Application address for scientific and technical information on this document

Dr. Kerim Munir
Director, Mental Health & Developmental Disabilities Program
The Children’s Hospital, Boston
Harvard Medical School
300 Longwood Avenue
Boston, MA 02115
USA
Tel : +1 617 3557166
Fax : +1 617 7300049
E-mail : kerim.munir@childrens.harvard.edu

Project Editorial Group
Kerim Munir (Harvard University), Tuncay Ergene (Hacettepe University), İhsan Dağ (Hacettepe University) Neşe Erol (Ankara University) and Tamer Aker (Kocaeli University)

Scientific and Technical Advisory Core Group
Füsun Çetin Çuhadaroğlu (Hacettepe University), Özgür Öner (Dişkapi Hospital), Zeynep Şimşek (Harran University), Deniz Yücel (Children’s Hospital Boston)

Executive Support
Recep Akdağ (Minister), Necdet Ünüvar, İsmail Demirtaş, Cihanser Erel, Turan Büzgan, Mehmet Uğurlu, Fehmi Aydınlık, Tahir Soydal, Reşat Doğuşan, Hayati Baykan, Toker Ergüder, Ahmet Tunç Demirtaş ve Tuğba Kurtuluş (Ministry of Health) Ibrahim Akçayoğlu, (World Bank, Ankara Office)
Nuray Günüşhan (Prime Ministry Project Implementation Unit)
Seihat Ünal, Aygen Tümer (HATAM, Hacettepe University)

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Seedang Simonin, Peter Berman and James Ware (Harvard School of Public Health)
Joseph Marrone and William Kiernan (Institute for Community Inclusion, Boston)
Cengiz Kılıç (Abant Izzet Baysal University)
Abdulkadir Çevik, İşık Sayıl, Esfer Kerimoğlu, Emine Kölcü, Hamit Hancı (Ankara University)
Adnan Kisa, Şahin Kavuncubası (Başkent University)
Erol Sezer (Cumhuriyet University)
Semra Şahin, Necate Baykoç Dönmez, Nihal İlden (Child Development and Education Association)
Mustafa Namlı (Elazığ Mental Health Hospital, Elazığ)
Atalay Yörükoğlu (Retired Lecturers from Hacettepe University)
İşık Sayıl (Association for Suicide Prevention)
Gökhan Oral, Alattin Duran (Istanbul University, Cerrahpaşa Faculty of Medicine)
Bülent Coşkun, Tamer Aker, (Kocaeli University)
Nesrin Dilbaz (Numune Hospital, Ankara)
Nesrin Aşt (Turkish Psychiatric Nurses Association)
Rüstem Ağın (Selçuk University)
Hürrüyet Üğuroğlu (Association of Social Workers)
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Öğuz E. Berksun (Turkish Association of Social Psychiatry)
Ahmet Göğüş, İskender Sayek, Nazmi Bilir, Ayşe Akin, Serhat Ünal, Aykut Toros, Fatih Ünal, Dilek Aslan, Murat Sincan (Hacettepe University)
Kayhan Pala (Uludağ University)

Logistic Support
Adm Travel, Flap Tour, Tasarnmhanee
"Increasing the health status of our society, living in a healthier world and assuring better conditions for future generations is a universal international aspiration. Effective, accessible and high quality health system is indispensable for civil society. The duty of the state is to enable healthier conditions for all citizens, making them aware of the importance of heath and the need for building an effective infrastructure. In this light a primary health care approach is important as it recognizes the needs of all citizens we are providing services to and allows a more accurate determination of public health problems thus allowing for better development of more balanced policies. Meeting the basic health necessities of every citizen in cooperation with all sectors is one of our top priorities.

World Health Organization describes health as, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Physical health constitutes only one dimension of health. Mental and social health are interconnected concepts, which effect physical health as well. Being mentally and socially healthy can be regarded as the basic dimension of life in determining an individual’s relation with his or her family, social environment, work and the society. Mental health and its role in an individuals’s lifetime has long been neglected in our society. People still perceive health as physical well being; people visit their doctors when they think they have a physical disorder. A label of mental disorder is often deemed as equal to madness and often mental health is a concern that people are afraid to face or abstain from due to such stigmatized perceptions.

In our country, it is estimated that there over five hundred thousand individuals diagnosed with severe mental disorders, with at least 6 to 7 million citizens requiring treatment and many more diagnosed with moderate and mild mental disorders. Failure to make a proper diagnosis and delays in treatment of these disorders result in medical, social and economic losses. Integration of mental health services into general health services and a special emphasis of primary mental health care services will enable broader access, elimination of costs due to unnecessary examinations and medical tests, misdiagnoses and incorrect treatment. This approach will in turn lead to more efficient utilization of national and community resources. A strong mental health policy is an indispensable part of an efficient health care system. In this respect, the development of a long-term, permanent and consistent mental health policy is an initial necessary step. Priority mental health objectives and the strategies for fulfilling these objectives should be specified by paying due attention to the mental health conditions of our country with the participation of all related agencies. Activities planned by these interested agencies to improve mental health services will in turn enable the establishment of our objectives. The development of a National Mental Health Policy is therefore an extremely important yet challenging process and I would like to thank all the scientists at the outset who will help us provide a broad perspective, including the representatives of interested public agencies, non-governmental organizations who have contributed and all others who voluntarily made efforts in this cause."

Prof. Dr. Recep Akdağ
Minister of Health, Republic of Türkiye
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This document is a report prepared for the Development of National Mental Health Policy (NMHP) for the Republic of Turkey in support of the Marmara Earthquake Emergency Reconstruction (MEER) Project under the direction of the General Directorate of Primary Health Care in the Ministry of Health. A primary objective for development of a NMHP is to define the salient conditions in Turkey and to promote the development of balanced and effective mental health services available in primary care with special emphasis also of the vulnerability of the country at times of natural disasters and emergencies. A goal of this project from the outset was therefore to help stimulate collaboration between all relevant sectors and to ensure the participation of interested government and non-governmental agencies in order for them to be able to make contributions to the process in a balanced way.

In particular, this project provided me with an opportunity to learn about the health conditions in Turkey and to familiarize myself with the country’s rich social and cultural traditions. The inception of the Mental Health and Developmental Disabilities (MHDD) Program at the Children’s Hospital Boston, with federal funding from the National Institutes of Health in fall 1999 coincided with the aftermath of the tragic Marmara earthquakes that also brought me to Turkey. I subsequently volunteered and worked under the auspices of the with UNICEF Recovery Program for Turkish Children where I serving as a liaison officer with the Ministry of Health Mental Health. I had the privilege to meet many fine colleagues in universities and professional associations in the post disaster period. An outcome of this arduous and challenging work was our invitation to submit an application to compete for the NMHP project. The selection of our MHDD Program by the Ministry of Health to assist in this process followed World Bank fair competition rules. The familiarity of our program with Turkey and the conditions after the earthquake also made us particularly sensitive to the country’s needs. The project was able take into consideration existing programs, laws and strategies related to mental health across many sectors. We hope that development of a NMHP for Turkey for the first time in her history will serve as an important foundation and stimulus for establishment of sustainable mental health services across all regions of Turkey. We also hope that the contributions of so many mental health and allied health professionals and administrators has provided a significant and unprecedented consensus for shaping a universally shared concept for mental health that stands to enrich the mental health services in the country.

