MENTAL HEALTH CARE POLICY REFORM IN TURKEY:

USER GROUP PERSPECTIVES

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DECLARATION OF ORIGINALITY

I, Merve Kardelen Bilir, certify that

- I am the sole author of this thesis and that I have fully acknowledged and documented in my thesis all sources of ideas and words, including digital resources, which have been produced or published by another person or institution;
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ABSTRACT

Mental Health Care Policy Reform in Turkey: User Group Perspectives

The mental health policy of Turkey has been undergoing a transformation process since 2006. The main aim of this change is to prioritize the establishment of community-based mental health care services and to organize an accessible mental healthcare service network across the country. In this regard, this thesis explores the politics of mental health policy change in Turkey through a qualitative analysis of the views of mental health user groups on these changes. The main objective of this thesis is to analyze the politics of mental health policy change in Turkey and to understand the role of user groups in this process by a qualitative analysis of the views of mental health user groups on these transformations. There are 13 in-depth semi-structured interviews in this thesis that were conducted with representatives of mental health user groups in Ankara, Istanbul and Izmir between April and June 2018. The thesis reveals that this policy change took the form of the balanced care model, and the introduction of community-based mental health care centers provided to increase the utilization of mental health care services. However, it is not sufficient to bring a holistic view of the Turkish mental health system, which provides recovery-based services through medical and social support to empower individuals living with mental health issues. In addition, the user group representatives were included in this study believe that this policy change did not meet the expectations of user groups and remained insufficient in other respects.

ÖZET

Türkiye'de Ruh Sağlığı Politika Reformu: Kullanıcı Gruplarının Yaklaşımı

Türkiye'nin ruh sağlığı politikası, 2006'dan beri bir dönüşüm sürecinden geçmektedir. Bu değişimin temel amacı, toplum temelli ruh sağlığı hizmetlerinin kurulmasına öncelik vermek ve ülke çapında erişilebilir bir ruh sağlığı hizmet ağını kurmaktır. Bu bağlamda, bu tez ruh sağlığı kullanıcı gruplarının bu değişimlerle ilgili görüşlerinin niteliksel analizini yaparak Türkiye'de ruh sağlığı politikası değişikliğinin politikasına odaklanmaktadır. Bu tezin temel amacı, Türkiye'de ruh sağlığı politikası değişikliğinin siyasetini analiz etmekle birlikte bu süreçte kullanıcı gruplarının rolünü ve ruh sağlığı kullanıcı gruplarının bu dönüşüm hakkındaki görüşlerinin nitel analizini anlamaktır. Bu amaç doğrultusunda 2018 yılının Nisan ve Haziran ayları arasında Ankara, İstanbul ve İzmir'de ruh sağlığı kullanıcı gruplarının temsilcileriyle yürütülen 13 adet derinlemesine yarı yapılandırılmış görüşmeler gerçekleştirilmiştir. Araştırma sonucunda bu tez, bu politika değişikliğinin hastane-toplum dengeli bakım modeli halini aldığını ve toplum temelli ruh sağlığı hizmetlerinin açılmasının ruh sağlığı hizmetlerinin kullanımını ve erişimini arttırdığını ortaya koymuştur. Bununla birlikte, Türkiye'nin ruh sağlığı sisteminin ruh sağlığı sorunları yaşayan bireyleri güçlendirmek için tıbbi ve sosyal destek yoluyla iyileşme temelli ve bütüncül bir görünüm ortaya koymakta yetersizdir. Bu saha çalışmasında yer alan kullanıcı grupları temsilcileri de bu politika değişikliğinin kullanıcı gruplarının beklentilerini karşılamadığını ve başka yönlerden de yetersiz kaldığını yansıtmaktadır.

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CHAPTER 1

INTRODUCTION

What are the problems of people living with mental health issues in Turkey? Do they have challenges in common with the other disabled people in society? Is there a different type of social and economic stigmatization against people living with mental illnesses? So, could the community-based mental health policy change in Turkey offer a solution to these problems? What is the role and impact of user groups in this transformation? Inspired by these questions, the thesis analyzed views of user groups about the mental health policy change towards deinstitutionalization in the Turkish mental health system.

Mental health policy is in a branch of the broader headline of health policy; and it represents a triangle in a country's political system, along with health policy and its general healthcare system. The definition of mental health policy includes the laws, rules, regulations, and executions to provide mental health care services in the prevention of mental disorders, the provision of medical treatment to people living with mental issues, and improvement in the quality of life for these people (Rochefort, 1997).

In this context, the term “politics of mental health policy” refers to how a mental health system is governed by the state, and how and to what extent different actors and political institutions influence mental health policies. There are four core actors in mental health politics, and they are ranked as follows: the state, the private-sector, mental health care professionals, and user groups. The policy of deinstitutionalization in mental health care provision has been assessed by these four

actors. Recent policy implications have shown that user groups have gradually become important actors in policy-making, planning, treatment, the provision and evaluation of mental health care services. However, the visibility of user groups in these processes for the Turkish mental health system has shown slower development than in European countries.

Historically, mental health services have continued to evolve in three stages: the rise of asylums, the decline of these asylums and hospital-based mental health institutions, and the reform of mental health services (Thornicroft & Tansella, 2002; 2004). In these three periods, the center of gravity of mental health services has gradually changed from hospitals to community-based mental health services, which has evolved from the institutional-based services as a result of a deinstitutionalization movement. The term of deinstitutionalization in mental health policy can be defined as the closing and downsizing of large psychiatric hospitals and the introduction of smaller mental health care centers in the community. In time, the mission of psychiatric hospitals was transferred to these local centers which offer prevention, diagnosis, and treatment services.

The Turkish case is not an exception to this global trend. There has been a growing need for the provision of more qualified and sustainable mental health care services in country-wide. On this point, the National Mental Health Policy (NMHP) document was prepared as a guideline for shaping the future of the mental health policies of Turkey with the collaboration of the World Health Organization (WHO) and the Ministry of Health (MoH) in 2006. After this, the National Mental Health Action Plan was published in 2011 in order to establish a service network that is based on a user-centered and community-based mental health care service model throughout the country. The primary goal of these two policy papers is to prioritize

community-based mental health care services in Turkey and to organize an accessible and balanced mental healthcare service network across the country.

Within this framework, the main objective of this thesis is to analyze the politics of mental health policy change in Turkey and to understand the role of user groups in this process by a qualitative analysis of the views of mental health user groups on these transformations. The main research question of this thesis is the following: How do user groups view the mental health policy reform in Turkey? The aim of this thesis, therefore, is to gain insights into the views of user groups on the ongoing transformation of mental health policies in Turkey. There are sub-research questions: How are these policies compatible with the trends in the world? Is this process a deinstitutionalization or is a balanced-care model more consonant with the social, economic and political factors in Turkey? How did individuals living with mental health issues have organized in the associations of user-groups? What is the role and function of these user groups? In the light of these questions, this thesis involves the historical background leading to mental health reforms, the politics of mental health policy and the views of user groups with respect to these reforms within the Turkish context. The views of user groups constitute the core primary qualitative material of this research.

There are few studies on people living with mental health issues in the context of social policy in Turkey. The existing studies have concentrated mostly on epidemiological research on the prevalence of mental health issues, effective factors in mental health status and the utility of mental health care services. Also, they are about the mental health workforce and mental health institutions in Turkey. However, the growing literature in this field focuses on mental health policy analysis

— specifically, the content, boundaries, and actors of mental health policy in the context of Turkey.

There are two core reasons why developments in the field of mental health policy for people living with mental health issues in Turkey is important to study. First, a policy change in 2006 reflected a transformation towards community-based mental health care services in the Turkish mental health system, and it introduced many changes in terms of recovery-based social services and other benefits for people living with mental health issues. These changes have had remarkable influences on the users' lives as well as the life of their caregivers. The second reason is that analysing developments in the field of mental health policy for people living with mental health issues by presenting the point of user groups can shed light on the recent situation of health and social policies in Turkey.

The main hypothesis of this thesis is that this policy change is insufficient to bring a holistic view of the Turkish mental health system, which provides recovery-based services through medical and social support to empower individuals living with mental health issues. Deinstitutionalization in the Turkish mental health system since 2006 took the form of a balanced care model, and the introduction of community-based mental health care centers increased the utilization of mental health care services. The launch of community-based mental health care centers can be seen as the only policy initiative where the national mental health policy reform has been extended. On the other hand, the new model did not meet the expectations of user groups, and it remained insufficient in other respects.

This thesis contributes to the existing literature in the Turkish context by providing a discussion on the politics of mental health policy change in Turkey with

a qualitative analysis of the views of mental health user groups on these changes. The most important contribution of this thesis is an analysis of the policy changes towards "deinstitutionalization" in the Turkish mental health system by considering the role of user groups in this transformation. It clarifies the existing studies because it offers a discussion with a specific focus on the experiences of user groups, which includes individuals living with mental health issues and on the major decisions that are taken by service users. In this regard, this thesis emphasizes that the user groups who are actors in the politics of mental health policy are actively involved in policy-making, planning, treatment, provision and evaluation of mental health care services. This thesis also presents the examination of the historical process that led to the emergence of deinstitutionalization in the mental health policy. It traces the changes in mental health policies for people living with mental health issues in the context of Turkey. It focuses on the historical relationships between mental health policy, social policy, and the politics of mental health policy; it also presents contemporary developments in the area of mental health policy. For this reason, it is expected that this thesis will contribute to the existing literature on social policy and mental health policy in Turkey.

1.1 Research methodology

1.1.1 Unit of analysis

The research is composed of two main parts. The historical background of mental health policies for people living with mental health issues is in the first part. This part of the research was mainly composed of secondary sources, legislation, policy

papers, official statistics and reports, and reports of international organizations on this issue. In the second part, there are 13 semi-structured face-to-face in-depth interviews with representatives of mental health user groups who live in Ankara, Istanbul, and Izmir. They were the main qualitative material of this research and they were conducted between April 2018 and June 2018. The majority of the interviews were conducted in Istanbul, where the vast majority of mental health user groups and related organizations are located. One of the interviews was conducted in Ankara, which is the capital city of Turkey, and one was in Izmir, which is the third largest city in Turkey.

First of all, I listed all non-profit organizations in the mental health field of Turkey to recruit respondents for my study. There is not sufficient research on this issue, but it can be seen that the vast majority of non-profit organizations in mental health in Turkey have been founded by family members, mental health professionals and interested persons and/or professionals from the general public. It was a problem for my purpose because I wanted to focus on user-group perspectives in this thesis. In this regard, I designated two criteria for my sample. First, my respondents should come from user-centered non-profit organizations which are not composed of only family members, mental health professionals and interested persons and/or professionals from the general public. When I searched all organizations in the mental health field, I saw very few associations that are established and managed by user groups. Many were set up by mental health experts and they are closed to users. Second, the majority of the members of these organizations should be users, and users have a chance to manage these organizations. My main aim was to have direct access to representatives of user groups known as peer support groups and grassroots associations in national, regional and local levels.

I determined that the number of non-profit organizations in mental health field of Turkey remained limited to metropolitan areas; however, there are few associations in regions where there are psychiatric hospitals: Adana, Elazığ, Manisa, and Samsun. Also, the vast majority of existing user groups are diagnosis-specific groups, most of which are related to schizophrenia. Their number is nearly 30 across the country, and they are united under a national umbrella organization in Ankara. These organizations are based on voluntarism and mutual peer support, and they have cultural and occupational activities for their members. However, most of them stated that they had only a limited budget for more opportunities. The vast majority of them were founded by family activists, mental health professionals, and human rights advocates. Some of them have users who had administrative duties. There was only one peer support group that was led by a group of users, and another one became a user group organization as a result of a non-governmental organization project.

1.1.2 Sampling

In line with the conceptualization of Guest et al. (2006), I used a homogenous purposive sample which was arranged as thirteen interviews. The sample was comprised three groups: representatives whose had a mental health issue, those with a family member who was living with a mental health issue, and those who's with human rights advocacy expertise in the mental health field.

1.1.3 Methods

Thirteen in-depth semi-structured interviews were conducted with representatives of user groups in this research. The interviews were designed as semi-structured because semi-structured interviews have the potential to enrich the content of a dialogue between the researcher and the respondent.

Eight of the 13 respondents were female, and 5 of them were male. I did not ask the participants for their age, but generally they were middle-aged. The majority were users; 7 of the 13 had a mental health issue and they are classified as users in the Turkish mental health system. They had received mental health treatment for many years from psychiatric hospitals, community-based mental health centers, and private psychiatry clinics. Three were primary caregivers. They have an individual in their nuclear family living with mental health issues, and they dedicated themselves to their family member. In this regard, they pioneered the establishment of these organizations, and they have undertaken the whole responsibility for their family members as well as for these organizations. Three of 13 respondents defined themselves as a human rights advocacy expert in the mental health field. They emphasized that they have worked to support the rights-based struggle of individuals living with mental health issues.

1.2 Outline of the chapters

The thesis continues with the second chapter, which is a literature review on mental health policy, politics and mental health services. Chapter 2 starts with a brief summary of health and mental health policy, and it continues by providing the reader with the historical background of deinstitutionalization. Following this, it focuses on

criticisms against deinstitutionalization and it discusses the balanced care model as an alternative service provision policy for people living with mental health issues. It ends by presenting the politics of mental health policy and the four core actors in the fieldwork of mental health care.

The third chapter is on the history of mental health policy and politics in the Turkish context. It examines how mental healthcare policies in Turkey were transformed over the course of three periods. These periods are classified to show the relationship between Turkey's political history and mental health policies. In this regard, it emphasizes the continuation and disassociations in mental health policies up to the present.

The fourth chapter provides an analysis on the views of user groups about the mental health policy change towards deinstitutionalization in the Turkish mental health system. The perspectives of representatives of user groups are classified in three thematic areas: the policy of deinstitutionalization from the National Mental Health Policy in 2006, user group criticisms of the lack of social support in the community-based model as practiced in Turkey, and the role of user groups in the Turkish mental health system.

The conclusion chapter discusses the findings of the field study with reference to the existing literature.

CHAPTER 2

THEORETICAL BACKGROUND

Health policy constitutes one of the multidisciplinary research fields and it is considered as one of the milestones in the modern welfare system. Mental health policy is one of the branches under the broader headline of health policy, and it is situated within a country's political system, its health policy and its general healthcare system. In this regard, the chapter begins with an introduction to the content, boundaries, and analyses of health and mental health policy. Following these, the historical transformation of mental health services from hospital-based to community-based service provision is presented, along with debates the balanced care model. The section on the politics of mental health policy is based on the key actors in national mental health policy, and it ends by presenting critical points against the policy of deinstitutionalization.

2.1 Health policy and politics

While health constitutes one of the core fields of public policy and social policy, it does not perfectly fit in or reflect the general characteristics of these two fields. It presents an example of internal policy inconsistency (Ginsburg, 1992). Distinct features of health care policy have been neglected in the debates about the classification of welfare regimes for a long time, and health care policy has been analyzed in a limited number of studies in the welfare state literature (Ham, 1997; Moran, 1999, 2000; Kasza, 2002; Bambra, 2005). Today, there is a continuous

discussion on how the classification of welfare state should be, and the Esping-Andersen's (1990) iconic study, *Three Worlds of Welfare*, which analyses liberal (UK, USA, and Ireland), conservative (Germany, France, and Italy), and social democratic regimes (Denmark, Finland, and Norway) according to the labour market de-commodification levels of these countries. The criticism from different points of view on this Esping-Andersen's classification refers to the tendency to overgeneralize the range, his methodology, the absence of gender, and the neglected varieties in each category due to individual countries' internal diversity as well as the inadequacy of different branches of social services provision in his de-commodification index (Esping-Andersen, 1990, 1999; Bonoli, 1997; Arts & Gelissen, 2002).

Health systems consist of three components: financing, provision, and regulation. (Buse, Mays, & Walt, 2005; Greer et al., 2014). Health system is a regulatory, as a distributive, and also as a redistributive policy field, and health policy is accepted within the concept of public policy (Blank & Burau, 2007, p. 3). In this regard, health policy can be summarized as that “it is assumed to embrace courses of courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health system” (Buse et al., 2005, p. 6). The agencies include the government, the health professionals and the individuals applying to healthcare services. Increasing the role of the private sector in health care is the subject of political struggle and changes its scene considerably (Moran, 1999).

Today, health policy encounters a series of challenges such as increasing health expenditures, the shortage of human resources in the healthcare sector, new perspectives on the financing, provision and governance in healthcare in different regions of the world, the changing pathologies in the medical world as well as

growing input from medical technologies and emerging bio-ethical issues towards these all developments. While health policy faces these kinds of challenges, it has to answer to these demands and needs by creating innovative approaches, reforms, and models of finance, provision, and governance. The introduction of regulatory initiatives, increasing in marketization, public-private partnerships, and the decentralization of health governance can be counted as examples of responses to these challenges in health policy. As can be seen, the regulation of healthcare institutions requires economic resources and capabilities, but the state has limitations. These challenges in the health policy field have been defined as a "quadrilemma," and it involves that

> an economic objective (to control costs and the increase in health expenditure), a social objective (to guarantee equality of access to health care for all), a medical objective (to guarantee the highest quality of care and the optimum condition of health for the population) and a political objective (to guarantee the responsiveness of the health care system, the satisfaction of the professionals and the users, based on freedom and comfort of the patients and professionals). (Pavolini & Guillén, 2013, p. 193)

From this point of view, health policies can be thought of as a sum of purposeful and deliberate actions and efforts which are made with the aim of strengthening health systems in order to promote population health.

At this point, the analysis of health policy is assessed in light of the following statement: "Health policies and systems are complex social and political phenomena, constructed by human action rather than naturally occurring" (Gilson et al., 2011, p. 2). In fact, health policies are shaped by formal written documents, rules and guidelines which represent the decisions of policymakers about what policies should be implemented to improve healthcare systems as well as the health of the population (Sheikh, Gilson, Agyepong, Hanson, Ssengooba, & Bennett, 2011; Kuhlmann, Blank, Lynn, & Wendt, 2015). Therefore, the analysis of health politics by

considering political actors and processes of decision-making is necessary for an understanding of healthcare policy outcomes (Gilson, 2012). One approach to health care politics relies on the health policy triangle, which consists of actors, context and content and process respectively and considers this policy triangle, all the different elements in policy-making can be assessed together at the local, national, regional or global level (Buse et al., 2005, pp. 8-9). The term “actors” is at the center of this triangle, represents individuals, organizations, international companies and the state and government, the triangle has been used to explain the diverse factors of political, economic and social areas at both national and international levels. These factors can be grouped as situational, structural, cultural, international or exogenous (Leichter, 1979; Buse et al., 2005).

2.2 Mental health policy as a part of health policy

As a branch under the broader headline of health policy, mental health policy is situated within a country's political system, its health policy and its general healthcare system. There is an on-going discussion about the definition of mental health policy because of the specialty of the mental health sector; however, in general, mental health policy refers to the laws, rules, regulations, and executions which have been implemented by the government in order to provide mental health care service in these three following areas: the prevention of mental disorders, the provision of medical treatment to people living with mental issues, and improvement in the quality of life for these people (Rochefort, 1997).

Mental health policies have three components: regulation, financing, and the provision of mental health care services (Blank & Burau, 2007). The mental health

policy literature focuses on (1) the role of the state, (2) the collaboration between states and international organizations, (3) the role of medical associations, and (4) the division of labour between public and private initiatives. Depending on the financing model in a country's mental health system, different actors may have a differential impact on mental health policies. For example, the role of private insurers in the making of mental health policy is decisive in countries like the United States.

On the other hand, it is clear mental health policy has distinctive aspects that differentiate it from other general health policy issues. This distinctiveness has been referred as “mental health exceptionalism,” and “treating mental health problems and solutions as exceptional rather than commonly shared, and as substantially different from the problems and solutions that apply to other groups” (Rochefort, 1997, pp. 7-8). However, this tendency in treating mental health policy as a distinct policy domain has a potential risk for leaving mental health policy from general debates on public policy and health policies. It can also lead to a sharp isolation from socio-economic dynamics that lead to mental illnesses for example increasing unemployment, poverty, and inequality in a society.

Nevertheless, mental health policy is characterized by at least three factors: 1) stigmatization and 2) disagreement and 3) the role of the courts and judicial systems in mental health. First of all, mental health service users face stigmatization in political, social and economic respects, and secondly, there is still a considerable disagreement among professionals about the definition of some mental illnesses (Rochefort, 1997, pp. 7-8). The first one represents a continuous and a well-known isolation of individuals with mental disorders from the rest of society because of the presence of powerful stigma. Mental health issues are generally associated with irrationality, madness, dangerousness, violence, and insanity and there was a general

tendency that associated mental illness with demons, supernatural beings, and a belief in the weaknesses or immorality of the mentally ill (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Minas & Cohen, 2007; Scull, 2016). The second remarkable characteristic of mental health policies is a disagreement among experts about how mental health illnesses are defined and the nature of their complex relationship with external and internal factors—psychological, biological and social determinants. The variability in the definition of mental illness has revolved around a set of multifarious symptoms, this variability has transformed itself in time with the advancement of medical science, and the changing nature of meaning, understanding, and interpretation of mental disorders. The scope, effect, and treatment of these illnesses may vary in different contexts and with different patients. Therefore, this ambiguity and complexity in mental health policy have caused a difficulty in both policymaking and the provision of preventive, curative and custodial mental health care.

The important role of the courts and judicial systems are additional distinguishing characteristics of mental health policies from other social policy areas. Mental health policies sit at the intersection of law, medicine and psychology and civil rights issues, including property rights, informed consent, involuntary hospitalization, the regulation of disrupted institutions in mental health care services, and involuntary commitment (Levine, 1981; Weinstein, 1982; Weisstub, 1984; Marmor & Gill, 1989). It has been indicated that court decisions and legal regulations have always influenced mental health policies because of the state "parens patriae" responsibility in the police power and the liberty of individual (Hudson & Cox, 1991). In terms of the liberty of the individual and the civil rights movement, experts in mental health and the public paid attention to the existing

deterioration in mental health hospitals, and the basic arguments of deinstitutionalization and community care for people living with mental issues were uttered as a result of increasing emphasis on individual freedom. Today, the issue of mental health legislation is on the agenda of global law, alongside tobacco control policies, maternal and long-term care, non-communicable diseases, and universal health coverage (Gostin, DeBartolo, & Katz, 2017).

A qualified mental health policy analysis requires three types of information: first, the specific-background knowledge about what is mental health and how the health service works; second, the general information about how the state's policymaking works in mental health; and finally, how the government and the mental health policy confront each other (Rochefort, 1997, p. 3). Apart from the dynamics of domestic politics, the case for mental health policy must consider the influences of international organizations, for-profit and not-for-profit organizations, partnerships between the public and private sectors, and global civil societies. Today, the policy process has been transformed in every country; before that, policy analysis focused on politicians, state bureaucrats and interest groups. However, there has been a transition in policy-making, and larger set of actors has begun to play a role in the policy process (Buse et al., 2005). This changing nature of policymaking is explained as follows: “the policy environment is increasingly populated by complex cross-border, inter-organizational and network relationships, with policies influenced by global decisions as well as by domestic actions” (Walt, Shiffman, Schneider, Murray, Brugha, & Gilson, 2008, p. 310).

In this regard, there are five selected principles of policy analysis that have a special relationship with mental health policy, and these have been used in the analysis of mental health policymaking. The first principle is “thinking forward by

looking backward," and it determines the understanding how mental health institutions, programs, and policies in the past were transformed in line with today's conditions (Rochefort, 1997, p. 9). Former events and theories in mental health policy continue to influence the present mental health system, and historical materials and insights are used in several ways. Past policy failures and their analyses are utilized to provide the basis for assessing which mental health policy includes the continuation of and departure from former mental health policies. For instance, the accumulation of historical studies on abuses and unethical behaviours and treatment of people living with mental issues in mental health institutions contributed to the establishment of a more solid ground for debating deinstitutionalization in a roundabout way (Rochefort, 1997, p. 9).

"Top-down and bottom-up" is the second principle of mental health policy analysis, and it represents a combination of top-down and bottom-up policy analysis. Kiesler's (1997) distinction between bottom-up and top-down approaches are used for this research. The bottom-up analysis includes an assessment of the mental health system in terms of indicators such as capacity and the distribution of mental health services, the workforce, and technology. On the other hand, the top-down analysis is defined as what "the nation does in the name of mental health, whether intended or not, at what cost, to whom, and with what effectiveness" (p. 65). It seems that top-down analysis handles a broader critical point than bottom-up analysis to assess mental health policies, and it considers every detail such as medical human power, bed capacity, the number of community care institutions and so on in this issue. On the other hand, "bottom-up" means evaluating these policies from points of operators, users or clients of the same policies by looking into how different actors

are used to defining their expressions about mental health policies effectiveness and program processes (Rochefort, 1997, p. 10).

"The power of myth" is known as the third principle in mental health policy analysis. It is about popular and professional myths that emanate from many factors such as the mess of formal and informal service organization, media degenerations, the mismatch of clinical and public policy perspectives, fragmentary databases and the public ignorance of mental health problems. As a result of these factors, analysts in mental health policy may encounter widespread misconceptions, difficulties, untested assumptions, and indefinite facts (Rochefort, 1997, p. 11).

The fourth principle is about the place of values in policy analysis. It is one of the much-debated issues, and the dominant approach on this topic is based on the importance of value neutrality in the academic social sciences. According to this approach, a policy analysis should be grounded on "instrumental rationality." On the other hand, there are more recent arguments, which include the rule-based element in all policy actions. This element raises some social goods above others, and in this way, it is used to legitimize governmental authority by appealing to the importance of the public interest (Rochefort, 1997, p. 12). There are differences between a normative and an ideologically guided analysis in terms of the place of value. The normative one agrees with the value element in public policymaking, and it admits it as a part of policy analysis. Nevertheless, the latter starts with a political belief system such as liberalism or conservatism, and it analyses the particulars of a policy area as raw material to be used in its case (Rochefort, 1997, p. 12). The relationship between deinstitutionalization and the place of values is that if public policies stress values, the policy of deinstitutionalization in mental health institutions represents a

social movement with the right of citizenship, consumerism, de-medicalization, and mainstreaming.

As the last principle of mental health policy analysis, the "creative synthesis" principle emphasizes the importance of methodological eclecticism in policy analysis. This approach suggests two points: first of all, no single methodology or approach is sufficient to provide a comprehensive picture of the subject matter, and second, the choice of methodology should be determined with the direction of the policy topic being worked on and not vice versa (Rochefort, 1997, p. 10). In this respect, it can be said that different methodologies can be combined to establish a rewarding partnership. For example, Weisbrod (1983) focused on a cost-benefit analysis of community care of the mentally ill, and the author compared a series of costs (primary and secondary treatment, law enforcement, food, housing, burdens of family and mortality) and benefits (improvements in both physical and mental health, labour productivity and efficiency). He indicated that the community-based approach was generally more effective than hospital care at about the same cost.

The last pivotal issue in analysing mental health policy is the categorization of healthcare services according to their scope, content, and size within a general health system. There are three fundamental categories of health care provision: the first one is primary care, which includes general practitioners, well-patient physicals, ambulatory care, health promotion and education on prevention. Curative medicine constitutes the second category and it includes acute and hospital care, outpatient clinics, technology-based specialists and intensive care. Finally, chronic care long-term facilities, nursing homes, hospices, respite care, and home care represent the category of chronic care, which is generally associated with elderly care in the literature (Blank & Burau, 2004, p. 17).

