Research

Psikiyatride Güncel Yaklaşımlar-Current Approaches in Psychiatry 2026; 18(Suppl 1):325-344

doi: 10.18863/pgy.1919220

Qualitative Assessment of Access to Community Mental Health Centers from the Perspectives of Patients, Patient Relatives, and Healthcare Professionals

Toplum Ruh Sağlığı Merkezine Erişimin Hasta, Hasta Yakını ve Sağlık Profesyonelleri Açısından Nitel Değerlendirilmesi

Sultan Kökcealan[1], Yeşim Maçça Polat[1], Ayşe Okanlı[1], Beyza Şekeroğlu[1], Neslihan Dolu[2], Nesrin Karamustafalıoğlu[2]

[1]Istanbul Medeniyet University, İstanbul

[2] Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Training and Research Hospital, Istanbul

ÖZ

Amaç: Bu araştırmanın amacı, Toplum Ruh Sağlığı Merkezlerine erişim ve bu merkezlerdeki hizmet deneyimini hasta, hasta yakını ve sağlık personeli açısından değerlendirmektir.

Yöntem: Çalışmada niteliksel araştırma desenlerinden fenomenolojik yaklaşım kullanılmış, veri analizi tematik analiz yöntemiyle gerçekleştirilmiştir. İstanbul'da bir Toplum Ruh Sağlığı Merkezi'ne kayıtlı, amaçlı örneklemle seçilen 5 hasta, 5 hasta yakını ve 5 sağlık personeli olmak üzere toplam 15 kişiyle, her grup için beşer soru içeren 15 yarı yapılandırılmış açık uçlu soru aracılığıyla derinlemesine görüşme yapılmıştır.

Bulgular: Analiz sonucunda iki ana tema ortaya çıkmıştır: "Toplum Ruh Sağlığı Merkezlerine yönelik görüşler" ve "Aktivite/etkinlikler/hasta davranışları". İlk tema beş alt kategori altında hizmetlerin bireysel ve toplumsal düzeydeki algılanışını göstermiştir. İkinci temada ise sosyal ve terapötik etkinliklerin hasta davranışları üzerindeki etkileri altı alt kategoriyle ortaya konmuştur.

Sonuç: Sağlık personeli, sistemi bütüncül değerlendirerek hizmet kalitesine ve hasta davranışlarının olumlu desteklenmesine katkı sağlamıştır. Hasta yakınları, hizmetin etkinliği ve gönüllü katılım konusunda daha eleştirel tutum sergilemiş, daha görünür sonuçlar beklenmiştir. Hastalar kendi deneyimlerine, yalnızlık, sosyalleşme, başvuru nedenleri ve davranışsal değişimlere odaklanmış; bu da merkezlerin bireysel iyilik hâli açısından önemli bir sosyal alan oluşturduğunu göstermiştir.

Anahtar sözcükler: Toplum ruh sağlığı, hasta, hasta yakını, sağlık profesyonelleri

ABSTRACT

Objective: The aim of this study is to evaluate access to Community Mental Health Centers and the experience of services provided at these centers from the perspectives of patients, their relatives, and healthcare personnel.

Method: A phenomenological approach, one of the qualitative research designs, was employed, and data were analyzed using thematic analysis. A total of 15 participants—5 patients, 5 patient relatives, and 5 healthcare professionals—registered at a Community Mental Health Center in Istanbul were selected through purposive sampling. In-depth interviews were conducted using 15 semi-structured, open-ended questions, five per group.

Results: The analysis yielded two main themes: "views on Community Mental Health Centers" and "activities/therapeutic events/patient behaviors." The first theme, examined under five subcategories, revealed how the services are perceived at individual and societal levels. The second theme, comprising six subcategories, demonstrated the effects of social and therapeutic activities on patient behaviors along with participants' observations and assessments.

Conclusion: Healthcare personnel contributed to service quality and positive support of patient behaviors by evaluating the system holistically. Patient relatives adopted a more critical stance regarding the effectiveness of services and voluntary participation, expecting more visible outcomes. Patients focused on their own experiences—loneliness, socialization, reasons for seeking care, and behavioral changes—indicating that Community Mental Health Centers constitute an important social space for individual well-being.

Keywords: Community mental health, patient, patient relative, healthcare professionals

Address For Correspondence: Sultan Kökcealan, Istanbul Medeniyet University—Graduate School, Psychiatric Nursing, Istanbul, Türkiye

e-mail: sultankaramocu@hotmail.com

Received: 30.03.2026 | **Accepted:** 02.09.2026

Introduction

Mental disorders affect more than one billion people worldwide and impose a substantial burden on individuals' quality of life, family and social relationships, functioning, and countries' economic productivity (Patel et al. 2018, Arias et al. 2022, WHO 2025). In response to this global burden, international mental health policies recommend moving away from hospital-centered models and strengthening person-centered, recovery-oriented, rights-based community mental health services delivered in the environments where individuals live (WHO 2021). In many European countries, a transition has been taking place from a hospital-based model to community-based health care, in which individuals receive mental health services within their own living environments. The community-based mental health model consists of services that respect the individual rights of people with mental disorders, enable them to receive services where they live, and are structured particularly at the neighborhood level, thereby facilitating access to mental health services. Efforts have been made for many years to prevent patients from being confined to hospitals and isolated from society (Artukoğlu 2019).

In the context of the situation in Türkiye, the adoption of community-based mental health service delivery represents an important development. Community Mental Health Centers (CMHCs) are among the primary settings in which community-based mental health services are provided. These centers have established a service network extending from the individual to society through activities aimed at increasing the individual and social functioning of people with mental disorders by encouraging their participation in daily CMHC activities, maintaining various educational and psychosocial support activities for families, raising public awareness of mental disorders, and combating stigma (Bekiroğlu ve Demiröz 2020). CMHCs also aim to reduce hospitalizations among individuals with mental disorders, improve their social functioning, reduce the caregiving burden on those who provide care, and combat the stigma that exists in society toward individuals with severe mental disorders. In line with these objectives, CMHCs were planned to operate in cooperation with all health care institutions, particularly family health care services, as well as municipalities, provincial directorates of family, labor, and social services, universities, foundations, and nongovernmental organizations (Sağlık Bakanlığı 2011). The operating procedures of CMHCs were specified in a directive issued by the Ministry of Health in 2011. According to this directive, CMHCs were planned to conduct registration procedures, follow up individuals with severe mental disorders, provide educational activities for individuals and families, offer therapies, and perform other functions (Sağlık Bakanlığı 2011).

Although Community Mental Health Centers represent an important achievement in Türkiye's transition to community-based mental health services, the existing literature indicates that this service model has various structural and functional shortcomings. CMHC services need to be improved, particularly in service quality, planning, organization, workforce, and financing, while problems related to registration, disruptions in case management, differences in practices across centers, accessibility, and inclusiveness persist (Kayacan ve Kılıç 2023). In some centers, inadequate physical conditions, shortages of qualified personnel, problems with administrative support, and the evaluation of services using quantitative indicators have been reported to affect staff motivation and service quality adversely. Taken together, these findings indicate that increasing the number of CMHCs alone is insufficient and that these centers need to be strengthened in terms of workforce, service standardization, case management, interinstitutional cooperation, accessibility, and sustainable psychosocial support mechanisms (TPD 2020). When CMHC services are considered as a system for the provision of community-based mental health care, individuals with mental disorders who receive services, family members who provide care, mental health professionals working at the centers, and the various institutions and organizations with which the centers interact constitute the components of this system. For CMHC services to be successful, regular and sustainable communication and interaction among these components of the system are considered critically important (Karip 2023).

Studies on CMHCs in Türkiye have largely focused on individual dimensions such as patient satisfaction, regular attendance at the center, levels of social functioning, or caregivers' experiences. In contrast, this study evaluates access to CMHCs and service experiences not solely in terms of patient satisfaction or service utilization, but by comparatively examining the views of patients, patients' relatives, and health

professionals. This multi-stakeholder approach makes visible the relationships among individual well-being, caregiver burden, continuity of services, staff capacity, and the psychosocial rehabilitation function of CMHCs, thereby allowing service experiences, which have often been addressed in a fragmented manner in the literature, to be discussed within a more holistic and practice-oriented framework. In addition, the field-based nature of the study enabled the collection of data directly from participants' experiences with CMHCs.

Method

Research Design

In this study, a phenomenological approach, a qualitative research method, was used to examine in depth the views of patients, patients' relatives, and health professionals regarding access to CMHCs and their service experiences.

