals) and increase in traditional hospital care, (2) reduction of asylums, and (3) the emergence of the community-hospital balance model (Thornicroft and Tansella). 2003). The community-hospital balance model is an intermediate model aimed at the transition to community-based mental health practices. Community-based mental health houses protection of mental health; prevention, and treatment of mental illnesses; and rehabilitation of people with mental illness in the community (WHO 2007). The goals of community-based mental health are (Thornicroft and Tansella 2003, Jané-Llopis and Anderson 2007, Knapp et al. 2007, TR Ministry of Health 2012): (1) prevent the occurrence of mental illnesses, (2) ensure society to

take responsibility in, and participate to treatment, (3) follow-up the patients more closely based on a client-centered approach, as well as ensuring continuity of care, (4) prevent unnecessary hospitalization, (5) fighting with stigmatization, (6) produce data through conducting research on community-based mental health. A community-based mental health model aims to ensure de-institutionalization. This study focuses on the protective and preventive aspects of community-based mental health policies.

Preventive mental health aims to improve the individual's psychosocial well-being, competence, and resilience, and to ensure a supportive environment and supportive social conditions for people with mental illness by improving mental health awareness in the community (O'Briain 2007). Preventive mental health is considered to be a whole of efforts and services designed to prevent all aspects of mental illnesses, including biological, psychological and social aspects; early diagnosis and treatment of mental illnesses; support individuals with mental illness, and; develop mental health awareness in society (Attepe Özden 2015). Prevention of mental illnesses aims to reduce the risk factors acting on mental illnesses, prevent or delay the recurrence of diseases, reduce the frequency and prevalence of mental illnesses, and mitigate the effects of the disease on individuals, families and society (Mrazek and Haggerty 1994). Protective and preventive mental health services refer to prevention studies for the occurrence, course, and chronicization of the illness, and should be carried out as a whole. Determining risk factors and protective factors is extremely important in protective and preventive mental health studies. Monitoring, evaluation, rapid onset of treatment, and social support reduce the risk of illness for people under risk of mental illness. Being aware of the risks, knowing the protective factors and sharing them with the treatment team within the framework of the proactive treatment approach increases the success of mental health staff at each stage of the treatment (Thomas et al. 2016). Although risk factors vary from person to person, it is not wrong to suggest that biological, psychological, environmental and social factors bring risks. According to Rutter (1985), elements to cope with stress; such as the life experience of the individual, social support provided by the family and community, the cognition of stress factors by the individual, the level of self-sufficiency, and the level of self-esteem can all be considered as protective factors (Aksaray et al. 1999).

Preventive mental health levels

Preventive and preventive mental health services can be handled at three levels (Aksaray et al.1999, NSW Health Department 2001, WHO 2001, Doğan 2002, Doğan et al.2002, WHO 2004, Gültekin 2010, MEB Bakanlıgi 2012, Attepe Özden 2015, Davidson and Campbell 2016):

Primary protection

It refers to the studies to prevent the occurrence of the illness with no previous record of incidence. The objectives of primary protection identify the factors to cause the disease, reduce the risk factors, increase the resistance to the and preventing the spread of the illness. Practices available in the scope of primary protection are:

1. Identify stressful factors that adversely affect mental health on the social level, and develop necessary prevention and reduction policies,

2. Raise social awareness on mental illnesses and prevent stigmatization through training deliveries starting from the local level and spreading to the societal level,
3. Carry out studies to improve societal physical and mental health level,
4. Identify risk groups and take necessary precautions,
5. Carry out studies to prevent genetic transmission of psychiatric disorders,
6. Schedule informative activities on the physical and mental effects of alcohol and substance abuse,
7. Develop social services - i.e. employment, shelter,
8. Increase parenting skills by providing information to expecting parents about child development,
9. Conduct studies on improving the problem-solving skills of the individual and the family,
10. Develop social support programs to reduce or eliminate the stress level of the individual and the family,
11. Design programs to support and train individuals experiencing transitional periods such as retirement or divorce.

Secondary prevention

It refers to the studies that include early detection and rapid treatment of the illness, and reducing the duration and frequency of the disease. Under secondary protection, the following practices are carried out:

1. community-wide initiatives for early diagnosis of illnesses,
2. improve health services such as emergency services, outpatient clinics, day treatment programs, and inpatient services for early diagnosis and treatment,
3. provide information on mental illnesses and accompanying symptoms to teachers in the education system to eansure early diagnosis of mental illnesses,
4. informing the diagnosed patients, asl well as their immediate relatives and social environment about the illness and respective treatment methods,
5. follow-up discharged patients in their environment,
6. introduce institutions and organizations to be referred to in crisis, such as acute mental health problems,
7. establish hotlines to help people experiencing survival and situational crises (suicide, etc.),
8. educate the society on crisis intervention and similar information on diseases.

Tertiary protection

It refers to the studies for reducing disorders and disabilities caused by the illness, and post- treatment adaptation to the society. In a study they published in 1995 and conducted with 580 people, Schoenbaum et al. discovered that approximately one-third of the discharged patients were re-hospitalised, and the rate of re-hospitalization of patients visited at home tend to be lower (Schoenbaum, Cookson and Stelovich 1995). Parallel to these findings, Nelson et al. (2000) uncovered that discharged patients that are not followed-up afterwards are hospitalised twice as much compared to those not of. Tertiary protection studies play an important role especially in preventing recurrence of the illness. The following practices are carried out under tertiary protection:

1. carry out social support activities with the individual and the family during the recovery and adaptation period after discharge,
2. monitoring and home visits following the post-treatment psychiatric rehabilitation process,
3. uninterrupted provision of educational and therapeutic services to the individual and the family on things to do with acute illnesses,
4. collaborate with community resources through establishing social support groups after discharge,
5. if and when necessary, enroll the patient in partial hospitalization programs, and refer them to shelters, or refer them to treatment programs and services in line with their condition,
6. ensure functional social support systems.

Community-based mental health services provide treatment and support at a local level to people with mental illness and their families, in the context of healing, surviving in the community, protection from mental illness, and prevention of relapse. Protective and preventive mental health services, on the other hand, including but not limited to enhancing the conditions that pose a risk for socioeconomic status and housing, active participation in education and employment, and strengthening relations with the community and social networks (WHO 2004). Similar to the global level, the services are provided through TSRMs in Turkey. A team of psychiatrists, social workers, psychologists, ergotherapists and psychiatric nurses provide services at TRSMs. It is a multidisciplinary sector, where social work has a significant role in terms of emphasizing social justice and client rights, and focusing on the individual rather than the clinical symptoms of the disease (Bland et al. 2009, cited in: Courtney and Molding 2014). Social workers are introduced to the field of mental health back in late 19th and early 20th centuries (Cabot 1909; Cannon 1952; cited in Aviram 2002). Parallel to handling the biological, psychological and social aspects of health as a whole, a social worker working in the field of mental health provides support to the psychiatrist's roles in the context of protection, improvement and development at the individual, family and group level (Simpson et al. 2007; Tuncay 2018).