In addition, there are two kinds of healthcare provision settings types: ambulatory settings and hospital settings comprise the first one, and acute care with ambulatory and hospital settings is the second type (Blank & Burau, 2007, p. 79). When considering the definition of mental illnesses and their medical treatments, the scope of mental health care is based on curative medicine as well as chronic care, and it requires both primary and acute care in the level of ambulatory and hospital settings. The scope, content, and size of mental health care services in primary, secondary and intensive care varies according to country. However, the psychiatric reform referred to as deinstitutionalization starting from the second decade of the 20th century has changed to the provision of mental health care services from institution-based to community-based around the globe.

2.3 A brief history of mental health services

Throughout history, mental health services have continued to evolve in three stages: the rise of asylums, the decline of these asylums and hospital-based mental health institutions, and finally, the reform of mental health services (Thornicroft & Tansella, 2002; 2004). In these three periods, the center of gravity of mental health services has gradually changed from hospitals to community-based services; this transformation will be analyzed in this chapter.

2.3.1 From traditional asylums to the birth of mental hospitals

Throughout the nineteenth century and early twentieth century, the establishment of hospitals for mental disorders served as the core institution of care for people living

with mental issues as well as the homeless and needy populations. The history of mental hospitals dates back to the sixteenth century, but there were generally no special clinics for people living with mental issues in those small-sized institutions; they were collected with waifs, orphans, and elderly and disabled people who had shared the destiny of their poverty and helplessness in the same place. For example, the Bethlehem Royal Hospital that was founded in the thirteenth century by Simon Fitzmary, the sheriff of London, is accepted as the first public institution in Europe for people living with mental issues. As they started to constitute the majority among the others in Bethlehem in the fifteenth century, Bethlehem was specialized as the place in caring for them (Masters, 1977).

With the combination of economic growth, urbanization and market influences, the general attitude towards needy people and the mentally ill in those chaos had turned into a stricter way which was predicated on a belief in discipline, work and employment by establishing the of houses of correction. For this purpose, a new series of institutions developed, including general hospitals and homes for the needy during the seventeen and the eighteenth century. However, the concept of discipline and work was not applied to people living with mental issues and those with socially unacceptable behaviours; they were labelled as troublemakers because they ruined the disciplined environment. As a result of this, the heterogeneous population in work-houses was gradually fragmented in order to ensure the continuity of workflow, and the residents were collected in public and private institutions, prisons, or religious local-based institutions without any kind of license, or they were left to the discretion of their families (Scull, 2016).

Beginning in the late eighteenth century, the introduction of market economy broke down the traditional bonds in societies, paving the way for the reorganization

of society, as Karl Polanyi (1944) indicates “the running of society as an adjunct to the market” (p. 10). In this regard, institutions which were redecorated with high walls, fences, and railings promised a certain isolation and protection of individuals with severe mental disorders from the rest of society, and safety for families of the mentally ill as well as the local community. Increasing populations and commercialization in every part of Europe triggered the demands for continuity in the social order, and the old religious and charitable attitudes towards the disruptive people, including the “mad” ones, had progressively changed for the worse (Scull, 1993).

On the other hand, there was a disengagement from the idea of certainty of nature with the effect of changing thoughts, and the power of education by benignity and humanity came to the forefront towards mental issues in the eighteenth century. This approach transformed into a method for treating mental issues, and it was known as “moral treatment,” which was based on the motivation to wake up his “moral feelings” and using these as “a sort of moral discipline,” and the development of self-governance and self-control (Scull, 1993). As Samuel Tuke (1784-1857), who protested the existing mentality of violence and savageness in traditional madhouses emphasized:

> [by means of terror, lunatics] may be made to obey their keepers with the greatest promptitude, to rise, to sit, to stand, to walk, or to run at their pleasure, though only expressed by the look. Such an obedience, and even the appearance of affection, we not infrequently see in the poor animals who are exhibited to gratify our curiosity in natural history; but who can avoid reflecting, in observing such spectacles, that the readiness with which the savage tiger obeys his master is the result of treatment at which humanity would shudder? (Scull, 1993, p. 100)

There was a mental health reform movement at the end of eighteenth century and the early nineteenth century, and reformers such as William and Samuel Tuke, Philippe

Pinel, John Ferrari, and Edward Long Fox came to a mutual understanding on the idea of moral treatment. They either established private lunatic institutions as moral entrepreneurs, for example, Brislington House and the York Retreat, or they continued to work in state-supported asylums, including Bicétre and Salpétriere with their new treatment methodologies (Scull, 1989). Nevertheless, the idea of moral treatment led to a great optimism which resulted in the reorganization of the traditional lunatic asylums according to a more humanitarian way of moral treatment for people living with mental illnesses. This wave of optimism to the age of the mental hospital system in the nineteenth century (Scull, 1989; 1993; 2016). There emerged a general agreement over the separation of people living with mental issues from the rest of society and the requirement of establishing an isolated mental hospital network outside industrialized cities. Initially, the moral treatment ignited a heated conflict between religious authorities and medical science, but the medical professionals asserted their dominance in the expertise of pathology, treatment, and literature of madness; for instance, they published a series of journals on this topic, including the *Journal of Psychological Medicine and Mental Pathology*, the *American Journal of Insanity* and *Annales Médicopsychologies* (Scull, 2016).

There has been a continuous debate on the conditions of traditional asylums and the mental hospital system. Michel Foucault (1973) revealed that

> the old confinement had generally practiced outside of normal juridical forms, but it imitated the punishment of criminals, using the same prisons, the same dungeons, the same physical brutality. The justice that reigned in Pinel's asylum did not borrow its mode of repression from the other justice but invented its own. (p. 266)

The alienists, an archaic term once used to describe a psychiatrist, and the states simultaneously increased their responsibilities and dominance in managing and financing of these new hospitals in both Europe and North America. In the

nineteenth century, the period of “the first biological psychiatry” began to spread as a movement that questioned the relationship between genetics, the chemistry of the brain, and mental illness through systematic research. The possible answers to these questions were researched in universities and institutes as a part of a larger research movement in this branch of medicine. Psychiatry in this era also appealed to the clinical-pathological method in universities rather than asylums, and it resulted in the medicalization of psychiatry (Shorter, 1997, p. 70). The effect of social welfare movements has been referred as one of the core reasons for the establishment of large asylums, because of the increase in the role of states to provide care for those people living with mental issues in a society (Fakhoury & Priebe, 2007). In this regard, the structure of isolated and unwieldy mental health hospitals continued its original type of architecture, and the confinement of people living with mental issues in those hospitals was accepted as a procedure in mental health care for more than a hundred years.

In the first quarter of the twentieth century, both the size and number of asylums continued to rise; however, the financial resources of those asylums were reduced because of destructive world wars and economic difficulties related to them. In the post-war years, discourse towards people with mental health issues started to change. The existing stigmatized adjectives of individuals with mental disorders were changed from “insane”, “lunatic”, and “aliénés” to “mental patient”, “individual with mental illness” and “malades mentaux” in the United States, Britain and France in the 1930s and 1950s, respectively (Scull, 2016, p. 340). In addition, the series of “scandals” in various mental health institutions garnished the headlines of newspapers and journals; they were successful in putting a spotlight on these hospitals.

The first reformist movement did not aim to suddenly close these institutions; their intention focused on an internal amelioration in financial resources, management, and treatment to begin a transformation there. Thus, the number of mental health hospitals did not fall dramatically in Germany, France, Spain, Sweden, and Denmark; these countries transformed their mental health care systems over a long period of time. With the development and utilisation of pharmacologic interventions and the psychopharmacological revolution in the 1950s, the duration of hospital stays was shorter and the number of in-patients decreased. The debate on community-based model began with an anti-psychiatry movement in the 1960s. Gradually, the term "psychiatric hospital" conjured up an image of unethical medical treatments, lack of hygiene and unsanitary living conditions as well as overcrowding and malnutrition (Porter, 2002). As a result of this negative image, reformists advocated for smaller community-based mental health care centers to replace psychiatric hospitals in the last four decades.

2.3.2 The idea of deinstitutionalization

The above-mentioned transformation from institution-based mental health services to a community-based one can be summarized as the closing down and downsizing of psychiatric hospitals and the introduction of smaller mental health care centers within the community; its process is referred to as deinstitutionalization (Fakhoury & Priebe, 2007; Chow & Priebe, 2013). Bachrach (1976) highlights two principles that are important to the deinstitutionalization movement: the first one is abstention from the use of traditional institutions for the care of people living with mental issues, and concurrent expansion of community-based mental health care facilities for them. In

addition, according to Brown (1975), deinstitutionalization is basically about the prevention of inappropriate admissions to mental hospitals. On the other hand, deinstitutionalization is also defined as a protest movement which has polemical and empirical critiques of mental hospitals (Bennet & Morris, 1983). There are three essential components of this process: the reduction of inappropriate mental hospital admissions, the change of place in the provision of mental health care, and the introduction of community care.

The term community care refers to both care in and by the community, and it is supported by both libertarian radicals and fiscal radicals because of a change in place, method and financing of care delivery (Thornicroft & Bebbington, 1989). The processes of deinstitutionalization have been implemented for almost 60 years in many countries worldwide; nevertheless, the scope and content of this process varies between countries. These reforms began in the United States and England in the 1950s, and they expanded to the Scandinavian countries and continental and Southern Europe (Novella, 2008).

In the light of these circumstances, an international consensus has been reached over the need for a change in mental health care policies. New policy strategies have been promoted by the World Health Organization (WHO) and the European Union (EU) (Thornicroft & Tansella, 2003; World Health Organization, 2005; European Union, 2015). WHO has emphasized that "mental health care should be provided through general health services and community settings, large and centralized psychiatric institutions need to be replaced by other more appropriate mental health services" (WHO, 2003, p. 1). The main aim of these reforms was to transform the traditional institution-based system of care and establish a new community-oriented perspective in the provision of mental health care. There are

both internal and external factors that led to the adoption of deinstitutionalization in mental health systems, which include pharmacological and medical patterns as well as sociological and financial factors.

First of all, with the introduction of the modern pharmaceutical industry in psychiatry, a series of antipsychotic agents in growing numbers including reserpine and chlorpromazine were produced; their usage made a breakthrough in practicing modern psychiatry and paved the way for the idea of positive medical treatment outside walls of mental hospitals (Thornicroft & Bebbington, 1989; Sartorius, Gaebel, Lopez-Ibor, & Maj, 2002; Scull, 2016). The belief in the effectiveness of these tranquilizing drugs was powerful. As Merwin and Ochberg (1983) stated, "Mental health professionals began to advocate community care, in part, because of the introduction of psychotropic medications contributed significantly to systematic management of many severely psychotic patients and made discharging them back to the community possible" (pp. 99-100). The usage of drugs was always known in psychiatry; however, the systematic researches and experiments on the chemistry of the brain brought about the modern era of drug therapy. The introduction of antipsychotics and antidepressants paved the way for the pharmacological basis of the second biological psychiatry (Shorter, 1997, p. 246). Alternative institutional care models and treatment techniques such as community mental health centers, day-hospitals, and hostels with halfway houses, industrial therapy organizations and therapeutic communities were developed in different countries, starting in the mid-1950s (Thornicroft & Bebbington, 1989; Mechanic & Rochefort, 1990, 1992; Smoyak, 2004). In today's world, new technological devices such as computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), and electroencephalogram (EEG) have provided more detailed

medical information about the functioning of the brain, and they also contributed to changes in the approach to diagnosis.

The role of civil rights movements and their criticisms of traditional mental hospitals have been quite influential in deinstitutionalization. Most of these criticisms came in the form of social studies such as *Human Problems of a State Mental Hospital* (Belknap, 1956), *The Mental Hospitals* (Stanton & Schwartz, 1954), *The Psychiatric Hospital as a Small Society* (Caudill, 1958) and *Asylums* (Goffman, 1961). Psychiatrists also advocated for the movement of anti-psychiatry, e.g. Thomas Szasz and R. D. Laing. According to Goffman (1961), mental health hospitals are like prisons. He defines total institutions as places where "all aspects of life are conducted in the same place and under the same single authority" (Goffman, 1961, p. 6). The daily activities of patients such as sleeping, playing and working in there were scheduled under a strict medical authority, and the official aim of total institutions was selected as the baseline of different activities (Goffman, 1961). Goffman's ideas about mental health institutions were in line with the anti-psychiatry movement, which was excluded from institutional psychiatry for a while. The doctrine of long-term psychiatric treatment in mental hospitals was worn out with following studies of notable psychiatrists such as J. K. Wing (1923-2010), George Brown (b. 1930), Werner Mendel (1935-2005), and Fritz Redlich (1910-2004). The growing importance of sociological research in psychiatric care hospitals also contributed to a departure from hospital-based treatment to community mental health care approaches, indicating that "sociological research was at least partially responsible for the gradual emergence of an increasingly important alternative set of theoretical, therapeutic, and professional perspectives and models" (Rochefort, 1997, p. 40).

The role of finances is also important in deinstitutionalization. For instance, as Enoch Powell (1961), minister of health in England, revealed that the identity of mental hospitals was strongly associated with economic loss and negativism:

> There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside - the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault.

Since the early 1970s, the expenditures for public services has declined in England, which also affected the funding for mental health care services in the National Health System. The funding trends in the mental health sector have been associated with wider public expenditure trends: the control of financial and human forces, cost-containment and efficient savings by self-funding, and the centralization of decision-making processes (Thornicroft & Bebbington, 1989). After a speech by Enoch Powell, strict budget restrictions were imposed on old mental hospitals, and no new investments were made on mental health hospitals, which started the way towards the closure of mental hospitals in England over the years.

In the United States, the economic drivers also undertook a leading role. Starting in the 1960s, mental health care services in different states were funded from two sources: categorical programmes and reimbursement. The first was grants-in-aid to state, district and local services for targeted mental health care programmes; these were financial funds transferring from the United States government to the general federal revenue for a specific project. The other was government-run Medicaid and Medicare insurance funds, which were government-supported health plans for older and low-income Americans. In the reimbursement stage, for example, there was a powerful bias towards long-term patients in nursing, care homes and mental health hospitals, although there was a safety net for provisions and repayments. This policy

gradually caused a division between public and private sector patients; while public institutions provided long-term services, the private sector mostly offered acute services (Thornicroft & Bebbington, 1989, p. 741). The report of costs incurred in caring for people living with mental issues in both public and private institutions was expounded as about $1.8 billion yearly by John F. Kennedy and, the new construction plan for comprehensive community-based mental health care centers was put into practice with the Community Mental Health Centers Act of 1963 (Rochefort, 1997, p. 56).

With the Community Mental Health Act of 1963, and Better Services for the Mentally Ill White Paper of the British Government in 1975, it is accepted that the deinstitutionalization movement began in the United States and England. First, the act in the United States was related to directing the financial resources to community-based mental health centers (CMHC) rather than to large mental health hospitals and isolated asylums; the estimated number of people living with chronic mental issues was 1.7–2.4 million, and they only left 116 000 in state mental hospitals in 1983 (Thornicroft & Bebbington, 1989, p. 742). After that, the United States' mental healthcare service provision transformed towards community-based outpatient care with establishment of mental health care centers, nursing homes, residential facilities, mental health care teams, board, care homes, and half-way houses. In many places, multidisciplinary community-based mental health teams (CMHTs) were established as the basic building organization for adaptation of community mental health; these teams also provided specific treatments such as family treatments and cognitive behaviour therapy in order to blend pharmacological treatments in a suitable social context. As additional mental health care services, a primary care network with specialist back-up, intermediate community services

(ICS), specialized outpatients / ambulatory clinics, assertive outreach community treatment (ACT) and early intervention teams were organized to provide medical therapy inside a patient house or community (Sartorius et al., 2002, p. 135).

Over the last three decades, the provision of mental health services in England has also changed from hospital-based to community-based, with a decreasing number of admissions, patients, and beds in mental health hospitals. Nevertheless, this transition does not include a total closure of mental hospitals. Rather, it is based on establishing new psychiatric wards within general hospitals, specialized-supported housing and hospital hostels for individuals with mental disorders. Like in the United States, England's mental healthcare service has support organizations, including those for community mental health nursing, community mental health care teams for districts, and early intervention teams.

The policy of the United States and England has foreseen the provision of supported housing, the availability of forensic beds, and the limited number of involuntary admissions. According to recent data from six European countries on the number of psychiatric beds, forensic beds, supported housing, involuntary hospital admissions and people in prison, the number of psychiatric hospitals and beds has decreased in Western countries with deinstitutionalization; however, the number of supported housings, forensic beds, and the prison population have increased at the same time (Fakhoury & Priebe, 2007, p. 314). This situation is described in the literature as re-institutionalization. There are three major characteristics of reinstitutionalization: the rising numbers of forensic beds, involuntary hospital admissions, and places in supported housing (Priebe et al., 2005). Additionally, the term “trans institutionalization” refers to a changing of placement of individuals living with mental health issues from one type of institution to another (Fakhoury &

Priebe, 2007, p. 314) Whether this process of deinstitutionalization is described as re-institutionalization or trans institutionalization depends on the national balance, which is related to the changing numbers in hospital beds and institutionalized care (Fakhoury & Priebe, 2007, pp. 314-315).

As the second way of deinstitutionalization, the Italian mental health policy evolved from hospital-based care to community-based one with a total closure of mental hospitals after Law 180 was enacted in 1978. It was based on four points: the total closure of mental hospitals, the introduction of general hospital psychiatric units, the increase in procedures for compulsory admissions and the establishment of community mental health centres in specified local areas (Girolamo et al., 2007, p. 84). Before this enactment, the number of psychiatric beds in Italian hospitals tended to decline annually, starting in 1963. For example, there was a decline from 5,544 to 2,396 in psychiatric beds in the north-western region of Piedmont in between 1977 and 1981 (Thornicroft & Bebbington, 1989, p. 742). Nevertheless, Law 180 quickened this pre-existing trend in service provision for the mentally ill because it strictly reduced the number of psychiatric beds, wards, and hospitals across the state (Tansella, 1986). As a straighter dissolution policy in deinstitutionalization, Italy adopted a completely community-based mental health care system in place of hospital-based care, unlike the United Kingdom and the United States. In each specified geographical area, there were established community-based mental health care facilities with a mental health workforce. Nursing homes, community-based residential facilities, acute inpatient care facilities, day-hospitals, and centers have been established to provide inpatient care to people living with mental issues. Like the transformation in the United States and England, the transformation of the Italian mental healthcare system happened earlier than other European countries.

In the following years, this sharp transformation of the Italian mental health system caused the lack of psychiatric beds for patients who need long-termed inpatient care and forensic beds for convicted people living with mental issues. The Italian case shows us that changes in the provision of mental health care services from hospitals to community care services can be implemented as rapidly and consistently (Thornicroft & Bebbington, 1989, p. 742).

2.3.3 The balanced care: A model for low, medium, and high resource areas

The movement of deinstitutionalization resulted in fundamental changes in service provision of mental health care. As previously mentioned, there are three periods in the history of the mental health services, and in the third period, community-based and hospital-based services have shared a common aim to provide treatment and care for individuals living with mental issues. Nevertheless, most people in the world living with mental issues do not have access to effective treatment and care; for instance, while 30.5% of all adults who are affected by mental disorders have received effective treatment in the US, this rate is 27% across Europe and less than 1% in Nigeria (Thornicroft & Tansella, 2013, p. 849). The World Health Organization (WHO) describes this situation as a treatment gap: “The treatment gap represents the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder” (Kohn, Saxena, Levav, & Saraceno, 2004, p. 859).

In this regard, a balanced care model (BCM) within local settings is proposed for the planning and delivery of mental health services to people living with mental illnesses; this model aims to provide effective treatment and care for needs of adults

but does not directly focus on children, drug and alcohol disorders, intellectual disabilities or any kind of neurological disorders (Thornicroft & Tansella, 2002; 2004; 2013). The balanced care model involves both modern community-based and modern hospital-based care. While modern community-based care consists of local sites and settings outside hospitals and non-hospital long-term residential care, hospital-based care provides acute inpatient treatment in general hospital psychiatric units, but only when it is necessary (Thornicroft & Tansella, 2002). "Traditional hospital care" refers to old and large psychiatric institutions, and their practices in treatment are segregated from modern hospital-based care. The balanced care model is based on flexibility and adaptation to changing situations across different countries, and the flexibility and adaptation are indeed an advantage because of the variance between economic sources and needs of the local population in the globe.

In this regard, there has been an on-going controversy on what mental health services can be provided in the community and which should be hospital-based and which of these services are necessary or optional in different areas of the world. In this debate, countries, and regions are categorized respectively as low-, medium-, and high-resource areas according to their capabilities in mental health service (Thornicroft & Tansella, 2004). Changes in service provision arrangements have been experienced differently in different countries due to variation in socio-economic structures and culture as well as a country's capabilities. The term of "resource" is used here to refer not only the financial capability of a country but also the size of the medical workforce, their training, experience, and orientation as well as the contribution of family and social networks (Thornicroft & Tansella, 2004, p. 288). There are undeniable differences between low- and high-resource countries in terms of the number of psychiatrists, psychiatric beds, total health budget and health

spending (WHO, 2001; World Bank, 2002); and they cause change in the forms of service provision.

First of all, areas with a low level of resource (Step A) include primary care with a specialist back-up; they are likely to provide most of all their mental health services in primary health care level with the first assessment and examinations by primary health care staff (Thornicroft & Tansella, 2004). There is a limited setting for specialist back-up in terms of training, consultation, in-patient assessment and examination for complex cases in general hospitals. Some low-resource countries remain in the pre-asylum stage; there is no traditional hospital care for people living with mental issues, and the community care model is not accessible for them. When an economic resource is available for mental health service provision in these areas, policy-makers have to make a choice between building larger hospitals or developing decentralized community-based services (Alem, 2002).

Medium-level resource areas (Step A + Step B) have more varied mental health service components than the low level of resource one; they have an affordable mental health service provision in hospital-based settings besides primary care-based system with specialist back-up (Thornicroft & Tansella, 2004). Medium-level resource areas are also known as mainstream mental health care, and their core components are classified as follows: out-patient and ambulatory clinics, community mental health teams, case management, acute in-patient care, long-term community-based residential care, and the provision of rehabilitation and day-care services. In this category, all settings of service provision should be first enhanced and reorganized by policy-makers by considering the available resources and the needs of the local community. For example, interventions for developing mental health care services at this level should aim to provide low-cost case management that is a

coordination between the case manager, the primary care doctor and the mental health specialist (Thornicroft & Tansella, 2004).

Each component of the mainstream mental health care model can be improved with additional and diversified services when time and resources are suitable for this transformation. It is classified as high level of resource areas (Step A + Step B + Step C); in this model, the service components in the low and medium level have already been provided to individuals with mental illnesses. The opportunities in the high-level resource area are extensions of specialized out-patient and ambulatory clinics, specialized community-based mental health teams, assertive community treatment teams, early intervention teams, alternatives to acute in-patient care, acute day hospitals, alternatives to acute hospitalization to alternatives to long-stayed residential care (Thornicroft & Tansella, 2004).

In recent times, there has been an ongoing debate between those who are supporters of providing mental health treatment and care in hospital-based settings and those who prefer to provide it solely through community-based mental health services. Proponents of the balanced care model suggest that there is not enough evidence to favour either the use of hospital settings or community-based services alone. This approach makes two policy recommendations: first, there should be a fruitful coordination between the providers of primary care and a secondary (specialist) one in every level of resources; and second, the medical workforce in these service components should be appropriate to both the purpose of service stage (A, B or C) and the level of resources in the work field (high, medium or low) (Thornicroft & Tansella, 2004).

2.4 Criticisms of deinstitutionalization

One of the key issues that have been debated in mental health care politics is the success or failure of deinstitutionalization. Although the practices of deinstitutionalization have succeeded in preventing long-term hospitalization of people living with mental issues, its outcomes have been criticized in different countries under five headings: the treatment gap, inadequate preparation before discharging patients from mental hospitals, increased rates of suicide, increase in the family burden, and lastly, the re-creation of an authoritarian regime of traditional asylums in the new service components.

First of all, it has been argued that this trend led to major gaps in the existing service provision for people living with mental issues, and this treatment gap has been filled by non-traditional institutions, including private institutions, nursing homes, day-care centers and community-based residential facilities (Hudson & Cox, 1991, p. 40). The strongest criticism is focused on the inadequacy of the number of community-based mental health care centers. The term “revolving-door syndrome” is used to describe a functional shift from long-term residential care to the short-term and repetitive type of care (Morrall & Muir, 2002). The second criticism is related to inadequate preparation of patients before they are discharged from mental hospitals; this gap in treatment and care has caused an increase in homelessness and crime rates among long-term patients. Especially in the United States, the discussion of homelessness problem has been carried out with a focus on the deinstitutionalization movement. Opponents of deinstitutionalization in the United States have argued that there is a growing homeless population and that the proportion of people living with mental issues in this population has also increased. The rate of the same population with psychiatric symptoms and taking psychiatric treatments among homelessness in

the United States apparently increased after the closure and downsizing of mental hospitals (Rochefort, 1997, pp. 228-229).

As the third criticism, the increased suicide rates are associated with insufficient levels of care and medical treatment, for especially some groups of people living with mental issues and insufficient social integration (Fakhoury & Priebe, 2007, p. 314). In the fourth criticism, the outcome of deinstitutionalization has been criticized in many countries because of increases in the family burden, which has been termed as re-familiarization (Alzahrani et al., 2017; Shek & Pietilä, 2017; Jones & Kami, 2016). The common theme among caregivers' attitudes towards deinstitutionalization has focused on families' being overburdened due to not having respite from care responsibilities and inadequate financial and social support ((Alzahrani et al., 2017). Based on the statistical data of the Italian reform, the percentage of patients returning to families reached 70%, especially in the Southern part of Italy, and families of people living with mental issues have indicated that they had to leave their work or change their living standards in order to cope with their patients (EU, 2015, p. 14). The last criticism is on the authoritarian regime of traditional asylums that have been created by hospital administrations in the psychiatric clinics of general hospitals, and there has been a post-liberal draconian social control with new forms of surveillance in these wards (Wadsworth & Epstein, 1998; Carpenter, 2000; Morrall & Muir, 2002; Hazelton & Clinton, 2004).

2.5 The politics of mental health policy

According to Wendt (2015), healthcare politics and policy refer to two core areas: 1) health policy and 2) healthcare politics. While health policy includes the health

system characteristics and therefore how these systems work, the term of healthcare politics is used to define how healthcare systems are controlled and governed by the state and how these systems continue to be a center on the influence of actors and political institutions (Wendt, 2015). It can be said that the politics of healthcare is about actors and political institutions as well as modes of governance in the framework of healthcare, and it contains the role of governmental policy in the financing, delivering, and regulating of healthcare (Marmor & Wendt; 2012; Wendt, 2015).

The term "politics of mental health policy" is used to explain how a mental health system is regulated and governed by the state, and how and to what extent different actors and political institutions influence mental health policies. There are four core actors in the fieldwork of mental health care, and the regulatory role of the state is accounted as the most important one. Private-sector mental health care professionals and user-groups are also in the category of mental health policy actors. The policy of deinstitutionalization in mental health care has been assessed from different points of view by these actors.