The primary aim of qualitative research is to uncover perceptions and experiences, whereas phenomenology focuses on making sense of lived experience (Tekindal ve Arsu 2020). Phenomenological research is considered appropriate for understanding the common experiences of individuals who have experienced a particular phenomenon, and these shared experiences may be important for the development of practice or policy. The primary aim of phenomenological research is to gain an in-depth understanding of the experiences of individuals who have encountered a particular phenomenon and the meanings they attribute to those experiences. In this context, the phenomenological design provides an appropriate theoretical framework for explaining how patients, their relatives, and health professionals experience access to CMHCs and service experiences (Tekindal ve Uğuz Arsu 2020, Creswell ve Poth 2018). Thematic analysis, in turn, is a flexible and systematic method for identifying patterns, clusters of meaning, and themes in qualitative data (Braun and Clarke 2006). Accordingly, phenomenology served as the study's theoretical and methodological orientation, while thematic analysis was the process by which the data were analyzed and organized into themes in accordance with this orientation. The phenomenological design enabled an in-depth examination of how patients, patients' relatives, and health professionals experienced and made sense of the same phenomenon, while thematic analysis provided an appropriate analytical strategy for systematically identifying recurring codes, clusters of meaning, and themes within these accounts. Therefore, thematic analysis was used in this study not merely as a descriptive classification tool, but as a methodological bridge that made both the shared and divergent aspects of participants' experiences visible.

Sample

The study sample consisted of 15 participants registered with a CMHC in Istanbul, including 5 patients, 5 patients' relatives, and 5 health professionals. Purposive sampling was used in the study. In this context, particular care was taken to select individuals with relevant experience who could provide information consistent with the purpose of the study (Ural 2011).

The sample size was determined based on the principle of data saturation, which is widely used in qualitative research. Data saturation is defined as the point at which data obtained from new interviews begin to repeat and no longer generate new codes or themes related to the research question. Guest et al. (2006) showed that, in purposively sampled in-depth interviews, core themes may emerge early, and that the main thematic patterns may become apparent with a limited number of interviews. A total of 9 patients, 6 patients' relatives, and 7 health professionals were included in the study. As the interviews progressed, it was observed that topics such as similar reasons for seeking services, service experiences, participation in activities, caregiver burden, staff approaches, access, and continuity of services began to recur after three interviews with health professionals and after five interviews with patients and patients' relatives, with no new themes emerging. Therefore, to ensure equal numbers across groups, data saturation was considered reached with five participants in each group (Guest et al. 2006, Guest et al. 2020, Hennink and Kaiser 2022). Priority was given to the participation of individuals who could contribute to the diversity of

information and data saturation, while individuals considered unlikely to provide data directly relevant to the research purpose were excluded from the study. Similarly, in their systematic review of empirical studies on saturation in qualitative research, Hennink and Kaiser (2022) reported that saturation could be reached with smaller samples, particularly in relatively homogeneous participant groups and studies with narrowly defined research aims. In this study, patients, patients' relatives, and health professionals were treated as separate stakeholder groups, and each group consisted of purposively selected participants with direct experience with CMHC access and services who were directly relevant to the research question.

Inclusion criteria for the patient group were being registered with the CMHC where the study was conducted, having sufficient cognitive and communication abilities to participate in the interview, having intact reality testing at the time of the interview, voluntarily agreeing to participate in the study, and providing written/oral consent. For the patients' relatives group the criteria were playing an active role in the care process of a patient registered with the CMHC or having closely observed the patient's service experience, having sufficient cognitive and communication abilities to participate in the interview, voluntarily agreeing to participate in the study, and providing written/oral consent. For the health professional group, the inclusion crtieria were being employed at the CMHC where the study was conducted, having at least six months of work experience at the CMHC, having experience related to CMHC service processes, patient follow-up, activities, or psychosocial support practices, voluntarily agreeing to participate in the study, and providing written/oral consent. The exclusion criteria for all participant groups were experiencing cognitive, communication-related, or clinical difficulties severe enough to prevent continuation of the interview process, exhibiting acute psychiatric symptoms, severe agitation, or marked difficulty in cooperation at a level that would prevent participation during the interview, declining to provide voluntary consent to participate in the study, or wishing to withdraw from participation during the interview.

Procedure

Prior to data collection, ethics committee approval was obtained from the Non-Interventional Scientific Research Ethics Committee of Bakırköy Dr. Sadi Konuk Training and Research Hospital (decision no. 2024-11-06, dated October 7 2024). Institutional permission was obtained from the education and planning board of the institution where the study was conducted. Voluntary participation was ensured, and both verbal and written informed consent were obtained from all participants.

Following the required ethics committee approval, face-to-face interviews were conducted with participants who agreed to participate voluntarily. The process was carried out in the CMHC setting between October 2024 and March 2025 by administering the Personal Information Form and conducting in-depth interviews with patients, patients' relatives, and health professionals, using the open-ended questions included in the semi-structured forms. It has been noted that interviewing individuals with severe mental illness and their relatives involves ethical and practical challenges. However, rich data can be obtained through appropriate planning, informed consent, the establishment of trust, and allowing participants sufficient space to express their narratives. When conducting qualitative research with these individuals, adaptable communication, creative and flexible interviewing approaches, the establishment of trust, and post-interview support processes are emphasized as important for both data quality and participant safety (Newman 2017, van Hoe et al. 2024). In this study, the interviews were conducted in a manner intended to minimize the cognitive and emotional burden on participants diagnosed with psychotic disorders, with attention to the use of time and space in ways that enabled participants to express themselves comfortably. Data depth was supported by conducting the interviews using a semi-structured form, arranging questions from general to specific, using probing questions such as "Could you explain this in a little more detail?" and "Could you give an example of this situation?", recording participants' notable bodily expressions in the researcher's notes, and comparing data concerning the same phenomenon across three different stakeholder groups: patients, patients' relatives, and health professionals. Therefore, the relatively short duration of the interviews in this study reflected an approach that was sensitive to the clinical characteristics of the study group, ethically protective, and designed to enable the experience-focused narratives required by the phenomenological approach.

During the interviews, participants' verbal and written consent and permission were obtained, and the conversations were recorded using an audio recorder. Participants' notable bodily expressions were also documented by the researcher. To ensure confidentiality and anonymity, identifying information was removed, and participants were referred to by identification codes (H1...H5 for the patient group, HY1...HY5 for the patients' relatives group, and SP1...SP5 for the health professional group). Data were collected through semi-structured in-depth interviews conducted between October 2024 and March 2025. The interviews were conducted face-to-face in an appropriate interview room within the CMHC, and each lasted approximately 20 to 30 minutes.

Measures

Personal Information Form

A "Personal Information Form" was used to collect general information about patients, patients' relatives, and health professionals. The researchers developed this form based on a review of studies in the literature. The form included questions appropriate to each group's dynamics, as identified in the literature. Participants in the patient group were asked about age, sex, education level, marital status, employment status, and diagnosis, participants in the patients' relatives group were asked about age, education level, degree of kinship, social security coverage, physical health problems, similar illness in the family, number of people in the household, and primary caregiver, and participants in the health professionals group were asked about age, profession, length of employment at the CMHC, field-specific training, history of psychiatric treatment, family history of psychiatric disorders, and satisfaction with their workplace.

Semi-Structured Interview Form

The semi-structured interview form was developed by the researchers in line with the purpose of the study to provide an in-depth evaluation of access to CMHCs and service experiences from the perspectives of patients, patients' relatives, and health professionals. During the development of the form, national and international studies addressing community-based mental health services, access to CMHCs, participation in services, patient and caregiver experiences, and health professionals' evaluations of service delivery were first reviewed (Tait et al. 2002, Xiao et al. 2017, Gözen ve Buz 2020, Karip 2023). Based on the literature review, reasons for seeking services at CMHCs, access to the center, expectations regarding services, participation in activities, the effects of services on daily life, observed changes in patient behavior, caregiver experiences, and health professionals' evaluations of the service process were identified as the main areas of inquiry. In the second stage, open-ended questions appropriate for the patient, patients' relatives, and health professional groups were developed in accordance with the identified thematic areas. Care was taken to ensure that the questions were non-leading, clear, and comprehensible, allowing participants to describe their experiences in their own words. The patient group was primarily asked about the process of seeking services at the CMHC, reasons for continuing to attend the center, experiences of participating in activities, and the center's contributions to daily life. The patients' relatives group was asked about observations during the care process, the center's contributions to the patient and family, difficulties experienced in accessing services, and expectations. The health professional group was asked about the functioning of CMHC services, accessibility, factors affecting patient participation, the contribution of activities, and views on improving the services. In the third stage, the draft interview form was submitted to two experts in qualitative research and mental health for review. Based on the experts' evaluations, the wording of some questions was simplified, repetitive questions were combined, and probing questions were added to elicit the experiences of each participant group better. Following these revisions, the content validity of the form and its alignment with the research purpose were strengthened. In the final stage, the interview form was reviewed to assess whether it was sufficiently clear and understandable for participants, and the questions were arranged from general to specific. In the final form, five brief, clear, and explicit questions were prepared for each of the following groups: patients, patients' relatives, and health professionals.