The roles and responsibilities of social workers working in TRSM - one of the institutions providing mental health services- are: identify patients in need of psychiatric help; contact patients or relatives, and invite them to the center; ensure patients are in contact with the center; ensure patients' adaptation to the center and treatment; design an intervention plan by assessing patients in their environment; ensure active participation of patients and their families, as well as continuing treatment; informed patients and their families about their rights; conduct multidisciplinary studies; provide psychoeducation services to the patient and their families, and make home visits with mobile teams; conduct inter-agency collaborative studies to resolve psycho-social and economic problems that may arise after treatment; ensure the patient manage and sustain relations with the family and the social environment; prepare the patient and the family to the discharge process; follow-up the post-discharge compliance process; and ensure inter-agency collaboration to fight with stigmatization; ensure policy planning for social change (Aviram 2002, Oral and Tuncay 2012, Charles and Bentley 2016).

Addressing the individual in his/her environment provides a framework for shaping social policies in the protective and preventive dimension of community-based mental health services. To produce relevant evidence-based policies, both service providers' and

service receivers' perspectives should be involved in the form of practical (experience) knowledge. In respect thereof, the study aims to analyse the services offered from a holistic perspective and to determine the requirements to improve them, by addressing the experiences of the social workers working at and patients receiving services from TRSMs together. To conduct an evidence-based and well-founded assessment at first background on mental health policies in Turkey will be provided.

Mental health system in Turkey

The earliest services for psychiatric patients in Turkey are provided in the first period of the Ottoman Empire, in the warehouse-type inpatient facilities called "tımarhane" (madhouse) and "bimarhane". In 1924, the first warehouse-type facility -İstanbul Bakırköy Mental Neurological Diseases Hospital- was established with Mazhar Osman's proposal, and followed by a series of warehouse-type hospitals founded in different regions of Turkey (Erkoç, brother and Artvinli 2010). Together with operational problems of hospitals, lack of capacity and the revolving door phenomenon, Turkey followed a similar path to the globe; thus, first, the number of asylums are increased, followed by a reduction, and a similar transition process to community-based service model.

Between 1945 and 1975, the WHO promoted "better health for everyone" approach, and the emphasis was put on on equitable and equal health policies. In the 48th European Regional Committee of the Conference, organised by the WHO, "Health for All, Objectives and Strategies for Turkey" paper listed the goals on improving community mental health, which was included in the national health strategy for 1998 - 2020 in the scope of "Health 21" main headings. At the European Ministers Meeting held in Helsinki in 2005, all the member states focused on completing their own mental health action plans. Following this, in the scope of "National Mental Health Policy" announced in 2006, efforts were put in place to design a national action plan (T.R.Ministry of Health 2011, Yılmaz 2012). Established with the directive of the Minister of Health, in 2007, the Mental Health Executive Board consisted of mental health professionals and association representatives in this field, who prepared the action plan including things to be done to improve preventive mental health services (T.R.Ministry of Health, 2011).

According to Turkey's Mental Health Profile Report (1998) throughout their life, approximately 18% of the population in Turkey experienced at least one mental illness. Currently, hospital-based service model is the most prevalent service model for mental health patients. In Turkey, the existing hospital-based service model includes, outpatient services; hospitalization during exacerbation/attack; inpatient care provided at hospitals to the homeless and those in need of care –despite having relatives (T.R. Ministry of Health, 2011). This model mostly serves for the mentally ill patients and focuses on "exacerbation/attack" periods. This model, where the medical dimension is emphasized and the psychosocial dimension is neglected, does not involve any psychosocial studies that prevent recurrence of the disease, increase social functionality or inform the society about mental illnesses. Which paves the way to the revolving door phenomenon (releasing drugs without discharge under the supervision of a doctor, frequent exacerbation due to lack of follow-up, etc., and returning to inpatient treatment), reinforcing the stigmatization and discrimination behavior of the society towards people with mental illness. One of the most important reasons causing this situation is the insufficient number of professionals in the field of mental health. According to the WHO data, in 2005, there

is one mental health and disease specialist, one psychologist and one social worker available per a hundred thounsand people in Turkey (Oral and Tuncay 2012).

Recent studies reveal that people diagnosed with any mental illness is mostly treated with drug therapy and/or therapy conducted by a psychiatrist or clinical psychologist (Yılmaz, 2012). Which shows that medical treatment is promoted and psycho-social dimension is neglected in Turkey. In contrast, current studies put forth that mental illnesses are not only limited to the medical aspect but bring about different social problems, as well. As much as being a source of mental problems, social problems may also stem from mental illnesses. While Prilleltensky (2001) explains mental health on a community basis, he also stressed out social problems, primarily poverty and social justice. According to the Republic of Turkey Ministry of Health's National Mental Health Action Plan (2011), mental health is a public health problem including social, economic, legal and medical dimensions.

In light of all this information, we may suggest that the hospital-based model responds only to the patient's treatment needs, but does not intervene in other problem areas to emerge. The European Union Progress Report 2009 for Turkey mentions limited progress on mental health, stressing the need specifically to protect child and youth health, through establishing community-based services, an alternative to institutionalization (Commission of the European Communities 2009). Together with international organizations like the European Union, professional organizations such as the Turkish Psychiatrists Association and the Turkish Psychologists Association, and NGOs such as Human Rights Intervention Association for Mental Health also pointed out the need for making changes in mental health policy in Turkey. In line with these ideas and needs, the National Mental Health Policy text published by the T.R. Ministry of Health, in 2006, includes transition to a community-based mental health system, integrating this system into the general mental health system and primary health care services, conducting community-based rehabilitation studies, improving the quality of mental health services, enacting laws in the field of mental health, advocating patient rights against stigmatization, increasing training deliveries, research and human resources in the field of mental health. As stated in the National Mental Health Action Plan for 2011-2023, Turkey plans to ensure transition to community-based mental health services in order to establish an integrated mental health system that meets all the needs of individuals with severe mental illnesses. However, it was also stated that in the short term "community-hospital equilibrium model" will be implemented first, before the transition to the community-based mental health model, due to the lack of necessary human resources. The Ministry of Health decided to set up TRSMs in April 2009, in the scope of the community-hospital balance model. During the planning phase, the systems of Finland, Italy, England, Germany, and the Netherlands were analysed on site (Alataş et al. 2009). As a result of pilot studies conducted in cooperation with these centers, the Directive on the Establishment and Operation of TRSMs was published in February 2011. According to information received from the Ministry of Health, as of November 2019, there are 175 TRSMs in Turkey; it is planned to increase this number by 236.

As referred in the 2011 Ministry of Health National Mental Health Action Plan, TRSMs are health units to inform individuals and families with serious mental illness in the relevant geographic region; to provide outpatient treatment and follow-up services; to carry out studies to improve skills in individuals and groups through rehabilitation,

psychoeducation, occupational therapy; and to provide follow up services in cooperation with psychiatry clinics - where necessary with mobile teams.