First, governments are generally key actors in the provision, financing and regulation of mental health care. This remains true to the present day, with a more complex structure. Current mental health policies and programs require the coordination of multiple levels of government at the federal, state and local levels and public and private tiers (Rochefort, 1997). The nature of the triangle relationship between government, public and private includes negotiation, conflict, and compromise as well as competition (Rochefort, 1997). As Brown and Stockdill (1972) indicate, "This is big business. Big business means big politics, and thus, mental health must hold its place in the political arena" (p. 669). In today's world, the

policy of deinstitutionalization has become a major consensus in the mental health policy area, and it has been widely promoted by national mental health policies in numerous countries. Behind this policy change, there are several variances in terms of its causes and implementations among governments, including external and internal legitimacy and cost-effectiveness impetuses (Shen & Snowden, 2014).

It is argued that the major provider of long-term care to people living with mental issues has shifted from state mental hospitals to private-sector industries, mostly as a result of deinstitutionalization. Since the late 1960s, there has been an ongoing movement toward deinstitutionalization around the world, and it has an apparent relationship with the emergence of the private sector in the field of care for people living with mental illnesses (Bickman & Dokecki, 1989). The private sector has become influential in both the process of deinstitutionalization policy and the development of different models in outpatient residential services, perhaps with the hope of benefit for their own organization. The privatization of community-based residential services is one of the most important results of deinstitutionalization in terms of social policy because the private sector took initiatives to meet the inadequacy of public services and it organized profit-making residential services as a new entrepreneurship (Piat, 1992).

Third, mental health care professionals (psychiatrists, psychologists, and nurses) are other key actors in the politics of mental health care. The professionals' assessment of the policy of deinstitutionalization and community care is positive and their medical associations generally represent them in mental health policymaking processes. For example, according to a study of professionals' beliefs and attitudes toward the policy of deinstitutionalization in Switzerland, there was a hesitation to support this change at first. Nevertheless, they are more positive than other people in

terms of the evaluation of community care; they have the most decisive attitude to community psychiatry (Lauber et.al., 2004). Although the belief in the importance of deinstitutionalization and community care is apparent among most of the professionals in Belgium, they too believe that their patient group did not exactly fit this approach because of their diagnostic characteristics, symptoms, and prognoses (Sercu & Bracke, 2016). As can be seen, the professionals emphasized the usefulness of community care for the needs of people living with mental issues, but they also stressed their hesitation from a medical viewpoint. They did not think that deinstitutionalization was a threat to the psychiatric model and their medical expertise (Sercu & Bracke, 2016).

Mental health service users are the last but not the least key actors in the politics of mental health care. There are many meanings of the term "mental health service user," and the users of mental health care services have been classified as either psychiatric patients, consumers of psychiatric services, or survivors of psychiatric treatment. Mental health service users are not a homogenous social group. They may differ from each other due to their approaches to mental health care services and the mental health policies in different countries. For example, people living with mental issues can be passive recipients of psychiatric care, consumers for choosing care or survivors for resisting care (Speed, 2006). A "user group" is usually established by users themselves, and the major decisions are also taken by service users. Families, professionals and interested members of the society may be involved in these organizations.

In the literature, one witnesses an increasing emphasis on user involvement in mental health services (Rogers et al., 1993). User involvement in mental health involves the development, organization, delivery, and evaluation of the mental health

services. In addition, user-led services are also administrated and staffed by users themselves across the United States and the United Kingdom (Tait & Lester, 2005). In this regard, the importance of service user involvement for both planning and provision of mental health services has been increasing in the last two decades. On this issue, the main transformation is related to questions of service users' rights and their consent for their medical treatment. Pilgrim and Lesley (1998) refer to three main factors in the determination of the level of user involvement in mental health care services: deinstitutionalization, the legitimacy of bio-medical theory and practice and the rise of the users' movement, and lastly, consumerism. They indicate that the policy of deinstitutionalization should be maintained in order to enhance user groups' roles in all aspects, including clinical, legal, political and ideological shifts (Pilgrim & Lesley, 1998).

With the growing role of user groups, the demands of patients for mental health policies and psychiatric care units were taken into consideration by governments. For instance, the Fédération Nationale des Association d'Usagers en Psychiatrie (FNAPSY) and Union Nationale des Amis et Familles de malades psychiques *(*UNAFAM), which are two main associations in the French mental health field, have become partners for health administrators and mental health care providers; they have ensured significant initiatives, recommendations and propositions to improve the existing mental health care policies for the care of people living with mental issues (Caria, 2009). Since the 1990s, health policy in England has emphasized the significance of user involvement in both planning and delivering mental health care services. Mental health service user-led organizations (ULOs) in England interact with mental health policy-makers to debate their ideas about the provision mental healthcare services (Rose et al., 2016).

In this regard, the evaluation of the level of user and carer involvement in mental health can be thought with Thornicroft and Tansella (1999a)'s model. They made a conceptual framework called the matrix model, where mental health care is seen as consisting of inputs, processes, and outcomes (temporal phases) at the national/regional, local or individual (geographical) levels. They characterized this model as follows: a new mental health law can be evaluated as an input at the national level, the operation of a community mental health team is a local level process, and the change in the quality of life of a service user due to treatment and care received can be seen as an individual outcome.

2.6 Conclusion

Turkey, in general, does not have a high level of resources in mental health care services, but it can be categorized in the medium level because of its strengths and deficiencies. For example, WHO asserts that in Turkey, public and private mental health services and mental health specialists are available in both town and cities, whereas local mental health services are not sufficient to respond the needs of patients in rural and semi-rural areas (WHO, 2001). At the level of provinces, there have been persistent deficiencies in terms of basic mental health services at the level of integration in primary health care. The lack of adequate funding of mental health services at the level of primary care—despite increases in population growth, urbanization and demand for mental health services—is another deficiency in Turkey's national mental health system (Republic of Turkey Ministry of Health, 2006). On the other hand, there are also an extensive network of basic health care

services and a traditional support network in the community (Republic of Turkey Ministry of Health, 2006).

From my perspective, this thesis will contribute to the analysis of the national policies for mental health in Turkey. In this regard, using the "thinking forward by looking backward" principle, first of all, the history of mental health policy from the beginning of modern Turkey to the present was analyzed by the contribution of historical researchers in this case (Artvinli, 2013). The historical background of mental health policies in Turkey is important to understand transformations in mental health institutions. In the second place, the principle of top-down and bottom-up that was explained by Kiesler provided my research a suitable ground for passing from policy design to implementation of national mental health policies in Turkey. The assessment of policies from top-down and bottom-up raises critical questions about current mental health policy debates, dilemmas, and effectiveness. Finally, the principle of creative synthesis will be used for analysing why the Turkish mental health care policy has been transformed from institution-based to community-based mental health care services, starting from the 1999 earthquakes.

CHAPTER 3

THE HISTORY OF MENTAL HEALTHCARE POLICY AND POLITICS IN TURKEY

3.1 Introduction

In this chapter, the historical background of mental health care policy and politics in Turkey will be traced to emphasize the continuation and disassociation of the mental health care field until the present. It analyzes how mental healthcare policies in Turkey were transformed during specific periods of time. Because mental health care policy is a part of a broader health policy, its historical background is intertwined with the history of social policy in Turkey. There are significant studies on the historical transformation of social policies from the last century of the Ottoman State to the Turkish Republic (Özbek 2002; 2006). As Özbek (2006) emphasizes, the history of social policy in Turkey is categorized into three periods: first, from the 1850s to the 1940s; second, from the 1940s to the 1980s; and third, from the 1980s to the present. Nevertheless, the history of mental health and politics is not involved to these studies. Artvinli (2013) provides valuable references to the relationship between mental health history and politics from the 1870s to the 1980s. According to Artvinli, the relationship between madness and politics is analyzed at three different stages from 1876 to 1924 during the Ottoman era. These periods have been categorized in a way that basically coincides with Turkey's political history. It can be said with reference to this study that the historical background of mental health care policy and politics in Turkey from the 1870s to nowadays is divided into three periods: 1) the institutionalization of psychiatry and hospital-based mental health services, 2) the introduction of community-based mental health care services in the

Faruk Bayülkem period, and 3) the Yıldırım Aktuna period and the policy of deinstitutionalization.

3.2 The institutionalization of hospital-based mental health services

The institutionalization of hospital-based mental health services in Turkey dates from the early nineteenth century to the mid-twentieth century, and it means the period of institutional mental health care for people living with mental issues. In this epoch, there were established traditional institutional treatment settings for the majority of people living with mental issues, and psychiatry was recognized as a medical discipline in its own right. There were three significant reforms at this point: first of all, the beginning of the medicalization of madness with the Regulation on Mental Asylums, which took effect on 15 March 1876; second, the establishment and restoration of mental health care hospitals across the country, and finally, the institutionalization of clinical and evidence-based Kraepelinian psychiatry among Turkish psychiatrists.

The Regulation on Mental Asylums was the first significant reform brought with the regulation of informal recording of the mentally ill and mental health institutions (Artvinli, 2013, p. 72). It was organized after the transfer of the Süleymaniye Mental Asylum to the Toptaşı Mental Asylum in 1873, and it was prepared by Luigi Mongeri, who was known as the Pinel of the Turks in the Turkish history of modern psychiatry (Artvinli, 2013, p. 50; Artvinli, 2018). The main structure of this document was on the administration, regulation, and licensing of both public and private mental health institutions and the registration, referring and the treatment for people living with mental issues (Artvinli & Etker, 2013). In

accordance with the spirit of the Ottoman modernization period in the nineteenth century, this regulation is accepted as a version of the French one, which was implemented on 15 June 1838 in France. The dominant effect of French École on the Turkish psychiatry maintained its authority until the adoption of German psychiatry and the establishment of the Bakırköy Psychiatric Hospital in 1924 (Artvinli, 2013, p. 163).

In this era, there was a process to institute a more bureaucratic and centralized state, and the increasing role of the state in social welfare mechanisms, including concerns for public health, security, and the prosperity of society as well as political control and legitimacy, should be considered in an analysis of policies of mental health in this period (Özbek, 2002, p. 325). As in the European states, the institutionalization of mental health hospitals and the ongoing regulative policies for them in the Ottoman Empire were related to the disintegration of traditional welfare systems and the transformation in economic, social and political areas. With the epidemic of cholera in the year of 1893, continuous problems such as overpopulation, lack of hygiene and insufficient capacity to provide treatment became insolvable for both administrators and patients. However, the structure of mental health institutions in the Ottoman Empire did not bear a resemblance to the European ones; their differences were related to the visibility of mental health hospitals. While state-owned mental hospitals were made visible in the nineteenth century all through Europe, the same institutions in the Ottoman State remained closed and distant from the public. For Europe, as Porter indicated, “The eighteenth-century madhouse had been a secret space, hidden from public scrutiny. Nineteenth-century reformers subjected it to the full glare of publicity” (Porter, 2001, p. 294). On the other hand, there were well-known rumours about the confinement of

political criminals in Ottoman mental hospitals. There were the censorship mechanisms in the medical school and the closeness of Toptaşı Mental Asylum for visitors during the long reign of Abdülhamit II (Usman, 1933; 1941; Artvinli, 2013). These claims about the visibility of mental health institutions were related with the policy management in both symbolism and image during the Hamidian Regime in between 1876-1909. The visibility showed itself in two major points and these were related to correcting the general degenerate image of the Ottoman state in the international media and to presenting a positive image to the civilized world (Deringil, 2009).

After the Second Constitutional Era was established on 23 July 1908, the expansion of freedoms, especially freedom of speech and the press caused the doors of the mental hospital to open. The contaminated structure of the existing institution was reawakened in order to establish a form of political power by this new government (Artvinli, 2013, p. 177). There were three major developments in this the second period (1909-1912): 1) the organization of the directorate of health care in 1909, 2) the construction and repair of existing mental hospitals, and 3) the introduction in 1911 of a short-stay unit for people with acute mental issues (Artvinli, 2013). After a series of meetings of the committee in Istanbul, the idea of establishing a new, large, discipline-based mental hospital with work therapy that would be established in green areas outside the city was adopted by the government. However, the policy of amelioration was found appropriate for mental hospitals in the provinces, including Aleppo, Aydın, Edirne, Hüdavendigar, Manisa, and Damascus. Even if there was an ongoing intention to form regional mental hospitals in both provinces and capital of the Ottoman state from the 1876 order; it was not put into practice in this period, mainly because of financial constraints.

All of these transformations on mental health emphasize a reciprocal relationship between politics and the policy of mental health in three respects. First of all, there was a continuity with the changing political order between the first and second era, such as the medicalization of madness, the registration of people living with mental issues, mental institutions under the responsibility of the centralized government, and the establishment or renewal of mental hospitals. Second, the point of disengagement shows itself in the topic of care and security for people living with mental issues in provinces; there was a series of correspondences about how these people in the provinces could be managed in the society. The third one is related to the order of 14 December 1913 that determined internal regulations and administration. With the guidance of these regulations, the job definitions for healthcare staff and the medical examination steps for treatment of people living with mental issues were thoroughly explained; and it was also a basis for following the orders on this topic (Artvinli, 2013, p. 220; Artvinli & Etker, 2013).

The third reformist movement was initiated with two major developments: first, the department of psychiatry was proposed with contributing to neurology and neurosurgery. The second development was the establishment of an extended psychiatric hospital in 1924 in Bakırköy, Istanbul. In this period, Mazhar Osman Uzman (1884-1951), who was the most popular figure in the history of psychiatry in Turkey, was reappointed as head physician at Toptaşı Mental Hospital by the first republican government, and he and his medical team organized a new series of clinics that included neurology, neurosurgery, pathologic anatomy, and psychology; the école of Emil Kraepelin, who was accepted as the founder of modern scientific psychiatry, was adopted by Mazhar Osman and his followers (Artvinli, 2013, p. 257). The need for establishing broader and extensive mental hospital was frequently

included in the agenda of the republican government, however; there were continuous challenging budget restraints due to the destructive wars between 1919 and 1923. Nevertheless, after the initiatives of Mazhar Osman with the first government, the Reşadiye Barrack in Bakırköy was reorganized and converted into a psychiatric hospital in 1924 by building additional pavilions to separate people living with mental issues from each other, according to the severity of their disease. Apart from the leadership of Mazhar Osman, there were young physicians like İhsan Şükrü Aksel, Fahrettin Kerim Gökay, Ahmet Şükrü Emed, Şükrü Hazım Tiner, and Talha Münir who tried to transform these ruined barracks into a hospital (Erkoç et al., 2011). With respect to the process of institutionalization of modern medicine and the development of professionalization perspective in the history of modern Turkey from the second half of the nineteenth century, Terzioğlu (1998) analysed the image of Turkish medical doctors: ‘‘The doctors constitute a "legitimate ground" for them to make social and political judgments about their society and act according to these judgments in their professional and social life’’ (p. 183).

The close relationship between the first generation of Turkish physicians and the process of modernization in both the Ottoman Empire and the Turkish Republic are analyzed from different perspectives to understand how medical doctors undertook a transformative role within these eras (Hanioğlu, 1986; Terzioğlu, 1998). In the light of these sources, the pioneering role of Mazhar Osman in the development of modern psychiatry, the medical education of young assistants in the Turkish psychiatry, and the transformation of mental health policies in Turkey can be considered together. Cemal Dindar indicates that modern psychiatry in Turkey can be identified as a child of Bakırköy and the Turkish Republic (Yalçıner et al., 2009). The period of Mazhar Osman led to the institutionalization of clinical and evidence-

based Kraepelinian psychiatry among the Turkish psychiatrists in later times (Yalçıner et al., 2009, p. 214).

In this period of removal and restoration, the occupations of mental patients should be considered; they worked in construction and agriculture and raising livestock. The discipline of work, obedience, and non-restriction were three parts of the moral treatment from the early eighteenth century, and the idea of non-pharmaceutical treatment for mental health disorders could be implemented in partially isolated green fields with huge gardens. On the other hand, the idealized theme that patients should work in order to supply a wide range of needs of the hospital and should be engaged in an occupation as treatment was not systematically maintained in Bakırköy, and they were gradually phased out in the following years (Artvinli, 2013, p. 270). Undoubtedly, the remnants of the problems coming from the Ottoman era manifested themselves as a continuous inadequacy of mental health hospitals all around Turkey. Even if though were two recently opened hospitals in Elazığ and Manisa in 1925, the need for institutions to provide mental health care had retained its importance. The unbalanced situation among the total population, health professionals, mental health hospitals and bed numbers made it difficult to resolve existing problems such as overpopulation, lack of hygiene and malnutrition in mental institutions. For those years, the general situation in mental hospitals along Turkey was depicted as follows:

> The condition of the chronic services in the inner garden was much worse. The patients lay naked in places. Their heads were all shaved and they all looked alike. It was frightening to get into the services. They were eating their food with their hands. The light bulbs were broken into the water, and all of the patients were given a standard glass of water. (Yalçıner et al., 2009, p. 85)

The steady overpopulation of Bakırköy Mental Hospital was also related to the general socio-economic background of people living with mental issues in Turkey;

they lacked access to social services, social rights, regular income, secure employment and basic care from their relatives or the state. Their loneliness is narrated in the memoirs of the healthcare staff:

> The services were in the form of two large wards, in the middle there was a tribute. The patients were standing all day in this airless breeding ground or sitting in the places. Most of them were naked, no clothes, no blankets. There were bunk beds in the wards, but there were no beds, no mattresses, and two patients in some beds. The patients were in lice and they were not checked whether they were bathing or not. There was a heavy smell in the services. Each service had a patient who was guiding all the patients, and the patients were cleaning the service. (Yalçıner et al., 2009, p. 129)

Most of the families of people living with mental issues have tried to provide basic care for them; however, the treatment process for chronic mental disorders requires continuous financial and emotional support, and this process is often regarded as an economic burden by the family. As a nurse from Bakırköy indicated, there were two types of patient families: 1) the lost family and 2) the visiting family. Some of the chronic patients were abandoned by their families in the hospital garden and they were recorded under the name of "unknown" because they did not know or remember even their names. The second type included patient families who occasionally visited their patient but made these visits secret. The stigmatization and discrimination against people living with mental issues is a known and ongoing situation in Turkey and around the world (Thornicroft, 2009/2014). For Turkey, stigmatization shows itself primarily in two ways. First of all, there is a tendency to prejudge people with mental issues because these people do not have willpower (Ozmen et al., 2004). According to a study of 707 people, 52% of the participants thought that schizophrenia was related to "poor personality" and because it was derived from poor personality, individuals living with schizophrenia were dangerous; they should be isolated from society (Sağduyu et al., 2003). The second one is about social distance. More than 700 people in Istanbul were asked their attitudes towards

people living with mental issues, and 65% of them stated that they kept a social distance; they did not want to marry individuals living with depression and they did not want to work with them (Ozmen et al., 2004).

Apart from hospitals in Elazığ and Manisa, psychiatric hospitals were opened in Samsun, Ankara, Adana and Gaziantep during the 1970s. Also, new hospitals were established in Trabzon and Bolu in the 2000s (Artvinli, 2013, p. 273). In Istanbul, the most populated city in Turkey, the Erenköy Psychiatric Hospital opened in 1976. Additionally, there are three private hospitals: the Yedikule Surp Pırgiç Armenian Hospital, the French Lape Hospital, and the Balıklı Greek Hospital, all of which belonged to the non-Muslim community in the Ottoman Empire. They continue to provide mental health care services.

Consequently, the legacy of this initial period in the modern history of psychiatry and hospital-based mental health services in Turkey was the establishment of institution-based mental health care services across the country. This legacy represented a cultural, political and social consensus on a mental hospital as the foundation of qualified mental health care for people with mental issues.

3.3 The introduction of community-based mental health care services in the Faruk Bayülkem period

The beginning of systematic community mental health systems extended from the end of the Second World War to the 1970s, and the term “community mental health systems” represents extensive private-practice psychiatry, the advent of effective psychoactive medications, and the establishment of day care and outpatient clinics in most psychiatric hospitals. The gradual inclusion of mental health in social insurance

plans and the welfare state constitutes the key theme for these years in the European countries. For example, The Mental Health Act of 1959 in the United Kingdom was on a decrease in psychiatric beds and an increase in day hospitals and community services. For the framework of Turkey, this second period, that is, from the mid-1960s to the 1980s, is also referred to as the first wave of community-based care because of the introduction of new and outpatient mental health care clinics in the Turkish mental health system.

The paradigms and practices in mental health care institutions have a reciprocal relationship with the general agenda of public policy and political events in Turkey. After the Turkish coup of 1960, psychiatry in Turkey was preparing to meet changing insights and new concepts in the treatment of mental disorders: community-based mental health services. This wave of reform began with Faruk Bayülkem, who started his career in Bakırköy and was appointed as chief physician in June of 1960, just after the coup. The fundamental transformation of this reform movement was a change in the stigmatized language of mental disorders, patients, and mental health institutions. Bayülkem initiated a series of education and information campaigns in order to attract attention of the society as well as the media. In this regard, an open-door policy was implemented, and new departments were established with the leadership of more educated and professionalized nurses, social workers, and psychologists in clinics for advanced psychiatric rehabilitation and academic studies of psychiatrists. Small workshops were opened to produce goods like socks, carpets and gauze, and assembly-line work in factories provided supportive treatment mechanisms to ease the discharge of patients from mental hospitals (Bayülkem, 1977).

In this era, a meeting was organized for debating national mental health policy and programs on 17 June 1964 and the Mental Health Directorate was founded in 1967 under the Ministry of Health (MoH). Before that, issues about mental health were discussed in National Health Councils at different times (Dağ, 2003). As the first part of socialization, mental health institutions had the experience of spreading into society in the 1960s (Goodman, 1994; Çiner & Fişek, 2010). The socialization of health services in Turkey was accepted by the National Unity Committee, which was a military committee organized after the 1960 coup d'état on 5 January 1961. The policy to socialize health services under the Act/Law 224, which was prepared by Nusret Fişek, had two points: the growing obligations of the state that came with the 1960 Constitution, and a change in the understanding of the health services in a social state (Talas, 1992). In this framework, new health stations and hospitals in cities and villages planned and began to open according to their population. As an extension of socialization policy, mental health dispensaries opened in different neighbourhoods of Istanbul: on 7 July 1962 in Aksaray, 23 May 1963 in Kocamustafapaşa, 1 June 1963 in Kasımpaşa, 7 December 1963 in Eyüp, 16 June 1964 in Üsküdar and 26 July 1963 in Sağmalcılar. These were generally poor districts of Istanbul (Yalçıner et al., 2009). After these initiatives, a day hospital with an outpatient clinic was opened in Beşiktaş, and a half-way house and sheltered workplaces were opened in Bakırköy in 1970 (Bayülkem, 1977). At the national level, a policy to increase the capacity of mental hospitals in different parts of Turkey began in Adana, Ankara, Gaziantep and Samsun during the 1970s (Artvinli, 2013).

In sum, this second period refers first to the integration of mental health care into the general health system and social insurance programmes and second, the introduction of community-based mental health care services, which meant an

increase in convergence between asylums and communities. These changes in the treatment of mental disorders are referred to as community-based mental health services because these services have provided basically outpatient psychiatric treatment for the mentally ill. The introduction of mental health dispensaries and centers, a day hospital, a half-way house, and sheltered workplaces are also relevant to the law on the socialization of health services and the integration of primary health care into the general health system. Despite the opening of outpatient clinics and rehabilitation activities in the hospital, the number of beds was insufficient compared to the number of patients and there was a misery similar to the period of the asylum. Undoubtedly, the disorderly administrative structure, financial problems, frequent changes in political authorities and governments, and a lack of human resources have also have factored into the closing of dispensaries.

3.4 The Yıldırım Aktuna period and the policy of deinstitutionalization

In the history of the social policy of Turkey, the 1980 coup d'état signalled the third period. In the mental health policy framework, this era can be divided into two periods: before and after the 1999 earthquakes in the northwest of Turkey. These earthquakes caused a transformative change in the community in many ways, including mental health care policy and services.

3.4.1 Before the year 1999

As a result of the organizational structure, the mental health policy of Turkey was conducted by both central and provincial officials. While the Ministry of Health

(MoH), the central office, pursued its structural reforms to centralize and systematize the national mental health system and programs, mental health hospitals and dispensaries in the provinces tried to sustain their administrative, financial and medical services with limited budgets. This section will focus on the history of mental health care policy and politics in the largest provincial office, the Bakırköy Psychiatric Hospital, and the Ministry of Health (MoH) as the central official.

In the delivery of mental health care services, psychiatry was in trouble in the world because of growing challenges from the deinstitutionalization movement, which caused a decrease in the number of patients and beds at large psychiatric hospitals and introduced smaller mental health care centers within the community during the 1960s and 1970s. The scope of psychiatric hospitals has been restricted in the United States and other Western countries, e.g. Italy and Spain and in most of the Western European countries, including Germany, France, and England. The neoliberal wave known as the Reagan and Thatcher era led to the change of health and mental health policies that influenced by the tradition of neo- Kraepelinian psychiatry, which is based on symptomatic nosology that includes a detailed checklist of symptoms, evaluation, and diagnosis in a clinical framework (Compton & Guze, 1995). The importance of external clinical signs became more influential than environmental and psychoanalytic factors. This returns to biological psychiatry and the new developments in psychopharmacology at the time led to a transformation in mental health policy. The impact of these changes that converted existing mental health institutions was not properly adopted by countries which did not have qualified mental health services, including Turkey. However, the impact of these changes showed itself in Bakırköy Psychiatric Hospital during the 1980s.

In the framework of Turkey, the period of Yıldırım Aktuna between 1979 and 1988 at Bakırköy Psychiatric Hospital is an example of this change; there were remarkable improvements that included improvements in both the physical conditions and the number of personnel of the hospital. During the 1980s and 1990s, this hospital was the most advanced psychiatric hospital in the country and was a training center for psychiatrists; it served about 20% of all psychiatric patients in Turkey and 25% of the assistants in psychiatry received their training in this hospital (Erkoç et al., 2011). Aktuna founded the Bakırköy Mental Hospital Foundation in 1980; donations and media campaigns were started in order to establish 1,170 beds, additional facilities, and new service units, including an Alcohol and Drug Addiction Treatment Centre. He retired from the military as a lieutenant colonel and his uncompromising discipline in the hospital was associated with authority and oppression, but which were effective after the coup d'état (Yalçıner et al.,2009).

Nevertheless, the significant inpatient numbers were reduced in order to decrease the number of psychiatric beds. The responsibility for care was turned over to the families of these patients; the inadequacy of community-based mental health care facilities for these chronic patients paved the way for more homelessness and increases to the family burden. The mental health dispensaries in Istanbul was gradually closed due to financial constraints and administration troubles in this period. Psychiatrist Adil Üçok (2009), who was in administrative positions in Bakırköy for many years, summarized this period:

> At that time, you know there was a trend in Italy. A man, like our Yıldırım Bey, pours all the hospitals into the street. Evacuated all the mental hospitals. Now I really liked the work of Mr. Yıldırım. On the other hand, I am very sorry that there is no other place in our society that can help the mentally ill. Many mental patients stayed in the street, in the uncovered. We reduced the number from 4,500 patients to 2,000 patients. (Yalçıner et al., 2009 p. 218)

As it can be understood from these evaluations, discharging patients from mental health institutions in this era cannot be evaluated as an output of planned policy; rather it was a poorly organized initiative and led to the victimization of lonely individuals living with mental issues due to the lack of community-based mental health services.