Data Analysis

The audio recordings obtained from the participants were transcribed by the researchers. The transcripts were analyzed using MAXQDA 24 software in accordance with thematic analysis, a qualitative research method. In this study, MAXQDA 24 was used to organize the data, systematically store the codes, track code-theme relationships, and conduct comparative evaluations across participant groups. The software enhanced the transparency and traceability of the analytical process through tools such as the code matrix, hierarchical code system, code map, and code cloud. However, the processes of coding, theme development, and interpretation were carried out based on the researchers' analytical decisions. The coding process was conducted inductively in accordance with the stages of thematic analysis proposed by Braun and Clarke (2006). First, after the audio recordings had been transcribed, the researchers read all interview transcripts multiple times to become familiar with the data. During the initial readings, meaningful statements considered relevant to the research questions were identified as open codes while remaining as close as possible to the participants' own accounts. At this stage, the codes were derived from recurring experiences, perceptions, expectations, difficulties, and evaluations of services expressed in the accounts of patients, patients' relatives, and health professionals. To ensure consistency among the researchers, a portion of the interview transcripts was independently coded during the initial coding process. The resulting codes were then compared and evaluated for meaning, scope, and labeling. Codes with similar content were merged, codes with unclear scope were redefined, and the extent to which the code labels represented participants' statements was discussed. In cases of disagreement during the coding process, the relevant participant statement was revisited, and a consensus was reached by considering its context. This process was intended to reduce researcher bias, improve code consistency, and strengthen the traceability of the analytical process.

In the transition from codes to themes, codes representing similar domains of meaning were first grouped into subcategories, which were then combined into higher-order themes based on their relationship to the study's purpose. For example, codes related to reasons for seeking services at the CMHC, interest in or willingness to attend the center, staff approaches, access, and service processes were organized under the theme "Views on the CMHC," whereas codes related to participation in activities, the contributions of activities, changes in patient behavior, regular or irregular participation, and the continuation of activities in the home environment were organized under the theme "Activities/Events and Patient Behaviors." During theme development, care was taken to ensure that each theme was meaningful and internally coherent while remaining distinct from the others.

In the final stage, the developed themes and subcategories were reviewed again by all researchers, and their adequacy in representing participants' accounts, alignment with the study's purpose, and ability to reflect the perspectives of the different groups were evaluated. The distribution of codes across patients, patient relatives, and health professional groups was compared using MAXQDA 24, however, theme naming and interpretation, as well as the interpretation of the findings, were based on the researchers' analytical evaluations. Thus, the transition from codes to themes was carried out not merely as a technical classification process, but as an interpretive analytical process that made visible both the shared and divergent aspects of participants' experiences.

Trustworthiness

The direct involvement of researchers in qualitative studies (Braun and Clarke 2013) and concerns regarding validity and reliability in qualitative research (Arslan 2022) have created a need to establish the "trustworthiness" (Lincoln and Guba 1985) of studies in terms of objectivity. In response to this need, the COREQ Checklist (Attepe Özden et al. 2022) and the SRQR Checklist (Tekindal et al. 2021), which have been introduced into the literature and adapted into Turkish, were used as references. In addition, the study was reviewed independently by two experts in accordance with these checklists. The SRQR score was 18/21 (85% of relevant items met), and the COREQ score was 26/32 (81% of relevant items met), the necessary revisions were then made.

Reflexivity

The interviews were conducted and audio-recorded by a female researcher who had received training in qualitative research, was a specialist in psychiatric nursing, and had been actively working in psychiatry for more than 10 years. The researcher was not employed at the institution where the study was conducted and had no relationship with any of the participants. Given the possibility that the researcher's professional experience in the relevant field could introduce researcher-specific influence and affect the study's objectivity, the questions and responses were evaluated by both other researchers and an independent researcher with expertise in qualitative research to minimize research bias.

Results

The evaluation in this study was conducted with the participation of patients who directly receive CMHC services, patients' relatives who have the opportunity to observe their experiences, and health professionals involved in service delivery. Subcategories related to the themes identified from the data obtained during the research process were defined through codes. Relationships among the codes were visualized using code maps and a hierarchical structure, thereby supporting the analytical process not only in content terms but also in contextual and relational terms. Through this holistic approach, CMHC services were evaluated multidimensionally, and participant-based recommendations for improving service quality were presented. Because code frequencies have limited interpretive value in qualitative research, the analysis focused primarily on content and meaning and was supported with participant quotations.

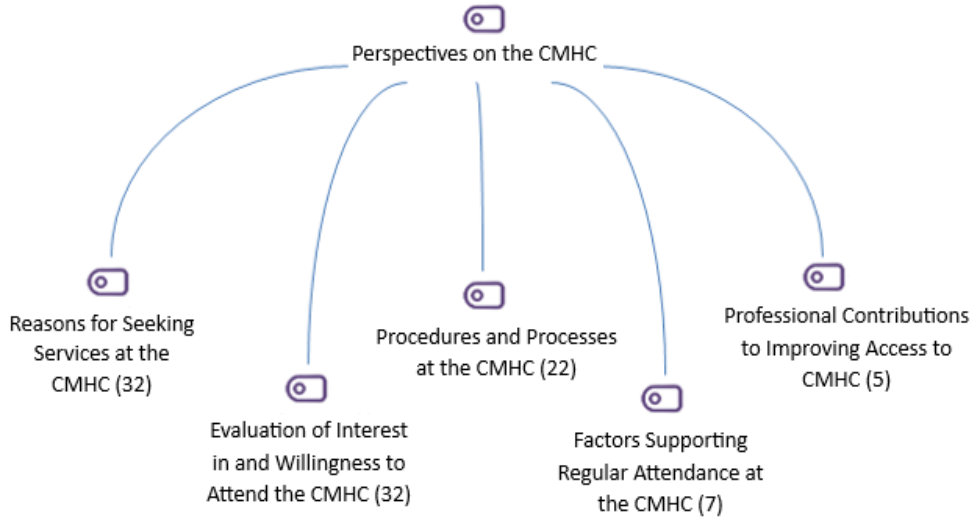


Figure 1. Hierarchical subcode model for perspectives on the CMHC

The two main themes that emerged from the data analysis were Views on the CMHC and Activities/Events/Patient Behaviors. These themes enable CMHC services to be evaluated at both organizational and individual levels, providing an in-depth perspective on the strengths of the institution and areas open to improvement. They also provide constructive feedback regarding the sustainability and accessibility of CMHC services.

The theme of Views on the CMHC encompasses levels of satisfaction with CMHC services, expectations, problems encountered, and recommendations. Participants' perceptions of CMHC services, communication experiences, and evaluations of the psychosocial support activities provided at the center were analyzed under this theme (Figure 1).

Within the theme of Activities/Events/Patient Behaviors, the effects of social and therapeutic activities organized at the CMHC on patient behaviors, levels of participation, activity content, and their contributions to patients' daily living skills were evaluated. Positive and negative changes observed in patient behaviors were also addressed within this theme (Figure 2).