I would like to express my special thanks to all the officials who supported this important initiative at each step. My gratitude must also be extended to the many scientists who responded to our call for help with a very broad perspectives. I also thank all the public authorities and institutions (governmental and non-governmental) that contributed to our efforts. I am personally grateful to the representatives of many non-governmental organizations and professional associations for their enthusiasm and for the seriousness by which they attended to their responsibilities. The development of a NMHP is a shared and fundamental aspect of the health services system in Turkey. This first formal report prepared in this direction should be considered as an initial but crucial step among many future steps for the development of an effective and sustainable National Mental Health Policy for the country.

This work therefore represents the contribution of many scientists on both a national and international scale. We are very proud that at the end of this profoundly significant and difficult task, a policy document has been established that takes into consideration the sociocultural traditions of Turkey and views of many that would otherwise have been silent. This document is expected to be a basic foundation document in the development of forthcoming and new policies related to mental health programs and practices in the country. Following the launch of our project, it has been a pleasure for us to see that mental health professionals can focus on this issue and carry out the work in many independent ways by organizing additional activities. In the final analysis completion of this first NMHP for Turkey ought not to be viewed as a final result but the beginning of an inclusive process in the service of all citizens. We are pleased that the NMHP document has been endorsed by the Government of Turkey and can now be regarded as an ever-changing document that is dependent on the contemporary needs of Turkish society.

I would sincerely like to thank the Honorable Minister of Health Recep Akdağ, Necdet Ünüvar, İsmail Demirtaş, Cihaner Erel, Turan Buzgan, Mehmet Uğurlu, Fehmi Aydınli, Tahir Soydal, Reşat Doğuşan, Hayati Baykan, Toker Ergüder, Ahmet Tunç Demirtaş and Tuğba Kurtuluş (Ministry of Health); Myron Belfer, Alex Cohen, Leon Eisenberg, Gordon Harper, Judy Palfrey, Julius Richmond, Ludwig Szymanski (Harvard Medical School); Deniz Yücel, Verda Tunalıgil, (Children’s Hospital Boston); Musa Tosun and Medaim Yankı, Duran Çakmak (Çakmaklı Mental Health Hospital, Turkey); Vamik Volkan (University of Virginia); Phillippe Heffrinck, William Gardner, Mine Süngün, Ayşe Yalın, Nurper Ülküer, Yakut Temuroğlu and Jane Barham (UNICEF, Turkey); Toril Araldsen,
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Best regards,

Kerim M. Munir, M.D., MPH, D.Sc., MH/DD Program, Childrens Hospital, Harvard Faculty of Medicine, Boston, ABD

Specialist in Adult Psychiatry (Massachusetts General Hospital/American Board of Psychiatry and Neurology Committee)
Specialist in Child and Adolescent Psychiatry (McLean Hospital/American Board of Psychiatry and Neurology Committee)
Doctorate in Psychiatric Epidemiology & Mother and Child Health (Harvard University School of Public Health)
The National Mental Health Policy (NMHP) as declared by this document represents a statement by the Ministry of Health of the Republic of Turkey in accordance with the principles and international standards set forth by the World Health Organization (WHO) taking into consideration the salient conditions in the country. The Ministry of Health of the Republic of Turkey intends to use the NMHP as a reference in directing future questions and discussion related to the development of mental health programs and strategies in the country.

A series of activities have been completed in line with the NMHP objectives. As part of the NMHP process, three separate national conferences were held with the participation of invited representatives in each relevant sector and the approval of the Ministry of Health. In these conferences valuable information was gathered on the plans, strategies and resources of these sectors. The invited local experts also examined possible international initiatives in relation to the needs of the Turkish Republic.

A number of professional organizations with interest in the field of mental health sector in Turkey compiled written suggestions of the NMHP. Additional contacts were made with relevant non-governmental organizations and opportunities given to make further comment. A number of visits were also made to institutions across Turkey in the field of mental health. The policy group made presentations in national and international conferences. The prior country relevant research and available literature were taken into consideration. Considerable attention was paid to disaster preparedness in the country especially given the inception of this process in the aftermath of the Marmara earthquakes. In addition, statistical data and records on mental health from the archives of the General Directorate of Primary Health Care in the Ministry of Health were requested and taken into consideration to the extent possible.

The World Health Organization (WHO) Service Guidance Package for extending the scope of the NMHP formed the basic reference resource for our initial work; this package provides structured modular information to assist countries in improving the mental health status for their societies. The modular structure of the package elaborates on different dimensions of mental health. Our study group therefore uniquely adapted these modules to the country specific conditions in Turkey. The parts listed in this NMHP report for Turkey therefore represent adaptations. In this document the NMHP for Turkey is organized under eight parts: organization of services, treatment and rehabilitation services, child and adolescent mental health, financing, quality improvement, legislation, advocacy, training and research and human resources. The salient contemporary situation in the country is examined under each part; the objectives and strategies proposed for fulfilling them are listed; and the responsible agencies involved specified. In the section on recommendations the strategic priorities are also included.

As a conclusion, it is emphasized that the NMHP ought to be understood as the inception of a process, meaning that the importance attached to development of a NMHP for Turkey is a continuous one and that NMHP ought to be considered as a living and ever evolving document taking the changing future circumstances in the country.

Key Words: National Mental Health Policy, Policy, Mental Health, World Health Organization, Republic of Turkey
The goal of the National Mental Health Policy (NMPH) for Turkey is to mobilize needed resources for the effective establishment of accessible and balanced mental health services according to the country’s needs. The NMHP document is an important first reference guide for arrangements to be undertaken by the Ministry of Health of the Republic of Turkey for its implementation, as well as for the formulation of future strategies, plans and programs to address population needs.

As part of the NMHP process, a series of activities have been completed in line with the project objectives. Three separate national mental health conferences were held with the participation of the representatives of mental health and allied sectors with opportunity for them to submit further recommendations in writing. The conferences led to valuable information regarding proposed plans, strategies, resources and opportunities for discussion of international initiatives for the development of a NMHP. The recommendations were examined by local experts and their feasibility further elaborated upon according to country specific needs as well as the responsibilities of the Ministry of Health. Written recommendations of the professional organizations acting in mental health and allied disciplines on the development of NMHP were also compiled and have been included. Contacts were made with non-governmental organizations. Visits were made to representative institutions providing a range of mental health services; presentations were made in national and international meetings; previous research completed in the country were examined; and relevant information on the mental health practices of the Ministry of Health and the Provincial Health Directorates were obtained. During the studies due attention was also been given to the new developments in the earthquake region. Finally, statistical data and records at the archives of the Ministry of Health on mental health were requested and considered in all the analyses to the extent possible.

This project used the World Health Organization (WHO) Service Guidance Package for development of national mental health policies as a resource guide. We further adapted the WHO modules to country specific needs. Current situation in Turkey was examined under each module heading; objectives and strategies proposed listed; and related and responsible agencies identified.