The primary purpose of TRSMs is to provide individuals with severe mental health problems biopsychosocial interventions to prevent hospitalization; to minimize possible disability, and to restore or improve lost functions. These versatile interventions stand as a one-stop-shop guidance center for multidisciplinary assessment and care, by a team of psychiatrists, social workers, nurses, psychologists and ergotherapists. While psychiatric nurses in the UK and social workers in Germany are in the forefront in the TRSM systems; the Turkish system is established more on psychiatrists. The care plan for the patient is prepared by the TRSM team in cooperation with the patient and family, taking into account the patient's symptoms, education, income, work and accommodation, relationship with the family and social environment, and biopsychosocial status. The care plan is created by the collaboration of the TRSM team, patient and family. Designing a care plan requires taking into account a patient's strengths, weaknesses and vulnerabilities, motivation and coping strategies.

In TRSMs, psychoeducation classes are provided to patients, their families and relatives, delivering information on diagnosis, course of the disease, drug use and side effects, exacerbation and factors to trigger exacerbation, common causes of exacerbation, signs and access to various services in case of exacerbation. In coordination with the respective hospital units and primary health care institutions, municipalities, the Provincial Directorate of Ministry of Family, Labor and Social Services (AÇSHİM), Turkish Employment Agency (İŞKUR) that offer support services for the community, individuals, their families, stabilization of social functioning of the patient is ensured, and further, efforts are made to increase their participation in social life (education, employment, etc.). Necessary studies are implemented through identifying the needs of the families caused by the patient in care, or the illness. Additionally, in the scope of fighting with discrimination and stigmatization on the macro level, TRSMs play an advocacy role on behalf of the service providers (T.R. Ministry of Health, 2012).

Our research aims to evaluate the feasibility of community-based mental health services from a holistic perspective, in the context of the experiences of and assessments by social workers working in TRSMs that provide services in the field of protective and preventive mental health, and patients utilising these centers services. One of the goals of this rerearch is contributing to policy development and designing services tailored for patients as well as social workers. In the framework of the afore listed key purposes we will elaborate on the following questions; "(1) What kind of services are provided in TRSMs in the context of protective and preventive mental health in micro, mezzo and macro dimensions? (2) What are the assessments, expectations and recommendations regarding the provision of protective and preventive services in the context of the experiences of social workers working in TRSMs? (3) What protective and preventive services are provided to patients utilising TRSM services? (4) What are the assessments, expectations and suggestions of patients receiving TRSM services, regarding protective and preventive mental health services, in line with their personal experience? "

Method

This research is designed as a qualitative research to make evaluations through the experiences of social workers working at TSRM service centers –where basic protective and

preventive mental health services are provided- , and patients facilitating the services of these centers, in Turkey. This paper aims to acknowledge the awareness of social workers who are providers of protective and preventive services, and that of patients receiving these services, through self-expression, sharing experiences and making evaluations on the services; thus ensuring a holistic perspective in the evaluation of preventive and preventive mental health services.

Participants

Qualitative and purposive sampling techniques are preferred in this research. Purposive sampling is a method in which the researcher identifies a selection of samples from individuals or groups to provide the most eligible answers in line with the researcher's objectives, based on the criteria or characteristics determined in accordance with the purpose of the research (Dattalo 2008). In that respect, in line with the objectives of this research, in each research province, social workers working in one of the TRSMs for +1 year are identified. The selection criterion for patients is having received services from these centers and having cognitive breakdown levels allowing them to provide meaningful answers to research questions (examined by a psychiatrist and social worker). In -depth interviews are conducted with thirteen patients; data collection process was terminated when the participants provided similar responses thus data is saturated. Six social workers were interviewed because in the research province there are eight TRSMs, six of which were included in the study, as these were deemed eligible by the hospital boards, and only one social worker was actively working in each eligible center. To ensure confidentiality, credentials and home towns of the participants are not provided. The social workers involved in the research are named as SHU1, SHU2; whereas the patients were named as K1, K2.

There are a total of 6 social workers to participate in the research; 1 male and 5 females. Their age varies between 27 and 49, with an average age of 40.33. All of the participants hold a bachelor degree in social work, further two of them also hold a master's degree in various fields. The average professional practice experience as social worker is 14.33 years; and the time spent in TRSM is 3 years on average.

Table-1: Sociodemographic data on social workers involved in the research

Nickname	Gender	Age	Education Level	Professional Practice	time spent in TRSM (years)
SHU1	Male	45	Undergraduate-Social work, Graduate-Public Administration - ongoing.	8	6
SHU2	Female	34	Undergraduate-Social work	10	2.5
SHU3	Female	27	Undergraduate-Social work	4	2.5
SHU4	Female	49	Undergraduate-Social Work- Graduate – Occupational Health and Safety	25	2.5
SHU5	Female	41	Undergraduate-Social work	18	2
SHU6	Female	46	Undergraduate-Social work	21	2.5

Information on gender, age, education level, professional practice and the time spent in TRSM for the social worker interviewees are presented in Table 1.

A total of 13 patients participated the research:, 6 females and 7 males. The youngest patient is 24 years old and the oldest is 58 years old, and the average age is 42.07. Almost all patients are diagnosed with schizophrenia, only one patient is diagnosed with

psychosis. The average age of diagnosis is 22.84 (compulsory military service age is assumed to be 20; discharge age is assumed to be 21 years, start of udergraduate study age is assumed to be 18 years). 5 of the patients were hospilatised before applying to TRSM, 5 of them did not receive any type of inpatient treatment, and 3 patients did not respond to this question. On average, participating patients utilised TRSM services for 19.84 months. None of the participants are hospitalised since receiving TRSM services.

Table-2: Sociodemographic data on patients involved in the research

Nickname	Gender	Age	Diognosis	diagnosed age	years in treatment before TRSM	years in inpatient treatment before TRSM	the time they received TRSM services	statuswhether or not being hospitalised in TSRM process
K1	Male	44	Schizophrenia	17	23 years	4 times	66 months	-
K2	Male	27	Schizophrenia	17	10 years	-	12 months	-
K3	Male	35	Schizophrenia	21	13 years	No response	24 months	-
K4	Male	37	Schizophrenia	21	17 years	Hospitalised	5 months	-
K5	Female	44	Schizophrenia	16	27 years	Hospitalised	10 months	-
K6	Female	47	Schizophrenia	21	15 years	-	5 months	-
K7	Female	47	Schizophrenia	18	29 years	-	12 months	-
K8	Female	36	Schizophrenia	18	16,5 years	No response	17 months	-
K9	Female	24	Schizophrenia	17	2 years	-	24 months	-
K10	Female	52	Schizophrenia	26	23 years	No response	36 months	-
K11	Male	58	Schizophrenia	46	10 years	3 times	24 months	-
K12	Female	47	Psychosis	24	20 years	7 times	36 months	-
K13	Male	49	Schizophrenia	35	11 years	-	36 months	-

Information on gender, age, diagnosed age, years in treatment before TRSM, years in inpatient treatment before TRSM, the time they received TRSM services, and whether or not being hospitalised during this period are presented in Table 2.

Data collection process

Researchers have designed and used two semi-structured interview forms for social workers and patients. Available literature and field observations are utilised in line with the research objectives, when preparing the semi-structured forms. The semi-structured interview form created for social workers consists of two sections; namely, a) sociodemographic data (age, gender, education level, and time spent working in mental health sector, etc.); b) the services provided, and comments and evaluations about these services.