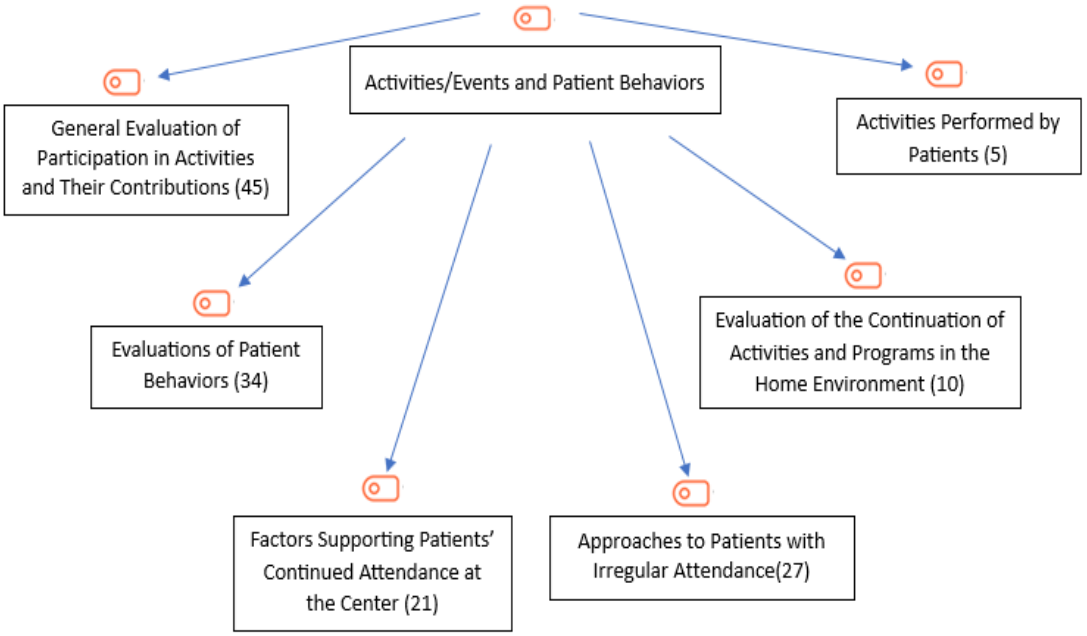


Figure 2. Hierarchical subcode model for activities/events and patient behaviors

Table 1. Participants' sociodemographic characteristics

Patient Group		**Patients' Relatives**		**Health Professionals**	
Age	Min.–Max.: 35–53 Mean: 41.4	Age	Min.–Max.: 41–65 Mean: 53.4	Age	Min.–Max.: 26–46 Mean: 34.2
Gender	Female: 3 (60%) Male: 2 (40%)	Education Level	Illiterate: 1 (20%) Literate: 1 (20%) Primary education: 3 (60%)	Profession	Nurse: 2 (40%) Social worker: 1 (20%) Psychologist: 1 (20%) Occupational therapist: 1 (20%)
Education Level	Primary education: 2 (40%) Middle school: 3 (60%)	Relationship to Patient	Mother: 3 (60%) Spouse: 2 (40%)	Length of Employment at the CMHC	1–3 years: 4 (80%) More than 3 years: 1 (20%)
Marital Status	Single: 4 (80%) Married: 1 (20%)	Social Security Coverage	Yes: 3 (60%) No: 2 (40%)	Field-Specific Training	Yes: 3 (60%) No: 2 (40%)
Employment Status	Not employed: 5 (100%)	Physical Health Problem	Yes: 4 (80%) No: 1 (20%)	History of Psychiatric Treatment	Yes: 3 (60%) No: 2 (40%)
Diagnosis	Schizophrenia: 2 (40%) BD: 3 (60%)	Similar Illness in the Family	No: 1 (20%) Yes: 4 (80%)	Family History of Psychiatric Treatment	No: 4 (80%) Yes: 1 (20%)
		Number of People in the Household	5+ people: 3 (60%) 3–4 people: 2 (40%)	Satisfaction with Workplace	Yes: 5 (100%)
		Primary Caregiver	Self: 5 (100%)		

BD: Bipolar Disorder, Min.–Max.: Minimum–Maximum, CMHC: Community Mental Health Center

Regarding the sociodemographic characteristics of the participants, who constituted the focus underlying the development of these themes, the patient group ranged in age from 35 to 53 years, with a mean age of 41.4 years, and women represented a higher proportion of the group (60%). All participants had a middle school education or below, 80% were single, and none of the patients were employed. Of the patients, 40% had been diagnosed with schizophrenia and 60% with bipolar disorder. The caregivers ranged in age from 41 to 65 years, with a mean age of 53.4 years. The majority of participants were mothers (60%). All participants had an education level of primary school or below, and 60% lived in households with five or

more people. The findings draw attention to crowded living conditions within the home. A total of 80% of caregivers had health problems of their own (e.g., diabetes, hypertension), indicating a potentially concerning relationship between caregiving burden and their own health. All participants were found to assume the role of primary caregiver alone. Of the patients' relatives, 60% had Social Security coverage, and 80% reported a similar illness in the family. Participants in the health professional group ranged in age from 26 to 46 years, with a mean age of 34.2 years. The professional distribution consisted of 40% nurses (n = 2) 20% social workers (n = 1) 20% psychologists (n = 1), and 20% occupational therapists (n = 1). The proportion of professionals who had received field-specific training was 60%. Although 60% had a history of psychiatric treatment 20% reported a family history of psychiatric treatment. All participants were satisfied with their workplace (100%) (Table 1).

Perspectives on the CMHC

This main theme includes participants' general perceptions of the CMHC, their expectations regarding the services, and their evaluations. The theme was examined under five subcategories, revealing how CMHC services were perceived at both the individual and societal levels. The subcategories under this theme were visualized using a hierarchical code model (Figure 1).

Reasons for Seeking Services at the CMHC

This category encompasses individuals' motivations for seeking services at the CMHC and the reasons underlying their attendance.

H1: "I only recently found out that there was such a place. This year, I started taking part in the activities. I joined some activities here. There was something called "drama," and I took part in it. The instructor left. It was good, and I had gotten used to it. At first, it seemed strange to me. I thought, 'What good is this going to do me? What is it going to do, cure me?' Then I just stayed with it. I had lost my older brother around that time too. I came here simply so I wouldn't have to stay at home. Before that, I would only come to see the doctor and then leave. I even asked the nurses why they hadn't told me about this. At least I can come here and sit for a while. I like it when they ask me, 'How are you? Are you doing okay?' and show that they care."

H2: "My mother referred me here because I'm very hyperactive. I want to set an example for my family. For everyone, really. I want them to know that being ill isn't something bad. Illness, I mean... that anyone can become ill, that it isn't something to be ashamed of, that psychiatry isn't something to be ashamed of... I want to show my family that by coming here and spending time here."

HY1: "She's afraid of people. She doesn't want to come. I encourage her myself. I tell her, 'Look, my daughter, this is good for you.' If you keep not going out, you'll shut yourself away at home and then you won't want to see anyone. That isn't right. That's how I encourage her. There's nothing else I can do."

HY2: "It's not really like that. My spouse isn't a social person, isn't active. Lazy, you could call it that. You know, for him life is just eating, drinking, and lying down or sitting around. That's all... someone with no goals, no purpose, no plans or projects. He doesn't have that drive to say, 'Let me work on something, make an effort, achieve something.'"

HT5: "No, he doesn't want to come. He's very afraid that they'll admit him, take him away, and hospitalize him in Bakırköy. He got scared, and I don't know what else to say. If I don't bring him myself, he definitely won't come. Just getting him out of the house wears me out. May God bless them. When the nurse calls, he comes without much trouble. If she doesn't call, there's no way I can get him here. He says, 'You're going to take me to the hospital, aren't you? You're going to have me admitted, aren't you? You're going to call the police, aren't you?' He was taking medication. He was taking Lithuril and Seroquel. I couldn't get him to take his medication, so we switched to injections. The injection helped a little, but now he seems withdrawn. Then again, he has started talking a lot again. And he also lashes out at his daughter and won't leave her alone."

Participants' statements indicate that seeking services at the CMHC was motivated not only by treatment needs but also by factors such as coping with loneliness, reducing withdrawal within the home, establishing social contact, being in a safe environment, and seeking support. In patients' accounts,

attending the center was most often associated with psychosocial needs such as "not staying at home," "having someone ask about them and notice them," "socializing," and "showing that having an illness is not something to be ashamed of." This indicates that, from the patients' perspective, the CMHC is experienced not merely as an institution where clinical services are received, but as a supportive setting that reduces social isolation, strengthens feelings of acceptance and belonging, and provides a meaningful space for social contact in daily life.

Statements from patients' relatives indicate that attendance at the center often resulted from family encouragement rather than the patient's intrinsic motivation, and reflected efforts to help the patient leave the house, prevent social withdrawal, and maintain functioning. In this respect, their accounts reflect expectations that the caregiving burden will be shared and that the patient's participation in daily life will be supported. In particular, statements concerning fear of hospitalization, resistance to treatment, social withdrawal, and tensions within the family indicate that access to the CMHC may be a fragile process when a relationship of trust has not been established.

Taken together, these findings suggest that reasons for seeking services at the CMHC are intertwined at the individual, familial, and institutional levels. For patients, attendance is primarily associated with socialization, receiving attention, and seeking a safe environment outside the home, whereas for patients' relatives, seeking services at the center appears to be associated with the need to manage the patient's behavioral symptoms, reduce the burden within the household, and obtain professional support.

Evaluation of Interest in and Willingness to Attend the CMHC

Participants' interest in the CMHC, their level of attachment to the center, and their expectations regarding the services were evaluated under this subcategory. This category reflects the attitudes of both patients and patients' relatives toward the CMHC. It indicates that positive perceptions of the CMHC are widespread and that these institutions are regarded as needed service settings.

H2: "It feels like therapy. For example, I receive support from you. I mean, I've been to all kinds of hospitals, and none of them helped me. I came here, and this place helped me. ... I mean, there's always something that draws me here. There's something here that touches my heart."

H3: "I used to feel happy when I came here. Because, for example, I'm good at math. They ask a question and I answer it. That makes me happy. I enjoy it, I feel better, I feel peaceful. Now I've reached a point where I get overwhelmed if I stay away too long. It becomes something you can't do without. Sometimes I think, even if I just go there, sit for a while, and talk a little, that's enough for me. I'm happy here."

H4: "There was a period when I couldn't even do the housework. I was in a very bad state, very depressed, and went through some really difficult times. But occupational therapy helped me a lot, and I apply what I learned there in my daily life."

H5: "I think when we come here, the doctors should listen to how we're feeling, provide treatment, and guide us. Sending a patient away without listening to them, without understanding them, without even looking at their face means leaving the patient to their own fate. These kinds of things could be improved because there are words that can bring someone back from the brink of death, and there are words that can push someone toward death. Some words can comfort a person. They can stop someone from thinking about suicide, give them hope, give them a reason to live. When the nurse who takes care of us calls and asks how I am, just having someone check on me improves my morale and my state of mind. Because the world we live in is very difficult. It feels good to know that there is someone who thinks about you."