The modules proposed under the Service Guidance Package of WHO are to be considered as one possible breakdown allowing systematic examination. The eight parts adapted in the NMHP document for Turkey includes: organization of services, treatment and rehabilitation, child and adolescent mental health, financing, quality improvement, legislation, advocacy, training and research and human resources. These parts were adapted from the WHO package in a manner to allow for examination of each module according to the situation in Turkey. The parts are complementary and ought not to be considered separately. In this respect, all treatment and rehabilitation services are intertwined with organization, financing, legislation, training and research and human resources. There may be a tendency to give more emphasis to one part over another depending on the special interests of a given sector. Nevertheless, the NMHP for Turkey ought to be a coherent and considered process. We therefore caution against a fragmentary self-interest based approach and recommend that the this document be considered in a holistic fashion by weighing in country disparities, needs and limited resources.

Listed below are the forty three summary objectives adapted from the eight WHO modules in Parts 5-12 of the report according to the conditions in Turkey. The background situation and rationale for these objectives and strategies are discussed in detail under each relevant part in the full report.

**Module 1: Organization of Services for Mental Health**

**Objective 1:** To eliminate barriers in access in mental health services,

**Objective 2:** To enhance the administrative structure in management of mental health services at both central and provincial levels,

**Objective 3:** To develop scientific mechanisms to continuously monitor and evaluate mental health system across the country,

**Objective 4:** To enhance the mental health service delivery at the provincial level,

**Objective 5:** To meet the urgent mental health need arising from natural disasters and emergencies including accidents, terror, migration and other crises

**Objective 6:** To permit the introduction of private sector mental health services to augment mental health care under the public sector,

**Objective 7:** To establish an organizational structure responsible for development of rehabilitation programs and services in mental health system.
Objective 8: To ensure coordination of public and private agencies in the mental health system.

Objective 9: To ensure synergy and coordination between allied professionals and associations involved in the mental health system.

Module 2: Treatment and Rehabilitation Services

Objective 1: To improve the interface between treatment and rehabilitation.

Objective 2: To adopt an individual and family centered approach to treatment and rehabilitation.

Objective 3: To implement complementary and comprehensive modern treatment approaches that includes pharmacological and psychosocial interventions within a complementary and comprehensive treatment model.

Objective 4: To give necessary priority for the treatment and rehabilitation in substance use and its social consequences.

Objective 5: To develop community based approaches in treatment and rehabilitation.

Objective 6: To provide training to employers under the scope of rehabilitation in the workforce and to ensure inclusion of mentally ill persons in the workplace at specified levels as productive citizens.

Objective 7: To provide community based home care and family support and stabilization services for seriously mentally ill individuals for inclusion in society.

Objective 8: To develop rehabilitation programs based on an individual’s needs and strengths.

Module 3: Child and Adolescent Mental Health Policy

Objective 1: To identify high risk children and adolescents and to develop targeted programs.

Objective 2: To improve quality and number of professionals engaged in child and adolescent mental health system at all levels.

Objective 3: To improve coordination among all relevant disciplines in child and adolescent mental health and to raise awareness of synergy between the sectors in cost efficiently addressing urgent current need as well as in improving quality of care.

Module 4: Mental Health Financing

Objective 1: To identify the scope of financing of mental health services within the general health care.

Objective 2: To identify the existing sources of mental health financing across other sectors.

Objective 3: To identify the financing source base for mental health services.

Objective 4: To identify the efficient means of allocating the collected funds.

Objective 5: To link budget management and accountability.

Objective 6: To purchase effective and efficient mental health services when necessary.

Module 5: Quality Improvement for Mental Health

Objective 1: To consider service quality as well as quantity in delivery of mental health services.

Objective 2: To identify quality improvement standards in mental health.

Objective 3: To identify and authorize individuals to ensure quality improvement in mental health services.

Objective 4: To sustain the application of quality improvement standards in mental health services over the long term.

Module 6: Mental Health Legislation

Objective 1: To develop mental health laws encompassing universal rights and compliance with United Nations conventions and international law.

Objective 2: To enact a law protecting the rights of patients with mental illness.

Objective 3: To update existing legislation in mental health according to universal standards.

Objective 4: To enact legislation allowing implementation of the Convention on the Rights of the Child.

Objective 5: To enact legislation governing professionals in the field of mental health as a single piece of legislation or a framework law.
Module 7: Advocacy for Mental Health

**Objective 1:** To facilitate non-governmental organizations (NGO’s) to lead advocacy activities to promote the fundamental individuals with mental illness in eliminating stigmatization and discrimination.

**Objective 2:** To advocate improvement of rights and working conditions of professionals delivering mental health services.

**Objective 3:** To raise awareness of politicians and key decision-makers on need for mental health advocacy.

**Objective 4:** To raise awareness of all relevant segments in society on importance of mental health advocacy.

**Objective 5:** To sustain mental health advocacy activities over the long term.

Module 8: Training, Research and Human Resources in Mental Health

**Objective 1:** To urgently increase both the number and quality of trained professionals at all levels in the mental health system.

**Objective 2:** To plan for and provide additional personnel in priority mental health services with provision of specified employment positions for them.

**Objective 3:** To support scientifically sound and culturally relevant research to systematically study mental health indicators across all regions in the country.

**Main Recommendations for the NMHP**

Main objectives and goals covering the structure of the NMHP can be briefly summarized as follows:

There is a need to integrate evidenced based methods in primary health care services and to underscore the importance of improving quality and quantity of locally available mental health services in the provinces. The primary health care system is the initial contact for most individuals that enables early diagnosis and treatment. If family practice model is enacted the responsibility of family practitioners will be increased to facilitate both primary general and mental health services. The primary health care system nevertheless will continue to play an important coordinating role with the secondary and tertiary care referral institutions. In this respect, it remains a significant goal to provide appropriate training for physicians and other health care professionals practicing in the primary health care system for the proper identification, diagnosis and treatment of salient mental disorders with specific reference to the demographic and cultural profile of the local population in each province.

There is a need to conduct systematic screening of important mental disorders in the community and to raise awareness for the development of mental health programs that allow for early identification and treatment for individuals at risk. Preventive mental health services will need to be developed in the provinces to focus on these activities.

It is important to strengthen the cooperation, consultation and communication among all institutions delivering mental health, social and educational services in the country. Lack of cooperation continues to be a major obstacle and is an endemic sociocultural and administrative problem that needs to be addressed urgently. Furthermore, emphasis ought to be given to establishment of cooperation both within as well as between all allied disciplines and sectors.

The patients and their families ought to be at the core of a harmonious and accessible system of mental health services. Legislation needs to be enacted urgently to legitimize patient rights and to overcome their stigmatization and isolation. The legislation should allow patients and their families to have access to mental health services and a have voice in care delivery.

The delivery of evidence-based mental health practice is universally valued across all sectors. A core group experts selected based on merit ought to provide ongoing advice on policy matters. Specific recommendations have been made on this issue under the module on organization of mental health services. In addition, Mental Health Teams ought to be developed under the Ministry of Health and
Mental Health Directorates in the Provinces for implementation of mental health services plan with specific adaptation to each province according to demographic and sociocultural needs. It is important that the membership of the Mental Health Teams remain interdisciplinary with involvement of community interest and advocacy civil groups. In a similar light a National Mental Health Council should be established nationally with a rotating membership based on scientific merit to advice regarding the activities of the Mental Health Teams in the provinces.