The bureaucratic studies on national mental health policies in the Ministry of Health (MoH) were started in the 1960s; however, the sustainability of these initiatives was not sufficient to structure and maintain a well-qualified policy. The Ministry of Health (MoH) was reorganized to be more effective, and the Department of Mental Health was founded under the authority of the General Directorate of Basic Health Services in 1983. One year later, Mental Health Division Directorates were established in the Provincial Health Directorates. The Head of the Department of Mental Health took the existing studies on mental health care from the beginning, and the first aim was to determine the actual situations and problems of mental health care facilities and to serve people living with mental issues all around Turkey. There were five primary objectives of this department: (1) improvement of the mental health service system, (2) improvement and development of preventive mental health services, (3) integration of mental health services with general health services and access to treatment services across the country, (4) the importance of mental health in a healthy life, and (5) the protection of society from harmful habits (Dağ, 2003). In the light of these goals, it can be argued that Turkey towards a more holistic and comprehensive way of policy-making in mental health; the three principles which were emphasized by the head of mental health department can be summarized as follows:

1. Mental health services, especially protective mental health services, are indispensable for general health and must be considered as part of overall health services.

2. Mental health care services should not be seen as a matter that can be solved solely by the Ministry of Health (MoH) or the health sector in general. The cooperation of other ministries (the Ministry of National Education, the Ministry of Youth and Sports and Labour and the Ministry of Social Welfare, the Ministry of Interior, and the Justice Ministry), with institutions affiliated to the Prime Ministry (Turkish Radio and Television Corporation (TRT), the State Planning Organization (DPT), the Religious Affairs and the Scientific and Technological Research Council of Turkey (TÜBİTAK) and voluntary organizations, the realization of inter-sectoral solidarity and coordination for successful mental health service were the prerequisites of the process.

3. It is necessary to constitute a mental health policy which places emphasis on medium and long-term mental health programs for the sustainability of mental health care services, the general health policy, scientific opinions and the realities of the country (Coşkun, 1987).

The country was divided into five different regions according to the place of mental health hospitals: Bakırköy and Erenköy in Istanbul, Manisa, Adana, Elazığ, and Samsun in the central Anatolia region). The employees of this department began to deliver a set of surveys to 67 provinces and to arrange investigative tours to these provinces to collect and identify general information on mental health care treatments and the main problems.

Apart from the staff of the ministry, the central team included psychiatrists who worked at different mental health care institutions in Ankara, and they were appointed as the responsible parties for these five regional hubs. Each region had also a regional communication team that included a psychiatrist and a psychologist, and they successfully organized regional trips, meetings and programs in this era (Coşkun, 1987).

Under the leadership of the head of the Department of Mental Health, a Mental Health Development Meeting was organized on 25-27 June 1987 in Ankara, and participants with an expertise in mental health exchanged views. As a sign of collaboration with World Health Organization (WHO), Professor Norman Sartorius, who was the WHO Head of Mental Health Department, and Professor Sampaio Faira, who was the WHO Head of the European Regional Mental Health Department, attended this meeting. As Sartorius pointed out, this was the right time for Turkey to develop a national mental health policy and program because there were increasing problems in mental health care services and the government wanted to solve these ongoing problems. The existence of educated people who were eager to study mental health policies and the collaboration between the World Health Organization and Turkey were presented as two other factors (Sartorius, 1987).

The fundamental conclusion of this meeting was on a holistic viewpoint that emphasized cooperation and collaboration between different branches in the structuring of mental health policies for Turkey (Dağ, 2003). Four working groups on the topics of protective mental health studies, improvement of mental health, psychosocial aspects of general health service, and treatment and rehabilitation studies were organized at the end of the meeting, and it was estimated that researchers could provide a detailed report and a program for developing a better

national mental health program in the following year. However, this aim was not accomplished in this period.

The First National Health Congress was organized to analyze health care services of Turkey using an integrated approach and to propose the health reform proposal; the main objective of this congress was to arrive at a functional consensus to solve ongoing problems in the health sector (Gökçay, 1992). At this Congress, a mental health working group was formed by 12 experts who debated various topics in mental health and prepared a detailed report on four main issues: (1) the organization, administration and practices in mental health services, (2) the regulation and coordination between different branches of mental health care, (3) the collection of data on mental health services, and (4) education programs in the media on mental health (Dağ, 2003).

In the following year, the Second National Health Congress was arranged in April 1993 by the Ministry of Health (MoH), and participants coming from all related sectors were gathered in order to assess the outputs of the first congress and to continue studies of working groups on all possible health issues. The mental health working group designed two main plans of action and an implementation plan for the main topics from the first congress. They highlighted the institutionalization and organization of mental health services in both the centre and the periphery (the establishment of national and regional mental health coordination councils), the increase in the number of psychiatric clinics and emergency units and the number of psychiatrists in general hospitals, and the constitution of a national mental health law to protect patients' rights on involuntary hospitalization (Dağ, 2003).

As it can be seen, the deficiencies, inadequacies, and mistakes in mental health care policies of Turkey were prioritized and a set of solutions was proposed which could be essential steps to solving continuous problems in these two national health congresses. A draft of a national health policy was prepared to submit to the Grand National Assembly of Turkey (TBMM), and the issue of mental health was addressed in Aim 28 with the following statement: "By 2000, all levels of health and social services will integrate mental health services" (Dağ, 2003). There were five basic goals for improvements to the comprehensive community-based mental health care services all around Turkey:

1. Preventive and therapeutic mental health care services should be considered together and they should be integrated into primary health care.

2. Mental health services should be widely available in general hospitals.

3. Care for people living with mental issues should be included in social services.

4. Risk factors for mental health should be identified and addressed by the community-based mental health care services.

5. The medical workforce in mental health should be expanded.

Consequently, the National Mental Health Department of Turkey worked with discontinuous mental health expert teams and international consultations, including the World Health Organization. The cooperation and collaboration at any level of the Ministry of Health and in different ministries remained quite low because coalition parties were competing for different interests because of bureaucratic barriers. The law draft became obsolete because of government and coalitions during

the 1990s, but it should be noted that the discussions on mental health policies at the ministerial level and the drafting of laws in the parliament are two very remarkable steps in the establishment and maintenance of a community-based service model.

3.4.2 Moving forward after two massive earthquakes

On 17 August and 12 November 1999, there were two massive earthquakes in the northwest of Turkey. Apart from these two big earthquakes, a total of 1,391 aftershocks were recorded between 17 August and 14 December 1999. According to Government Crisis Centre reports, over 18,000 people lost their lives, 48, 901 people were injured, and more than half a million were in need of shelter (Munir et al. 2004).

The first earthquake, on 12 August 1999 measured 7.4 on the Richter scale (RS) and it affected the Marmara region, the major industrial heartland of the country. It led to the loss of 17,127 people, 44,000 people were injured and 250,000 buildings were ruined (Munir et al. 2004). There were hundreds of aftershocks after this first earthquake. Three months later, there was another powerful earthquake on 12 November 1999; its magnitude was 7.2 on the Richter scale (RS). This second earthquake led to 850 deaths, 4,500 wounded, and 13,000 buildings were severely damaged (Government Crisis Center, 1999a-b). Apart from them, this successive earthquake affected adversely the mental health of the socio-economically depressed people in the Marmara region, especially in the Düzce province (Munir et al. 2004). The estimated rate of post-traumatic stress disorder (PTSD) was 43% and 22% among 1,000 people who were living in shelters 8 months after the disaster (Başoğlu, Salcıoğlu, and Livanou, 2002). Fourteen months after the disasters, these rates were

63% and 42% among 1,027 people (Livanou et al., 2002) and they declined to 39% and 18% among 586 people who were living in shelters after 20 months (Salcıoğlu, Başoğlu, and Livanou, 2003). As these studies on Turkey's earthquake survivors indicated that the estimated rates of chronic PTSD and depression among earthquake survivors continued their effects in the long run. There were initiatives to analyze psychiatric morbidity and psychosocial problems among earthquake survivors and to provide treatment and follow-up to them in the long term. One of them was the Psychological Support and Psychiatric Treatment Project for Psychological Problems Caused by the Earthquake in Adapazarı and it was managed by a group of mental health professionals from two major psychiatric departments in Istanbul. As the findings proved that it is important to plan long-term psychological interventions after a major earthquake. It is important to plan training programs for primary care physicians and community mental health services in order to decline the rates of PTSD and depression (Gökalp, 2002). On the other hand, Dole (2015) states that the ability of the earthquake survivors to rebuild their lives was also related to their ability to access long-term aid, which was determined by their wealth and property.

The magnitude and intensity of these two earthquakes caused a massive crisis in the country. As well as the humanitarian consequences, there was a huge economic cost to these disasters; industrial infrastructure systems, railway transportations, electrical grid, and water lines were devastated. Several earthquakes across the world have led to the realization that there is also a gamut of mental health troubles in the aftermath of such catastrophes. Mental health professionals and policymakers started paying special attention to the need for post-traumatic treatment for effective disaster work. As Dole (2015) emphasized, the approach of psychotherapeutic and psycho-social to the treatment of psychological trauma

became more important than the biological psychiatric approach in the mental health field. In the process, there were new developments in the concepts of psychological trauma and in the definition, diagnosis, and epidemiology of PTSD in Turkey. The field of post-earthquake psychiatry generated numerous academic studies that were made accessible in publications, conferences, and collaborations with international experts (Dole, 2015).

The crisis in Turkey revealed two important consequences. First of all, there was still an inadequacy in the provision of mental health care services in the country's 81 provinces. Attempts were made to address the lack of outreach services by psychiatrists who were under the umbrella of the Turkish Medical Association and the Psychiatric Association of Turkey, the Turkish Psychologists Association, the Psychiatry Departments of major Universities, and the Bakırköy Research and Teaching Hospital for Psychiatry and Neurology (Dole, 2015). Second, there was an impressive support from international communities in terms of humanitarian aid, rescue efforts, economic support, and medical and mental health services. After the declaration of national emergency by the government, the International Federation of Red Cross and Red Crescent Societies sent their search and rescue teams to the earthquake region with tents, food, blankets, and medical aid (Dole, 2015). Turkish and foreign mental health professionals worked together in outreach services that were organized in tents. Apart from them, there were many countries, including Israel, Germany, Greece, Japan and Russia, and international NGOs that sent their search and rescue teams, humanitarian aid and outreach programs to Turkey (Hürriyet, 1999). Nearly 80 international and 100 national NGOs participated in the first intervention stage with 3,622 personnel (İşbir and Genç, 2008). These efforts initiated a new era of cooperation and solidarity across countries, and it paved the

way for a “seismic diplomacy,” especially between Greece and Turkey (Munir et al., 2004, p. 243).

In 1999, the general healthcare system of Turkey encountered an increasing demand for better quality health services across the country. There were three main reasons for this demand: the high birth rate, rapid urbanization, and rising income and education levels (Munir et al., 2004). Turkey's healthcare system for this period was conducted by the state (Yılmaz, 2017, p.72). In this regard, the state undertook also the responsibility for provision of mental health care services across the country.

As emphasized above, the Directorate of Primary Health Care and the provincial directorates of health were in charge of the delivery of mental health care within the primary health care services in provinces. The Ministry of Health also has responsibilities over the establishment of preventive and primary health care services, the integration of mental health and primary care, identification of risk-behaviour groups, the creation of psychiatric units in state hospitals; development of rehabilitation facilities, and the collection of data and research. In 1997, the Ministry of Health announced a memorandum on the strengthening of primary healthcare services. According to this memorandum, delivering mental health care services from the primary healthcare level provided cost-effectiveness, efficiency, and preventive function in terms of mental health. Nevertheless, there were insufficient fundamental mental health services at the primary healthcare level until 1999. Public psychiatric services in Turkey remained quite insufficient in terms of a qualified medical workforce, facilities and an intense patient flow from primary level to secondary. General physicians who were appointed to these primary health care clinics in provinces did not have expertise in mental health, and this deficiency resulted in the breakdown of the referral system and the limited recognition of mental

health disorders in primary care level. As Kılıç and colleagues' epidemiological study showed, many people living with mental issues and their families preferred to travel to main cities to seek help from psychiatrists in those cities. Mostly, they were not referred to psychiatry by their general physicians in primary health care centers; rather they searched to apply directly to psychiatric units or psychiatric hospitals. The findings analyzed that only 4% of 582 patients in various psychiatric centers in Ankara had been referred by their primary physicians, while 42% of them had been referred by a hospital doctor and 53% of them came directly (Kılıç et al., 1994).

The lack of trained professionals also constituted an important barrier to the delivery of services (Yılmaz, 2012, p. 17-18). The number of mental health professional appointments remained low in the mental health directorates of provinces. The majority of psychiatrists in Turkey worked in state hospitals in three metropolitan cities: Istanbul, Ankara, and Izmir. The national ratio of the total population per psychiatrist remained around 1 per 100,000 populations, while it measured as 1 per 50,000 in Istanbul. The same ratio was calculated at more than 16 per 100, 000 in the United States and 10 per 100,000 in the European Union in the same period (Republic of Turkey Ministry of Health, 2006, p. 26). Despite the fact that half of the Turkish population of 65 million was under 25 years of age and a third of the population was under 15 years of age at the time of these earthquakes, there were only 50 child psychiatrists in the country. The ratio of child psychiatrists was about 1 per 500,000 for children and adolescents. These child psychiatrists worked mostly in 13 child psychiatry units of university hospitals in three major cities of Turkey; Istanbul, Ankara, and Izmir. There were 6 units which were also located in university hospitals in Adana, Antalya, Bursa, Gaziantep, Kocaeli, and Trabzon. Beyond that, Ankara, the capital city of Turkey, had only two adolescent

units in adult psychiatry clinics, and Istanbul also had only one adolescent unit in the Institute for Child Health (Republic of Turkey Ministry of Health, 2006, p. 26).

These deficiencies in the number of available mental health services at the primary level and mental health professionals came to light after the 1999 earthquakes. In the earthquake provinces, many families with children, adolescents, and elders, as well as local police, firemen and municipal workers, all encountered psychological problems, acute reactions, co-occurring depressions, and sleep and eating disorders. To address these needs, there were two collaborations between the Turkish and World Psychiatric Associations, and between the Turkish Child and Adolescent Psychiatry Association and its European partners. There were three goals of these collaborations: (1) the establishment of basic mental health care services at the primary health care level, (2) the integration of mental health care in the rest of general health care services, and (3) the introduction of community mental health care services in the provinces (Munir et al., 2004, p.239). As a result of these initiatives, there were two main projects to target the psychological and mental health activities for children, mothers and families and to develop a national mental health policy for the country. These were the Recovery Plan for Turkish Children, and the Marmara Earthquake Emergency Reconstruction (MEER).

In the first project, the main aim of the Recovery Plan for Turkish Children was the provision of a normalized environment for children and their families in the post-disaster provinces. It was implemented in consultation with the Government of Turkey. The $14.2-million project was funded by the United Nations Children's Fund (UNICEF) in Ankara. One of the missions of UNICEF, namely child-friendly environments, has provided for the needs of children and mothers in post-disaster situations by ensuring to them child and maternal care, primary school education,

and basic health and pediatric care, including nutrition, hygiene, water, sanitation, youth activities, and parental support. In this respect, the concept of a child-friendly environment was adopted as a model for children and mothers who were living in tent camps and prefabricated cities. Their efforts included supplying clean water, sanitary public facilities, immunization and hygienic measures for nutrition and basic medical supplies. The organization's activities were classified into four sections: health and nutrition; water and environmental sanitation; education and the psychosocial school projects. They supplied healthcare, social and educational services, guidance and research centers and community mental health services (UNICEF, 2001). During these activities, UNICEF collaborated with the Ministry of National Education (MoNE), the Ministry of Health (MoH), Turkey's Department of Social Service and its Child Protection Administration, the Turkish Psychological Association, and many national and international NGOs including the Center for Crisis Psychology (Bergen, Norway) and the Trauma Center (Allston, Massachusetts) (Munir et al., 2004).

The second project, the Marmara Earthquake Emergency Reconstruction (MEER), started with a Protocol that was signed between the World Bank (WB), the Ministry of Health (MoH), and the Project Implementation Unit under the Prime Ministry on 7 February 2001. The collaboration between the World Bank and the Turkish Government on healthcare issues had been established in the 1990s, and as Yılmaz indicates that “The World Bank has continued to be one of the key players in Turkey's healthcare policy” (Yılmaz, 2017, p. 67). The main aim of the Protocol was to diminish the physical damage of the earthquakes in the Marmara region; 1% of the loan for the general project was used for both mental health-related projects and development of community-based mental health care services (Republic of Turkey

Ministry of Health, 2006). Before the MEER project, there were two projects on Turkey's disaster recovery operations, i.e., the Erzincan Emergency Earthquake and Reconstruction (1992) and Emergency Flood and Earthquake Recovery (1998) projects. According to a report of the World Bank, these two earlier projects constituted valuable lessons and a good basis for the implementation of future operations like MEER (World Bank, 2007). In this point, the mental health part of the Marmara Earthquake Emergency Reconstruction (MEER) Project was based on the establishment of community-based mental health care services with trauma-related treatments, first for the earthquake zones in the northwest of Turkey, and later across the whole country. The program's funding was provided by the World Bank and other co-financiers, mainly the European Investment Bank. It was on the reconstruction and recovery activities, and disaster risk mitigation and emergency preparedness in 3 months. The mental health part of the project was announced in the Implementation Completion and Results Report on 7 June 2007.

> Component B - Trauma Program for Adults. This component was designed to finance the development of a trauma program for adults to complement the UNICEF/Ministry of Education program for children. The objectives were to contribute to the immediate reduction of the negative effects on health and functional ability among adults affected by the earthquake, including the restoration of normalized living and working conditions in the affected area, support the strengthening of community mental health services, ensuring that the whole country is better prepared for future disasters, and to support the reconstruction of working life and the reinsertion of adults into the workforce in the earthquake zone. (World Bank, 2007, p. 4)

The mental health project was related to the strengthening of quality of mental health services according to the country's needs and conditions at the time of the earthquake emergency. Primarily, the project on mental health services for earthquake zones planned to establish community mental health centers in each province with mental health professionals who are expert on trauma-related treatments and long-term mental health services for earthquake survivors. It involved a series of psychological

and organizational support for businesses that were affected by the earthquakes and increase in public awareness for the relationship between natural disasters and mental health issues. Next, the training for the personnel of Mental Health Directorate at both central and provincial levels and preventive mental health training for primary health care personnel constituted other activities in this project. Last but not least, the development of National Mental Health Policy for Turkey came up under the scope of the Mental Health Project. This time, need for a national policy that would establish community-based mental health services was also accepted by The General Directorate of Primary Health Care as a major objective. It was described as "the beginning of a new era for the development of a national mental health policy" (Munir et al., 2004, p.246). In the name of the Republic of Turkey, there was a call for consultancy services from relevant institutions:

> The Republic of Turkey wishes to allocate a certain portion of the loan granted by the International Bank of Reconstruction and Development (IBRD) for the payments to arise within the framework of the contract to be concluded on Procurement of Consultancy Services on the development of National Mental Health Policy (NMHP). (Republic of Turkey Ministry of Health, 200, p. 22)

There were five consultancy topics on the development of mental health policy under this call. The first one was to identify a Mental Health Policy for Turkey that involved analyses of existing mental health strategies at the national, provincial and municipal level. The second was about the evaluation of the strategies, plans, and resources of the different institutions in which related to mental health. Third, the role of international organizations and initiatives on mental health described one of the key actors in the making of mental health policy for Turkey. The preparation of recommendations for short- and the long-term measures to diminish the effects of natural disasters on the mental health and the set of treatments for emergency and post-traumatic disorders constituted the fourth topic in this framework. Finally, the

last topic was the organization of a series of national workshops on National Mental Health Policy. In this regard, an interdisciplinary team was formed by experts from the International Mental Health and Developmental Disabilities Program (MHDD) at the Boston Children's Hospital, and Harvard Medical School in cooperation with colleagues from Hacettepe and Ankara Universities. The MHDD group responded applied to the call for consultancy services, and they collaborated with the Ministry of Health to identify a national mental health policy for Turkey. In the light of all the above-mentioned requirements, they organized three conferences in Ankara: National Mental Health Conference 1, 12-13 December 2002; the National Mental Health Conference 2, 10-12 March 2003; and the National Mental Health Conference 3, 4 July 2006. Additionally, the core MHDD group coordinated a series of national and international meetings with the Minister of Health, the Scientific Mental Health Advisory Board of the Ministry of Health, professional associations in the mental health field, and representatives from universities and major non-governmental organizations and other invited colleagues. The major topic of these conferences and meetings were the provision, financing, and organization of child, adolescent, and adult mental health care services across the country. There were also increasing awareness of patients' rights, the need for mental health legislation and the establishment of comprehensive inter-agency coordination. The core cause of this awareness's is related to Turkey's efforts to join European Union and the changing demography of the Turkish society. Turkey has transformed itself into a more urbanized society with nuclear families in metropolitan cities; in this point, the rights and needs of individuals living with mental disorders who need treatment, care, housing, social support, income security, employment have moved to the top of the agenda. According to reports from conferences, speakers from different

organizations that deal with Turkish psychiatry, child and adolescent psychiatry, psychology, counselling and guidance, public health, nursing, psychiatry nursing, social service and child protection presented their recommendations and opinions on national mental health policy during these meetings. Apart from these associations, far-reaching discussions and nationwide polling were conducted in regional psychiatric specialty hospitals and provincial mental health departments so as to represent all actors in the field of mental health policy. However, as Munir et al. remark, that the representation of the Turkish public remained at a low level even though there was an effort to encourage participation in the consultation and policymaking process from the government (Munir et al. 2004, p.247). After a series of activities in line with the requirements within the call, a document was published in 2006 entitled the *Republic of Turkey National Mental Health Policy* (NMHP). In this document, the main reference is based on the World Health Organization (WHO) Service Guidance Package. The package consists of eight parts: (1) organization of services, (2) treatment and rehabilitation services, (3) child and adolescent mental health, (4) financing, (5) quality improvement, (6) legislation, (7) advocacy, (8) training and research and human resources.

The two destructive earthquakes in the northwest of Turkey paved the way for magnifying the existing deficiencies of mental health care services in the provinces. They have been categorized as “central disasters” that caused a transformative change in the community (Munir et al. 2004, p. 249). In the earthquake zones, national and international NGOs and professional associations came to the forefront in the provision of mental health services to earthquake survivors. Also, these earthquakes caused the transformation of the country in many respects, not just the public mental health system. For example, the level of

stigmatization of mental illness declined, and cooperation between national and international mental health professionals and associations became more productive. However, the main point is that there was an accepted consensus on the need for more comprehensive mental health services, training and research at the national, provincial and municipal levels. In this context, because the Marmara and Düzce earthquakes had serious impact on the country, they have opened "a window of opportunity" for developing a more modern perspective to mental health policy in Turkey (Munir et al., 2004, p. 249).

The 1980 military coup d'état in Turkey initiated the third period, and it can be split into two sections: first, before the 1999 earthquakes; and second, from 1999 until today. After the two destructive earthquakes in the northwest of Turkey, there were two projects — the Recovery Plan for Turkish Children (UNICEF) and the Marmara Earthquake Emergency Reconstruction (MEER) — designed to restore the living conditions of the earthquake survivors, support economic recovery and the resumption of growth, and create an institutional framework for disaster risk management and mitigation for the future. The scope of the MEER project extended the development of a national mental health policy for Turkey. Even if there were previous national mental health policy consensus and activities from the 1960s, these initiatives did not eventuate in a specified mental health policy framework until this project. The support of the General Directorate of Primary Health Care in the Ministry of Health also provided remarkable contributions in the introduction of the National Mental Health Policy in Turkey. In this time, professional associations and concerned interest groups participated in national councils, workshops, and symposia; they had a chance to express their ideas. On the other hand, the MEER project addressed the challenging difficulties that arose between the World Bank

team and its government counterparts. There were the weaknesses of the institutional set-up in the healthcare system of Turkey, the degree of institutional resistance among coalition parties, political difficulty on redistribution of ministerial responsibilities, and competing priorities coming from competing interest groups in this field (Munir et al., 2004; WB, 2007).

In conclusion, as Yılmaz (2012) emphasizes, mental health policies in Turkey concentrated on inpatient mental health services rather than outpatient and community-based mental health services until this policy change. This concentration on inpatient services is a significant problem; because it has failed to prevent mental health issues. The last stage of intervention in mental health services, hospitalization, became the first intervention in this mental health system. This situation is not compatible with a community and recovery-based mental health care model and individual rights of people living with mental health issues (Yılmaz, 2012, p. 22).

3.5 The emergence of mental health user groups in Turkey

Although there is not sufficient academic research on this issue, it can be stated that most non-profit organizations in the mental health field of Turkey have been founded by family members, mental health professionals and interested persons and/or professionals from the general public. They are known as a user groups and peer support groups, and they are organized as grassroots associations at national, regional and local levels. Their activities are based on volunteerism and mutual peer support; they have also provided cultural and occupational activities. They are involved in the formulation of public policy at the national level, and mental health practice and service development at the local level.

The first user group was founded as a diagnosis-specific group at Istanbul in 1996 by voluntary mental health professionals and family members. According to the founding member of the association, it was administered first by mental health professionals; however, it has been managed by users and their families for nearly 15 years. Diagnosis-specific groups of Turkey are established mostly for schizophrenia, and their number has reacted to nearly 30 across the country. It is known that most of these organizations have been founded and managed by family members and mental health professionals. They united under the national umbrella organization; this federation of schizophrenia associations consisted of nine diagnosis-specific groups in different cities of Turkey.

Additionally, there are two peer support groups: Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). They were started for people with substance misuse issues in 1988 in Izmir, Istanbul, and Ankara.

3.6 Conclusion

The history of mental health policy is closely linked to health and social policy. There are other studies related to Turkey's social policy history, but they have a limited information about mental health policies (Özbek 2002; 2006). At this point, Artvinli's study (2013) as a reference point, puts emphasis on the relationship between mental health history and politics from 1870s to 1980s in Turkey (Artvinli, 2013). In this regard, the historical background of mental health care policy and politics in Turkey from the 1870s to the present is examined under three periods: 1) the institutionalization of psychiatry and hospital-based mental health services; 2) the

introduction of community-based mental health care services in the Faruk Bayülkem period, and 3) the Yıldırım Aktuna period and the policy of deinstitutionalization.

The first period refers the institutionalization of psychiatry including neurology and neurosurgery in the years from the 1870s to the 1960s. Three remarkable changes took place in this era; first, the beginning of the medicalization of madness on 15 March 1876; second the establishment and restoration of mental health care hospitals across the country; and finally, the institutionalization of clinical and evidence-based Kraepelinian psychiatry among the Turkish psychiatrists.

The introduction of community-based mental health care model in the F. Bayülkem period constitutes the second period, and it points out a series of novel concepts in the provision of mental health care services in Turkey, starting from the beginning of the 1960s to the 1980 coup d'état. These changes in the treatment of mental disorders are referred to as community-based mental health services because these services have provided basically outpatient psychiatric treatment for the mentally ill. The introduction of mental health dispensaries and centers, a day hospital, a half-way house, and sheltered workplaces are also related with the socialization of health services and the integration of primary health care to the general health system.