The semi-structured interview form created for patients consists of three sections; namely, a) sociodemographic data, b) services received from the institution, comments and experiences about these services, and c) suggestions regarding services. To collect research data, the ethical committee approval was obtained with the official letter of Hacettepe University Non-Interventional Clinical Research Ethics Board dated 10.09.2017 and numbered GO 17/552-17. Further, necessary permissions to conduct a research in TRSMs were obtained from the Provincial Directorate of Health Services. During the data collection process, in-depth interviews with social workers and patients were held face-to-face, by using semi-structured interview forms. Interviews lasted between 50- 90 min.

Statistical analysis

The data is collected with the consent of the participants by using semi-structured interview forms, in the form of voice and sound records; and was put through descriptive analysis using MAXQDA 12 package program, which is one of the available qualitative data analysis aids. Descriptive analysis depicts participants' personal experiences and comments about the events and situations (Day 1993). Descriptive analysis remains true to the original data, as much as possible, is kept and participants' remarks can be quotated, if and when necessary (Yıldırım and Şimşek 2000). During the analysis process the data is coded; thus, the codes and themes of the research are identified based on the frequently repeated topics and concepts in the texts. The results of the research, which aims to analyse community-based mental health practices in the context of protective and preventive mental health in Turkey, through the experiences of service providers and service receivers in particular, pointed to various themes; namely, studying the patient and the period of illness, studying the patient's family and social environment; social studies and social policy making.

Results

The sociodemographic findings of the research reveal that mainly young and middle-aged male patients receive services from TRSM.

> "Since schizophrenia is a condition mainly encountered in middle ages, most of our patients are in 30 and 55 age group … Our male schizophrenia patients is slightly more populated than females"(SHU5, 41 years old, Female, 18 years of experience).
>
> "In our region, females are more hesitant to seek services from our institution. Having low education levels, families are more protective and preserved, when it comes to females. They assume men as a potential threat for them, or some families believe thar women's awareness will be raised and their authority would be shakes, if they let females to our centers. … many women participate religious communities as to having low education levels"(SHU2, 34 years old, Female, 10 years of experience).

One of the most important findings that emerged as a result of in-depth interviews was both patients and their social environment have low awareness on the mental health of patients; that they were referred to religious leaders/clerics who adhere to religious myths (amulets, possessed by demons, etc.) and carry out so-called exorcism before patients seek TRSM treatment, and got dissappointing outcomes. The social workers who suggest that the education level in the region is mostly primary education or less, under-

lined the fact that before TRSM service, when patients sought help from religious leaders they face accusations and negative comments that cause relapse; however, due to low education level it's a frequently preferred method to respond to mental health, in general.

> "… They assume it's a sort of religious guidance. … We tell them that this is a condition/disease that requires medical treatment, and ask them to whom they have consulted before. Almost all of them have sought help from a pseudo-religious leaders. When it comes to mental health they have no awareness on the issue as, they believe that the patient is under spell" (SHU1, 45 years old, Male, 8 years of experience).
>
> "... My sister's husband is overwhelmed by such pseudo-religious guidance; he referred us to a religious preacher but not satisfied at all. When we have no idea on the issue, we immediately consult to a religious preacher "(K6, 47 years old, Female, Diagnosed with Schizophrenia).

In the scope of the research findings, in addition to gender distribution in the willingness to participate to treatment, and patients' and their social enviroment having low of awareness on the mental health issues, more themes are identified, and presented below in Table-3, under four headings.

Table-3. Themes and sub-themes

Themes	Sub-themes
Studies on the Patient and the period of illness	Psychoeducation
	Occupational Therapy
	EKPSS courses
	Information Delivery on Rights and Services, Advocacy
Studies on the Patient's Family and Social Environment	Familty Training
Community-Oriented Studies	Introduction of TRSMs
	Fighting with Discrimination and Stigmatization
	Risk Screening
Studies on Social Policy Making	Shortcomings in Employment Policies

Studies on the patient and the period of disease

Separate psychoeducation facilities are provided in TRSMs for patients and their families, as to the low level of knowledge about mental illnesses in the society. Social workers and patients stated that in psychoeducation classes issues such as types of mental illness, coping with conditions, the importance of regular use of medication, and communication with people with mental illnesses are rendered. Social workers suggest that the purpose of these trainings is to provide patients with insight and awareness on their condition, as well as improving self-care and communication skills. The experiences of patients show that these trainings facilitate the psychosocial side of treatment. For instance, K11, who was hospitalised three times, admitted that he realised he had no awareness on his illness during these ten years of illness until he was involved in these classes/treatment.

> "Here at TRSM, they delivered classes, and provided information on my illness. I learned everything here, I learned about the scope of my disease here. They informed us about the treatment, things to pay attention to, that drugs should be used on time, so on and so forth. I have been sick for 10 years, but I learned everything here "(K11, 58 years old, Male, Diagnosed with Schizophrenia).

"I used to think that schizophrenia was a very bad thing, but only here I have been provided with all the necessary information, and realisd that it is nothing more than an ordinary illness. As long as you get your treatment you will be fine..." (K13, 49 years old, Male, Diagnosed with Schizophrenia).

"… involves information on the illness; what the disease is … are available medical treatments, types of treatment, what may happen, etc. information is provided here. Besides, problem solving skills, interpersonal skills, or the scope of preferred daily life activities are also provided. This is the available content "(SHU6 SHU, 46 years old, Female, 21 years of experience).

One of the most frequent comments about working with individuals is occupational therapy and EKPSS courses available. Research findings put forth that occupational therapy improve patients' social functionality and self-confidence.

"We shouldn't consider these trivial. These activities mean them as a means of gathering, a way of existence, a way to feel useful "(SHU3, SHU, 27 years old, Female, 4 years of experience).

The information provided by social workers and patients reveal that most of the time no ergotherapists are available in the centers; therefore, occupational therapy programs are covered by the employees on a voluntary basis; and that the available therapies should be designed and diversified in line with the needs of the patient population to recevie the service.

"Indeed these are fall in the scope of ergotherapists. We are way too much involved in the field of ergotherapists, this is because there is no available position. We wish to have ergotherapists available in each and every TRSM, however we do not have one in this TRSM. Fortunately our nurses undertakie this responsibility; sometimes I cover it myself "(SHU3, 27 years old, Female, 4 years of experience).

"I believe there is room for improvement. Activities should be a little more diversified. We should have authentic activities"(K7, 47 years old, Female, Diagnosed with Schizophrenia).

While there are ergotherapists available in half of the TRSMs included in the research, the findings reveal that no ergotherapists work in the other half, thus such services are covered by trainers from public education centers under the supervision of a social worker, psychologist or nurse.

The findings extracted from patient interviews reveal that occupational therapy improves the individual awareness and social functionality of the patients, enhance their adaptation skills, codependence skills/sense of belonging; thus, contributing to their treatment.