There is an urgent need to develop new community based mental health programs. Mental health legislation should therefore be enacted to promote access to uninterrupted services in the community.

There is an urgent need for additional investments with regards mental health and social services in all provinces with emphasis on population growth, migration and regional disparities. Such investments should include increasing bed capacity in the hospitals on the one hand and establishing mental health care teams available 24-hour a day for emergencies. In principle, services for patients with serious mental illness (SMI) should be available in each province close to their families and communities. Tertiary care programs should be accessible to the communities and not contribute to isolation of patients with SMI away from their homes.

Adequate information and support should be available in service delivery as well as management. Information technology and online resources should be made accessible locally in the provinces. This is helpful in terms of services as well as management. Establishment of hotlines and support services also plays a major role in mental health promotion, patient and provider education and programs to reduce stigmatization.

In implementing a coherent NMHP both those receiving services (patients, families, and the communities) as well as providers delivering mental health services in the field ought to be polled at suitable intervals to identify unmet needs and measure outcomes. This is also important for acknowledgement of successes and development of incentives to reward such successes.

It is important to develop indicators to assess the performance of mental health providers and newly established programs. This necessitates identification of a vision on how the service should be structured. In this respect there is overarching need to assess the overall community effectiveness of the programs.

Regardless of the success attained by the primary health care services in identifying and preventing early problems and the role played by the Regional Mental Health Hospitals in provision of tertiary care services and training, the current system is not sufficient to meet service requirements of the community. It is important to refer to the contributions of the other parties in charge of mental health and other sectors, besides those delivering and receiving such services.

Objectives of the NMHP are: to establish readily accessible community based mental health services to mobilize community based resources in various sectors; to assist patients and their families; and to minimize the effects of stigmatization and discrimination.

Both prevention and treatment ought to be focused on patients and families who are recipients of services. Furthermore, both the prevention and treatment ought to be integrated with and coordinated within the general health and social services.

In summary, the strategic mental health priorities for Turkey are:

- To deliver evidence-based, cost-effective, high quality, and requisite mental health services in accordance with universal standards; to use state of the art technology to develop community based services accessible to all citizens with special emphasis reduction of geographical disparities; to emphasize individual and family based care; to maintain liaison with schools in promoting preventive interventions; to establish coordinated care within relevant sectors.

- To develop programs to deal with mental health problems likely to arise secondary to natural disasters and emergencies; to develop disaster preparedness programs with a detailed national plan in case of future emergencies; to develop
training of adequate personnel; to allocate the necessary resources to ensure rapid implementation of such programs under national conditions.

- To allocate specific financial resources to enrich mental health services as compared to other competing health expenditures in the national budget; to enact legislation for the use of necessary funds for the development of rehabilitation services; to prioritize preventive mental health services by taking into account population demographics, growth, migration and socioeconomic disparities across regions; to pay attention to relevant professional workforce trends.

- To raise public awareness in the community as part of an urgent program to address stigmatization, discrimination and exclusion resulting from prejudice against mental illness associated with lack of knowledge; to address universal rights with consideration of international mental health and disability rights.

- To provide quality training and develop adequate number of mental health professionals in allied disciplines with consideration not only of psychiatry, child psychiatry, psychology, social work, but also psychiatric nursing, child care and development, counseling and guidance, rehabilitation, family and marriage therapy, occupational therapy, speech therapy, among others; to identify and track measures of recruitment, performance and academic and regional mobility of mental health professionals; to consider the need of the provinces with regards to allocation of professionals; to ensure an equitable distribution of mental health professionals across the provinces.

- To introduce inpatient mental health services at general hospitals in the provinces and districts to relieve the intensive patient burden on tertiary institutions delivering add-on primary and secondary care services and thus enabling them to function as centers of excellence for specialized mental health care and research; to lift this latter obstacle to promote more focused training and research programs; to establish nationwide and community based rehabilitation centers to the same end; to consider at all times the dynamic and changing demographic factors in the country due to social, economic and political reasons, with regards to the organization of mental health and rehabilitation services mentioned herein; to make the necessary related modifications in a timely manner, i.e., to establish a mental health service system responsive to emerging social conditions.

- To involve families, relevant social and community based interest groups to assume a major role in achieving a desired and satisfactory level of mental health services mentioned, including programs to raise awareness in a broad sense; to enable the necessary coordination to facilitate the activities and role of volunteer mental health services and the work of national non-governmental organizations (NGOs) in the community; to enact the necessary pieces of legislation to facilitate the work of NGOs sharing the mental health burden and costs; to continue to make the necessary amendments in the legislation required to allow the NGO's to effectively cooperate with international organizations within the framework of harmonization with the European Union (EU) Acquis Communautaire; to include the NGOs in the coordination boards proposed for service organization in terms of mental health and other relevant practices; and to provide the NGOs with the opportunity to have a say in the decision-making processes without disregard of national priorities.

A clear declaration of the political will and commitment of the Ministry of Health and Republic of Turkey for the implementation of a NMHP as envisioned in this document is the most crucial contribution of this project. It is necessary to have a continuous and consistent support in all matters related to legislation and future action steps by the Government of Turkey with respect to the general principles and recommendations listed herein. The future success of the NMHP hinges upon continuing political commitment, awareness and respect for the mental health of all citizens irrespective of their circumstances.

A misleading conceptualization with regards to development of future mental health services across all sectors was observed while preparing this work - this fallacy is that specialized services is only the concern of limited professions within a broad sector as mental health. As is clear from the scope of the NMHP declaration, a number of interest groups, agencies and professions need to
mobilize to share the burden of mental health services for the population at large, various sectors, agencies and professions have been listed under the heading “relevant agencies and institutions” at the end of each objective in each module. These “relevant agencies and institutions” will share the responsibility and help develop a synergy with the Government of Turkey for a cohesive mental health system. What is important for the related parties is not to shift responsibility or blame to others but to assume the appropriate expertise in solving problems together. Development of mature agency, accountability and professional ethics is key in this approach. In other words, there is a need to assume selfless agencies and institutions that serve public needs. Therefore paraphrasing the ethos of John F. Kennedy’s Presidential inaugural address in 1960, the NMHP requests that in developing a modern mental health system all relevant agencies and institutions ought to ask not what the country can do for their profession, but what they can do to better the mental health system in Turkey.

As is clear from the report therefore a major priority is an equitable distribution of the burden of disparities in availability of mental health services in Turkey and the need to deploy various professions and agencies in a coordinated and extensive manner to address the urgent needs in the country. In this respect, the government must ensure that the NMHP is adopted by all the relevant parties. This is one way of complying with the cost-effectiveness principle, an obligation that all governments assume, that delivering services has to be cost effectively available to those in need in great numbers. Otherwise, if these responsibilities are not shared and there is no unified front it is likely that the mental health care funding will be compromised. As it will be observed in this ensuing report, majority of our recommendations in the NMHP will safeguard this important principle. The development of NMHP is therefore a reciprocal process in which both governmental, non-governmental and to some extent private agencies will need to cooperate in the service of normalizing the mental health of all citizens.