The third period, in other words, the Yıldırım Aktuna period and the policy of deinstitutionalization, refers to the ongoing era of the 1980 military coup d'état to the present. It can be divided into two sections: the first is about the initiatives of Yıldırım Aktuna in the Bakırköy Psychiatric Hospital, and the second focuses on the effects of the 1999 earthquakes and the introduction of the National Mental Health Policy. Primarily, Aktuna's reforms decreased the number of inpatient patients as

well as psychiatric beds by discharging patients from mental institutions; these reforms of Aktuna were considered a partial policy of deinstitutionalization (Artvinli, 2013). He made a series of initiatives for discharging of mental health institutions and organizing donations and media campaigns to build new service units and facilities. The second section of this period includes the introduction of the National Mental Health Policy in 2006. After the two destructive earthquakes in the northwest of Turkey in 1999, the scope of the Marmara Earthquake Emergency Reconstruction (MEER) project was extended to the development of a national mental health policy for Turkey. The goals of this policy were to prioritize community-based mental health care services in Turkey and to organize an accessible and balanced mental healthcare service network in the whole country (Republic of Turkey Ministry of Health, 2006; 14-16). However, the MEER encountered challenging difficulties such as the weaknesses of the institutional set-up in the healthcare system of Turkey, the degree of institutional resistance among coalition parties, political difficulty with the delegation of ministerial responsibilities, and competing priorities coming of interest groups in this field (Munir et al., 2004).

Historically, the transformation of mental health care policies in Turkey is compatible with the general developments in the world; namely policy changes in this area are consistent with the overall global trends. For instance, the medicalization of madness and the institutionalization of psychiatry in the first period were experienced in parallel with the same process in other countries. This process of the institutionalization of psychiatry is related to well-accepted ideas in the world that were based on moral treatment, educational guidance of people living with mental issues and the establishment of hospital-based institutions for them. After that, during the 1960s, there was a transformative change towards a community-

based mental health care model and deinstitutionalization in both Europe and the United States. Because mental health hospitals had been criticized for overcrowding, inadequate funding, provision of care and alienation, they triggered the policy of deinstitutionalization. These developments also caused limited community-based mental health services and deinstitutionalization policy in the provision of mental health services in Turkey. On the other hand, the policy of deinstitutionalization was not implemented as rigidly as the example of Italy; and the development of community-based mental health care services have remained in limited capacity across the country compared to other European countries.

Consequently, it is worth noting that there were four common problems of the mental health system in Turkey within those periods; limited capacity of mental health services, overpopulation, stigmatization, and lack of state support. In this context, the current situation of mental health care policies of Turkey has focused on meeting urgent mental health care needs and finding permanent solutions to these ongoing problems. Today, there are three reference points in the making of mental health policy; one of them is the importance of providing mental health services at primary care level; the other focuses on the need to integrate such services within the general health care system; and the last one puts emphasis on the introduction of community mental health services in the province. The matter of regional inequities and appropriate allocation of resources to different regions in terms of the number of psychiatrists, psychologists, nurses, psychiatric beds and mental health centers have constituted other priorities in this field. However, there are currently five regional psychiatric specialty hospitals (in Istanbul [Bakırköy, a nationally recognized hospital], Adana, Elazığ, Manisa, and Samsun) that have carried the overall mental health burden of the whole country and have maintained extensive training and

research in mental health. They provide inpatient treatment, mostly for people living with chronic mental issues who have generally long lengths of stay at hospitals, but there are limited sources for community-based rehabilitation and social services in these hospitals. Since the introduction of the National Mental Health Policy in 2006, the number of community-based mental health care centers (Toplum Ruh Sağlığı Merkezi (TRSM) in Turkish) has been increased gradually since 2011 to provide outpatient treatment (Yılmaz, 2012, p. 16). Additionally, the general health system of Turkey has an ongoing problem in referral and follow-up for regulating applications to hospitals and for this reason, many patients have to apply to psychiatric hospitals directly, not only for tertiary care but even for primary and secondary care. This problem is also related to the unequal distribution of psychiatrists, hospitals, community-based mental health care centers, and social services in Turkey.

CHAPTER 4

USER GROUP PERSPECTIVES ON THE MENTAL HEALTH CARE POLICY REFORM

4.1. Introduction

In mental health systems around the world, the role of user groups has gradually become an important aspect of policy-making, planning, treatment, provision and evaluation of mental health care services. In the Turkish mental health system, those users have become a relevant group for mental health policy changes. However, Turkey has shown a slower development than European countries.

This study is based on 13 semi-structured face-to-face in-depth interviews with representatives of mental health user groups who lived in Ankara, Istanbul, and Izmir. The vast majority of these organizations are located in Istanbul, while one of them is based in Ankara and the other one is active in Izmir. These organizations were founded mostly by family activists, mental health professionals, and human right advocates; however, users were incorporated into administrative bodies. Only one of them was established as a peer support group that was led by a group of users, while another one became a user group organization as a result of a non-governmental organization project. Seven of the 13 respondents were users of the Turkish mental health system and they constituted the majority of the representatives of user groups. Only three of the respondents were primary caregivers with users in their nuclear family, and also, three had human rights advocacy expertise in the mental health area and they continue to represent their organizations.

The main objective of this chapter is to analyze the politics of mental health policy change from National Mental Health Policy in 2006 and the role of user groups within this transformation of mental health policies in Turkey. There are three sections in this chapter. First of all, I will explain the mental health policy change in Turkey from 2006 to onwards, and I will focus on how user groups have been interpreting this transition. The perspectives of the representatives about the policy of deinstitutionalization and their evaluation of these policies constitute the core of this section. Second, the main theme is user group criticisms of the transition to the community-based mental health care policy; they concentrate on problem areas including community-based mental health care institutions, stigmatization, labour market participation and employment, restricted access to regular income support and lack of housing support. In the last section, the role of user groups in the Turkish mental health system will be investigated to analyze their function and power in terms of both the policy process and their involvement in the planning, treatment, and provision of mental health services.

4.2 The policy of deinstitutionalization in the National Mental Health Policy of 2006

In 2006, the National Mental Health Policy (NMHP) was published by the Ministry of Health of the Republic of Turkey. The main aim of this policy document was to establish a national mental health policy framework which would be compatible with the principles and international standards of the World Health Organization (WHO). The NMHP was used as a reference document for future policies, questions, and discussions related to the development of mental health programs and strategies across the country.

The National Mental Health Action Plan was published by the Ministry of Health in 2011. The main point of this plan was to establish an accessible community-based mental health service network that provided user-centered mental health care and treatment. According to this plan, the users constituted the center point for the mental health system in Turkey and the establishment of the community-based mental health service model would be implemented in three stages: short-term activities in 2011-2012; medium-term activities in 2013-2016; and long-term activities in 2017-2023. As declared in these two statements, the mental health policy of Turkey has been undergoing a transformation from hospital-based mental health care services to the balanced care model, in other words, the society-hospital equilibrium model since 2006. The Turkish reform did not aim at full deinstitutionalization or the establishment of a completely community-based mental health care system (Yılmaz, 2012). In the present study, the policy of deinstitutionalization mainly implies the establishment of community-based care and achieving a society-hospital balanced model. Today, mental health care services in Turkey are mainly carried out by the public sector in both hospital settings and community-based outpatient centers. There are eight service fields, according to the size and population of the geographical region. There are nine state and three private psychiatric hospitals across the country. In the context of the "second generation" community-based services, day hospitals and rehabilitation centers were founded in Kocaeli and Istanbul in 2004 and 2006, respectively. As the first step in this transformation towards the community-based model, community-based mental health care centers were launched in February 2011. In the following section, the mental health policy change of Turkey will be analyzed from the viewpoint of user groups.

4.2.1 Approaches of user groups to deinstitutionalization

With the National Mental Health Policy and the National Mental Health Action Plan, a significant policy change started in the Turkish mental health system. During these developments, some common terms in the present study, including deinstitutionalization, community-based mental health model, and balanced care, were placed at the top of the policy agenda. Despite the increased use of these terms by the Ministry, mental health professional associations, non-governmental organizations and user groups, there is not a commonly accepted definition of deinstitutionalization. In the interviews, while some of the participants had general opinion on what deinstitutionalization is and how deinstitutionalization should be implemented, most of them did not have full knowledge in this field. As one of the respondents expressed that

> First of all, I want to say, now you are using the concept of deinstitutionalization, we are also using it, but now we are talking like a concept that everyone seems to be using. But, actually, it is not. When we go to the Community-Based Mental Health Center (TRSM) training, we are talking about deinstitutionalization, which is a concept that they have heard for the first time.
>
> (G5, Istanbul, female, human rights advocate)

As the respondent above stated, deinstitutionalization is not a well-known term, not only for users but also for mental health professionals and caregivers.

Inpatient care has long constituted an important part of psychiatric treatment, and it is closely associated with users' medical history. Studies show that users who have experienced inpatient care in psychiatric institutions tend to identify these institutions with their negative experiences of inpatient services and the problematic nature of hospital discharge in their lives (Glasby & Lester, 2005). Some of them have expressed that they are traumatized because of staying in these institutions

because of the environment of these institutions; they basically lost their freedom and privacy (Glasby & Lester, 2005).

There is no publicly available statistical data on involuntary and forced treatment in psychiatric hospitals in Turkey. However, according to the report of Human Rights in Mental Health Initiative Association (RUSIHAK), the rate of involuntary hospitalization and forced treatment can be between 70% and 85% (it includes forensic psychiatry units), and seclusion, prolonged physical restraint, and chemical restraint are frequent practices in psychiatric institutions of Turkey (Mental Health Europe, 2017, p. 171). At this point, two of the respondents' opinions of and experiences in mental health institutions might be given as an example from Turkey.

> We need to be an institution, we need those institutions, but these institutions are not solution-oriented. We put patients in these institutions, we put the doctor and the drugs into these institutions, so we treat them.
>
> (G2, Istanbul, male, user)

> When I stayed in the hospital, my days were passing between the four walls. I said that I drank a tea; I could not, I could not go outside, I was imprisoned. My only friend was just cigarette. There was a non-com (it means a nickname to refer the personnel who did cleaning in the hospital) and a nurse... They should put me in prison, but they should not put me in Bakırköy.
>
> (G4, Istanbul, male, user)

As the respondents expressed, the image of mental health institutions is mostly associated with negative thoughts and experiences. They thought institutions in mental health do not provide effective solutions to individuals with mental disorders. Even if there is not a shared definition of deinstitutionalization among the respondents, some of the participants indicate their opinions on what deinstitutionalization is, what they mean by deinstitutionalization and how the policy of deinstitutionalization should be implemented with community-based mental health perspective in this context. For example, one of the respondents interpreted what

deinstitutionalization means and she expanded the consideration of the development of community care for other user groups.

> Deinstitutionalization is absolutely not loneliness, leaving someone alone or discarding. On the contrary, as we say "institution" to a system in which all the life of both the cure and the life passes, the whole life is closed, the whole life has been regulated from the morning wake up hour, daily clothes to daily care and needs, that is the personal needs are decided by the institution. Deinstitutionalization actually comes out of this, that is to say, "everybody's needs are one and the same and this need should be met by that institution." It is to get rid of this understanding and also to destroy this understanding.
>
> (G5, Istanbul, female, human rights advocate)

There is a well-known and ongoing inadequacy in terms of both the size of the mental health workforce and physical capacity in Turkey. According to the National Mental Health Action Plan; there were 7,356 psychiatric beds for a total population of 73,722,988 people in 2011 (Republic of Turkey Ministry of Health, 2011). These rates were also very low compared to the OECD countries. The number of psychiatric care beds in Turkey was 6 per 100,000 population, while the 2011 OECD average was 68 (OECD, 2014 p. 112). The number of psychiatrists per 100,000 population was less than five; while on average, there were 16 psychiatrists per 100, 000 population across OECD countries (OECD, 2014 p. 178). The number of other professionals working in mental health i.e. psychologists, nurses, and social workers, was also lower than in other countries. For instance, the number of mental health nurse was less than 3 nurses per 100,000 population in Turkey, while the OECD average was 50 mental health nurses per 100,000 population (OECD, 2014 p. 180). The data on psychologists also fell behind the OECD average; Turkey had 2 psychologists per 100,000 population and the OECD average was 26 in the same year (OECD, 2014 p.181).

Despite the inadequate service and human workforce capacity, mental health issues have continued to arise in the society; according to Ministry figures, the number of applications to health institutions with psychological complaints increased 27.7% between 2011 and 2016 (Hürriyet, 2017). Nevertheless, the existing service capacity is not sufficient to handle this increasing demand.

Although it is known that deinstitutionalization refers to decreasing the number of beds in psychiatric hospitals and to maintaining treatment in the community, some participants objected to reducing the number of psychiatric beds in Turkey.

> Why do not I agree (with the policy of reducing beds)? I think that the policies that are actualized will vary according to the conditions of the country. When talking about 600,000-700,000 individuals who have already been diagnosed, 10% of the mental health hospital beds should be protected, no matter what the number of beds. We can call them expanded community-based mental health centers.
>
> (G1, Istanbul, male, primary caregiver)

As observed in the quote above, respondents emphasized that there is an ongoing shortage of mental health professionals and the lack of mental health services, and they approached deinstitutionalization with hesitation due to a limited number of professionals and lack of availability of services.

4.2.2 User group opinions of the deinstitutionalization of the Turkish mental health system

There is an ambiguity in the definition and content of deinstitutionalization. Respondents, however, generally identified deinstitutionalization with the newly opened community-based mental health care centers. During the reform process, the

scope of community mental health services has been expanded towards halfway homes, sheltered homes, day hospitals, other tertiary prevention and rehabilitation facilities, and sheltered workplaces. These services include preventive mental health care and programs, psychosocial treatments, follow-up, and treatment of the users in the community after the completion of the acute treatment in hospital. These services, with the exception of sheltered workplaces, are principally operated by the Ministry of Health.

The community-based mental health centers are planned to provide services for individuals with serious mental illness and their families in the relevant geographical region. The users are informed and their treatments and therapies are followed closely by the mental health teams in these centers. According to the Regulation on Community-Based Mental Health Centers, each team should include a psychiatrist, psychologist, nurse, social worker, ergo therapist, occupational therapist and other assistants (Republic of Turkey Ministry of Health, 2011). However, the lack of mental health workforce constitutes a tough obstacle for the establishment of the planned team in the instruction. These centers distinguish themselves from hospital-based services by providing rehabilitation, work and occupational therapies and workshops. One participant describes these centers as follows:

> There are hobby areas. There are wood painting workshops and sports activities. There is an area where people can sit and drink tea and they can have a conversation.
>
> (G3, Istanbul, female, user)

The National Mental Health Policy in 2006 provided a basis for the transition to community-based services in mental health policy. One of the respondents thinks that the United Nations Convention on the Rights of Disabled Persons in 2009 was related to this transition.

> In 2009, the government published something like the UN Convention on the Rights of Persons with Disabilities. Until this disability-rights treaty, the state had no mental health law, so there was a disability administration under the Prime Ministry. Disability management was an organization without an executive power, it just stayed on paper. So, the Republic of Turkey went to the declaration of the rights of disabled people that was published in 2009, the government at the time took this signature, it became a party. So, the government says that I accepted them and I will arrange my rules according to your conditions and I will change. First of all, the Ministry of Family and Social Policy was established suddenly. Until that time, there was not such a thing. Every article brings something and all institutions must fit them. In other words, the community-based mental health care centers were opened suddenly in order to comply with the disability rights declaration.
>
> (G13, Ankara, female, primary caregiver)

As the respondent above pointed out, Turkey signed this agreement in 2009 and it has influenced many aspects of Turkey's current disability policy since that day. According to the respondent, the establishment of the Ministry of Family and Social Policy and the community-based mental health centers were two main results of this agreement.

It is an important finding coming from one participant that while deinstitutionalization requires a more systematic and holistic viewpoint to transform existing institutions, this kind of holistic viewpoint is lacking in this reform.

> Mental health policy requires a general overview. It requires gathering the Ministry of Health, the Ministry of Justice, the Ministry of Internal Affairs, the Ministry of Finance and the Ministry of Finance. It is a dimension in itself because you say that I will change the system and the size of the finance is very important, it is the same in the foreign countries. These are such huge transformations, I see the lack of a most systematic view. All the relevant parties should come together, and the second thing it needs is well-conducted research.
>
> (G7, Istanbul, female, human rights advocate)

As the respondent above stated, there is a lack of a holistic viewpoint in the transformation of the mental health policy in Turkey. There are other criticisms of this reform and they are directed to its contents. For example, one of the respondents

expressed her analysis about the context of community-based mental health centers as follows:

> The targets were good, the transition to community-based politics was mentioned for the first time, it was the first legal text. So, it's definitely an important step. Yes, the TRSM was opened and it keeps on opening; when it first started, it was very fast and then it slowed down, but the content… Unfortunately, they have become a little more like restructured hospitals.
>
> (G5, Istanbul, female, human right advocate)

As the respondent above emphasized, National Mental Health Policy in 2006 was a remarkable development because it paved the way for the establishment of community-based services. However, the existing services that the community-based centers provide do not differ from the services that mental health hospitals offer.

On the other hand, the policy of community-based services was also interpreted with a sceptical point of view; because it was not seen as a user-focused policy. As emphasized before, the financing of mental health treatment and care services constitute one of the impulses behind deinstitutionalization. According to one of the respondents, the reason for this transformation to community-based services was related to financial reasons in the context of Turkey.

> But if you go to such a policy, it is to reduce the costs in Turkey. The patient who stays in the hospital costs electric, water, food and drugs, so I do not think that it is done as a patient-focused change.
>
> (G10, Izmir, female, human right advocate)

User satisfaction is described as "a key goal of a responsive health system" (Stokes et al., 2015) and there are two important criteria in evaluating and increasing the satisfaction among service users and service providers in the National Mental Health Policy. While general satisfaction with all health services tended to increase steadily between 2006 and 2012 (Republic of Turkey Ministry of Health, 2009; 2011), there

is currently no statistical data on users' satisfaction level for community-based and hospital-based mental health services.

On this point, the trends for user satisfaction levels in all health services can provide an insight that leads us to think about three factors: the waiting periods, the complexity level of hospital operations and procedures, and the time period allocated per patient. For the mental health system of Turkey, the most stressed effect of community-based mental health centers is to provide easier access to drugs, treatment, and therapy. For instance,

> Quick access to drugs is important, there is a physician, a nurse there etc. It is close to family physicians. There is also quick access to psychiatric treatment and yes, it is important to have easy access to health.
>
> (G5, Istanbul, female, human right advocate)

As the respondent above emphasized, access to medical support and medications became easier after the reform. Most of the participants in my fieldwork shared their experiences with mental health settings in Turkey; they said that there was a change with the opening of community-based mental health centers in terms of easier access to mental health treatment and care. For instance,

> I think it is going well, I am looking positively. Why, you ask? I am telling you because I lived in Bakırköy Psychiatric Hospital between 2006 and 1994, the Erenköy Psychiatric Hospital and the Alcohol and Drug Addiction Treatment Centers (AMATEM), and we passed a very troubled period. But now I can give my blood, take my drugs within half an hour in my health care center. I have a psychologist and a psychiatrist who can explain myself to when I am feeling stress. It is a very big blessing for me.
>
> (G4, Istanbul, male, user)

As the respondent above stated, the establishment of community-based services has made life easier for users. Two of the participants also compared their old and new experiences in mental health institutions.

> I am against the closure of the hospital, but I want the activities around the hospital to multiply. I agree with the opening of TRSM, we need psychiatrists and psychologists to continuously understand ourselves. When I was going to check the hospital in 1994, we had the following rule: we went to the emergency room in the morning, and when we took the file out of the polyclinic, we went to the doctor first, then we went to the doctor for blood, then we went to the doctor again. You did not go to stay in the hospital, but you went there as an outpatient, but it is very difficult, I went there a day in a week or a day within ten days; it is a torment for me. But now our day hospital works as good.
>
> (G4, Istanbul, male, user)

At this point, it is an important finding that users' new experiences in mental health institutions are more positive than before. Additionally, the establishment of the community-based residential facility was also seen as another improvement by one of the respondents.

> We have advanced from that day to this, the opening of nursing homes is promising. According to the old system, it is better.
>
> (G6, Istanbul, female, not user)

It is seen that although there is no available statistical data on user satisfaction with mental health services, the strengthening of primary health care, the opening of community-based centers and community-based residential facilities have had an impact on mental health treatment and care for users. For example, one of the participants described the mental health centers as follows:

> It responded to a great need here. On the one hand, there are also rehabilitation workshops, for example, I use the music workshop. This is like an oasis in the middle of Istanbul and it is one of the best places in the country.
>
> (G12, Istanbul, male, user)

On the other hand, Prior (1991) suggests that the development of community-based care for users is related to a shift in the psychiatric discourse over time—from a biomedical model to the mentality of shared responsibility and social networks among different stakeholders. In our case, the transition of Turkey's mental health

institution is open to debate in terms of whether it can provide services in a community setting. Participants who are more familiar with the term of deinstitutionalization say that existing mental health centers have continued to serve in hospital-based service mentality rather than a community-based one. For instance,

> You call 40 or 50 people to the community-based centers. My friend says that I am covered by insurance for example, he left the association and started to go to the community-based center. I ask why and he says that I am covered by state security. He does not have a guarantee, he takes half of his mother's monthly pension, and he lives alone. He says that when I go to a place, I have a guarantee. Maybe, he does not have too much money, he needs to eat in there. It is also a humiliation; you need to eat, then there are psychologists, psychiatrists, nurses who are making money, but it does not work. In fact, it is not deinstitutionalization. It may seem good to collect them and educate them there, but the content is also very important. Do you reach your goal, can you cure him, can you give him a job, a girlfriend, a marriage…? These are very important.
>
> (G2, Istanbul, male, user)

It is seen that the ongoing processes in community-based mental health centers and the policy of deinstitutionalization differed from each other from the perspective of one of the respondents. It is not a negligible issue the respondent laid stress on the importance of the content of community-based practices in these centers. There is some criticism on the existing hospital-based practices which the respondents referred to. For example,

> There are only psychiatric hospital-based practices. Community-based practices are low and they do not have enough staff. There are not enough psychologists, psychiatrists, social workers or psychological counsellors who provide mental health services at schools, compared to the population of the country. The education system is really inadequate. For example, at least a core education program was established for pediatric psychiatrists or adult psychiatrists, but there is no standard training program for psychologists, psychological counsellors, or social workers.
>
> (G10, Izmir, female, human right advocate)

As emphasized above, according to the participants, the policy of deinstitutionalization has been squeezed in hospital-based practices. The lack of

mental health workforce and the inadequacy of the education system in the mental health area constituted two problems.

As stated by the World Health Organization, preventive mental health services should be disseminated and integrated into primary health care services. Mental disorders prevention is a comprehensive and holistic policy; it is based on reducing prevalence, recurrence of mental illness as well as symptoms, or the risk condition. It includes preventive policies for people with mental illness, their families and the society (WHO, 2005). However, psychiatric-based mental health services are more prevalent than preventive mental health services in Turkey. Two of the respondents also criticized the insufficiency of preventive mental health services.

> I look again, it says that the medical and psychological care in the psychotherapeutic intervention. It means that they have to give them together. Here, too my patients, so many patients say that I do not want to go to psychiatry, I do not want to use medication, I want to try to heal with psychotherapy. Yet, how does the system work in the public sector? In the hospitals, patients must first go to a psychiatrist, he/she cannot directly go to a psychologist. Then you have the right to refuse his treatment. He has such a right, that is, he has the right to refuse treatment as long as he does not seriously damage himself or herself. He has the right to choose the specialist of his choice, and this right has been taken away.
>
> (G10, Izmir, female, human right advocate)
>
> So, there are no preventive mental health services, this issue was also spoken about this mental health law. Preventive mental health services are very weak. For example, community-based mental health centers serve people who have been already diagnosed. It closes its doors to people who have never been diagnosed, who are prone to violence and who have not yet been diagnosed. So, they have no mechanisms locally.
>
> (G5, Istanbul, female, human rights advocate)

The transition to community-based services has facilitated the development of effective preventive programmes and policies; but it is clear that more initiatives are needed for the whole population, including groups at risk.

The dominance of the biomedical model has affected the lives of people living with mental issues, not only at the point of treatment but also in other institutions. It might also lead to the medicalization of social problems in this context. For example, one participant claimed that this authority of the biomedical model is a factor that makes life difficult for these individuals and that it affects other areas of life outside the hospital.

> Of course, in diagnosis, medicine is very important. No one can take its place, but in the process of treatment and other parts of the life of that individual, medicine should now be taken to the other side, taking the second role and transferring this issue to other institutions. The process should be lifted out of the hospital setting; then, the relationship with your state will become more humanitarian.
>
> (G5, Istanbul, female, human right advocate)

4.3 User group criticisms of the lack of social support in the community-based model as practiced in Turkey

The policy of deinstitutionalization requires major changes in the organization of care for users and collaboration between families, the health system, social welfare services, and other relevant institutions (WHO,2003a). In this regard, deinstitutionalization has a potential to increase the quality of life of users and to reduce their isolation and stigmatization against them.

Deinstitutionalization also has a potential for the adaptation of the recovery movement. Rather than the traditional cure-oriented approach, the recovery movement has been defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful, and contributing life, even with any limitations caused by illness" (Anthony,

1993). Recovery is not a linear process or an outcome and it is basically about the improvement of an individual's strengths and capacities by mobilizing formal and informal support systems. According to Anthony (1993), the recovery model in a mental health service system requires a community-based service network and other support mechanisms across the country. In this framework, these support mechanisms are used to enhance the recovery process among individuals with mental disorders and they are related to accessing to the labour market, regular income support, and housing support.

In sum, the sufficient provision of community-based services undertakes the very important role to provide social support and to enhance the recovery process for individuals with mental disorders in every aspect (Yılmaz, 2012). However, there are fundamental criticisms of user groups about the lack of social support mechanisms (tackling stigmatization, employment support, regular income support, and housing support) in the new mental health policy.

4.3.1 Shortcomings of the newly established community-based mental healthcare institutions

Despite the fact that these centers have responded to an important need and made a positive impact for many users, they have also criticized their medical interventions for having a narrowly-based medicalized conceptual framework. It is based on the usefulness of a medical point of view, and de-hospitalization is not seen as a threat to the psychiatric model. In this thesis, the quality of community-based services has been questioned in terms of their effects on users' recovery process by two of the respondents. For example,

> There is only medication treatment, the therapies do not treat them like a real person, these therapies are done as entertainment. There is an adult person here, but they see him as a child and when they do a therapy, I feel that, there is no such a view that he is an adult and he can recover or take responsibility for his recovery.
>
> (G7, Istanbul, female, human right advocate)
>
> The community-based mental health centers seem to serve the established purpose but they do not respond to the different needs of individuals. So, there is no socialization here by collecting those people and doing wood painting. People do not make their own choices again.
>
> (G5, Istanbul, female, human right advocate)

The other contradictive issue is about mental health professionals who are working in these centers. When it comes to the balanced distribution of personnel, it is quite important to increase the quality of both services and team members. For this reason, the service providers should be specialized in the mental health area; it will be a more effective way to reach users in this way. However, one of the respondents indicated that the time of examination remained limited and the method of treatment was based on drugs.