"When I feel bad this is the first place that comes to my mind. Here, I feel absolutely free, independent. I can do whatever I want. Usually I hesitate to take the floor in wedding parties, anyhow, here I lead the group dance. I manage it myself, I feel active. For example, I attended painting classs several times, and I painted Van Gogh's Sunflowers. Being able to paint triggered a feeling in me. You create a work of art; it makes you feel something – as if you can manage to do things. Actually, you know, sometimes you consider yourself to be empty, or you know, like ... unuseful. But as as long as you create something, you feel more active, you become aware of yourself "(K9, 24 years old, Female, Diagnosed with Schizophrenia).

One of the most important findings of the research is that EKPSS courses are provided to ensure employment for patients receiving services from TRSMs, to improve their social functionality. Social workers stated that they provide a class to prepare for EKPSS

exam for patients who comply with the accession criteria (primary and high school graduates). During the interviews, it was identified that there are no teachers available to deliver these courses in half of the TRSMs; thus, social workers prepare patients for the exams, moreover problems may occur if and when patients are placed in a position other than their province of residence. Besides, it is reported that patients are not placed in jobs in line with their education (i.e. those who hold engineering degrees are offered cleaning jobs). Patients, on the other hand, enunciated their appreciation for the commitment of social workers, as well as the difficulties of being opt out of the employment system:

"The patient wants to be useful/active; they hold degrees, they believe that they can be useful. We are trying to find placements for those patients. 7-8 of our patients, who are university graduates, will take the exam. We are happy if we manage to include them in the system and ensure they are a functioning person for the state. We wish to involve thebest ones in the public service, and ensure they socialize and even enhance their cognitive level "(SHU1, 45 years old, Male, 8 years of experience).

"So the teachers strive for employment of patients. .... 6-7 of our patients left here. To ensure a living, as well as making , so that they can pass the exam and become public servants. Previously some other patients also left, and each time teachers support them – call them, visit them. (K1, 44 years old, Male, Diagnosed with Schizophrenia).

Research findings reveal that social workers provide information to patients about patient rights, to ensure they can enjoy them to the full. Almost all of the patients participating the research enunciated that they had no knowledge of their rights before utilising TRSM services; thus, were informed by the social workers in these centers, and received support to access their rights.

"I inform the people who are referred here about their social rights; that they can enjoy disabled rights , which requires a formal disablity report, as well as the criteria to receive, where to get, where and how to use a disablity report ... People who are diagnosed with schizophrenia do not assume themselves to be ill or disabled; therefore when we make mention of disability, they hesitate. The first thing to do is to inform them, and make sure they accept their condition "(SHU3, 27 years old, Female, 4 years of experience).

"I… I didn't have a report, and they helped me to obtain one. They made sure I received a disablity report. Since then, I use some means of transportation for free. So it seems that I was not aware of my rights. I've learned them here "(K11, 58 years old, Male, Diagnosed with Schizophrenia).

One of the patients stated that the Social Security Institution announced a huge amount of debt when he applied for the disability pension; then the social worker in the center empowered him, informed him about his legal rights, and the problem was resolved together, with his advocacy.

The findings of the research suggest that TRSMs ensure continuous treatment and follow-up services in accordance with the purpose of community-based mental health services, decrease the frequency of hospitalization, and improve self-confidence, social functionality and communication skills of the patients.

"Patients are discharged after receiving medical treatment, regardless of where they would stay, its conditions, with whom they are staying with, as well as their economic and social status, which is why exacerbation increases constantly. We researched this data after TRSMs are established. For

example, we had a patient, who was previously hospitalised at least twice a year and faced exacerbation; now he is no more hospitalised. … If and when we manage to ensure proper places to stay, as well as the financial situation, patients are no more hospitalised. That is, we have patients who have not been hospitalised for 3-4 years, who have previously been hospitalised twice a year" (SHU1, 45 years old, Male, 8 years of experience).

"Thinking I was cured I quit my medication, but then I got ill again… It has always been the same. But since I started coming here, I am taking my medication regularly "(K6, 47 years old, Female, Diagnosed with Schizophrenia).

"At first my mother accompanied me to here, I was not able to come alone; she used to wait for me downstairs, and we returned back home together. Then I started coming alone"(K12, 47 years old, Female, Diagnosed with Psychosis).

"For instance, I was living in a dormitory with many people but I was not in contact with a great many of them. Now… I know almost everyone, I am in contact with everyone… Most importantly, I am attending my classes"(K9, 24 years old, Female, Diagnosed with Schizophrenia).

Research findings suggest that thanks to TRSMs, patients go through major changes; hence, the number of such centers should be increased.

"I wish we had TRSM centers years ago, then I would not have attempted suicide 3 time . I almost died, I have spent months in hospitals. … Now I'm fine, I'm much better. I come here 5 days a week. Previously I was not able to get out of the house for 10 years, mark my words. It was so tense that I was not able to leave my room – I used to refuse leaving my room and not to eat for about 2 days, 3 days and 4 days. I was hungry, but wasn't able to go out and buy some bread; I wasn't able to order food for myself. Things improved after I referred here. Now I use the subway to go to my house. I feel comfortable. How I may put it in words: I consider myself not a sick person but as a new born…. People are very surprised; they were surprised to see me recover. They can't figure out how I managed to heal. In other words, they can't believe that I have improved to this extent. I used to be an introvert person; someone shy, giving the looks, not getting advice from anyone. But now I'm content, calm. Most importantly, I've learned how to speak properly, I've learned how to travel, I've learned how to eat. I learned everything here. Here ... Thanks to our teachers, our nurses, I feel like I am given a second chance. When my sister saw me, she was so surprised. I used to grow a beard and refuse to get cleaned. My brothers used to give me a bath by force. But not now things have changed. I am all clean, I take a shower, I can go out and walk. It all started here. The number of these centers should be increased instead of hospitals "(K11, 58 years old, Male, Diagnosed with Schizophrenia).

At the end of the conversation after the sound recorder was off K11 stated: "You my use my credentials, I am not ashamed of anyone. I'm schizophreniac. "Iit is as normal as having cancer."

Studies on patient 's family and social environment

Research findings reveal that collaboration with the family is important to ensure patients gain insight, which can be achieved through family education; trainings deliverd to the families raise their awareness as well as improving communication skills.

"At first, the family may respond,"having experienced it for years we have a great deal of understanding for this illness" but at the end of the training they admit, saying," now that we can see we had no understanding for this illness before, we've learned a great deal here."

"… My mother was informed about how to communicate with schizophrenia patients, how to treat them, the symptoms of schizophrenia. After my mother attended those meetings and training delive-

ries, her approach changed; her adapting an understanding attitutude towards me made my life easier "(K12,47 years old, Female, Diagnosed with Psychosis).

SHU2 -one of the social workers- also mentioned that the use of medicines in psychiatric illnesses is very important in exacerbation; thus, during training deliveries necessary information is provided to patients and families about the use of medication, the symptoms of exacerbation, as well as conducting multidisciplinary team work in the form of case studies to mitigate exacerbation, and ensuring cooperation with patients and families.

"Now, as a team, we make observations every day. The doctor follows up patient's medication use; and the psychologist follows up patient's daily condition – whether any problems occur at home. And if and when there is one, we make cooperation and invite the family to discuss possible problems at home, and their solutions. Or, sometimes, problems are reported by friends, such as, stating Ahmet did not take his medicine today, or Ahmet has plans to run away from the house. We make house visits ro resolve the problem "(SHU2, 34 years old, Female, 10 years of experience).