The NMHP report has been prepared by adapting the WHO guidelines and taking into consideration the current situation in Turkey including the relevant national and international literature. The NMHP of Turkey ought to continue to require and benefit from revisions in the light of emerging conditions in the future. In other words, the current NMHP activities ought to be considered not a final result but the beginning of a dynamic process. It is hoped that future revisions of this living document will overcome any perceived deficiencies but nevertheless follow similar level of scientific caution in their approach.
According to the World Health Organization (WHO) a National Mental Health Policy (NMHP) for a specific country is a formal document authorized by the Ministry of Health and designed to improve and enhance the mental health status of all citizens with special emphasis on setting objectives, identifying priorities in addressing such objectives and proposing strategies to fulfill them. As envisioned in this report, the NMHP stipulates six main components: (1) decentralization; (2) inter-sectoral cooperation; (3) comprehensiveness; (4) equality; (5) sustainability; and (6) community participation. The NMHP proposed in this report for the Ministry of Health of the Republic of Turkey is structured by strictly following these six principles.

A Mental Health Program is a national action plan that includes all relevant and allied sectors for effective implementation of a NMHP. This program identifies and organizes the activities required to fulfill the objectives specified in the NMHP and includes matters related to the actions to be taken, distribution of responsibility among the several sectors, time schedule and resource allocation. A number of different mental health programs may be implemented at the same time in order to fulfill various objectives. This has been a model for countries that have successfully identified a NMHP. The Republic of Turkey plans to develop and implement several mental health programs in the upcoming years under the coordination of the Ministry of Health in order to fulfill the objectives proposed under the umbrella of a NMHP. Approaches involving such Plans, Programs and implementation mechanisms mentioned herein within the scope of a NMHP are discussed in detail in Parts 2 and 3 of the report.

WHO has been encouraging all countries over the past two decades and more to identify a coherent NMHP that will serve as a guide for effective mental health services across the country. As a result of these efforts, 60% of the countries in the world have in fact identified and implemented a formal NMHP. These countries correspond to 85% of the world’s population. Nevertheless, 40% of the countries still do not have a NMHP in place; Turkey has been formally included in this latter category. The NMHP for Turkey proposed in this report therefore serves as the first extensive attempt to help guide mental health plans, programs and practices in the country under the auspices of the Ministry of Health. The document is intended to be integrated within the General National Health Policy and to be used to improve and enhance the countrywide integrated general health and mental health services.

BACKGROUND OF THE STUDY

The efforts undertaken on behalf of the Ministry of Health of the Republic of Turkey in the past three decades to achieve a final NMHP in accordance with international standards were given a major impetus following two major earthquakes that struck the country in August and November 1999. These devastating earthquakes not only resulted in unprecedented loss and physical destruction, but also exposed the crucial importance of mental health and the need for development of services in the community.

Marmara Earthquakes

In less than a minute, at 3:02 a.m. on August 17, 1999, the lives of the Turkish people changed forever. A major earthquake measuring 7.4 on the Richter scale (RS) struck the nation’s Marmara region, which includes Istanbul and the heavily populated industrial heartland. The estimated loss of life under the massive destruction of buildings far exceeded the official toll of 18,000; many people were not recovered. An additional 45,000 people were injured, and more than half a million were in immediate need of shelter. One percent of the overall Turkish population was directly affected by this earthquake. The province and port city of Kocaeli ( İzmit), the naval dockyards at Gölcük, the provinces of Yalova and Sakarya with its ancient capital Adapazarı, and the mountainous province of Bolu (on the pass between Istanbul and Ankara) bore the brunt of the sustained tremors. Nearly 80% of Gölcük’s buildings were damaged or destroyed – not just by the powerful initial tremor, but also by a six-foot drop in the seabed that triggered a tidal wave that engulfed part of the coastal town. The adjacent cities of Bursa and Eskişehir, as well as the districts of Avciyar and Başgöl in the Istanbul province, were also affected. The proportionate impact in the United States would be analogous to 100,000 lives lost, 225,000 injured, and 2.25 million in need of immediate shelter. The earthquake’s economic impact was equally devastating: one third of Turkey’s industrial infrastructure came to a standstill because of disruptions to the road and railway transportation systems, water and sewage lines, electrical grid, and oil-refining capacity.
Düzce Earthquake

Three months later, on November 12, 1999, the Kandilli Observatory in Istanbul measured a second powerful earthquake in the same general region as the first; measuring 7.2 RS, its epicenter lay roughly 50 miles (just under 100 kilometers) immediately east of the first in the provinces of Düzce and Bolu (Figure 1). An additional 850 persons were killed, 4,500 injured, and 250,000 made homeless. Further injuries were minimized for a variety of reasons. Fearing the effects of aftershocks, many inhabitants had left their homes and were living in tents. Moreover, unlike the Marmara earthquake, which had struck in the middle of the night, this second, Düzce earthquake struck at 7:00 p.m., when most people were awake. Also important was that, due to the previous, nearby Marmara earthquake, the emergency response teams were already close at hand, as were various NGOs that had mobilized in the region. Even so, this second earthquake proved to have an especially distressing impact on the residents of the socioeconomically depressed town of Kaynaşlı in the Düzce province. A similar situation was noted by Goenjian and colleagues with respect to the Yerevan earthquakes and described conceptually by Yehuda and colleagues among Holocaust victims. Making matters even worse was that the approaching winter proved to be especially harsh, isolating survivors and restricting access to this mountainous region.

Geological and Psychological Aftershocks

From August 17 to December 14, 1999, a total of 1,391 aftershocks measuring between 2.4 and 5.2 RS were recorded—an average of 12 per day. Initial assessments completed in the earthquake provinces showed that those who were psychologically affected included not only many families with young children and elderly grandparents, but also local police, firemen, soldiers, and municipal workers. Many relatives and friends were missing, and supply lines for basic services and goods were impaired or destroyed. Acute stress reactions were common, and the need for urgent aid was paramount.

By January 2000 some 150,000 people were still accommodated in tents, with prefabricated settlements (which came to be referred to as “cities”) being established continually. The reestablished education and health services were functioning under severe constraints. The Recovery Plan for Turkish Children under the UNICEF earthquake emergency program had estimated that more than 25% of the teachers in the region had been effectively incapacitated—either because they had been victims of the earthquakes themselves or because they returned to their homes in other parts of the country.

MARMARA EARTHQUAKE EMERGENCY RECONSTRUCTION (MEER) – TRAUMA PROGRAM COMPONENT MENTAL HEALTH PROJECT

The Department of Mental Health, Directorate General for Primary Health Care Services, Ministry of Health, Republic of Turkey was authorized to implement the Marmara Earthquake Emergency Restructuring (MEER) Project – Trauma Program, as per the Agreement of 23 November 1999 signed between the Republic of Turkey, considered to be a high risk earthquake area. The Protocol was signed by the World Bank and the Ministry of Health and the Project Implementation Unit under the Prime Ministry on 7 February 2001 with a view to mitigate the physical damage caused by the earthquakes in the Marmara Region; 1 percent of this loan was allocated for psychosocial and mental health related projects and development of community based mental health services. The NMHP was only a very small part of these revitalization efforts.