> So, when we go to the examination, in general, they listen to us for 10 to 15 minutes at most, and when we talk about our problems, the solution is definitely a drug. It is a fact.
>
> (G3, Istanbul, female, user)

In Turkey, a study conducted on 45 community-based centers indicates that the working personnel in these centers consisted mostly of nurses (24.7%) and auxiliary staff (24.7%), while the number of psychologists was 15.1%, and psychiatrist were 12.6% of the total number (Bilge et al., 2016). The high number of nurses and auxiliary staff in the centers may be a positive power for our case because the role of community mental health nursing is essential for improving community-based mental health services. Nevertheless, mental health nursing requires a master's

degree in mental health nursing; and the number of specialist mental health nurses is not a sufficient number for the whole country. Two of the respondents criticized community-based practices in these centers. For instance,

> This policy is inadequate, okay, the patient will heal in society, nobody can deny it. But we send the patient directly to the community-based center without preparing the patient.
>
> (G6, Istanbul, female, primary caregiver)
>
> It is missing because it is not framed right. There is not much activity in the community-based center. The doctor is trying to carry out these services from the public education center with a service procurement tender but the public education teacher says, "I do not serve in the same room with schizophrenia."
>
> (G13, Ankara, female, primary caregiver)

As emphasized above, the transformative power of mental health nursing is not evaluated as enough in my fieldwork, the participants mentioned that the services are not adequate for them in terms of both quality and quantity.

4.3.2 Stigmatization

Stigmatization in the context of mental health is associated with a chronic negative attitude towards people living with mental issues. It is based on discriminative attitudes and behaviours and it may reveal a social sanction (Goffman, 1963). There are two different types of stigma that may cause different effects, including fear, isolation, authoritarianism, and benevolence (Corrigan & Watson, 2002). The first stigma type is the social stigma, which is derived from psychiatric labels and it has prejudicial beliefs and behaviours towards people living with mental issues. Perceived stigma is the second one: the internalization of discrimination and individuals with mental disorder have self-prejudicial opinions against themselves

(Corrigan & Watson, 2002). Perceived stigma is also described by one of our participants in my fieldwork.

> Patients have also tedium, isolation of oneself; they have stigmatized themselves.
>
> (G2, Istanbul, male, user)

According to Thornicroft (2009/2014), there is no declared country, society or culture that individuals with mental disorders and other people have been evaluated as equal to each other. Even if there are not many comparative studies in different countries, the emotion of self-shame and the experience of accusation and discrimination are two common patterns where stigma are examined (Thornicroft, 2009/2014). Additionally, three important causes of stigmatization are ignorance, stereotypes, and discrimination, and the process of stigmatization consists of four periods as labelling, stereotyping, discriminating, and losing stature with denial and isolation (Thornicroft, 2009/2014). In our case, the cause of stigmatization was expressed over an effect of a narrowly-based medicalized conceptual framework by one of the respondents.

> Because the system is going through the medical system, there is a diagnosis that is given by the medical authority; even if you are an adult or child in the mental health field. Of course, this is not a problem. Of course, the medical authorities will diagnose; but the other public institutions that include the administrative courts, the school, the university, the institution that can be encountered in any area categorizes you by using your diagnosis and completely separates you from each other. In other words, we say that there are prejudices in society, but all institutions of the society are also moving through these prejudices. The society just imitates it.
>
> (G5, Istanbul, female, human right advocate)

As for the behaviour of stigmatization, the ignorance about mental disorders is also similar across the world, regardless of differences between countries. There is a

series of studies in different countries, including Germany, Greece, Poland, and Turkey. According to the Turkish studies, the 208 adults in a village near Manisa, Turkey thought that individuals living with schizophrenia are aggressive and should not be free in the community, and 61.5% of the sample did not want to be a neighbour of individuals living with schizophrenia, and 61.1% of the sample would not rent their homes to them (Sartorius and Schulze, 2005). In this regard, one of the respondents shared his experiences on stigmatization.

> This society is ignorant about mental health. You have a big trouble but telling it to others is also a big problem. You are told that you have physical health, you have reasoning; so, you do not want to work because you are lazy. You have to answer these kinds of accusations. Yes, stigmatization also comes from there, the family and the social environment.
>
> (G12, Istanbul, male, user)

As emphasized in the second chapter, the stigmatization and discrimination against individuals with mental disorders have manifested themselves in two ways in Turkey (Ozmen et al., 2004). The first is a tendency to accuse individuals of imagining mental disorders; and the second one is on social distance (Ozmen et al., 2004). The stigmatization in Turkey has caused a situation that has isolated needy mental patients from the rest of the society or has left them in an unprotected position. The effect of stigmatization is a common pattern that users have encountered with different types of stigmatization in their lives; and they indicated that there is also an ignorance about mental disorders. For instance,

> My trouble started with stigmatization because I could not find anyone to talk to, I could not tell anyone I was addicted to drugs and alcohol. For about a decade of my life, I was offended by people; I left myself alone. Nobody understands me, I already had a stigma; I was labelled as crazy. Being used and stigmatized. I want them to treat us like human beings, everyone may be in trouble like us, everyone is a candidate for illness; so, I have been suffering for 24 years because I did not tell this.
>
> (G4, Istanbul, male, user)

4.3.3 Obstacles to labour market participation and employment

It is a known fact that many people living with mental issues have more difficulty finding work and protecting their existing jobs than other people. Business affects mental health positively because it offers the use and control of skills, new opportunities, purposes, and economic resources. It is also related to having a respectable social position and personal contacts. On the other hand, having a mental disorder is one of the obstacles to participation in the workforce across the world; and one of the causes of this situation is stigmatization. For example,

> It is not possible to find a job because of this illness. There are very well-qualified ones among them; they graduated from two universities, there are engineers, lawyers among them. Then they can only work if there are part-time jobs. There are too many problems. There were two reasons to open this café, one of them was to prove that schizophrenic patients could work, and the second one was to break the prejudice.
>
> (G13, Ankara, female, primary caregiver)

Employers are reluctant to hire people with mental illnesses. In fact, most of the countries have legal orders to employ of disabled workers; employers have to fill the disabled labour quota in their own workplaces, but they remain reluctant. According to research on national workforce surveys from the United Kingdom, the proportion of employed people with a physical disability in the general population is 65%; while the proportion of employed in the general population people with a psychological disorder is 20% (Thornicroft, 2009/2014). Another study indicates that the attitude of employers varies for physically disabled persons and persons with mental disorders; 60% of these employers stated that they recruited physically disabled persons, but less than 40% of them would think about hiring a person with mental disorders in their workplace (Thornicroft, 2009/2014). Similarly, in Turkey's case, individuals who have mental issues are more disadvantaged than those with physical disabilities

in the field of recruitment. Our participants referred to their experiences to illustrate that persons with mental disabilities are more stigmatized than people living with physical disabilities in working life.

> There is already a stigmatization in the field of disability; but there is a different stigmatization in the field of mental health among the other disabled people. When there is a note of "mental disorder" in your report, he avoids you, he does not recruit you. Plus, there is a problem of the guardianship related to your circumstances during the work. In fact, this problem is related to public opinion, if something will change in any case, the society has to do something.
>
> (G2, Istanbul, male, user)
>
> Apart from that, there are common prejudices against our illness in the society; we have to work on this issue. There are friends who can find work opportunities. For example, they want to work, they are going to the workplace. We are assessed according to our disability status, so employers are asking what is your disability and he says that I have a psychiatric illness like schizophrenia, employers do not hire him. They hire other handicapped persons, but the workplaces are scared of people with psychiatric disorders. There is such a disadvantage.
>
> (G11, Istanbul, male, user)

As stated above, there is a more negative attitude toward individuals with mental disorders, and it constitutes an obstacle to their labour market participation and employment. One of the respondents emphasized that it is also a common behaviour in the public sector.

> I understand that the supervisors in the workplaces have thought that disability means only physical disability; so, they do not think of mental disorders. For example, the director of my daughter said to me that the state will do something like I will pay a salary of 1,000 TL in every month for these patients, he said that they cannot work in such places. But there is also a child in a wheelchair in the room; there is a disabled person. So, he works but when it comes to our patients, everyone is afraid that they may be hurt.
>
> (G13, Ankara, female, primary caregiver)

In Turkey's mental health policy, another obstacle to participating in employment is associated with the insufficiency of vocational rehabilitation centers. These centers, as a part of community-based services, assist people with disabilities at the point of

employment. Various services from these centers provide jobs and maintain the employment for them. The focus group of vocational rehabilitation is the person who has a physical or mental impairment, and the main goal is to break the barrier to employment. Starting from the 1960s, community-based mental health services were started with the opening of a day hospital, community mental health clinics, sheltered workshops, supervised work placement, and half-way homes. Occupational therapies, courses, and sheltered workshops were included in the treatment procedure. However, there was a decrease in the community-based services during the 1990s (Yazici et al., 2007). As a part of the National Mental Health Policy, these services were re-established in the psychiatric hospitals in the 2000s. However, one of the respondents evaluated the function of vocational rehabilitation as quite insufficient. For example,

> The main problem is that we do not have a rehabilitation center after the outgoing from the hospital. They will be rehabilitated first and after the rehabilitation center, there is no vocational rehabilitation center. We do not have programs for recruitment and placement.
>
> (G6, Istanbul, female, primary caregiver)

Despite the prejudices, the desire to work is higher among individuals with mental illness. For example, based on the research of people living with mental illnesses in Britain, while 52% of people with various disabilities responded that they wanted to work, this rate increase to 86% among people with mental illness, phobias, and/or panic disorders (Thornicroft, 2009 p. 57). Even if there is no statistical data on the thought of work among individuals with mental disorders in Turkey, the desire for labour market participation was also indicated in my fieldwork.

> Young people do not always have to go to these community-based mental health centers. Some of our friends do not want to work, but we also have friends who want to work. They need to be able to provide workplaces and they need to help in order to socialize.
>
> (G11, Istanbul, male, user)

Today, according to the disabled staff statistics of State Personnel Directorate, the number of the current office staff is 2.051,578 while the number of quotas for disabled staff is given as 61,728 (State Personnel Directorate, 2018). The total number of disabled civil servants in this quota is 51,814. The number of employed officers with orthopedic disabilities is 14,854; the number of sight-disabled people is 10,360; while the number of employed officers with emotional and mental disabilities is 1,289; 243 of them are female and 1,046 of them are male (State Personnel Directorate, 2018). A collaboration between different stakeholders i.e. employment agencies and community-based centers to create job opportunities for individuals living with mental issues was proposed by two of the participants.

> We are pleased with the functioning of the community-based centers. We are also pleased to say our expectations that we are now adding that these centers are fully working and supporting, but there are people who are taking rehabilitation; there are young people. These centers ought to have a protocol with the Turkish Employment Agency and the employment expectations of the members from these centers ought to be met. I say it will not be life-long rehabilitation.
>
> (G11, Istanbul, male, user)

> According to their skills, the patients take courses, they are trained and they are placed in the workplace, like a protected workplace. Here, we closed the hospital; so, you come to the community-based mental health centers. What are they doing? They have nothing more than what we do, there is less than we do. What makes them superior to us? The doctor, the nurse, it is okay, I cannot say anything; but the rest is a run-around. Make a picture etc. It is not enough. They need food, they need to work.
>
> (G6, Istanbul, female, primary caregiver)

4.3.4 Restricted access to regular income support

The issue of regular income support for people living with mental issues in Turkey can consider with the disabled pensions and the home care support. The foundation of these supports' dates back to 1976, with the approval of Law 2022, which provided a small monthly benefit payment for the elderly or the disabled poor. With the adoption of the Turkish Disability Act in 2005, an increase in the disability pensions was regulated. The category of psychosocial disability was included in the Disability Act that was enacted in 2014.

According to the relevant articles of Law 2022, when people with disabilities over the age of 18 are in economic deprivation, they can benefit from a disability pension, a regular cash payment paid in three consecutive months. If the disabled person is under the age of 18, the family can undertake responsibility for him or her to benefit from the income support. However, they have to prove their degree of the disability by presenting a medical board report, which is given only by authorized health institutions. The degree of disability has to be above 40%; disability entitlements and pensions are tied to this percentage in the medical report. Also, there are two additional criteria for entitlements to the disability category. First, the income level of the household must be below a determined level; second, there must be no close relatives who can undertake the financial responsibility for the disabled person. In my fieldwork, the eligibility criteria for the disability category are also criticized. For instance,

> My daughter was diagnosed at her early age and she could hardly feel the economic strain in the economic sense, she was also a girl, but the parents are experiencing this financial distress. Now, the constitutional safeguard is valid until the age of 18, who's going to look after my daughter after the age of 18? Let's say the family will take care of her, what kind of support did we give to the family? Now let's say that there is a very interesting thing about home care support; the monthly income of household members should not exceed two out of three of the minimum wage. 950 TL approximately, 950 * 3 = 2,850 TL is enough for you. Let's say we do not give it anymore when it is 2,851 TL. In this case, the relatives of the patient try to increase the number of residents in their homes. We are fooling each other on paper.
>
> (G1, Istanbul, male, primary caregiver)

According to the Mental Health Europe (MHE) report, the scope of disability-related allowances does not include personal assistance and personal budget system (Mental Health Europe, 2017). The main caregivers of the disabled person are their family members, and the family has a right to use the disability pension and home care support. However, some service providers and NGOs indicated their suspicions on this issue that this money has been used to meet for daily expenses of the family and rather than for the wellbeing of the disabled person (Avşaroğlu, 2018). In this regard, people living with mental issues are mostly tied to their guardianships and they indicate their expectations in terms of financial support. For instance,

> They could be financially more supportive.
>
> (G3, Istanbul, female, user)
>
> They have financial troubles and in fact, they are mostly tied to the hospital. It is also a big problem.
>
> (G5, Istanbul, female, human rights advocate)

In the point of medical board reports, there are also some critical issues. First, the percentage of the disability can vary among different health institutions; and the disabled person has to apply more than one hospital to take their medical board reports in this process. Second, the appointments for obtaining of the health board reports are full-capacity; and new appointments are not be given in a short time.

Thirdly, the validity of this report is often limited to 2 years and it is a recurrent process every 2 years. These three issues were also referred by two of the respondents in my fieldwork.

> The disability pensions are a disgrace, plus the fact that our children who receive the disability pensions is disgraceful and having to repeat the medical board reports is also a disgrace.
>
> (G1, Istanbul, male, primary caregiver)
>
> When a physically handicapped person retires, he or she can work according to the disability rate. There is no objection, but our siblings who have schizophrenia cannot work when they are retired. The report is being renewed, and a sibling who is 60 years old is classified as recovered and the disability pension is cut.
>
> (G1, Istanbul, male, primary caregiver)

As the respondents stated, people living with mental issues are generally tied to their legal guardianships because they do not have their own source of income. Their expectation is to take regular financial support in order to break their dependency.

4.3.5 Lack of housing support

Mental illness may also have an effect on housing. The issue of housing is a distinctive field where exclusion and discrimination can be observed more clearly. In the past century, we have seen that large mental health institutions served as a long-term residence for people with mental disorders. With the policy of deinstitutionalization, the role of these former institutions in housing has been transferred to long-term home-care services in the community in different country settings. According to research, long-term home care provided in the community is less costly and it is also preferred by most users (Thornicroft, 2009/2014).

Community-based institutions offer a more qualified life than the large, isolated hospitals (Thornicroft, 2009/2014).

Even if there is a demand from users to live in community-based institutions, a phenomenon of "not in my backyard'' is used to express stigmatization on the issue housing. This phrase represents the tendency of people to oppose community-based services being established in their districts (Thornicroft, 2009). There are basically two arguments that come from the opponents. They tend to ensure their security and the value of their properties because they think that individuals with mental disorders may be dangerous and they may cause a decrease in the value of properties in this neighbourhood (Thornicroft, 2009/2014).

The types of housing and the duration of life with the family among cultures are two different factors in the topic of housing. In Mediterranean societies, where the protection of the family is predominant, adult individuals tend to live together with their families (Thornicroft, 2009/2014). This divergence between different countries also causes variability in housing policies applied to individuals with mental disorders.

In the context of Turkey, the role of family is constructed as the main caregiver with an attitude of protectiveness towards their family members; and they normally take full responsibility for them. It may recreate the dependency of individuals with mental disorders in their families. Community-based residential support is quite limited; the concept of residential support is based on "hope houses" that have been established across the country in order to provide community-based social care for people living with mental issues. Since 2016, 140 hope houses have opened as a part of community-based residential support across the country, and part

of them are reserved for individuals living with mental issues. Nevertheless, one of the respondents said the following:

> I had an experience with hope houses, which are half-way houses for people who are like us, for people who do not have economic power or family, but these hope houses have a manager of the institution and institutions have tended to protect (us).
>
> (G2, Istanbul, male, user)

Although people living with mental issues prefer community-based facilities for housing and long-term care because of a better life compared to old mental health institutions (Thornicroft, 2009/2014), but the example of “hope houses” in the Turkish case was evaluated as restrictive by users.

4.4 The role of user groups in the Turkish mental health system

With the introduction of new care models in health provision such as the person-centered approach, the recovery model, and shared-decision-making, the involvement of service users and their caregivers in health care came to the fore in order to reshape the services (Wallcraft et al. 2011; Storm& Edwards, 2013). This policy has been promoted by the World Health Organization; it argues that user involvement is essential for improved service quality (WHO, 2005). The development of patient-centered mental health care services requires the elimination of the lack of representation of service users and their caregivers.

According to Tritter (2009), the term “user’’ and “caregiver involvement’’ described a "way in which patients and their families will be able to draw on their experience and apply their priorities to the development, organization, delivery, and evaluation of the mental health services" (p. 276). User involvement is categorized as

direct or indirect, individual or collective and proactive or reactive in this context. The method of “indirect involvement” is used in the mental healthcare area because users and their caregivers have been invited to generate information by decision makers; however, the final decision is taken by the decision makers (Tritter, 2009). The individual and reactive involvement are indicated as other categories in the mental healthcare area (Samudre et al., 2016).

Over the last four decades, there have been mental health policy interventions to increase the number of service users and the involvement level of their caregivers in policy making, planning, service delivery, service monitoring and evaluation, training, advocacy, and research. In this regard, the involvement of users is categorized as two levels: first, the formulation of policy at the national level, and second, service development at the local level.

4.4.1 Attitudes towards user participation in policy processes

When the large mental hospitals facilities transformed into smaller mental health services in general hospitals and community-based centers, the place of psychosocial support also changed to a local and municipal context. It is argued that the welfare system has become more fragmented in several Western countries; as a result, the deinstitutionalization process has brought an expansion in the number of actors i.e. private companies and alternative providers (Markström & Karslsson, 2013). Although there is not an equal or linear development across countries and regions, the roles of service users and their caregivers are in a stronger position than they were previously.

There are several models of user involvement in the policy process. Apart from self-help, the provision of services outside the public sector, advocacy, anti-stigma, and public education initiatives, there is also lobbying and political activism to influence policy and practice. The user groups may become stakeholders to participate in the planning and delivery of mental health services. In this point, the user involvement at the policy level is used to increase patients' or patient organizations influence on the delivering of mental health services (Rose et al. 2002). The main motivation of the user groups as grassroots organizations focuses on the issue of patients' rights and they have some initiatives on laws, official policies, and practices in this area. On the other hand, the political effectiveness of these organizations has been questioned; for example, political advocacy and service provision are known as two functions of the non-profit user organizations in the Swedish mental health care and support system. However, the role of user organizations has remained limited and dependent on the goodwill of the government at the national policy level (Markström & Karslsson, 2013).

The role and power of user groups in Turkey's mental health system have increased over time; however, their effect has not still reached the expected level in the eyes of user groups. The policy on strengthening user groups was included in the National Mental Health Policy in 2006. This initiative was based on two points: to facilitate the work of non-governmental organizations advocacy and human rights and to eliminate stigmatization and discrimination against service users and their caregivers (Republic of Turkey Ministry of Health, 2006). The non-governmental organizations have taken technical and financial support to be actively involved in the mental health system from the Ministry of Health. I asked the participants questions on the level of their involvement in political processes. Some of them

indicated their ongoing participation in various meetings about community-based mental health services. For instance,

> I have been invited to meetings of the Ministry of Family and Social Policies and the World Bank. Those meetings are about the education of the people in family medicine and community-based mental health centers. WHO Representatives in Ankara, they also came here and they liked us very much, so I joined the meetings as a representative with them. Therefore, we also participate in these deinstitutionalization meetings.
>
> (G13, Ankara, female, primary caregiver)
>
> During the time of another association, I talked to ministries i.e. the Ministry of Health, the Ministry of Family and Social Policies. We have not met official such bodies as our association, but we met with some local groups such as chief physicians, provincial health directorates, and municipalities.
>
> (G11, Istanbul, male, user)

As emphasized above, two of the respondents participated in meetings which were conducted by different stakeholders, including ministries, international organizations and provincial health directorates at both the national and the local level.

For Turkey, it was emphasized in the previous chapter that user groups are mostly organized at the local level; there is only one federation that is a national umbrella organization of the diagnosis-specific group. Some of them have provided peer support, but the framework of these supports is actually dominated by family members and professionals. At this point, user-group influences on policy-making have been achieved only through attending meetings which are organized by ministries, international organizations, professional associations, and non-governmental organizations. The scope of these meetings is relevant to community-based mental health centers, mental health legislation, involuntary hospitalization and treatments in institutions. For instance,

> There were the counsellors of the Ministry of Health at the Bakırköy psychiatric hospital and when they worked on plans for the community-based mental health centers, they relied on the mental health policies of 2006; I was with them. I knew that team and they were getting opinions from us too. Then, community mental health centers began to open. These are the things we wanted.
>
> (G11, Istanbul, male, user)

Turkey still does not have mental health legislation; therefore, it is declared as one of the necessary steps in the National Mental Health Policy in order to protect the rights of individuals with mental disorders against stigmatization, discrimination, exclusion and human rights abuses (Republic of Turkey Ministry of Health, 2006). A few representatives from user groups were invited to mental health legislation meetings in the commission; two respondents explained their participation.

> There were some suggestions on the written text, so we talked about them. Since there are all professional organizations psychologists, psychiatrists, psychiatrists, social psychologists, children psychologists, everyone is going to work for their own cause. Since this law came out, what will happen to our future, everyone looked from this point of view. We were there, I was there with the service user viewpoint that you are there for me, you are there for my sake.
>
> (G2, Istanbul, male, user)
>
> In 2006 and 2008, we had two civil monitoring projects. The most important thing I attended legislative talks. Yes, there were mental health legislation negotiations before the elections, and we participated in them. There were 15 meetings, and we joined 12 of them with our representatives and members, and in fact, the law text went to the parliament. We had some initiatives taking place on the service user side in order to make the text of the law more relevant to the contracts of the present day.
>
> (G5, Istanbul, female, human rights advocate)

As emphasized in the previous chapter, according to Thornicroft and Tansella (2005)'s conceptual framework, a new mental health law was evaluated as an input at the national level. However, there is still not an input at the national level in terms of

mental health legislation. The involvement of user groups in mental health legislation meetings is a significant point, but no conclusion was reached.

I also received negative comments from some participants on this issue. Two of the respondents said that they were not involved in either the ongoing political transformations and or the mental health legislation process.

> No, unfortunately, not. I have a 20-year-old child who is diagnosed and I am the president of the association and the representative of the federation in Istanbul, but nobody has knocked on our door.
>
> (G1, Istanbul, male, primary caregiver)
>
> There was nothing that we joined as an association. We were established at the very beginning of these law meetings where the Mental Health Legislation was presented for comments. We were already involved in the Mental Health Legislation debates; we had asked to enter the meeting, but as far as we were informed, our request to enter the meeting was not accepted by the other groups.
>
> (G10, Izmir, female, human rights advocate)

As the quality and quantity of user groups have increased, their real effects on the political process have become a topic for further research. The main question on whether or not the user movement has had an impact on mental health policy across countries was analyzed in Europe with the mental health Declaration for Europe and the mental health Action Plan for Europe (Rosa & Lucas, 2006). At the international level, there was a consensus on the need to empower people with mental health disorders and their organizations; they considered “the experience and knowledge of service users and their caregivers as an important basis for planning and developing mental health services” (WHO, 2005).

Today, the political impact of user groups, which have national, local and regional chapters, can differ among countries. For example, the impact of them can be seen in mental health policies at the national level in Western European countries.

On the other hand, the user groups are mostly organized at the local level in the United Kingdom because of funding mechanisms. While the power of user groups is limited to a few national organizations at the regional level rather than the national one in the context of Southern European countries, Eastern European user organizations have insufficient initiatives in terms of user group influence on mental health policies (Rose & Lucas, 2006).

It is also worth noting that even if the involvement of these user groups was not comprehensive, the participants thought their efforts contributed to the ongoing transformation of the mental health policies of Turkey on some points. One of them is about community-based mental health centers; the other one is about taking written permission and records for electroconvulsive therapy. For instance,

> I think that it had a lot of influence, absolutely. They are on the (patient) council, the mental health action plan in 2011, for example, now there are a lot of effects on this mental health action plan. We started in 2006 for the EKT (electroshock) to be done with an anesthetic. So, it was transformed immediately, what we can do is that the chief physicians were making meetings and we were invited to one of them, so an interaction began. They said that what happens in the world, what is a community-based service model, we are going to the balance model, the community-based mental health centers were opened. I do not think that it's all ours, but I think it was accelerated with this interactivity because there were a lot of different sources at the same time. For example, they summoned us, and the provincial health directorate has called us to speak at least 3 times since 2009.
>
> (G7, Istanbul, female, human rights advocate)
>
> Partly, of course, we were enlightened by each other. We reflected that there is no support other than medication, there was no salary and no institutional support from the various meetings at that time, we expressed these in every press interview. We do not have a mental health legislation. These repetitions had taken into consideration. There has always been an interaction.
>
> (G11, Istanbul, male, user)

As stated above, the involvement of user groups influenced community-based mental health centers, treatments, and interventions in mental health institutions. The matrix model of Thornicroft and Tansella (1999a) describes the operation of a community

mental health team as a local process, and the change in the quality of life of a service user due to treatment and care received as an individual outcome. In this regard, according to the respondents' answers, the effect of user involvement can be seen at both local and individual levels.

The involvement of user groups can be evaluated as a good point because when the state paves the way for well-developed policies in this field, the user groups might be considered as the stakeholder in that process. However, the important thing here is not just the participation of these groups in certain organizations. The main point is that user groups should be equal with other stakeholders in the decision-making process; otherwise, their influences on policy-making are bound by just attendance and consultation. At this point, some scholars remark that the stakeholder model in health policy-making causes a power imbalance between different stakeholders (Rose & Lucas, 2006). Also, Hickey (1998) listed four steps: information/explanation, consultation, partnership and user-control in user involvement. The former two are described as a "consumerist approach" and the latter two Hickey describes as, "a process of democratization" and refers to active citizenship (Hickey, 1998). The term "active citizenship" should be assessed with the level of service user involvement in mental health care. In my fieldwork, one of the respondents shared her concern for future. For instance,

> Positive? Yes, we think so but whether the commission itself will be effective, that is a question. It was a disappointment to all participants when the process was suspended due to the elections. The process was good, but after that, it was very uncertain and we did not know how much we will be involved in the next step.
>
> (G5, Istanbul, female, human rights advocate)

In Turkey's framework, user groups said that they were involved in some policy-making process at different levels, but they also expressed their concerns about the future.

4.4.2 User involvement in mental health care planning, treatment, and provision

User involvement in the planning and provisioning of mental health services has been supported since 1990s. There are two different methods; first, indirect methods such as surveys and focus groups and second, direct participation of service users. Direct participation basically involves service user-led organizations and patient councils. They have remarkable potential in terms of encouraging partnership between users and providers of mental health care services. Additionally, direct participation of users might pave the way for contributions to clinical academic research, studying new questions, developing advanced models for mental health services and promoting the term “expertise by experience”. Today, the value of expertise by experience is accepted as a policy initiative by user groups and it has a potential to construct partnerships with service users and professionals in terms of planning and delivering services. Mental health service user-led organizations (ULOs) in England interact with mental health policy-makers in order to present their own ideas about mental healthcare service provision. Patient councils were established across countries in order to represent the views of inpatient individuals with mental illness (Hudson, 1999).