As supported by the research findings, social workers inform the individuals and the families about available psychosocial interventions for the patient and family, at the individual or group level, to raise awareness of the illness and prevent the exacerbation, as well as increasing their problem solving skills to support the individual and the family through emphasizing coping methods and support mechanisms. In addition, it is planned that social workers will serve the social environment of patients at mezzo level. However, all participants responded negatively when asked "Are there any services offered by TRSM to your social environment?". Then, they are asked about their preferred services, if available. The majority of the participants stated that they do not want services offered to their social environment other than their families; thus, they merely share their condition with their families, they hesitate to leave a bad impression on the social enviroment, believing that their enviroment will not be interested in such activities for they are not ill.

"Even families cannot form acceptance for the illness, leave aside others; I do not know what to expect from others therefore I neither want them to be informed nor coming here. I do not tell anyone I am coming here"(K6, 47 years old, Female, Diagnosed with Schizophrenia).

Interviews with the experts revealed findings such as, if and when they have time and if there is cooperation, experts make school visits for awareness raising; if and when a patient is employed, they get in contact with the workplace to ensure cooperation; however, as to having limited time and resources, they have to limit the services provided to the social environment mostly with the family.

Community-oriented studies

Findings obtained in the scope of the research show that there are available studies on the promotion of TRSMs at the macro level, combating discrimination and stigmatization, and risk screening.

Social workers stated that promotion of TRSMs initially start, on the local level, with inhouse staff and then spread to affiliated hospital; then they visit the family physicians offering primary care services to introduce their work; then, with regard to regional ad-

ministration, preferably they visit the mukhtars and police departments; however macro level promotion activities should be carried out by T.R. Ministry of Health.

"We designed trainings for family physicians and invited them to our premises, we gave them a tour. We went to the mukhtars and gave out our brochures. Sometimes the relatives of our patients, and their family visits us; the word travels and neighbors also come. This is what happened so far. But I believe we require more work on the ministry-level. Since everything we do is based on official approvals, you cannot come up with an idea and implement it immediately. As I said, I can not just leave my office and visit each mukhtar's office anytime. We need more time and, more inter-institutional cooperation as well as awareness raising (SHU1, 45 years old, Male, 8 years of experience).

"I believe the Ministry of Health does not provide enough the informative public awareness raising activities of on the promotion of Community Mental Health Centers. In other words, there are a lot of informative advertisements about unnecessary drug use, smoking, etc. but there is not in this issue "(SHU5, 41 years old, Female, 18 years of experience).

Significant findings on stigmatization is acquired during interviews with social workers working in and patients receiving services from the TRSMs in the research province. Social workers and patients stated that the society is generally prejudiced against mental illnesses and, that they label people with mental illness capable of giving harm. Social workers suggested that it establishing TRSM centers within the community will profundly be the correct approach to overcome such prejudices.

"At first, when this place was established, residents one of the apartments objected, arguing that they have children, playing on the street, and they don't want people with mental illnesses around their children. 2 years have passed. If our patients see an animalon the street (cats) they feed them with their own food, they clean the garden, they bring added value to the community; after the community started knowing them, their prejudices are destroyed, the barber on the other side of the road overcame his prejudices, as well as the grocery store and the greengrocer's prejudices this is why such centers should be established within the community, rather that a special district far away" (SHU2, 34 years old, Frmale, 10 years of experience).

The narratives of the patients are mostly point out that as they are doubt the reaction of their social environment, they hide their illnesses and receiving service from this center.

"As a family we all have hidden my disability. We never explain, we never spoke up. I am using a nickname here, too. I rold people to call me Luna here. Outside, in the socierty I am K7, but here I am Luna"(K7, 47 years old, Female, Diagnosed with Schizophrenia).

Research findings indicate that there is a tendency stigmatize people with mental illness in the society, and these individuals are exposed to discrimination and marginalisation. At this point, it is necessary to work with the society, and to cooperate with the institutions and organizations that shape the society -especially the media and education institutions-.

"… We articulate as 'that man is a schizophreniac'. As if it is his name. The illness becomes a means of punishment, labeling. First of all, we should prevent this, and then comes informative and educational activities"(K13, 49 years old, Male, Diagnosed with Schizophrenia).

"… .The language used by the media needs to be improved. In the news coverage we see centences like 'the schizophrenic patient did such and such to his father'; that is the biggest form of stigma, it begins there" (SHU1, 45 years old, Male, with 8 years of experience).

One of the important studies at TRSM at macro level is risk screening. Social workers stated that they conduct treatment and follow-up studies not only with patient and medicine treatment, but also in all areas of the patient's social environment and family, education, work. However, risk screening studies are mostly limited with genetic risk factors; studies on sociocultural risk factors are not conducted, and risk screening activities mostly focus on patients with diagnosis, and those having exacerbation.

"Since we are concerned not only with the patient but also with his family, we are determining the needs of al family members within the scope of protective-preventive services. We make home visits. If there is a child in the house, we make a risk assessment…. Additionally, when they have attacks, some of our patients turned to crime and substance. They cease to take medication time to time; those are when they get married or run away from home. Their families find them in other cities and bring them back. We try to prevent them from turning to crime, substance or other risk factors. This is not only about dtug treatment; its social dimension is quite important… "(SHU2, 34 years old, Female, 10 years of experience).

SHU5 -one of the participants- stated that they should cooperate with the Ministry of National Education in their risk prevention activities; and that mental illnesses mostly occur during high school period, in his own words:

"…High school teachers and university lecturers should be trained. Because schizophrenia is an illness to occur usually in adolescence, and is diagnosed in young adulthood. … When you look at the history of our patients, they are often very introverted. These people can be very successful and skillful at school, but they may become introverted and have trouble communicating. Teachers should be alerted on this issue and warn families"(SHU5, 41 years old, Female, 18 years of experience).

Research findings reveal that risk screening carried out within the scope of protective and preventive services should not be limited to the patient, but should be extended to other family members - especially children.

"Protective-and preventive service starts in the family. … Children with schizophreniac parents go through a very difficult situation. … .. those children have no facility to study at home,… also, as to a possible genetic transition, they may get ill in the future. For instance, those children may join the labor force at an early age, trying to earn their living. Or they may go to school and usurp other children and try to make money. Their emotional needs are often not met. They should be supported more in this sense, the number of practitioners should be increased…. Other members of the family co-residing with a person with schizophrenia are also our patients, as much as persons with schizophrenia"(SHU2, 34 years old, Female, 10 years of experience).

Studies on social policy development

Results of the survey shows that, despite having shortcomings, community-based mental health practice, which is rather an emerging system in Turkey, is vital for people with mental illnesses. Findings reveal that the single most shortcoming is in social policies for the employment of people with mental illness. Although social workers opened EKPSS training courses to increase employment rates, the research findings reveal that patients had stigmation and discrimination problems in employment.

"Our patients say that they were employed, they found a job. They are dismissed after admitting using psychiatric medication. This is why they don't want to mention their illnesses. They say they remain in their jobs as long as they make no mention"(SHU1, 45 years old, Male, with 8 years of experience).