The overall “Mental Health Project” historically envisioned a restructuring of mental health services according to the population needs and prevalent conditions in the country by enhancing the quality and accessibility of mental health services in a manner to also include mental health education of the people, and improvement of the capabilities and skills of the primary care health professionals and personnel that had shouldered a majority of the burden in the delivering ad hoc and inadequate mental health services at the time of the earthquake emergency.

The following actions were proposed under the scope of the over arching Mental Health Project:

- To develop a National Mental Health Policy (NMHP) for Turkey;
- To provide preventive mental health training to the primary health care personnel;
• To introduce public awareness campaigns and aiming at improving and enhancing mental health;
• To provide “Program Management and Psychological First Aid” training to the personnel of Mental Health Directorate both at the central and provincial level;
• To meet the training and office supply needs of the Provincial Mental Health Directorates.

Methodology for the Development of NMHP
In terms of resources under the Mental Health Project, the NMHP constituted a symbolic component of the MEER resources available to the Ministry of Health as outlined above. In this light, the Ministry of Health developed a tender in order to select an entity to stimulate activities for the future development of a NMHP for Turkey. The MHDD Program was competitively selected in meeting the proposal requirements among a number of international groups submitting applications according to MEER guidelines.

CALL FOR EXPRESSION OF INTEREST

Republic of Turkey
Ministry of Health
Marmara Earthquake Emergency Restructuring Project (MEER)

CONSULTANCY SERVICES FOR DEVELOPMENT OF NMHP FOR TURKEY

Loan No. 4517-TU

This call for expression of interest follows the General Procurement Notice published at “Development Business” of the United Nations on volume 554 of 16 March 2001.

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 “NMHP”.

The proposed consultancy services cover the following:

1. To identify a Mental Health Policy for Turkey upon detailed analyses of the existing mental health strategies at the national, provincial and municipal level in a manner to also include the developments in the aftermath of 1999 August and November earthquakes;
2. To assess the strategies, plans and resources of the institutions playing a role in mental health;
3. To identify and analyze the international initiatives on mental health and ensure their feasibility to the needs of the Republic of Turkey;
4. To prepare a detailed set of recommendations for the short and long term measures to minimize the impact of disasters on the mental health of the individuals and the society of the Republic of Turkey and to provide for emergency and post-disaster trauma treatment, in manner to also cover the institutional and budgetary resources required for effective implementation of the proposed strategies;
5. To organize a series national workshops with a view to develop Mental Health Policy.

The MHDD group conducted its activities in the light of all the aforementioned requirements. The national and international experts, approved by the Mental Health Department of the Ministry of Health were convened at three conferences in Ankara (National Mental Health Conference I, 12-13 December 2002, National Mental Health Conference II, 10–12 March 2003; and National Mental Health Conference III, 4 July 2006). In the first and second conferences participants were given the opportunity to work jointly during in
round table discussion meetings. In all these conferences to which representatives of all the relevant sectors on mental health were invited by the Ministry of Health, valuable information was obtained on by the MHDD group regarding the plans, strategies and resources available in these sectors. The national and international presentations highlighted numerous subjects relevant to the modules of this report based on WHO guidelines that were evolving for the first time at the time. These guidelines were translated into Turkish and appraised for their feasibility.

In addition to the national conferences, the core MHDD group and Ministry of Health representatives also made study visits to select public and private mental health institutions and centers in different parts of the country. The MHDD group also collected and subsequently analyzed data, whenever available, on the mental health strategies in place in these regions. The project group also attended meetings with national authorities as well as representatives of major non-governmental organizations and professional associations in mental health fields and requested written formal recommendations. These documents have been included in full in the Appendix and many of the recommendation integrated into the main body of this report. The final version of the report was approved by a review committee of national mental health leadership selected by the Ministry of Health.

The MHDD program national and international membership participated in additional national and international meetings that highlighted parallel activities for the NMHP development activities in Turkey. Among these, an important meeting organized under the auspices of the Ministry of Health included a day conference on “Improving Mental Health Services” chaired by Prof. Rüstem Aşkin, upon the call of Prof. Recep Akdağ, Minister of Health. The meeting was held in Ankara on 10-11 June 2004 at the Ministry of Health with the participation of Scientific Mental Health Advisory Board of the Ministry of Health, Professional Associations in the field of Mental Health, university representatives and other invited colleague again with the approval of the Ministry of Health. Following the discussions at this meeting, a list of recommendations for improvement comprising of 27 items aiming specifically at improving the existing Mental Health Services in Turkey was presented to the Minister of Health. A monitoring board comprised of five individuals was established in order to monitor the implementation of these recommendations with the approval of the Minister. It was decided to have two representatives from the Ministry of Health and one representative from each professional association on this Board. Due attention was given for the integration of the decisions taken in this meeting to the policy document prepared as per the relevant international standards. The specific decisions and recommendations of the Scientific Mental Health Advisory Board of the Ministry of Health are included in Appendix 3.

The developments in the earthquake disaster region were carefully assessed in detail during the course of the project. The National Institute of Health (NIH) supported MHDD Program activities in fact funded a number of research activities in the earthquake provinces through competitive research fellowships. Throughout the tenure of this program a number of visits were made to the earthquake provinces. In addition, statistical data and records at the archives of the Ministry of Health on mental health services were requested but were only partially available as no formal surveillance mechanism existed on the status of mental health services. Nevertheless, the information obtained was carefully considered during the analyses to the extent possible.

Although there has been no formal NMHP in Turkey according to the WHO standards this had not been due to lack of effort. In fact, a number of preliminary but important efforts were undertaken on the subject with keynote meetings held by the Ministry of Health over the past three decades. These activities and recommendations have been duly referenced in a systematic study presented at the National Mental Health Conference I and subsequently published in 3P Psychiatry Psychology Psychopharmacology Journal, a national publication. This paper has been included in Appendix 4.

The NMHP report is therefore an outcome of a range of systematic activities as described above. A number of epidemiological studies and major research on risk factors conducted in the country on mental health outcomes were examined by the MHDD working group and considered during the writing of the report. Before proceeding to the mental health situation and subsequent modules of the report, we shall briefly summarize some of the salient historical background information that has influenced the underlying NMHP philosophy.
Mental Health Policies: Recent Global Trends

Many developed countries have witnessed a shift from institutional hospital-based systems to community-based models in the care of persons with serious mental illness (SMI). This transformation had occurred in the latter half of the 20th century. Lack of humane conditions through end of 1950's and increasing cost for maintaining institutions had began to result in a gradual discharge of majority of patients with SMI from state run public mental hospitals, with similar reduction in personnel or outright closure of these institutions. There has therefore been an important paradigm shift for care of these patients in the community. This coincides with the mental health movement of the 1960s and beyond in the United States with subsequent development of alternate levels of care involving residential treatment centers, partial or day hospitals and intensive outpatient programs. Providing care of patients out of the institutional context or avoidance of hospitalization altogether is obviously a complex transitional process that continues to be debated in many developed countries. It is not the intent of this present report to discuss these issues. Needless to say, the practice of providing care for patients out of institutions in the public sector has not altogether succeeded to accompany development of appropriate community programs and services.