As a direct user involvement example from Turkey, a patient council was established as a result of a non-governmental project at the Bakırköy Psychiatric Hospital, and service users have continued to gather every week. Basically, the

council expresses problems of individuals who stay in the hospital and submits its recommendations to the hospital management. The main goal is to participate in a decision-making mechanism in the hospital. One participant commented on the patient council as follows:

> ("From inside or outside? Everything opens up when you say that he is from me.". She explained in this way the activation of the patient council for 9 years and the concept of user involvement). They (the patient council) are only patients and people who they know, and they ask for themselves. Then, there is no resistance (in physicians and healthcare managers). This is very important, it is full user-involvement. I saw afterward that there was such a mistake within associations. I was a bit aware of this in the association; when I was in Bakırköy, I realized that the dynamics came from working there, it's easy to criticize from the outside, so let's just say "I cannot do it." It is not the case, the perception should not be evaluated as a threat to her. When I say I want this for myself, it is not perceived as a threat and I think it's a good thing.
>
> (G7, Istanbul, female, human rights advocate)

Although there is no meaningful data on the effect of service user involvement in mental health care planning, treatment, and provision, one participant shared her observations about the influences of service user involvement.

> If we talk about the service providers, of course, we can see that we can make changes. The service workers, except for doctors, especially nurses and social workers are more willing to work with open-minded people. So, we can see their influence more clearly. We visit afterward, but among psychiatrists, for example, we face a slightly thicker wall, because they have the medical view coming from their training that is very difficult to break down.
>
> (G5, Istanbul, female, human rights advocate)

Another issue is service user involvement in health professional education. Although the benefits of this involvement in education for both students and service users have been emphasized, studies on service user involvement in the Turkish medical education is limited (Duygulu & Abaan, 2013). The role of service users is to share their medical histories with medical students, and they have mostly played a role in developing the communication skills of medical students (Duygulu & Abaan, 2013).

According to one study on service user involvement in the assessment of clinical practices of nurses, 68.2% of the nursing students thought that service user involvement in the assessment of clinical practices was a positive movement for more qualified clinical practices. On the other hand, 26.3% of them were neutral and 4.5% of them were opposed. The nursing students stated their concerns about the objectivity and knowledge of service users in the clinical assessment process. The study found these concerns remarkable because they are similar to those discussed in the general literature (Duygulu & Abaan, 2013). It is clear that further research is needed on this issue. In my fieldwork, there was no direct question on involvement in medical education; however, one participant summarized her observation on the general perception of user involvement in Turkey.

> While they are talking on users, you see that we are adults and they (users) are children. There is such a distinction in their discourse. As a perspective, I even passed the point of taking their own decisions; they (users) are seen as very deprived people, and they are often sedated.
>
> (G5, Istanbul, female, human rights advocate)

4.5 Conclusion

The importance to involve users and their caregivers in the reform of mental health services is now widely accepted. User groups have participated actively in policy-making, planning, treatment, provision and evaluation of mental health care services. In this point, the main aim of this chapter was to analyze the policy changes towards "deinstitutionalization" in the Turkish mental health system by considering the role of user groups in this transformation.

First of all, the policy of deinstitutionalization was evaluated by the participants in terms of two thematic areas: approaches of user groups to

deinstitutionalization and their effect on deinstitutionalization of the Turkish Mental Health System. It is seen that there is an ambiguity over a set of terms such as deinstitutionalization, community-based mental health model, and the balanced care. The reason for this ambiguity is related to lack of mutually accepted definition about what deinstitutionalization is and how deinstitutionalization should be implemented in Turkey. The balanced care in mental health policy, in other words, the society-hospital equilibrium model has been supported by the Ministry of Health (MoH) since 2006; but it was indicated by the participants that there is an ongoing confusion in the minds of service users, their caregivers as well as mental health professionals.

In my fieldwork, deinstitutionalization was associated with three points: discharging from mental health institutions; decreasing the number of psychiatric beds and the opening of community-based mental health centers. The expanding network of community-based centers across the country paved the way for easier access to mental health services for users and their caregivers. The majority of the participants shared their satisfaction with community-based mental health services including day hospitals, and other tertiary prevention and rehabilitation facilities. On the other hand, there were negative attitudes in my fieldwork: the capacity of existing mental health institutions, the size of the mental health workforce and the hospital-based service mentality and practices in existing mental health services were three opposing arguments reflected by some of the respondents. They thought that there were a number of factors that paved the way for the mental health policy change in Turkey since 2006 and that deinstitutionalization involved reducing the existing psychiatric bed capacity and it did not compromise with Turkey's conditions. The other issue mentioned by most of the participants was that the hospital-based service mentality and practices still protect their authority in mental health services and this

was not compatible with the policy of community-based and recovery-oriented mental health services.

The analysis of the user groups' representatives indicates that there were five different thematic areas for user group criticisms: community-based mental health care institutions, stigmatization, labour market participation and employment, restricted access to regular income support and lack of housing support. Most of these criticisms are related to the general socio-economic conditions of individuals with a mental disorder. Because the policy of deinstitutionalization has the potential to improve in the quality of life of users, I basically asked the participants about their problems, and their answers were mostly about mental health services, employment, housing, income, education and stigmatization. While most of the participants had a positive impression of mental health centers, they also criticized the insufficient mental health and rehabilitation services, the mental health professionals and the medical interventions.

The lack of a policy aiming at tackling the social stigma was another criticism; the participants thought that individuals with mental disorders have been marginalized in the society in terms of employment, education, and housing. Stigmatization arose basically from two points: distrust of individuals with mental disorders and the tendency to distance them socially. Due to the effect of stigmatization, they reflected that they have been excluded from the labour market and have encountered discriminative attitudes in workplaces. It is known that the Turkish family is excessively protective, but there is a weakening of traditional support mechanisms for providing of income and housing. The problem of regular income and housing support for individuals with mental disorders are other criticisms made by most of the participants. The criticisms show that there are some

prioritizations among user groups because they have suffered from the existing healthcare institutions, stigmatization, limited access to the labour market and regular income as well as restricted housing support policies.

There were two points in analysis of the role of user groups in the Turkish mental health system: user involvement in policy processes and in mental health care planning, treatment, and provision. The lack of representation of service users and their caregivers is a well-known characteristic of the Turkish mental health system; however, the role of user groups has increased in both the formulation of policy at a national level and service development at a local level. In this framework, some participants shared their political activities; they were involved in some policy-making process at different levels by attending the meetings. Their scope was limited to community-based mental health centers and services, medical interventions, psychiatric institutions, and mental health legislation. In terms of user involvement in mental health care planning, treatment, and provision, the patient council in Bakırköy Psychiatric Hospital was given as a positive example by one of the participants. Clearly, there should be more inclusive practices at the local level. The respondents who participated in policy processes put emphasis on the importance of their involvement in the ongoing transformation of the mental health policies of Turkey; however, they referred also their concerns for the future.

CHAPTER 5

CONCLUSION

‘‘How do user groups view the mental health policy reform in Turkey?’’ is the main research question of this thesis. It examined the politics of mental health policy change in Turkey through a qualitative analysis of the views of mental health user groups on these changes. As a result of the National Mental Health Policy in 2006 and the Mental Health Action Plan in 2011, the mental health policy of Turkey has been undergoing a transformation process since 2006. The aim of this transformation has been to prioritize the establishment of community-based mental health care services in Turkey and to organize an accessible and balanced mental healthcare service network across the country. Against this background, this thesis analyzed this mental health policy change towards “deinstitutionalization” in the Turkish mental health system since 2006.

This thesis relies on a qualitative research study which includes 13 semi-structured face-to-face interviews with representatives of different mental health user groups. The views of these participants, both as people affected by these changes and as actors in the reform process, are crucial for a better understanding of the mental health policy changes.

This thesis relied on Artvinli's study (2013) to explain the main three periods in the history of mental health policy and politics in Turkey: first, the institutionalization of psychiatry and hospital-based mental health services; second, the introduction of community-based mental health care services in the Faruk Bayülkem period; and lastly, the Yıldırım Aktuna period and the policy of

deinstitutionalization. While the first period—from the 1870s to the 1960s—involved the medicalization of madness and the institutionalization of clinical and evidence-based psychiatry, the second period—from the 1960s to the 1980 coup d'état—introduced community-based mental health services. Finally, the third period, the Yıldırım Aktuna period, introduced the policy of deinstitutionalization.

Today, the main features of the mental health system in Turkey can be summarized in three points. First, there is a shortage of both the size of the mental health workforce and the physical capacity in Turkey. The system has nine public and three private psychiatric hospitals across the country, and it provides outpatient mental health services in 149 mental health centers to 32,307 active users (MHE, 2017, pp. 169-170). The insufficient number of psychiatric beds for individuals who need long-term inpatient care and the insufficient number of forensic beds for convicted criminals living with mental health issues are two well-known problems in the physical capacity of mental health services. According to the National Mental Health Plan, the number of community-based mental health centers will reach 236 by 2023, and the number of psychiatric and forensic beds will be also regulated and increased (Republic of Turkey Ministry of Health, 2011, pp. 65-70). Second, the mental health workforce and physical capacity of mental health care services in Turkey are insufficient and they are lower than those in OECD countries (OECD, 2014). The mental health specialists in the country practice mainly in public hospitals in Ankara, Istanbul and Izmir. Thirdly, the establishment of preventive and primary health care services and the integration of mental health and primary care includes preventive policies for people with mental illness, their families and society. However, the mental health system in Turkey is based on psychiatric-based mental health services rather than preventive mental health services.

At the discursive level, the historical trajectory of mental healthcare policies in Turkey more or less resembles global developments, which included a transformation from hospital-based mental health services to community-based ones. However, Turkey differs from other countries in its rather limited experience with the institutionalization of psychiatry and the establishment of mental health hospitals, which is evidenced in the limited availability of medical personnel in mental health and mental health service provision.

The policy of deinstitutionalization, which has become the dominant global paradigm in mental health policy, does not imply a total closure of mental health hospitals, as happened in the case of Italy. It generally means the gradual reduction in the capacity of these institutions and an increase in community-based mental health care services. In Turkey's mental health system, the reform promoted balanced care in mental health policy, namely the society-hospital equilibrium model. In this thesis, the term “deinstitutionalization policy” was used to refer to the balanced care model (BCM), which involves both modern community-based mental health care and modern hospital-based one (Thornicroft & Tansella, 2002; 2004; 2013). In former studies, it indicates that community-based mental health services require both organizational changes of the place where mental health services are presented and holistic reforms in other fields including medicine, nursing, psychology and social workers (Yılmaz, 2012). In this context, this thesis analysed the views of user groups on this policy change.

The views of the participants on the policy of deinstitutionalization in this thesis were examined under two headings: first, approaches of user groups to deinstitutionalization as a broader policy direction and second, their experiences about and narratives on the practice of deinstitutionalization in the Turkish mental

health system. It is important to note that there is an ambiguity over the exact definition of key concepts such as deinstitutionalization, community-based mental health model, and the balanced care in the literature, which can be partly explained on the basis of "mental health exceptionalism". This exceptionalism originates from ongoing disagreements over the definition, effect, and treatment of mental health illnesses (Rochefort, 1997).

An analysis of the interviews demonstrated that the term "deinstitutionalization" evoked three issues in the minds of the participants: 1) discharging patients from mental health institutions; 2) decreasing the number of psychiatric beds, and 3) the opening of community-based mental health centers.

The first one, discharging from mental health institutions, included personal experiences on mental health institutions. Some participants who had long-term inpatient treatment in hospitals expressed that they had negative experiences with mental health institutions in their medical history. Although I did not have any specific question on their experiences in psychiatric institutions, they shared their personal stories, which were mostly negative. These narratives are in line with the sharp criticisms of psychiatric institutions in the social sciences literature (Belknap, 1956; Stanton & Schwartz, 1954; Caudill, 1958; Goffman, 1961). Goffman (1961) defined mental health institutions as "total institutions," where the daily activities of patients were scheduled under a strict medical authority. Glasby & Lester (2005) showed that inpatient care in psychiatric institutions is generally associated with negative experiences because of the problematic nature of these institutions. Even though there is no publicly published data on involuntary and forced treatment in psychiatric hospitals in Turkey, the report of Human Rights in Mental Health Initiative Association (RUSIHAK), indicated common practices such as seclusion,

prolonged physical restraint and chemical restraint in these hospitals. It argued also the rate of involuntary hospitalization and forced treatment in mental health institutions of Turkey might be anywhere from 70% to 85% (Mental Health Europe, 2016).

With respect to the second issue, informants associated deinstitutionalization with decreasing numbers of psychiatric beds. Some respondents indicated their concerns about the reduction in the number of available beds. They underlined the ongoing shortages both in the mental health workforce and mental health services across the country. It can be argued that their concerns are well-founded because there is a well-known and ongoing inadequacy in both the size of the mental health workforce and the size of the physical capacity of mental health institutions in Turkey. When Turkey is compared to OECD countries, Turkey has a significant shortage both in medical workforce in mental health and mental health provision capacity (OECD, 2014).

My fieldwork showed that the third issue informants associated with the policy of deinstitutionalization is the opening of community-based mental health care centers as a part of community-based services. The majority of the respondents associated these newly opened mental health care centers and other community-based services with the policy of deinstitutionalization in the mental health system. They emphasized that the opening of community-based centers provided them easier access to mental health services, medications and other rehabilitation facilities and activities.

All respondents shared their experiences about and narratives on the practice of deinstitutionalization in the Turkish mental health system. While sharing their

experiences, they compared their experiences with their previous experience with hospital-based services. Overall, respondents reported that their experiences with community-based mental health services have been more satisfying. The most emphasized point in the interviews has been the easing of access to mental health treatment, care, and medications with the establishment of community-based model.

Some of the respondents also referred to the National Mental Health Policy in 2006 as a remarkable development; which led to the transformation to community-based mental health care services. However, they indicated that this reform did not have a systematic or holistic viewpoint; and the newly opened centers have largely failed to function as community-based services. They have rather become an outpatient institution only. This idea led informants to argue that the reform was mainly undertaken to decrease public expenditures on mental health, rather than introducing a holistic user-focused mental health service. As Thornicroft and Bebbington (1989) argue, financial constraints were one of the leading factors that led to the adoption of deinstitutionalization in mental health systems. The changes in the funding of the mental health sector have also been associated with wider public expenditure trends. For example, there were strict budget constraints for old mental health hospitals in the era of Powell in England, and the Kennedy administration in the United States was also known for changing the financial resources for community-based mental health centers (CMHC) rather than large mental health hospitals and isolated asylums (Thornicroft & Bebbington, 1989; Rochefort, 1997). While Turkey was not a generous spender on mental health care before the reform, informants suggested that the reform was still partly guided by cost containment concerns.

Although all the respondents stated their overall satisfaction with easier access to medical treatment, medications and care in the community-based mental health settings, some of them who were more familiar with the term deinstitutionalization voiced their criticisms on the quality of mental health services provided in these settings. In the literature, Prior (1991) argues that the community-based care for individuals with mental health issues must involve teamwork between different professions sharing the same goals. However, my fieldwork showed that informants did not recognize a considerable difference between the approach of the community-based mental health care institutions and that of mental health hospitals, as psychiatrists still protect their authority over the provision of care.

In fact, the establishment of community-based services has been promoted specifically to provide a sustainable and efficient recovery process for individuals with mental health problems. According to Anthony (1993), a mental health system with the recovery model has a community-based service network and other support mechanisms, including the labor market, regular income support, and housing support. However, my fieldwork demonstrated that the services in community-based settings were questioned by the respondents due to their purely medical approach to users' recovery processes. The vast majority of respondents suggested that the new model did not provide them with social support mechanisms in terms of anti-stigmatization, employment support, regular income support, and housing support.

Despite the fact that the new model is also predicated upon medical care only, all respondents emphasized their need for different forms of social support services. In fact, studies on other country contexts show that the rate for the desire to work reached 86% among people living with mental health issues (Thornicroft, 2009 p. 57). There is no publicly available data on the desire to work for the Turkish case,

but the fieldwork suggested that the desire to participate in the labor market was also mentioned by the majority of the respondents. My fieldwork revealed that individuals with mental disorders encountered tough obstacles to labor market participation due to two factors. The first is related to a powerful stigma against individuals with mental illnesses; the vast majority of the respondents indicated that there is a more negative attitude against them compared to persons with physical disabilities. In this point, the Turkish case bears a striking resemblance to the previous literature. As Thornicroft (2009/2014) states, the attitude of employers is different towards physically disabled persons and persons with mental disorders. While 60% of these employers stated that they recruited the physically disabled persons, less than 40% of them thought about hiring a person with mental disorders in their workplace. As the second cause of obstacles to labor market participation, the insufficiency of vocational rehabilitation centers was mentioned by the respondents. The main aim of vocational rehabilitation centers for individuals with mental disorders is to remove the existing barriers to employment. While the previous literature on Turkey refers to the incorporation of sheltered workshops, supervised work placement and occupational therapies into the new mental health care model (Yazici et al., 2007), my fieldwork showed that most informants evaluated their impact as quite insufficient.

This study also shows that the new model largely fails to support people with mental health issues to become autonomous individuals. Informants suggested that this failure is due to the following factors: the lack of regular income support and the problem of guardianship. My fieldwork revealed that the eligibility criteria for income support schemes for people with disabilities are very tight. These criteria include both a medical report indicating disability and living under a specific income

threshold. My fieldwork showed that informants fail to benefit from income support schemes due to "recovery" being entered in their medical board reports and/or their income level. The previous literature on the use of at-home care allowances for people with disabilities in need of social care in Turkey finds that this money has been mostly used to meet daily expenses of the family (Avşaroğlu, 2018), and it does not involve personal assistance or a personal budget system (Mental Health Europe, 2017). The respondents stated that people with mental health issues are expected to depend on their legal guardians or family members, which seriously limits their autonomy and hampers their full recovery.

Informants also underlined the lack of community-based residential support as a limiting factor. Most informants lived with their parents. The social welfare system in Turkey expects that the family to be the main caregiver that should undertake the whole responsibility for people with mental health issues. In this regard, the situation of Turkey is similar to other Mediterranean societies where the protection of the family is dominant, as Thornicroft (2009/2014) emphasized. The previous literature demonstrated that people living with mental health illnesses prefer to live in community-based housing facilities because they are less costly and they have more autonomy over their lives compared to old mental health institutions (Thornicroft, 2009/2014). "Hope houses" are the only alternative that people living with mental health issues have if they do not want to live with their families. But the capacity of this residential support is limited, and some respondents evaluated them as restrictive for service users.

Overall, informants think that the user group involvement in the Turkish mental health system and mental health policy making increased during the recent reform process. There is a growing literature on the involvement of service users and

their caregivers in health care. This is found very valuable for enhancing user group roles in clinical, legal, political and ideological shifts (Pilgrim & Lesley, 1998; Rogers et al., 1993; Wallcraft et al. 2011; Storm& Edwards, 2013). With respect to lobbying and political activism to influence policy and practice, as Markström and Karslsson (2013) state, there is no linear development trajectory that applies to all countries and regions; but the service user and their caregivers are now in a stronger position than they were previously because of the effect of a more fragmentary welfare system. The Turkish case supports this argument. The 2006 National Mental Health Policy for the Republic of Turkey openly declared that it would strengthen user groups in all aspects. My fieldwork also demonstrated that the visibility of user groups has increased over time at both national and local levels. The majority of the respondents mentioned their participation in various policy meetings about community-based mental health centers, mental health legislation, involuntary hospitalization and treatments in institutions. These meetings have been conducted by different actors such as ministries, international organizations and provincial health directorates. Even though the majority of the respondents had attended policy meetings and participated in mental health legislation process, they doubted the effectiveness of their participation in influencing the policy and legislative outcomes. and record requirements for electroconvulsive therapy. Today, Turkey still does not have a mental health legislation, but there is a proposed mental health law which was prepared with the participation of interested actors' over the course of a year in Grand National Assembly of Turkey (TBMM). It is still waiting to be brought to a vote in the parliament. Some respondents suggested that their participation was effective in the establishment of community-based mental health centers and the introduction of written permission.

My interviews and one previous study (Duygulu & Abaan, 2013) demonstrated that a small number of examples emerged in user involvement in planning and provision of mental health services in Turkey. The patient council model, which has become a common method of user involvement in other contexts (Hudson, 1999), was established at the Bakırköy Psychiatric Hospital by a mental health advocacy organization. The council meets every week and their function is to represent the views of individuals with mental health illnesses in the hospital and the community-based center. One respondent stated that medical professionals tend to treat them like children, which limits service user involvement in Turkey.

The deinstitutionalization in the Turkish mental health system that started in 2006 took the form of the balanced care model, which was put into practice with the launch of community-based mental health care centers. Although most informants agree that this change eased access to mental health treatment, medications, and care, they suggest that the new model remained insufficient in other respects.

It is expected that the policy change towards deinstitutionalization and community-based mental health care would bring positive improvements to both the quality of life of service users and the acknowledgement of the core principles of the recovery movement. In order to meet these expectations, the establishment of community-based mental health care system requires an expanding service network with other support mechanisms such as housing, financial support, anti-stigmatization legislation, and employment support. However, this thesis shows that this policy change falls short of introducing a holistic perspective to the Turkish mental health care system that would facilitate recovery not only through medical support but also through social support that would empower individuals living with mental health issues. User group representatives interviewed in this study report that

stigmatization, limited access to the labor market and regular income as well as restricted housing support undermines the success of the community-based mental health care model in Turkey. Last but not the least, the thesis demonstrates that the role of user groups has increased in both formulations of policy at the national level, and the service development and provision at the local level. However, their representation in policymaking and service development and provision remains unsatisfactory. The analysis made here demonstrates the need for a more inclusive policy making and implementation in the Turkish mental health care system, the effective representation of user groups would provide valuable inputs for a holistic transformation in mental health care policy.

APPENDIX A

SEMI-STRUCTURED INTERVIEW QUESTIONS IN ENGLISH

1) How do you assess Turkey's National Mental Health Policy which has been conducted since 2006?
2) Have you taken part in the works which were carried out by the Ministry of Health and / or other public actors in the process of ongoing mental health policies? Have you had the opportunity to share your own perspective with these public actors?
3) (If there is a positive answer for second question) Do you think that your views have an impact on mental health policies? If you think it is, where do you see this effect? If not, what are the implications of not being effective?
4) What do you think the main problem areas in Turkey's current mental health policy?
5) When you look through perspective of individuals living with mental health issues, what are their main problems? Can these problems be solved by health policies only?
6) How can the problems which you are talking about be solved?
7) In the last decade, deinstitutionalization has been promoted, especially by international institutions; it seems to be the main target of mental health policies. What do you think of deinstitutionalization?
8) “Turkey is progressing in the deinstitutionalization process in the mental health field.” Do you agree with this statement? If yes / no, why?

9) In Turkey, should the community-based mental health model and deinstitutionalization be adopted, as was the case in Italy? What are your views on this issue?

10) How do you assess the decrease in the number of psychiatric beds in existing hospitals and the opening of community-based mental health centers? Is this new model of provision in mental health more positive for individuals living with mental issues compared to the past? If yes / no, why?

APPENDIX B

SEMI-STRUCTURED INTERVIEW QUESTIONS IN TURKISH

1) Türkiye'nin 2006 yılından beri yürüttüğü Ulusal Ruh Sağlığı Politikasını nasıl değerlendiriyorsunuz?
2) Ruh sağlığı politikalarının değişim sürecinde Sağlık Bakanlığı ve / veya diğer kamu aktörleri tarafından yürütülen çalışmalarda rol aldınız mı? Bu süreçte kendi bakış açınızı kamu aktörleri ile paylaşma olanağı buldunuz mu?
3) (İkinci soruya olumlu yanıt verildiği taktirde) Paylaştığınız görüşlerinizin ruh sağlığı politikalarına etkisi olduğunu düşünüyor musunuz? Olduğunu düşünüyorsanız, bu etkiyi nerelerde görüyorsunuz? Olmadığını düşünüyorsanız, görüşlerinizin etkili olmamasının önündeki etkileri nelerdir?
4) Sizce Türkiye'nin güncel ruh sağlığı politikasındaki temel sorun alanları nelerdir?
5) Özellikle ruhsal rahatsızlık yaşayan bireyler açısından baktığınızda, bu bireylerin karşılaştıkları esas sorunlar nelerdir? Bu sorunlar yalnızca sağlık politikaları ile çözülebilir mi?
6) Sizce bu bahsettiğiniz sorunlar nasıl çözüme kavuşturabilir?
7) Özellikle son on yılda uluslararası kurumlar nezdinde kurumsuzlaştırma ruh sağlığı politikalarının esas hedefi haline gelmiş görünüyor. Siz kurumsuzlaştırmaya nasıl yaklaşıyorsunuz?
8) "Türkiye'de ruh sağlığı alanında kurumsuzlaştırma sürecinde ilerlemektedir." İddiasına katılır mısınız? Evet / Hayır ise neden?

9) Türkiye’de, İtalya örneği gibi, tamamıyla toplum temelli bir ruh sağlığı sunum modeli ve kurumsuzlaştırma politikası uygulanmalı mıdır? Bu konuda görüşleriniz nelerdir?
10) Mevcut hastanelerin yatak sayılarının düşürülmesi ve toplum temelli ruh sağlığı merkezlerinin açılmasını nasıl değerlendiriyorsunuz? Ruh sağlığı alanında ortaya çıkan bu yeni hizmet sunum modeli eskiye oranla ruhsal rahatsızlığa sahip bireylerin lehine mi olmuştur? Evet / Hayır ise neden?

REFERENCES

Alem, A. (2002). Community-based vs. hospital-based mental health care: the case of Africa. *World Psychiatry*, 1(2), 99-100.

Alzahrani, S. H. Fallata, E.O.' Alabdulwahab, M.A., Alsafi, W. A., Bashawri, J. (2017). Assessment of the burden on caregivers of patients with mental disorders in Jeddah, Saudi Arabia. *BMC Psychiatry,* 17: 202. doi: 10.1186/s12888-017-1368-1

Anthony, W.A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16(4), 11–23.

Arts, W. & Gelissen J. (2002). Three worlds of welfare or more? *Journal of European Social Policy,* 12(2), 137–158.

Artvinli, F. (2013). *Delilik, siyaset ve toplum: Toptaşı Bimarhanesi (1873-1927*). İstanbul: Boğaziçi Üniversitesi Yayınevi.

Artvinli F. & Etker Ş. (2013). Bimarhaneler ve mecanin yönetimi: iki taslak ve süregelen tartışma. *Osmanlı Bilimi Araştırmaları,* 14(2), 1–40.

Artvinli, F. (2018). 'Pinel of Istanbul': Dr. Luigi Mongeri (1815–82) and the birth of modern psychiatry in the Ottoman Empire. *History of Psychiatry*, 29(4), 424-437.

Avşaroğlu, N. (2018). *A cash-for-care scheme targeting children with disabilities in Turkey: Parent / caregiver perspective* (Unpublished Master's Thesis). Boğaziçi University, Istanbul, Turkey.

Bachrach, L. I. (1978). A conceptual approach to deinstitutionalization. *Hospital & Community Psychiatry,* 29(9), 573.

Bambra, C. (2005). Worlds of welfare and the health care discrepancy. *Social Policy and Society*, 4(1), 31-41.