HY1: "She even made a flower here and showed it to her older sister. She was happy about that. She drew something and said, 'Look, sis, I drew these,' and showed it to them. She was happy. Sometimes she wants to come. Sometimes she doesn't. She doesn't want to come. But look, she came today. She came willingly. My daughter likes people. She likes communicating with people."

SP1: "The CMHC can be like a bright, vivid sun for patients, something illuminating and warming."

SP2: "The CMHC may be like a service that helps remove the stones and pebbles blocking the flow of water in a running river, helping to clear those obstacles together."

Participants' statements indicate that patients experience the center as a place with which they form an emotional bond, receive support, and meet their need to feel noticed and accepted. Patients' expressions such as "it feels like therapy," "there's something here that touches my heart," "I'm happy," "I feel peaceful," and "it becomes something you can't do without" suggest that the CMHC is not merely an institutional service unit for them, but a psychosocial support setting that provides continuity, trust, and a sense of belonging in daily life. This finding suggests that willingness to attend the CMHC carries a meaning far beyond clinical benefit and that patients' relationship with the center is associated with restorative functions such as reducing social isolation, supporting self-worth, and strengthening participation in daily life.

Statements from patients' relatives indicate that interest in the center may fluctuate. Some patients were reported to attend willingly at times, experience satisfaction from showing family members what they had produced during activities, and enjoy communicating with others. However, this willingness is not always stable. Symptoms of illness, low motivation, social withdrawal, and previous experiences with the center may affect willingness to participate. Therefore, interest in the CMHC cannot be explained solely by individual motivation. Rather, it is a multidimensional process shaped by family support, staff attitudes, the extent to which activities match the patient's interests and abilities, and the reassuring atmosphere of the center.

The metaphorical expressions used by health professionals also highlight the protective and supportive function of the CMHC for patients. Describing the center as "a bright, vivid sun" or as "an institution that helps remove obstacles in a running river" indicates that health professionals view the CMHC as a support system that facilitates the course of patients' lives, strengthens hope, and accompanies them in coping with the obstacles they encounter. This perspective suggests that sustaining patients' interest in and willingness to attend the CMHC requires establishing a relationship based on trust, recognizing individual needs, and making a meaningful contribution to the person's life.

Taken together, these statements suggest that interest in and willingness to attend the CMHC emerge at three levels: for patients, emotional attachment, belonging, and well-being, for patients' relatives, the expectation that the patient's social participation and functioning will be supported, and for health professionals, an institutional resource that reduces barriers in the patient's life and supports the recovery process. Interest in and willingness to attend the CMHC should therefore be evaluated in relation to trust-based relationships, meaningful activities, social contact, and the continuity of psychosocial rehabilitation.

Procedures and Processes at the CMHC

This category encompasses the service processes, referral mechanisms, and patient registration and follow-up systems implemented within the CMHC. Participants' statements particularly highlighted bureaucratic procedures, continuity of care, and individualized care practices.

SP1: "During initial registration, whichever staff member is next in line, whichever counselor is assigned, meets with the patient or the patient's relative. There is a patient information form, and they complete that. They conduct an in-depth interview. Of course, the patient first meets with the physician. The physician evaluates whether the patient is eligible for registration based on the diagnosis, and then the patient and the patient's relative meet with the assigned counselor. At the same time, detailed information is provided about CMHC services. They are shown around the CMHC, and the physical facilities and so on are explained."

SP 2: "We already have a system in place. But we have this particular drawback. We have more than 700 patients. Each of us is responsible for at least 125 patients. Unfortunately, we cannot plan an individualized intervention for every patient because we have so many patients."

SP 5: "If there is a medical summary, we check whether the patient is eligible or whether there are currently any exclusion criteria, such as substance use. Then we conduct an interview. We take the patient's history

there. There is something I try to do in my interviews. It was something we were taught during the CMHC training sessions, in the training provided by the Ministry of Health. The idea is actually not to focus too heavily on the illness. Instead, the interview should be more oriented toward identifying the patient's strengths."

Participants' statements indicate that procedures and processes constitute a structural domain that directly determines service quality, accessibility, and the feasibility of individualized care. In the accounts of health professionals, the high number of registered patients and the heavy caseload per staff member were particularly prominent. This situation makes it more difficult for the CMHC to sustain its intended community-based, person-centered, and psychosocial rehabilitation functions and limits its capacity to develop individualized intervention plans for each patient, conduct regular follow-up, and provide needs-based support.

SP2's statements that "we have more than 700 patients" and "each of us is responsible for at least 125 patients" make the central tension in service delivery visible. On the one hand, the CMHC model aims to ensure regular patient follow-up, assess individual needs, and support psychosocial functioning, on the other hand, high caseloads and limited staff capacity make it difficult to fully achieve these goals in practice. Therefore, procedures and processes should be regarded not merely as components of administrative workflow, but also as critical determinants of service accessibility and effectiveness.

SP5's statement regarding a strengths-focused interview approach indicates that processes within the CMHC are not exclusively illness-centered and that some professionals adopt a recovery-oriented assessment approach that identifies individual strengths and supports personal capacities. This approach is consistent with the fundamental principles of community-based mental health services. The sustainability of an individualized process depends on structural conditions such as adequate staffing, sufficient time, an effective registration system, regular follow-up mechanisms, and internal coordination. These findings indicate that procedures and processes at the CMHC both establish the framework for professional service delivery and may constrain service quality due to high patient volumes, insufficient staffing, and difficulties in developing individualized intervention plans.

Strengthening CMHC processes requires staffing plans proportionate to patient caseloads, feasible individualized care plans, robust registration and follow-up systems, and institutional capacity that supports psychosocial rehabilitation activities.

Factors Supporting Regular Attendance at the CMHC

This category includes motivational and environmental factors that influence regular attendance at the CMHC.

H1: "I like it when the nurses ask me, 'How are you? Are you doing okay?' and show that they care."

H4: "Peace. How else can I put it? For example, during those depressive periods, when I come here and they approach me with kindness and warmth, I feel better right at that moment, in a way. I could say this place is my second home."

SP4: "As a metaphor for the CMHC from the patients' perspective, I think of a glass enclosure. I mean, it is a place where they are not completely disconnected from the outside world, but at the same time it is more sheltered and safer."

SP5: "The CMHC can be a roadmap for patients. I mean, it depends on where they want to go, because that is how they use this place. If their goal is medical treatment, they use it only for that. Whatever path they have drawn for themselves, whatever future they envision, that is how they use it. Those who live more colorful lives can use it in more colorful and varied ways. For those who feel more hopeless and helpless, I think this place is dark, it does not really offer them anything."

Participants' statements indicate that regular attendance at the CMHC is shaped by the relationship of trust, staff attitudes, a sense of belonging, the protective nature of the setting, family support, and the meaningful psychosocial opportunities offered by the center. Patients' appreciation of being asked "How are you? Are you doing okay?" and their description of the center as a "second home" indicate that regular

attendance is driven not only by the need to receive services, but also by the experience of being noticed, valued, and accepted. In this respect, the CMHC functions for patients not merely as an institution where treatment is accessed, but as a social setting in everyday life where safe relationships can be established, loneliness reduced, and a sense of belonging fostered.

Patients' relatives' description of the CMHC as being like a "mother's embrace" indicates that the center is perceived as a source of trust and relief not only for the patient but also for the caregiver. This expression suggests that regular attendance is closely associated with family support and that caregivers' trust in the center may facilitate continuity of attendance for patients. Particularly because individuals with mental disorders may experience fluctuations in motivation, social withdrawal, and resistance to services, the role of family members in referral, encouragement, and follow-up processes may be regarded as an important factor supporting regular attendance.

The metaphors of a "glass enclosure" and a "roadmap" used by health professionals highlight the dual function of the CMHC in supporting regular attendance. The "glass enclosure" metaphor suggests that the center provides a protective, safe, and structured environment without completely disconnecting patients from the outside world, whereas the "roadmap" metaphor indicates that patients may use the center in different ways according to their own needs, goals, and recovery processes. In this context, regular attendance is associated less with a standardized attendance pattern than with the meaning patients attribute to the center, the relationships they establish with staff, the center's accessibility, and the extent to which the activities offered align with their lives.

Taken together, these statements indicate that interventions aimed at increasing regular attendance should not be limited to appointment follow-up, continuity of the counseling relationship and the involvement of patients' relatives in the process, and even in activities, should also be supported.

Professional Contributions to Improving Access to CMHCs

This subcategory encompasses the effects of health professionals' professional competencies on access to CMHCs and service quality. Participants particularly emphasized that CMHC staff members' attentiveness, level of knowledge, and referral skills played a positive role in facilitating access to services.