In many developing countries public psychiatric services have remained inadequate in general terms and undoubtedly continue to suffer from serious lack of resources. These include lack of qualified personnel, inadequate facilities and intense patient flow. Nevertheless, the trend to assume humane care of patients with SMI in the community and impetus for improvement the quality of services given to them gives reason for optimism. Among these changes also were advances in neurobiological understanding and treatment of SMI and changing social and public attitudes. Other developments include successful preventive interventions targeting common disorders such as depression and anxiety. Developmental psychology also has led to more optimistic formulations of problems that have inception in early childhood and adolescence. Furthermore, clinicians, irrespective of their location, have better access to a greater range of scientific information; psychotropic medications are more readily available and more efficacious for certain disorders. From a community treatment and inclusion perspective, research also points to improve efficacy of psychological and psychosocial preventive interventions in mitigating adverse outcomes. This all bodes well for development of community based approached in NMHP in Turkey, a developing country with a strong university based tradition and rapidly evolving commitment to international education.

Mental Health in Turkey: Strengths and Weaknesses

Turkey remains a middle income developing nation with a youthful population. The country has finally started full membership negotiations with the European Union (EU) in October 2005 the outcome of which is yet not so clear. The country’s dynamic and increasingly highly literate population has a huge potential for labor with particular reference to the development of necessary human resources for rapid advances in the health sector, provided, of course, that the required level of job opportunities will continue to be developed. There have been intensive efforts in the country for some time with a view to harmonizing the entire legislation of the country with the EU Acquis Communautaire in line with the process of membership to the EU. Health related laws and legislation is also being revised to this end and the necessary amendments and reforms performed for harmonization. Start of the negotiations with the EU is a concrete step taken on the way for ultimate EU membership in the next two decades. Although the EU membership have been a goal for half a century the process ought to be considered as an opportunity for Turkey irrespective of the final outcome. These changes are expected to lead to even faster developments in the field of health given the impetus of the Government of Turkey to improve health conditions of her citizens.

Despite the unequal distribution of resources and problematic employment conditions, many health personnel in Turkey are able to make use of high technology. In particular at certain centers in major cities practice models demonstrate superior standards observed in developed countries. Nevertheless, the majority of health institutions maintain traditionally established organizational structures. The revolving fund system in place in the developed hospitals allows for flow of funds with concrete steps taken by administrators to improve conditions as professional and modern entities. Nevertheless, the reward system in financial terms is not based on objective measures of job performance. There is limited opportunities for physicians given their share in the revolving fund under new legislative arrangements. Improvements in the future of newly established models may lead to more equitable rewards based on performance.
Authority and responsibility in service delivery, audits and organization are based on a central, bureaucratic and political organizational structure and thus bring along certain advantages and disadvantages. Majority of the training in particular in adult psychiatry is provided centrally by the Ministry of Health.

Although there are major problems in operational terms associated with personnel allocation and supply of equipment, there is a strong physical infrastructure and services network with regards basic health care services. Care and support of the children, the elderly, patients with SMI and disabled is often provided by family members who provide an excellent traditional support network in the community. This cultural strength thus relieves the burden of the under vested health care system in the country to a certain extent. Although there are many deficiencies in the general health care system of the country, there have been significant declines in the infant mortality rates, mortality due to many preventable infectious childhood diseases, as well as tuberculosis and malaria. This decline has been achieved with the successful efforts of the health care institutions and the establishment of a network of primary health care centers across the country dating back to the keynote public health legislation in 1961.

The 1999 Marmara earthquakes were the most devastating natural disaster in Turkey with the exception of the 1939 Erzincan earthquake with a death toll of almost 40,000 people. Nevertheless, the Marmara earthquakes represent the most recent keynote event that highlighted the persistent deficiencies with regards the organization of mental health services at the level of provinces. Neither the Law of 1961 on Socialization of Health Care Services nor the more recently proposed and implemented reforms under the scope of the Program for Transformation in Health adequately cover basic mental health services at the level of integration in primary health care in the provinces.

Increasing population growth, urbanization and demand for mental health services associated with inadequate level of investment in health care services in general also contribute to a negative picture when accompanied also with this pre-existing gap in organization of basic mental health services at the provincial level. This historical gap in mental health services have actually been on the agenda since 1980’s that has led to initiatives by the Ministry of Health beginning in the 1980s to develop decentralized mental health services. Nevertheless, most of these efforts have not led to any tangible change in policy.

There has been inadequate resource allocation to the health sector due to high levels of domestic borrowing and this is likely to continue in the near future. The lack of adequate funding of mental health services in primary care within the overall health sector has been a subject of criticism by leading figures in mental health field. It has also been noted that the failure to correct the situation at the provincial level, may make mental health services non-functional. The problem has been further exacerbated by increasing demand in urban centers with migration of patients for basic mental health care to tertiary care and training institutions in major cities. The opportunity for transformation in mental health services in Turkey following the Marmara earthquakes has so far remained an ideal. The political will to find solutions hopefully will lead to a meaningful integration of mental health and general health services under the scope of the program for transformation in health, optimistically prior to future similar disasters that will highlight this important void if unchanged.

During the preparation of NMHP emphasis have been given to development of evidence-based and professional standards in mental health practice. The development of a national medical curriculum in medical schools across Turkey is an important strategy to improve the mental health education of future physicians many of whom stand to serve as general practitioners in the provinces. There is an important need for standardization of medical education in this respect which is also likely to help in the campaign to reduce stigma and link mental and physical well being.

Department of Mental Health established in 1983 has rarely been run by the authorities having specialty expertise in the field of mental health. Conflict of bureaucratic priorities and lack of coordination between the agencies have created many challenges in the execution of projects requiring inter-sectoral cooperation and transparency to a great extent. Therefore, integration of different projects has been facilitated through the mediation of the Project Implementation Unit established under the Office of the Prime Minister. Majority of the posts at the mental health directorates at the provincial level remained vacant due to lack of adequate personnel appointments.
The majority of the psychiatrists in the country are mainly practicing in Ankara, Istanbul and Izmir, including the hospitals under the Ministry of Health. The ratio of the total population per one psychiatrist is 1:100,000 in Turkey. For comparison purposes, this ratio is more than 16:100,000 in the United States according to the data of American Psychiatric Association. This ratio is reported to be around 10:100,000 in the EU.

Considering that one third of the Turkish population is under age 18, the ratio child psychiatrists serving the population of youth age 18 and under is 1:500,000. Likewise, 80% of the total number of child psychiatrists in the country are again concentrated in the three major cities, where 13 of the total 19 child psychiatry units are located and majority of these child psychiatry specialists are practicing at the university based hospitals. The remaining six child psychiatry units are located at the universities in Adana, Antalya, Bursa, Gaziantep, Kocaeli and Trabzon. There are two adolescent units under the adult psychiatry clinic in Ankara and one adolescent clinic under the Child Health Institute in Istanbul.

As a result, the total number of mental health specialists in Turkey with a population of over 70 million is about 2000, including the adult and child psychiatrists, clinical psychologists with a doctoral degree, social service workers, psychological counseling and guidance experts and psychiatric nurses. Again, the vast majority of this personnel practice in the three major cities in the country.