Başoğlu M., Salcıoğlu E., Livanou M. (2002). Traumatic stress responses in earthquake survivors in Turkey. *Journal of Trauma Stress,* 15(4), 269–76.

Bayülkem, F. (1977). *Bakırköy'de 50 yıl*. Istanbul: Bakırköy Ruh ve Sinir Hastalıkları Hastanesi.

Bayülkem F. (1998). Türkiye'de nöroloji-nöroşirurji ve psikiyatri tarihi gelişmesi. Istanbul: Readaptasyon Derneği Yayınları.

Belknap, I. (1956). *Human problems of a state mental hospital*. New York: Blakiston Division, McGraw-Hill.

Bennet, D. & Isobel, M. (1983) Deinstitutionalization in the United Kingdom. *International Journal of Mental Health,* 11(4), 5-23.

Bickman, L. & Dokecki, P. R. (1989). Public and private responsibility for mental health services. *American Psychologist,* 44(8), 1133-1137.

Bilge, A., Mermer, G., Çam, O., Çetinkaya, A., Erdoğan, Elif., Üçkuyu, N. (2016). Türkiye'deki toplum ruh sağlığı merkezlerinin 2013-2015 yıllarının profili. *Kocaeli Üniversitesi Sağlık Bilimleri Dergisi,* 2(2), 1-5.

Blank, R.H., & Burau, V. (2007). *Comparative health policy.* Basingstoke, United Kingdom: Palgrave Macmillan.

Bonoli, G. (1997). Classifying welfare states: A two-dimension approach. *Journal of Social Policy*, 26(3), 351-372.

Brown, B. & Stockdill, J.W. (1972). The politics of mental health. In S.E. Golann and C. Eisdorfer (Eds.) *Handbook of community mental health.* New York: Appleton-Century-Crofts.

Brown, B.S. (1975). *Deinstitutionalization and community support systems.* Bethesda, Maryland, United States: National Institute of Mental Health.

Buse K., Mays, N., & Walt, G. (2005). *Making health policy*. United Kingdom: Open University Press.

Caria, A. (2009). Psychiatric patients' rights and users' groups. *International Journal of Mental Health,* 38(4), 70-76.

Carpenter, M. (2000). It's a small world: Mental health policy under welfare capitalism since 1945. *Sociology of Health and Illness*, 22(5), 602-620.

Caudill, W. A. (1958). *The psychiatric hospital as a small society.* Cambridge: The Commonwealth Fund by Harvard University Press.

Chow, W. S. & Priebe, S. (2013). Understanding psychiatric institutionalization: A conceptual review. *BMC Psychiatry*,13:169. doi: 10.1186/1471-244X-13-169

Compton, W. & Guze S.B. (1995). The neo-Kraepelinian revolution in psychiatric diagnosis. *European Archives of Psychiatry and Clinical Neuroscience,* 245(4-5), 196-201.

Corrigan, P.W. & Watson A.C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry,* 1(1), 16–20.

Coşkun, B. (1987). Resources, difficulties and solutions regarding mental health services in Turkey [in Turkish]. *Toplum ve Hekim,* 44: 5-11.

Coşkun, B. (1988). Activities of the department of mental health [in Turkish]. *Mental Health Bulletin [Turkey]*: 1-7.

Çiner, U. C. & Fişek, Gürhan A. (2010). *Sağlıkta sosyalleştirme: "Genel" ile "Yerel"in önemi.* Retrieved December 20, 2018 from http://sosyalpolitika.fisek.org.tr/saglikta-sosyallestirme-

%E2%80%9Cgenel%E2%80%9D-ile-%E2%80%9Cyerel%E2%80%9Din-onemi/

Dağ, İ. (2003). The systematic studies on national mental health policy in Turkey [in Turkish]. *Psikiyatri Psikoloji Psikofarmakoloji Dergisi*, 11(1), 59–67.

Deringil, S. (2009). *The well-protected domains ideology and the legitimation of power in the Ottoman Empire 1876-1909*. London: I.B. TAURIS Publishers.

Dole, C. (2015). The house that Saddam built: Protest and psychiatry in post-disaster Turkey. *Journal of the Ottoman and Turkish Studies Association*, 2(2), 281-305.

Duygulu, S. & Abaan S. (2013). Turkish nursing students' views on practice assessments and service user involvement. *Contemporary Nurse*, 43(2), 201-12. doi: 10.5172/conu.2013.43.2.201.

Erkoç Ş., Kardeş, F., Artvinli, F. (2011) Bakırköy Prof. Dr. Mazhar Osman Ruh Sağlığı ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi'nin kısa tarihi. *Düşünen Adam Psikiyatri ve Nörolojik Bilimler Dergisi, 25. Yıl Özel Sayı*, 1-12.

Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. London: Polity.

Esping-Andersen, G. (1999). *Social foundations of post-industrial economies*. Oxford: Oxford University Press.

European Union. (2015). *Joint action on mental health and well-being, towards community-based and social inclusive mental health care*. Retrieved December 20, 2018, from http://www.mentalhealthandwellbeing.eu/assets/docs/publications/WP5%20Final-20151203075843.pdf

Fakhoury, W. & Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: Major changes in the provision of mental healthcare. *Psychiatry*, 6(8), 313-316. doi: 10.1016/j.mppsy.2007.05.008

Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception / Michel Foucault; translated from the French by A. M. Sheridan Smith.* New York: Tavistock Publications.

Gilson, L., Hanson, K., Sheikh, K., Agyepong, A.I., Ssengooba, F., Bennett, S. (2011). Building the field of health policy and systems research: Social science matters. *PLoS Medicine*, 8(8), e1001079. doi: 10.1371/journal.pmed.1001079

Gilson, L. (2012). *Health policy and systems research a methodology reader*. Geneva, Switzerland: the WHO Document Production Services.

Ginsburg, N. (1992). *Divisions of welfare: A critical introduction to comparative social policy.* London: Sage Publication.

Girolamo, G., Bassi, M., Neri, G., Ruggeri, M., Santone, G., Picardi, A. (2007). The current state of mental health care in Italy: problems, perspectives, and lessons to learn. *European Archives of Psychiatry and Clinical Neuroscience*, 257(2), 83–9.

Glasby, J. & Lester, H. (2005). On the inside: A narrative review of mental health inpatient services. *The British Journal of Social Work*, 35(6), 863-879.

Goffman, E. (1961). *Asylums essays on the social situation of mental patients and other inmates.* New York: Garden City Anchor Books.

Goodman, N. M. (1994). Turkey's experiment in the "socialisation" of medicine". *The Lancet*, 4(1), 36-38.

Gostin, O. L., Bartolo, M.D., Katz, R. (2017). The Global Health Law Trilogy: Towards a Safer, Healthier, and Fairer World. *The Lancet,* 21: 390(10105), 1918-1926. doi: 10.1016/S0140-6736(17)31261-8.

Gökalp, P. G. (2002). Disaster mental health care: the experience of Turkey. *World Psychiatry,* 1(3), 159-160.

Gökçay, İ. (1992). Ulusal sağlık kongresi ve sağlık reformu. *Toplum ve Hekim*,7 (50), 2-3.

Greer, S. L., Fahy, N., Elliott, H., A., Wismar, M., Jarman, H., & Palm, W. (2014). *Everything you always wanted to know about European Union health policy but were afraid to ask.* Retrieved December 20, 2018, from http://www.euro.who.int/__data/assets/pdf_file/0008/259955/Everything-you-always-wanted-to-know-about-European-Union-health-policies-but-were-afraid-to-ask.pdf?ua=1

Guest, G., Bunce, A., Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Family Health International Field Methods,* 18 (1), 59–82.

Ham, C. (Eds.). (1997). *The politics of healthcare reform: Learning from international experience.* Oxford: Oxford University Press.

Hanioğlu, Ş. (1981). *Bir siyasal düşünür olarak doktor Abdullah Cevdet bey ve dönemi, (Dr. Abdullah Cevdet bey as a political philosopher and his time*). Istanbul: Üçdal Neşriyat.

Hazelton, M. & Clinton, M. (2004). Human rights, citizenship and mental health reform in Australia in P. Morrall & M. Hazelton (Eds.) *Mental Health: Global Policies and Human Rights* (pp.41-60). London: Whurr.

Hickey, G. (1998). Exploring the concept of user involvement in mental health through a participation continuum. *Journal of Clinical Nursing,* 7(1), 83-88.

Hudson G. C. & Cox, A.J. (1991). *Dimensions of state mental health policy.* London: Praeger.

Hudson, M. (1999). Psychiatric hospitals and patients' councils. In Newnes, C., Holmes, G. and Dunn, C. (Eds.) *This is madness: A critical look at psychiatry and the future of mental health services* (pp.135–47). Ross-on-Wye: PCCS Books.

Hürriyet, (1999, August 18). *Yardım Yağıyor.* Retrieved December 20, 2018 from http://www.hurriyet.com.tr/gundem/yardim-yagiyor-39096785

Hürriyet, (2018, June 9). *5,5 milyon kişi haykırıyor:Biz de varız.* Retrieved December 20, 2018, from http://www.hurriyet.com.tr/gundem/5-5-milyon-kisi-haykiriyor-biz-de-variz-40863172

İşbir, E. G. & Genç, N.F. (2008). Afetlere müdahalede uluslarası örgütlerin rolü: 1999-Marmara Depremi örneği. *Amme İdaresi Dergisi*, 41(3), 73-97.

Jones, J. L. & Kami L. (2016). Understanding Deinstitutionalization: What Families Value and Desire in the Transition to Community Living. *Research and Practice for Persons with Severe Disabilities*, 41(2), 116–131.

Kasza, G. (2002). The illusion of welfare regimes. *Journal of Social Policy.* 31(2), 271–287.

Kiesler, C. A. (1987). The guilds: Their organization, members and potential contributions In. L. J. Duhl & N.A. Cummings (Eds.) *The future of mental health services: Coping with crises*. New York: Springer.

Kılıç, C., Rezaki M., Üstün T.B., Gater R.A. (1994). Pathways to psychiatric care in Ankara. *Social Psychiatry and Psychiatric Epidemiology.* 29 (3), 131–6.

Kohn, R., Shekhar S., Levav, I., Saraceno, B. (2004). The treatment gap in mental health care. *Bulletin of the World Health Organization.* 82: 858-866.

Křížová, E., Janečková, H., Běláček, J. (2016). Family carers' perspectives on integrated community care in the Czech Republic. *Central European Journal of Public Health,* 24(4), 289–296.

Kuhlmann, E., Blank, R.H., Lynn, I. Wendt, C. (Eds.) (2015). *The Palgrave international handbook of healthcare policy and governance.* Hounds mills, Basingstoke, Hampshire; New York, NY: Palgrave Macmillan.

Lauber, C., Anthony, M., Ajdacic-Gross, V., Rossler, W. (2004). What about psychiatrists' attitude to mentally ill people? *European Psychiatry*. 19(7), 423–427.

Leichter, H. A. (1979). *Comparative approach to policy analysis: Health care policy in four nations.* Cambridge: Cambridge University Press.

Levine, M. (1981). *The history and politics of community mental health.* New York: Oxford University Press.

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., Pescosolido., B.A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health*. 89(9), 1328-1333.

Livanou M, Başoğlu M, Marks I. M. (2002). Beliefs, sense of control and treatment outcome in post-traumatic stress disorder. *Psychological Medicine.* 32(1), 157–65.

Livanou M, Başoğlu M, Salcıoğlu, E., Kalendar D. (2002). Traumatic stress responses in treatment-seeking earthquake survivors in Turkey. *The Journal of Nervous and Mental Disease,* 190(12), 816–23.

Marmor, T.R. & Gill, K.C. (1989). The political and economic context of mental health care in the United States. *Journal of Health Politics, Policy and Law*. 14(3), 459-475.

Marmor, T. & Wendt, C. (2012). Conceptual frameworks for comparing healthcare politics and policy. *Health Policy,* 107(1), 11– 20.

Markström U. &Karlsson, M. (2013). Towards hybridization: The roles of Swedish non-profit organizations within mental health. *Voluntas: International Journal of Voluntary and Non-profit Organizations,* 24(4), 917-934.

Masters, A. (1977). *Bedlam*. London: Bedford Square, Michael Joseph LTD.

Mechanic, D. & Rochefort, D. A. (1992). A Policy of Inclusion for the Mentally Ill. *Health Affairs,* 11(1), 128-150.

Mechanic, D. & Rochefort, D. (1990). Deinstitutionalization: an appraisal of reform. *Annual Review of Sociology,* 16: 301–327.

Mental Health Europe. (2017). *Mapping and understanding exclusion: Institutional, coercive and practices across Europe*. Retrieved December 20, 2018 from https://mhe-sme.org/wp-content/uploads/2018/01/Mapping-and-Understanding-Exclusion-in-Europe.pdf

Merwin M., & Ochberg, F. (1983). The long voyage: Policies for progress in mental health. *Health Affairs,* 4(2), 96-127.

Minas, H. & Cohen, A. (2007). Why focus on mental health systems? *International Journal of Mental Health Systems*, 1(1), 1-4.

Ministry of Health of Turkey. (2009*). Progress report-health transformation program in Turkey.* Ankara: MoH Publication No: 749, ISBN:978-975-590-273-9.

Ministry of Health of Turkey. (2011). *The National Mental Health Action Plan (2011-2023).* Retrieved December 20, 2018, from https://www.psikolog.org.tr/doc/ulusal-ruh-sagligi-eylem-plani.pdf

Ministry of Health of Turkey. (2012). *Turkey Health Transformation Program assessment report (2003-2011).* Retrieved December 20, 2018, from https://sbu.saglik.gov.tr/Ekutuphane/kitaplar/SDPing.pdf

Ministry of Health of Turkey (2015). *The National Mental Health Policy (NMHP) for Turkey.* Retrieved December 20, 2018, from https://www.mindbank.info/item/69

Moran, M. (1999). *Governing the healthcare state: A comparative study of the UK, the USA and Germany*. Manchester: Manchester University Press.

Moran, M. (2000). Understanding the welfare state: the case of health care. *British Journal of Politics and International Relations*, 2 (2), 135–160.

Morrall, P. & Muir-Cochrane, E. (2002). Naked social control: seclusion and psychiatric nursing in post-liberal society. *Australian e-Journal for the Advancement of Mental Health*, 1(2), 2-11.

Munir, K., Ergene, T., Tunalıgil, V., Erol, N. (2004). A window of opportunity for the transformation of National Mental Health Policy in Turkey following two major earthquakes. *Harvard Review of Psychiatry*, 12(4), 238-251. doi: 10.1080/10673220490509615.

Niaz, U. (2006). The concept of post-traumatic stress disorder today. *Journal of Postgraduate Medical Institute (Peshawar - Pakistan)*, 22(4), 365-366.

Novella, E. J. (2010). Mental health care in the aftermath of deinstitutionalization: A retrospective and prospective view. *Health Care Analysis*, 18(3), 222–238.

OECD. (2014). *Making mental health count: The social and economic costs of neglecting mental health care*. Paris: OECD Publishing. doi: http://dx.doi.org/10.1787/9789264208445-en

Osman, M. (1933). *Sıhhat almanakı.* İstanbul; Kader Matbaası.

Ozmen, E., Ogel K., Aker, T., Sağduyu. A., Tamar, D., Boratav C. (2004). Public attitudes to depression in urban Turkey – the influence of perceptions and causal attributions on social distance towards individuals suffering from depression. *Social Psychiatry and Psychiatric Epidemiology*, 39(12), 1010-1016.

Özbek, N. (2002). *Osmanlı İmparatorluğu'nda sosyal devlet: Siyaset, iktidar ve meşruiyet (1876-1914).* İstanbul: İletişimYayınevi.

Özbek, N. (2006). *Cumhuriyet Türkiye'sinde sosyal güvenlik ve sosyal politikalar.* Istanbul: Emeklilik Gözetim Merkezi.

Pavolini, E. & Guillén, A. M. (Eds.) (2013). *Health care systems in Europe under austerity: institutional reforms and performance.* Houndmills, Basingstoke, Hampshire; New York: Palgrave Macmillan.

Piat, M. (1992). Deinstitutionalization of the mentally ill: theory, policy and practice. *Canadian Social Work Review*, 9(2), 201-213.

Pilgrim, D. & Waldron, L. (1998). User involvement in mental health service development: How far can it go? *Journal of Mental Health*. 7(1), 95-104.

Polanyi, K. (1944). *The great transformation*. Boston: Beacon Press.

Porter, R. (Eds.) (2001). *The Cambridge illustrated history of medicine*. Cambridge: New York: Cambridge University Press.

Porter, R. (2002). *Madness: a brief history.* Oxford & New York: Oxford University Press.

Powell, E. (1961). *Powell's Water Tower Speech*. Retrieved December 20, 2018 from http://studymore.org.uk/xpowell.html

Priebe, S., A.Badesconyi, A. Fioritti, F. Torres-Gonzales,L. Hansson, R. Kilian, T. Turner, D. Wiersma. (2005). Reinstitutionalization in mental health care: comparison of data on service provision from six European countries. *BMJ* 330: 123-126.

Rochefort, D. A. (1997) From poorhouses to homelessness: Policy analysis and mental health care London: Auburn House.

Rogers, A., Pilgrim, D. & Lacey, R. (1993). Experiencing Psychiatry: Users' Views of Services. London: Macmillan.

Rose, D., MacDonald, D., Wilson, A., Crawford, M., Barnes, M., Omeni, E. (2016). Service user led organisations in mental health today. *Journal of Mental Health*, 25(3), 254-259.

Rose, D., Fleischmann, P., Tonkis F, Campbell P, Wykes T. (2002). *User and carer involvement in change management in a mental health context: Review of the literature.* Retrieved December 20, 2018 from http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1201-017_V01.pdf

Rose, D. & Lucas., J.L. (2006). The user and survivor movement in Europe. In M. Knapp, D. McDaid, E. Mossialos & G. Thornicroft (Eds.), *Mental health policy and practice across Europe: The future direction of mental health care* (pp.336-355). McGraw-Hill Education: Open University Press.

Sağduyu, A., Aker T., Ozmen, E., Uguz, S., Ogel, K., Tamar D. (2003). Relatives' beliefs and attitudes towards schizophrenia: an epidemiological investigation. *Türkiye Psikiyatri Dergisi* 14(3), 203-212.

Salcıoğlu E., Başoğlu M, Livanou M. (2003). Long-term psychological outcome for non-treatment-seeking earthquake survivors in Turkey. *The Journal of Nervous and Mental Disease*, 191(3), 154–60.

Samudre, S., Shidhaye, R., Shalini Ahuja, S., Nanda, S., Khan, A., Evans-Lacko, S., Hanlon, C. (2016). Service user involvement for mental health system

strengthening in India: A qualitative study. *BMC Psychiatry* 16: 269. doi:10.1186/s12888-016-0981-8

Sartorius, N., Wolfgang, G., Lopez-Ibor, J. J., Mario, M. (Eds.) (2002). *Psychiatry in society.* Chichester: John Wiley & Sons Ltd.

Sartorius N, Schulze H. (2005). *Reducing the stigma of mental illness: A report from a global association.* Cambridge: Cambridge University Press.

Samudre, S., Shidhaye, R., Shalini Ahuja, S., Nanda, S., Khan, A., Evans-Lacko, S., Hanlon, C. (2016). Service user involvement for mental health system strengthening in India: A qualitative study. *BMC Psychiatry* 16: 269. doi:10.1186/s12888-016-0981-8

Scull, A. (1989). *Social order / mental disorder Anglo-American psychiatry in historical perspective*. Berkeley: University of California Press.

Scull, A. (1993). *The most solitary of afflictions madness and society in Britain, 1700-1900.* London: Yale University Press.

Scull, A. (2016). Uygarlık ve delilik – Kitabı Mukaddes'ten Freud'a, tımarhaneden modern tıbba akıl hastalığının kültürel tarihi (N. Elhüseyni, Trans.). İstanbul: Yapı Kredi Kültür Sanat Yayıncılık, (Original work published 2015).

Sercu, C. & Bracke, P. (2016). Stigma as a structural power in mental health care reform: An ethnographic study among mental health care professionals in Belgium. *Archives of Psychiatric Nursing*, 30(6), 710–716.

Sheikh, K., Gilson, L., Agyepong, I.A., Hanson, K., Ssengooba, F., Bennett, S. (2011) Building the field of health policy and systems research: Framing the questions. *PLoS Medicine*, 8(8): e1001073. doi: 10.1371/journal.pmed.1001073

Shek, O. & Pietilä, I. (2017) Family caregivers' views on the deinstitutionalisation of psychiatry in Russia. *The Journal of Social Policy Studies*, 15(1),143-156.

Shen, G.C. & Snowden, L.R. (2014). Institutionalization of deinstitutionalization: A cross-national analysis of mental health system reform. *International Journal of Mental Health Systems*, 8(1), 47.

Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac*. New York: Wiley.

Smoyak, S. (2004). US mental health policy: Progress and continuing problems in P. Morrall and M. Hazelton (eds.*), Mental health: Global policies and human rights* (pp.24-42). London: Whurr.

Speed, E. (2006). Patients, consumers and survivors: A case study of mental health service user discourses. *Social Science and Medicine*, 62(1), 28-38.

Stanton, A., Schwartz, H., Morris S. (1954). *The mental hospital: A study of institutional participation in psychiatric illness and treatment.* New York, NY, US: Basic Books.

State Personnel Presidency. (2018). Retrieved December 20, 2018 from http://www.dpb.gov.tr/tr-tr/istatistikler/engelli-personel-ve-omss-istatistikleri

Stokes, J., Gurol–Urgancı, I., Hone, T., Atun, R. (2015). Effect of health system reforms in Turkey on user satisfaction. *Journal of Global Health,* 5(2), 020403. doi:10.7189/jogh.05.020403

Storm, M., & Edwards, A. (2013). Models of user involvement in the mental health context: Intentions and implementation challenges. *Psychiatry Quarterly,* 84(3), 313-27. doi: 10.1007/s11126-012-9247-x.

Tait, L. & Lester, H. (2005). Encouraging user involvement in mental health services. *Advances in Psychiatric Treatment,* 11(3), 168–175.

Talas, C. (1992). *Türkiye'nin açıklamalı sosyal politika tarihi.* Ankara: Bilgi Yayınevi.

Tansella, M. (1986). Community psychiatry without mental hospitals- the Italian experience: A review. *Journal of the Royal Society of Medicine,*79(11), 664–669.

Tansella, M. & Thornicroft, G. (1998). A conceptual framework for mental health services: The matrix model. *Psychology Medicine,* 128(3), 503-8.

Terzioğlu, A. (1998). *Turkish medical doctors: historical experience and self-narratives* (Unpublished Master's Thesis). Boğaziçi University, Istanbul, Turkey.

Thornicroft, G. (2014). *Toplumun reddettiği* (N. Uluhan, T. Doğan & H. Soygür, Trans.). Ankara: İmaj Yayınevi. (Original work published 2009).

Thornicroft, G. & Bebbington, P. (1989). Deinstitutionalisation-from hospital closure to service development. *British Journal of Psychiatry,* 155: 739-753.

Thornicroft G. & Tansella M. (1999a). *The mental health matrix: A manual to improve services.* Cambridge University Press: Cambridge.

Thornicroft, G. & Tansella, M. (2002). Balancing community-based and hospital-based mental health care. *World Psychiatry,* 1:2.

Thornicroft, G. & Tansella, M. (2003) *What are the arguments for community-based mental health care?* Copenhagen: WHO Regional Office for Europe.

Thornicroft, G. & Tansella, M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care. *British Journal of Psychiatry,* 185: 283-290.

Thornicroft, G. & Tansella, M. (2013). The balanced care model for global mental health. *Psychological Medicine*, 43(4), 849–863.

Thornicroft, G. & Tansella, M. (2014). Are community mental health services relevant in low- and middle-income countries? *Epidemiology and Psychiatric Sciences*, 23:115-118. doi:10.1017/S2045796014000067.

Tritter, J. Q. (2009). Revolution or evolution: the challenges of conceptualizing patient and public involvement in a consumerist world. *Health Expectations*, 12: 275–287.

Uluğ, B. (2003). National Mental Health Policy Conference convened in Ankara [in Turkish]. *Bulletin of Psychiatry Association Turkey*, 3: 6.

UNICEF. (2001). *Less fearful, more active: The psychosocial project for children affected by the 1999 earthquake in Turkey.* Retrieved December 20, 2018, from https://www.unicef.org/turkey/pdf/ep1.pdf

Wadsworth, Y. & Epstein, M. (1998). Building in dialogue between consumers and staff in acute mental health services. *Systemic Practice and Action Research*, 11(4), 353- 379.

Wallcraft, J., Amering, M., Freidin, J., Davar, B., Froggatt, D., Jafri, H., Herrman, H. (2011). Partnerships for better mental health worldwide: WPA recommendations on best practices in working with service users and family carers. *World Psychiatry: official journal of the World Psychiatric Association (WPA)*, 10(3), 229-236.

Walt, G., Shiffman, J., Schneider, H., Murray, S.F., Brugha, R., Gilson, L. (2008). Doing health policy analysis: methodological and conceptual reflections and challenges. *The London School of Hygiene and Tropical Medicine Health Policy and Planning*, 23(5), 308–317.

Weisbrod, B.A. (1983) A guide to benefit-cost analysis, as seen through a controlled experiment in treating the mentally ill. *Journal of Health Politics, Policy and Law,* 7: 808-846.

Weisstub, D. N. (Ed.). (1984). *Law and mental health*. New York: Pergamon Press.

Weinstein, H. (1982). Mental health and the law. *New York University Medical Center /Bellevue Hospital Center*, 557-575.

Wendt, C. (2015). Health politics and policy. In J. Wight (Ed.), *International Encyclopaedia of the Social & Behavioural Sciences (Second Edition)* (pp. 663–668). Elsevier.

World Bank. (2002). *World Development Report 2002, Building institutions for markets*. Washington, DC: World Bank.

World Bank. (2007). *Turkey Marmara Earthquake Emergency Reconstruction Project. Report No: ICR0000131, Implementation Completion and Results*

Report (IBRD-45170). Ankara: Environmentally and Socially Sustainable Development World Bank Office.

World Health Organization. (2001). *World Health Report 2001. Mental health: New understanding, new hope.* Geneva: WHO. Retrieved December 20, 2018, http://www.who.int/whr2001/2001/main/en.

World Health Organization. (2003). *Organization of services for mental health*. Retrieved December 20, 2018, from https://www.who.int/mental_health/policy/services/4_organisation%20services_WEB_07.pdf?ua=1

World Health Organisation. (2005). *World Health Organization assessment instrument for mental health systems, WHO-AIMS Version 2.2.* Retrieved December 20, 2018 from http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf

Yalçıner, B., Gökalp, P. & Mumcu, C. (Eds.). (2009). *Bakırköy Akıl Hastanesi'nin gizli tarihi.* İstanbul: Okuyan Us Yayınları.

Yazici, A., Temiz, M., Erkoç, Ş., Yıldız, Ö. (2007). Psychiatric rehabilitation services in Turkey. *International Journal of Mental Health,* 36(3), 15-20.

Yılmaz, V. (2012). *İnsan hakları ve karşılaştırmalı sosyal politika yaklaşımı ışığında Türkiye'de ruh sağlığı politikaları: Tespitler ve öneriler.* İstanbul: RUSİHAK Yayınları.

Yılmaz, V. (2017). *The politics of healthcare reform in Turkey*. Cham: Palgrave Macmillan.