HY3: "I mean, when we come here, God bless her, I've known the nurse for years now, for quite a few years, and she is very attentive. After we have the tests done, she sees us regularly every three months. For example, she calls us every two months and asks how we are doing. I'm really very satisfied with both my doctor and our nurse."

H3: "Well, we meet with our doctor. Our doctor listens to us. At least the doctor listens and tells us what needs to be done."

SP1: "Establishing connections with different public or private institutions. What we did was explain the services we provide in detail and make promotional visits to institutions so that they could refer people who had applied there, had received a diagnosis, but had never used CMHC services. The sole purpose was to introduce CMHC services and encourage referrals to us. At the same time, more information about CMHCs could be provided on hospital wards. When a patient is discharged, the doctor should look at the patient's address during the consultation and refer the patient directly. I think staff in hospitals also need to know CMHC services very well. They need to explain them in detail to patients and their relatives."

SP2: "Psychoeducation is very important. Establishing a therapeutic bond and a relationship of trust with the patient is very important. Especially if the patient does not attend because of psychopathological reasons or because of the nature of the illness, I place great importance on individual counseling and establishing therapeutic relationships, including occupational therapeutic relationships."

SP3: "We could increase and structure interview plans for individual counseling. After getting to know each patient, we could develop an intervention plan, assess their needs and the areas in which they want support, create a program according to those needs, invite the patient, and arrange regular meetings. It could be once a week or once every two weeks. For employed patients, it could be once a month. It is very valuable for patients' productivity to create something tangible. It supports both their self-confidence and motivation. Our

workshops are also very valuable in that respect. We may discover a talent they did not even know they had. That is very valuable for them too. Increasing workshop activities, diversifying them, and informing patients about them are very important. Some patients may not even know that workshops are available here. We provide individual counseling, workshops, and activities. We organize outings, table tennis, and sports activities. By increasing these activities and going places together, such as on outings or for other activities, we could encourage them to come to the center more often. The nurse asked, 'If this place were a symbol or metaphor for patients, what would it be?' Health professional E.K. said, perhaps it could be an institution or service that helps remove the stones and pebbles that obstruct the flow of water in a running river. It may not affect the flow of water one hundred percent, and there may be large rocks in some places, but it can help remove those obstacles together, at least minimize them, and support the continuation of the flow of life. Because social functioning is very important at the CMHC, I would describe it as a service that helps restore the flow of that river to normal and supports patients in reaching a level of independence in their lives."

Professional contributions that improve access to CMHCs are concentrated in health professionals' roles in providing information, making referrals, conducting regular follow-up, establishing therapeutic relationships, and maintaining communication with families. Health professionals' calls and follow-up, patient-centered guidance, psychoeducation, and individual counseling practices increase trust in the center and continuity of attendance. In addition, interinstitutional collaboration and appropriate referral following discharge strengthen system-level access to CMHCs, rather than leaving access solely

Activities/Events and Patient Behaviors

This theme encompasses the effects of social, psychoeducational, and therapeutic activities carried out within the CMHC on patient behaviors, as well as participants' observations and evaluations. It also addresses patients' attachment to the center, the sustainability of activities, and the approaches adopted in cases of irregular attendance. The relationships among the codes derived from participants' statements are presented in Figure 2.

General Evaluation of Participation in Activities and Their Contributions

This category encompasses general evaluations regarding patients' level of participation in activities organized within the CMHC, the appropriateness of activity content, and their psychosocial contributions.

H1: "I've only recently gotten to know this place. I used to come before, but I would leave right away. They would prescribe my medication, and I would go home. I had never seen anything like this. Apparently, they have handicrafts here, painting activities, and then there is drama and theater."

H2: "I come for sewing and embroidery. You know, there's sewing and embroidery, crochet. I used to crochet hair clips and draw roses, things like that. I came for a month, and they taught me how to read and write."

HY5: "It contributes a lot. In terms of recovery and improvement, we have seen a great deal of benefit."

Participants' statements indicate that activities such as handicrafts, painting, drama, theater, sewing and embroidery, and literacy activities increase patients' interest in the center and contribute to their daily lives. Statements from patients' relatives also indicate that these activities support patients' improvement and recovery.

Evaluations of Patient Behaviors

This subcategory encompasses behavioral changes observed during patients' participation in activities and continued attendance at the CMHC. Participants stated that the activities had positive effects on patients' social skills, self-confidence, and behaviors related to daily living.

H4: "For example, they help me with organizing household chores, my sleep routine, and self-care."

HY1: "They talk with people around here. And then I've taken part here two or three times myself. Once she made a flower, and another time she made something with beads."

SP2: "It is very valuable for patients' productivity to create something tangible. It supports both their self-confidence and motivation. Our workshops are very valuable in that respect."

Participants' statements indicate that the activities provided at the CMHC support patients' behavioral functioning. Patients' reports that they receive support with household tasks, sleep routines, self-care, and daily living skills demonstrate that the center serves a rehabilitative function by helping structure everyday life. While observations by patients' relatives indicate that patients participate in productive activities and create tangible products, health professionals emphasize that this process increases self-confidence and motivation. Taken together, these statements suggest that CMHC activities support positive behavioral changes in areas such as productivity, self-care, and the organization of daily life.

Factors Supporting Patients' Continued Attendance at the Center

This category includes motivational, environmental, and structural factors that influence patients' regular attendance at the CMHC.

H5: "My home is close to here. I walk here, so I can get here easily."

HY1: "They treat us very well. No one has ever treated us badly. How can I put it? Think of it as something like a mother's embrace. That's how I feel, I don't know."

SP1: "I think it is the way their counselors approach them and the close relationships they establish with them. There is a client-counselor relationship here, and we are public employees. There needs to be a boundary somewhere, but because these are psychiatric patients and we see them frequently here, a bond and a close relationship eventually develop, and a more informal and warm language is used."

The statements indicate that factors such as ease of transportation, staff attentiveness, the appeal of activities, and individualized attention increase patients' likelihood of attending the center. Living close to the CMHC or arranging transportation to the center is an important structural factor that affects continuity of service utilization.

Approaches to Patients with Irregular Attendance

This subcategory encompasses strategies and approaches used with individuals who attend the CMHC irregularly, as well as health professionals' attitudes toward these patients. This code is important for the sustainability of services and provides insight into both follow-up mechanisms and re-engagement processes.

SP1: "CMHC services do not seem appealing to patients. I sometimes think they do not want to come because there is nothing attractive about the services for them. Frankly, I also think CMHC services are inadequate. I do not think the ideal CMHC model is being implemented. Because the number of patients is so high, the number of patients assigned to each counselor is also high, and proper services cannot be provided. That is why I think patients are justified in attending irregularly."

SP2: "That is one of the main purposes of home visits. There, the patient is in a different role, and we are the guests. The patient is the host. One of the purposes of home visits is actually to move away from the stigma that labels the patient. The patient has a different role there, the patient is the one receiving us. At the very least, we can strengthen our relationship of trust and create an environment for conversation. Through that bond, perhaps we can draw the patient a little more into treatment. I think we may also be able to improve social functioning somewhat. It may be useful to develop individualized intervention programs by strengthening the therapeutic relationship with each patient. For us, it is important to work effectively in the field, not only at the center."

SP3: "We call first and ask whether the patient is working, why they did not come, whether they have their medications, whether they are taking them, and if they have run out, where they had them prescribed. Personally, I prefer to communicate more with the family. Even if the patient is working or says they are taking their medication, what matters to me is always speaking with the family."

SP5: "With some patients, because they do not accept their illness, I prefer to stay in contact with the family. Otherwise, they already become more negative, and establishing a relationship of trust becomes even more difficult. But if the patient is somewhat open to talking and is not denying the illness, then without putting too much pressure on them, we follow up at certain intervals. The system already gives an alert every three months. With some patients, developing a relationship of trust takes a very long time, and even if they only see you occasionally and are not willing to have a conversation, simply reminding them of your presence can gradually help develop that relationship of trust."

Taken together, the statements suggest that approaches to patients who attend the center irregularly should focus on understanding the reasons for nonattendance, maintaining a relationship of trust, collaborating with the family, and making the service more meaningful from the patient's perspective. In this context, regular telephone follow-up, controlled communication with the family, individual counseling, home visits, diversifying activities to align with patients' interests and needs, and developing gradual participation plans for patients with low motivation may support re-engagement with the CMHC.

Evaluation of the Continuation of Activities and Programs in the Home Environment

This category includes evaluations of whether activities initiated at the CMHC are continued by patients at home. In particular, observations regarding the continuation of self-care, hobbies, exercise, and psychoeducational activities in the home environment were reported.

H1: "I didn't take part in any of these before. I attended the activities with the previous instructor. There was that Nasreddin Hodja story, and the instructor had us work on it. It was on paper, and we would take it home and practice it. We continued it at home too."

H4: "Before occupational therapy, I was getting help here from the regular psychologist. I mean, I was trying to apply it in my life. That information was useful to me."