"İŞKUR registers persons with mental disability to the disabled staff waiting lists, but employers do not prefer working with people with mental disabilities. Why? Because they don't know. They are is afraid. They believe people with mental disabilities may harm them. Also, as the media has a very negative attitude to this issue, people have prejudices. It is easier to built from sctratch the, then breaking down and rebuilding something wrong. Our job is pretty hard In this sense, and macro work is quite important" (SHU2, 34 years old, Female, 10 years of experience).

Social workers stated that the single most social injustice happens in employment. They stated that, in order to increase their social functionality and employment figures, patients who received disability pension by law numbered 2022, were referred to İŞKUR's vocational training courses; however, they suffered a loss of pension due to temporary social insurance activated during the training delivery. Social workers, uncovering the source of the problem advocate this situation in coordination meetings with the Ministry of Health, and made a solution offer. In addition, they also mentioned that problems in the employment of patients with mental disabilities, especially in positions for disabled staff in the private sector. Indeed, the need for focusing on studies to mitigate stigmatization and discrimination is emerging for community oriented studies.

Research findings manifest that one of the most important disruptions in the system is patients failing to make regular visits to the centers. During the interviews with social workers, all of the experts stated that only half of the registered patients participated in the activities, in addition to medical treatment.

"We have 176 patients, 60 of which are actively coming to our center. People are still not able to overcome the negative effect of stigmatization. We do not have any hospital logo in our buses, we do not wear white coats when we make house visits, we go like an ordinary person to prevent disclosure. …. Naturally people fear from stigmatization, which is why they are afraid to come here" (SHU2, 34 year olds, Female, 10 years of experience).

Discussion

The aim of this research is to contribute to making a holistic evaluation of protective and preventive services through the experience-based narratives of social workers working in TRSMs and patients receiving services from these centers. In the framework of developing evidence-based practices, findings of the research will contribute to policy making, as well as identifying the needs through the personal experiences of both service providers and receivers. The data collected on protective and preventive mental health services in the scope of the research are analysed under four headings; namely, studies for the individual; for the family and social environment; for the society and social policy development. The most significant finding of the research is TRSMs' achievement as an alternative to long-term inpatient treatment by providing continuity of treatment and follow-up; an agent to reduce the frequency of hospitalization, and contribute to enhancing the social functionality, communication skills and self-confidence of patients. Further, findings revealed that awareness on mental illnesses is low in the society, thus, such low awareness enhances stigmatization and discrimination, further manifesting an obs-

tacle for the employment of individuals with mental illness, together with inadequate social policy practices.

To resolve problems of and improve the functionality of the individual from the framework of social work discipline -which assesses the individual together with his/her social environment - it is essential to enhance individual-environment relationship as well as altering other systems with which the individual interacts,. A qualitative study conducted with 51 patients in 2012, revealed that patient are willing to develop an understanding of and be informed on their illnesses (Fossey, Harvey, Mokhtari Meadows 2012). Parallel to the available literature, it is found that the psychoeducations help the patients receiving services from TRSMs and their families in acquiring information on the biopsychosocial dimensions of the illness, and psychoeducations contribute to their empowerment through supporting the positive change and development of the patients and their families. According to Adverse Childhood Experience Survey (ACES) data, there is positive correlation between childhood and youth, and having a healthy family and children in adulthood; and there is negative correlation between neglect, abuse, impaired family functions, and having a healthy family and children in adulthood (APHSA 2013). Supported with these data, psychoeducation practices facilitate both the patient and his/her elementary family, as well as the future family, in ensuring healthy family functions and harmonious social life. To ensure the continuity of its positive effect, psychoeducations should be repeated periodically for better handling the burnout effect of mental illnesses on the caregiver, and the long-term memory functions depending on the patient's illness and medication. It is extremely important that psychoeducations do not become mechanical in order to provide interpersonal interaction and empowerment..

Research findings show that occupational therapy services offered at TRSMs increase the patient's awareness and social functionality; strengthens adaptation to the environment, co- dependency/belonging; and contributes to their treatment; however, occupational therapies are planned regardless of the demand and individual awareness of the patient. In a study conducted in Çukurova University Faculty of Medicine Hospital, based on occupational treatment studies with inpatients, while 91.66% of the participants stated that occupational activities contributed to their treatment, 81.25% stated that they wanted to participate in these activities after they were discharged (Çakmak et al. 2016). Another occupational therapy research in America revealed that the skill acquisiton pactices rendered in the scope of this therapy provided significant improvement in terms of individual independence (McGrath and Hayes 2000). Moreover, a 12-month study with 58 schizophrenia patients in Israel, pointed to improved memory and thinking processes for patients who received cognitive therapy and occupational therapy together (Hadas-Lidor et al. 2001). These research findings are in favor that of previous studies. However, the findings reveal that occupational therapies should be tailored to the patients' interests and needs. Indeed, a study with 81 patients with schizophrenia reckon patients' need for involving in activities in various fields, and an individual-based rehabilitation approach to be determined while designing treatment programs (Ekici et al. 2016). The results of both studies show that occupational therapies offered in the centers should be shaped and diversified according to the patient population receiving service. Within the framework of the ecological system approach, it is recommended to collect patient requests in TRSMs periodically, and shape occupational therapies accordingly in order to plan occupational therapies baring in mind the following criteria; such

as, the interests, feasibility, patients' social and physical environment, and desired achievements of the therapy.

Individuals with mental illness are also assumed to be people with mental disabilities. With regard to the disability severity level identified in individual disability reports, they have various social rights such as free transportation, and disablity pension. Research findings show that almost all of the patients had no awareness on this issue before receiving services from the center. Initially, patients were unwilling to embrace the term 'disability ', after being informed by social workers working in the center. However, efforts of social workers in informing them to enjoy their rights during service process improved their acceptance; hence, patients started to utilise their rights inline with their disability reports. Which reveals the role of social workers, both as agents of education in informing the clients about the human services they may utilise, as well as providing access to community resources with their mediator role. Such informative and advocacy activities play a significant role in accessing rights and social services.

Research findings reveal that the society has a low level of knowledge and awareness on mental illnesses. According to our study, the society assumes the symptoms of mental illnesses as "being possessed and spellbound", thus seeking remedy in "religious leaders" with social pressure instead of hospitals; yet, this situation both hampers the early diagnosis and triggers exacerbation. Due to the low level of knowledge and awareness in the society, observations pointed to a prevalent bias towards mental illnesses in the society, where persons with mental illness are perceived prone to violence, accordingly, where they are discriminized and stigmatized, resulting in hiding their condition. The findings suggest that at the macro level (studies on society and social policy) the efforts to change such negative approach is not at the desired level. In 2018, a qualitative study conducted with 11 participants -composed of psychiatrists, social workers, psychologists and nurses working in TRSM- rendered one of the most important problems faced by patients to be stigmatization (Attepe Özden and İçağasıoğlu Çoban 2018). Sartorius (2002) underlines careless use of words related to diagnosis to be the most obvious source of stigmatization; in respect thereof, Gormley and Quinn (2009) stated that it is more difficult to deal with discrimination and stigmatization of individuals with mental illness than to deal with the disease itself (Gormley and Quinn 2009). In order to reduce the levels of internal and social stigmatization for patients, ensuring social contact is strongly recommended, through training deliveries and awareness activities delivered by people who have gone through mental illness before (Goldie, Elliot, Regan, Bernal and Makurah 2016). In addition, the research results show that it is by the media that labels and discriminates patients the most, nonetheless, media support is required the most support to fight with stigmatization and discrimination. In present social context, in line with the easy access to mass media, it is recommended to cooperate with media organs to change the dominant stigmatizing media language to ensure social inclusion through altering social perception and socially accepted statements in combating stigmatization and discrimination. Research findings indicate that loss of rights in employment is mostly experienced by people with mental illness due to stigmatization and discrimination. Findings pointed out job counselors working at İŞKUR to be afraid of individuals with mental illness and not willing to employ or place them, as to having low awareness on mental illnesses. Turkish Employment Agency 2017 data demonstrate, merely 1633 job applicants out of 13190 persons with mental and psychological disabilities were placed. However, this figure does not indicate the exact number of people with mental disabli-

ties, as people with mental and emotional disablities are evaluated in the same group. Can Öz (2016), conducted a qualitative study with employers that have human resources department, on the employability of individuals diagnosed with schizophrenia: because the employers are ill-informed about the illness, they believe these patients to be prone to violence and aggressive, which is why they have worries about the wellbeing of the rest of the employees as well as a spoiled working environment, resulting in unwillingness to hire these individuals. Moreover, reserch findings pointed to conflicting/incomplementary social policies, overburdening employment of people with disabilities. With the law numbered 2022, the patients receiving disability pension are referred to vocational training courses to increase their social functionality and employment; however, due to the temporary social insurance made during the course, the patients lose their right to receive pensions, which make them hesitate to participate to the courses, as to having no post-course job security guarantee. On the other hand, inconsistencies are detected between EKPSS application requirements and recruitment conditions. The results of the research indicate that individuals with mental illness in the public and private sectors experience many difficulties in finding jobs, and their employment rates tend to be very low. Findings pointed to low or no productive participation of the patients in the society, due to insufficient inter-agency cooperation, stigmatization and discrimination. Hence, a retrospective study of Saruç and Kaya Kılıç (2015) on patients receiving services from a TRSM in Antalya revealed the fact that a significant portion of the patients (62.9%) were employed before the disease, while almost all (91.5%) were unemployed afterwards. Employability of people with mental illness should be increased in order to integrate medical and psychosocial treatment; by doing so, their social functionality and self-management will be supported by conducting group work under the guidance of the treatment team (Goldie, Elliot, Regan, Bernal and Makurah 2016). Considering the literature and findings, public employment facilities for individuals with mental disabilities should be reconsidered, and different approaches should be adopted than people with other disability types, as well as reevaluating employability criteria, harmonizing terms of EKPSS application and recruitment, thus conducting individual assessments for each applicant to ensure placements are in line with the patient's background - education and social environment/place of residence. To fight with prejudice, stigmatization and discrimination, is recommended that TRSMs collaborate with chambers of tradesmen and craftsmen and other professional chambers in the region in providing training to employers to employability of patients in the private sector; moreover, necessary measures should be in place to ensure patients with disabilities apply for competitive jobs, and placed in positions other than disability staff. It is recommended to deliver further trainings should to that İŞKUR staff – especially job councellors – who are the point of contact in the employment of patients, and to list the services designed for work-related social environment of the patients who are placed in disabled staff positions among the objectives and duties of TRSM.

Research findings show that risk screening studies are limited only to patients receiving services from the center, and not enough risk screening facilities are conducted for patients' social environment, families and children, mostly due to genetic predisposition. All programs to prevent mental illnesses around the world are based on reducing exposure to risk factors and empowering the individual by improving protective factors (Arango, et al. 2018, WHO 2004). It is extremely important to ensure good childhood period to determine the risk factors and the stress factors that cause the mental illness and the

disorders at the point of early diagnosis and intervention, and ensure appease (APHSA 2013). In contrast, this study revealed that TRSMs do not have any services tailored for children, as well as lack of inter-agency cooperation – i.e. the Ministry of National Education - on risk screening.

Research findings indicated the need to increase promotion activities for TRSMs. Findings show that TRSMs are not well known even in the health sector; there is not enough information on the kind of services provided, and social workers are unable to carry out desired promotion activities as to excessive workload. According to the research findings, one of the most problematic aspect of this service model is the absence of continuity in psychosocial treatment. It is possible to justify low number of patients coming to the center with the low awareness of the society and the patients about the functions of these centers, and worries for stigmatization. In the study conducted Bilge et al (2016) in Turkey with 42.45% of registered TRSMs, out of 6777 patients, merely 530 - corresponding to 7.8% - were permanent visitors to centers. In a study with 356 patients diagnosed with severe mental disorders, regular use of TRSM services (educational materials, treatment and monitoring, group therapies, easy access to the medical team, home visits) were proved to reduce hospitalization rates significantly (Kocamer Sahin, Elboga and Altindag 2019). Attepe Özden and İçağasıoğlu Çoban (2018) also found that community-based mental health practice rendered positive outcomes in the context of protective and preventive services. Considered together, these findings underline the importance of psychosocial intervention in treatment, and regular use of the services provided in TRSM.

Conclusion

The most significant finding of this research, where protective and preventive mental health services offered in TSRMs in Turkey are analysed through the personal experiences of social service professionals and patients, is that, ensuring the continuity of treatment and follow-up, TSRMs stand as a strong alternative to long term inpatient treatment, ensure reduction of the frequency of hospitalization, and contribute to the empowerment of patients, increased social functionality, communication skills and, accordingly, self-confidence. However, the findings rendered through the analysis of the statements of social workers and patients reveal that there is a lack of knowledge on mental illnesses at the community level; combined with religious myths, this situation paves the toad for patients referring to religious leaders before health institutions, which – in return - triggers exacerbation and delays the treatment. Additionally, low awareness in the society leads to stigmatization and discrimination of persons with mental illness. Findings show that people with mental illness experience discrimination most in employment, thus social policies in this area are inadequate. Possible influnence of research may bring to light a clear analysis functionality of policies in practice, and bridge the gap between implementation and policy making. In line with the insufficient numbers of TRSMs in Turkey, only six social workers participated to the research, as the number of TRSMs in the research province was limited; plus, merely 6 TRSMs agreed to participate in the study, and there is only one social worker in each participating center. In addition, to avoid any possible limitations, the cognitive destruction level of the patients to be interviewed is taken as a criterion – which, otherwise, may prevent them from giving meaningful answers to research questions (evaluated by a psychiatrist and social worker).

In the light of the common findings obtained with regard to the statements of social workers and the patients, it is recommended informative activities on mental illnesses are improved, activities to fight with stigmatization and discrimination are increased, and the inadequate social policies are enhanced. Last but not least, it is believed that viewpoint of families receiving services from TRSMs should be included in future researches to contribute to improving the services offered in TRSMs.

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