It is obvious that the life skills patients learned at the CMHC were also reflected in their daily lives.

Activities Performed by Patients

This category focuses on activities that patients engage in within the CMHC, such as painting, music, and sports.

H3: "I sing from time to time, and sometimes I work on math. I'm good at addition and subtraction. That's what we do. They ask me questions. Sometimes I sing songs too. That's how it goes. Or I know some history, I have knowledge about history. We talk about those things and chat. That's how the time passes."

H4: "They used to take us to the movies and things like that. That's how I remember participating. It was quite a while ago, though. Yes, I enjoyed it. We would leave from here and go together with the other patients, with friends. We had a good time."

SP2: "Increasing workshop activities, diversifying them, and informing patients about them are very important. Some patients may not even know that there are workshops here. We organize individual counseling, workshops, and activities. We organize outings, table tennis, and sports activities. By increasing these activities and going places together, whether for an outing or another activity, we may be able to increase their attendance at the center."

Participants' statements indicate that patients take part in a wide range of activities at the CMHC, including handicrafts, painting, drama, theater, sewing and embroidery, literacy activities, music, mathematics, conversation, trips to the movies, table tennis, and sports activities. These activities serve important functions for patients. The fact that some patients become aware of certain activities only later suggests that the activities offered at the center should be promoted more prominently and that patients should be guided based on their individual interests. Therefore, diversifying activities, announcing them regularly, and planning them in accordance with individual needs may strengthen the rehabilitative function of the CMHC.

Discussion

Access to CMHCs and service experiences were evaluated from the perspectives of patients, patients' relatives, and health professionals in light of the relevant literature. Patients' evaluations indicate that staff support, the need to cope with loneliness, and the need for socialization are prominent factors in regular, willing, and voluntary participation in CMHC services. This suggests that patients experience the center as a setting where safe social contact is established, and support is received in daily life. The literature similarly identifies friendly attitudes among health personnel, easy access to counselors and psychiatrists, attentive listening to patients' problems, and the provision of a peaceful environment at the center as factors supporting regular attendance (Sardoğan 2021). The multidisciplinary team approach, engagement with social networks, support for daily living, individually tailored support, and sustainable service structure emphasized in Van Genk et al.'s (2023) review of community-based mental health services also support this interpretation. These findings indicate that the therapeutic relationship and institutional atmosphere are key determinants of continuity in service use.

The theme of "Activities/Events and Patient Behaviors" highlights the psychosocial rehabilitation dimension of CMHC services. Participation in activities supports patients' socialization, productivity, daily living skills, and psychological well-being. Therefore, activities do not merely pass the time or provide an occupation, rather, they serve as rehabilitative tools that strengthen social functioning, participation in treatment, and engagement in daily life. The literature also reports that participation in social, course, and occupational activities supports regular attendance, insight, treatment adherence, and social functioning (Şahin et al. 2020, Sardoğan 2021). Gözen and Buz (2020) reported that occupational activities strengthen individual awareness, social functioning, environmental adaptation, and a sense of belonging. Çakmak et al. (2016) found that the majority of patients considered occupational activities beneficial to the treatment process. Saruç and Kılıç (2015) and Salık et al. (2025) showed that hobbies, handicrafts, reading, family support, and medication adherence support coping with the course of illness. Similarly, Deveci et al. (2008) and Söğütlü et al. (2017) demonstrated that psychosocial skills training had positive effects on treatment adherence, quality of life, symptoms, and daily functioning.

Evaluations by patients' relatives indicate that CMHC services are also important for caregivers, however, they are viewed critically because of inadequate services, disruptions in service processes, limited activities, and transportation difficulties. This finding suggests that patients' relatives expect tangible improvements from the center, reflected in patients' functioning and family life. Güvenç and Öner (2020) likewise reported problems with the center's functioning, staff attentiveness, activity adequacy, and transportation. Sohn et al. (2014) stated that access to services and treatment planning could be improved, while Kayacan and Kılıç (2023) highlighted shortcomings in workforce capacity, organization, financing, case management, service quality, and accessibility.

In terms of access, the findings indicate that accessibility and inclusion issues persist in CMHC services. Workforce shortages, organizational problems, variations in service quality, and transportation barriers may affect regular attendance at the center. Syed et al. (2013) reported that transportation barriers may lead to missed appointments, delayed care, and disruptions in medication use. Therefore, access to CMHCs should not be considered solely in terms of physical availability, transportation, referral mechanisms, regular follow-up, family support, and staff capacity should be evaluated together.

Statements by health professionals indicate that CMHC services face structural limitations in practice, including service conditions, limited activities, high patient numbers, and inadequate staffing. Özden and Çoban (2018) reported that health professionals generally viewed CMHC services positively but emphasized the need to strengthen structural and professional capacity to provide higher-quality services. In this respect, our study indicates that the CMHC model is considered valuable, but that high patient caseloads and limited resources make it difficult to implement the ideal model in practice. Kayacan and Kılıç (2023) identified workforce capacity, financing, organization, registration systems, case management, and variations in practices across centers as important areas requiring improvement in community mental health services in Türkiye. The Report of the Community Mental Health Centers Task Force of the Turkish Psychiatric Association (TPD 2020) also highlights problems related to physical conditions, qualified

personnel, administrative support, and service evaluation criteria. The findings of our study regarding high patient numbers, heavy caseloads per counselor, and the inability to fully implement the ideal CMHC model are consistent with these structural problems. Karip (2023) emphasized the need to strengthen sustainability, accessibility, interinstitutional collaboration, and caregiver involvement in CMHC services. Özden and Çoban (2018) likewise stressed that strengthening structural and professional capacity is necessary to improve service quality. In our study, the limited range of activities, some patients' lack of appeal to the center, and the dependence of home visits and telephone follow-up practices on staff capacity support these evaluations. Consequently, increasing staff capacity, diversifying activities, strengthening collaboration with families, and providing institutional support for individualized follow-up processes are necessary to ensure that CMHC services are delivered in an accessible, sustainable, and high-quality manner.

This study has several limitations. First, the study was conducted at a single Community Mental Health Center in Istanbul and included 15 participants: patients, patients' relatives, and health professionals. The purpose of qualitative research is not statistical generalization, but rather an in-depth understanding of experiences related to a particular phenomenon. In this context, the findings should be interpreted in light of the structural conditions of the center where the study was conducted, the characteristics of the participants, and their service experiences.

The small sample size and the use of purposive sampling may have resulted in limited representation of participants' views across diagnostic groups, caregivers with different characteristics, and health professionals with varying levels of professional experience. The low educational levels of patients and their relatives may also have influenced how some participants expressed their experiences verbally. In addition, the relatively short duration of interviews with individuals diagnosed with psychotic disorders may have resulted in some areas of experience being explored in less detail. However, efforts were made to enhance data depth through open-ended and probing questions, and a flexible interviewing approach designed to encourage participants to elaborate on their narratives. The study is based on self-reports and experiences described during the interviews. Therefore, participants' responses may have been influenced by recall bias, social desirability, or the interview setting. Health professionals' evaluations of the institutions where they worked may also have been influenced by their institutional affiliation or professional position. To reduce this limitation, data were collected from three different stakeholder groups, namely patients, patients' relatives, and health professionals, thereby allowing the same phenomenon to be evaluated from different perspectives.

Overall, CMHC services provide multidimensional psychosocial rehabilitation through social, psychoeducational, and therapeutic activities. Nevertheless, there remains a need to improve the transfer of activities to the home environment, re-engage patients with irregular attendance, ensure continuity of services, and strengthen collaboration with families. Therefore, it is important to plan activities in a more structured and traceable manner that is responsive to individual needs.

Conclusion

This study showed that access to CMHCs and service experiences are understood by patients, patients' relatives, and health professionals in different but interrelated ways. From the patients' perspective, the CMHC was regarded not only as an institution providing medical follow-up and access to medication treatment, but also as a supportive social setting for coping with loneliness, socializing, developing a sense of belonging, being in a safe environment, and maintaining daily living skills. Patients' relatives, in turn, viewed CMHC services in relation to expectations of sharing the caregiving burden, helping the patient leave the home, supporting social functioning, and observing tangible outcomes. Health professionals emphasized the psychosocial rehabilitation function of the center while also drawing attention to structural problems such as high patient numbers, insufficient staff and resources, the feasibility of individualized intervention plans, and the sustainability of services.

The findings indicate that, for CMHC services to be effective, they should be delivered in a manner that is visible, accessible, individualized, inclusive of families, and continuous. In this context, it is recommended

that the number of patients assigned to each counselor be reduced, the multidisciplinary team structure be strengthened, individualized care and rehabilitation plans be made more feasible, and follow-up mechanisms such as telephone monitoring and home visits for patients with irregular attendance be standardized. It is also important to diversify activities and workshops according to patients' interests, skills, and levels of functioning, systematically inform patients about these activities, and develop practices that support the transfer of skills learned at the center to the home environment.

To enable patients' relatives to participate more actively in the process, family psychoeducation, caregiver counseling, and regular informational meetings that strengthen collaboration with families should be planned. Supporting health professionals through in-service training on community-based mental health care, case management, working with families, motivational interviewing, recovery-oriented approaches, and psychosocial rehabilitation may improve service quality. At the policy level, CMHCs need to be strengthened both qualitatively and quantitatively across service indicators such as staff capacity, physical facilities, interinstitutional collaboration, accessibility, and registration and follow-up systems.

Longitudinal studies monitoring the long-term effects of CMHC services on patient functioning, caregiver burden, treatment adherence, quality of life, and social participation are important for evaluating the effectiveness of community-based mental health services and contributing to the development of evidence-based service models. Future research is recommended to include multicenter qualitative and mixed-methods studies with larger participant groups from different regions and different CMHCs.

References

Arias D, Saxena S, Verguet S (2022) Quantifying the global burden of mental disorders and their economic value. eClinicalMedicine, 54:101675.

Arslan E (2022) Nitel araştırmalarda geçerlilik ve güvenilirlik. Pamukkale Üniversitesi Sosyal Bilimler Enstitüsü Dergisi, 51(Özel sayı 1):395-407.

Artukoğlu P (2019) Türkiye'de toplum ruh sağlığı hizmetlerinin durumu: Kalitatif bir çalışma (Yüksek lisans tezi). İzmir, Dokuz Eylül Üniversitesi.

Attepe Özden S, Tekindal M, Gedik E, Erim F, Ege A, Tekindal A, (2022). Nitel araştırmaların rapor edilmesi: Coreq kontrol listesinin Türkçe uyarlaması. Avrupa Bilim ve Teknoloji Dergisi, 35:522-529.

Bekiroğlu S, Demiröz F (2020) Toplum ruh sağlığı merkezlerinden hizmet alan ağır ruhsal hastalığa sahip bireylerin sosyal işlevselliğinin incelenmesi. Toplum ve Sosyal Hizmet, 31:1053-1079.

Braun V, Clarke V (2006) Using thematic analysis in psychology. Qual Res Psychol, 3:77-101.

Braun V, Clarke V (2013) Successful Qualitative Research: A Practical Guide For Beginners. London, Sage.

Creswell JW, Poth CN (2018) Qualitative Inquiry And Research Design: Choosing Among Five Approaches. 4th ed. Thousand Oaks, CA, Sage.

Çakmak S, Aker T, Şahin N (2016) Toplum ruh sağlığı merkezlerinde uygulanan uğraşı aktivitelerinin tedavi sürecine katkısı. Anadolu Psikiyatri Derg, 17:17.

Deveci A, Esen Danacı A, Yurtsever F, Deniz F, Gürlek Yüksel E (2008) Şizofrenide psikososyal beceri eğitiminin belirti örüntüsü, içgörü, yaşam kalitesi ve intihar olasılığı üzerine etkisi. Turk Psikiyatri Derg, 19:266-273.

Gözen D, Buz S (2020) Toplum ruh sağlığı merkezinden hizmet alan bireylerin ve merkezde çalışan profesyonellerin deneyimleri. Toplum ve Sosyal Hizmet, 31:1459-1486.

Guest G, Bunce A, Johnson L (2006) How many interviews are enough? An experiment with data saturation and variability. Field Methods, 18:59-82.

Guest G, Namey E, Chen M (2020) A simple method to assess and report thematic saturation in qualitative research. PLoS One, 15:e0232076.

Güvenç NC, Öner H (2020) Views of patient relatives and health professionals about the reasons of the patients enrolled in the community mental health center to discontinue or irregularly continue the center. Int J Soc Psychiatry, 66:707-723.

Hennink M, Kaiser BN (2022) Sample sizes for saturation in qualitative research: A systematic review of empirical tests. Soc Sci Med, 292:114523.

Karip S (2023) Toplum ruh sağlığı merkezlerinde sunulan hizmetlerin ruhsal bozukluğu olan bireye bakım verenler ve ruh sağlığı profesyonelleri tarafından değerlendirilmesi (Doktora Tezi). Konya, Selçuk Üniversitesi Sağlık Bilimleri Enstitüsü.

Kayacan PA, Kılıç B (2023) Türkiye'de toplum ruh sağlığı hizmetleri: Kalitatif bir çalışma. Halk Sağlığı Araştırma ve Uygulamaları Dergisi, 1:56-64.

Newman D, O'Reilly P, Lee SH, Kennedy C (2017) Challenges in accessing and interviewing participants with severe mental illness. Nurse Res., 22;25:37-42.

Özden SA, Çoban Aİ (2018) Community based mental health services, in the eye of community mental health professionals. Journal of Psychiatric Nursing, 9:186-194.

Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P et al. (2018) The Lancet commission on global mental health and sustainable development. Lancet, 392:1553-1598.

Sağlık Bakanlığı (2011) Toplum Ruh Sağlığı Merkezleri Hakkında Yönerge. Ankara, Sağlık Bakanlığı.

Salık S, Doğan S, Yıldırım A, Kılıç M (2025) The experiences of patients enrolled in community mental health centers regarding the illness process. J Psychiatr Ment Health Nurs, 32:288-296.

Sardoğan C (2021) Toplum ruh sağlığı merkezine kayıtlı psikotik bozukluk tanılı hastaların TRSM programına düzenli katılım sıklığı ve ilişkili faktörlerin incelenmesi (Yüksek lisans tezi). İstanbul, İstanbul Kent Üniversitesi.

Saruç S, Kılıç A (2015) Toplum ruh sağlığı merkezinden hizmet alan bireylerin sosyal destek ve baş etme durumları. Toplum ve Sosyal Hizmet, 26:83-102.

Sohn M, Barrett H, Talbert J (2014) Community mental health center service use and consumer satisfaction. Community Mental Health J, 50:1-8.

Söğütlü L, Esen Danacı A, Savaş HA, Yılmaz E (2017) Toplum ruh sağlığı merkezinde izlenen şizofreni hastalarında psikososyal beceri eğitiminin etkileri. Anadolu Psikiyatri Derg, 18:121-128.

Syed ST, Gerber BS, Sharp LK (2013) Traveling towards disease: transportation barriers to health care access. J Community Health, 38:976-93.

Şahin S, Elbozan Cumurcu B, Ünal S (2020) Toplum ruh sağlığı merkezi hizmetlerinin tedaviye uyum, içgörü ve sosyal işlevsellik üzerine etkisi. Anadolu Psikiyatri Derg, 21:465-472.

Tait L, Birchwood M, Trower P (2002) A new scale for measuring engagement with community mental health services. J Ment Health, 11:191-198.

Tekindal M, Uğuz Arsu Ş (2020) Nitel araştırma yöntemi olarak fenomenolojik yaklaşımın kapsamı ve sürecine yönelik bir derleme. Ufkun Ötesi Bilim Dergisi, 20:153-182.

Tekindal M, Attepe Özden S, Gedik E, Ege A, Erim F, Tekindal A (2021) Nitel araştırmaların raporlanmasında standartlar: SRQR kontrol listesinin Türkçe uyarlaması. Opus International Journal of Society Researches, 18:5425-5443.

TPD (2020) Toplum Ruh Sağlığı Merkezleri Görev Grubu Çalışma Raporu. Ankara, Türkiye Psikiyatri Derneği.

Ural A (2011) Bilimsel Araştırma Süreci ve SPSS ile Veri Analizi. Ankara, Detay Yayıncılık.

Van Genk C, Roeg D, van Vugt M, van Weeghel J, Van Regenmortel, T (2023) Current insights of community mental healthcare for people with severe mental illness: A scoping review. Front Psychiatry, 14:1156235.

Van Hoe C, Moureau L, Verhofstadt M (2024) How to engage people experiencing severe and persistent mental illness in qualitative research: A descriptive and reflexive analysis. Int J Qual Stud Health Well-being, 19:2408817.

WHO (2021) Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches. Geneva, World Health Organization.

WHO (2025) World Mental Health Today: Latest Data. Geneva, World Health Organization.

Xiao J, Tourangeau A, Widger K, Berta W (2017) Discharge planning in mental health care: A qualitative study of patient and family involvement. Int J Ment Health Nurs 26:603-612..

Authors Contributions: The author(s) have declared that they have made a significant scientific contribution to the study and have assisted in the preparation or revision of the manuscript

Peer-review: Externally peer-reviewed.

Ethical Approval: Ethical approval for this study was obtained from the Non-Interventional Scientific Research Ethics Committee of Bakırköy Dr. Sadi Konuk Training and Research Hospital pursuant to date 07.10.2024 and number 2024-11-06. Participants provided informed consent prior to participating in the study.

Conflict of Interest: No conflict of interest was declared.

Financial Disclosure: No financial support was declared for this study.