One of the strengths of the Turkish health system is the delivery of the primary health care services through the health care clinics in accordance with the basic health care services legislation established following the adoption of the Law No. 224 of 1961 on the Socialization of Health Care Services. However, there is no systematic and functional mental health service in place in the primary health care grid across the country still to the present time. The consequences of the lack of these services were more fully appreciated in the aftermath of the earthquake disasters. General practitioners appointed to the health clinics are provided with a cursory level of mental health education at medical school. Only short term intermittent in-service training sessions has been provided to the general practitioners appointed to these primary health care clinics by the Ministry of Health selected national experts and / or in collaboration with national professional associations. Similarly, although the urban population of Turkey is increasing, the respective development and investment in the emerging health care sector, including the university and state hospitals do not seem to compensate the discrepancy in order to meet rapidly increasing needs in the future.

In the decade preceding the earthquakes, epidemiological studies had shown that many families with mentally ill family members preferred to travel considerable distances to seek help from specialists located in the main cities. According to the research conducted by researches in Ankara and Erzurum, the referral pattern for mental health services was different from that for general medical care; patients and families seeking mental health services would bypass primary care centers and seek help directly from psychiatric centers and specialists. The findings suggest that patients and their families recognized, and acted to surmount, the void in mental health services in primary care centers. Of 582 patients seen in these psychiatric centers during a calendar month, only 4% had been referred by their primary practitioners; 42% had been referred by hospital doctors; and 53% came directly. One percent of all the patients had consulted religious healers before going to the psychiatric centers. Despite the relative sparseness of psychiatric services in Turkey, the median time differential between requesting and receiving psychiatric services was only one week. By contrast, the delay was significantly longer when patients presented with somatic symptoms or consulted hospital based non-psychiatric specialists. The limited recognition of mental health problems in primary care and the inappropriate delays in hospital-based practice suggest that physicians practicing in those settings also need better training in how to recognize and manage basic mental disorders.

WORLD HEALTH ORGANIZATION AND THE NATIONAL MENTAL HEALTH POLICIES

World Health Organization (WHO) in particular after the World War II, has been conducting framework studies with a view to improve mental health status in the member countries. In this respect, WHO has developed the Service Guidance Package for to serve as a basis for the identification of National Mental Health Policies in member countries. This package covers practical information to assist countries to improve the mental health status of their general population. The objective for use of this Service Guidance Package
can mainly be summarized under four items:

- To identify policies and comprehensive strategies in order to improve mental health status of the general population through a community-based and preventive approach;
- To make optimum use of the existing resources;
- To deliver effective services to those in need of such services;
- To ensure integration of the mentally disordered persons with all the dimensions of social life and thus to increase their overall quality of life.

Service Guidance Package has been accepted by many ministries of health as a blueprint for development of national policies, plans and programs and to provide general framework for their implementation. The WHO Service Guidance Package was adapted to the conditions in Turkey under the following modules:

- Organization of Services for Mental Health
- Treatment and Rehabilitation Services
- Child and Adolescent Mental Health Policies
- Mental Health Financing
- Quality Improvement for Mental Health
- Mental Health Legislation
- Advocacy for Mental Health
- Training, Research and Human Resources in Mental Health

The NMHP for Turkey is examined under eight modules with a list of specific objectives. For each of the objective so identified, its underlying rationale and the current situation constituting its basis is briefly discussed and strategies to attain the objectives are described. Finally, the relevant public and private collaborating agencies and institutions necessary for the implementation of the strategies are noted. Similar structure is noted for each consecutive modules. Thus a consistent format has been used to allow for comparison between the objectives and strategies across modules.

The modules are briefly summarized below:

1. **Organization of Services for Mental Health**

The organization of services for mental health has a major impact on the effectiveness of the services and the success in fulfilling the objectives of the NMHP. There is no one single model for mental health services and the main service area and delivery of mental services depend on the social, cultural, political and economic structure of Turkey and the information and experience obtained as a result of available research in the respective field. The organization of services for mental health should be based on the principles of accessibility, well-coordinated services, sustainability, effectiveness, and respect for human rights and equality. The major concern of the service planners should be to ensure for integration in the delivery of mental health services in various fields of mental health practice. The majority of the services should include community-based mental health services, primary mental health services (first step), psychiatric services delivered under the body of state hospitals (second step) and the mental health services delivered by specialists at tertiary care centers (third step). The current situation, objectives and strategies identified for this module are discussed in Part 5.

2. **Treatment and Rehabilitation Services**

Various methods in psycho-social treatment and rehabilitation are recommended with a view to allow individuals with Serious Mental Illness (SMI) to recover social and professional skills in order to live independently in the society. Such treatment and rehabilitation
services can be delivered at home, outpatient clinic, intensive outpatient program, partial or day hospital, social club, or group home setting. The main focus of a community based mental health approach for individuals with SMI is ultimately the individuals’ social inclusion and integration in the workforce acquiring the capabilities to work, learn and live better functional lives.

The consideration of treatment and rehabilitation activities for the individuals with mental disorders within the community in Turkey is not deployed in a manner to cover all the eligible patients and these programs are mostly limited to project at certain state or university hospitals. Most patients are treated at the hospital centers and there are no systematic plans aimed for development of treatment and rehabilitation programs in the community. The current situation, objectives and strategies identified for this module are discussed in Part 6.

3. Child and Adolescent Mental Health Policy

The children and adolescents suffering from mental disorders vary with chronological age and developmental level and thus often present with distinct mental health needs compared to adults. Therefore the NMHP aimed at children and adolescents also includes guidelines for considered in a separate module. The target group of the NMHP module for children and adolescents ought to include the caregiving families, schools education institutions and teachers.

Three main objectives have been identified with respect to NMHP relevant for children and adolescents: First objective is to define risk groups; second objective is to improve and develop mental health services; and third objective is to ensure coordination between relevant disciplines related to mental health that also help raise awareness. The situation, objectives and strategies for this module are described in Part 7.

4. Mental Health Financing

Financing, is a mechanism that transforms plans and policies into actions by way of allocation of resources and therefore plays a major role in delivery of mental health services. Mental health financing is determined within a political and economic framework. Mental health financing is included under the general health financing in many countries and is shaped in line with the objectives of general health financing. Main considerations under mental health financing include mobilization of adequate capital to finance mental health infrastructure, allocation of funds for better service delivery according to needs and priorities, and control of service costs.

Health care services in Turkey are financed through the allocation from the general budget and financing of the health sector is to a great extent met from this source. Additionally, private health insurance schemes and personal expenditures of the individuals are also used for financing of health. A relatively small share is allocated for the financing of mental health services from the general health fund. The current situation, objectives and strategies identified for this module are discussed in detail in Part 8.

5. Quality Improvement for Mental Health

Every citizen is expected to have access to basic mental health services that are financially affordable and geographically accessible. Quality can be measured by whether the services are generating the desired outcomes and whether they are conforming to evidence-based practices.

Quality from the perspective of patients is to receive service based on needs, to recover from their complaints and to experience improvements in their quality of life. Quality from the perspective of families is perceived support and assistance for protecting the family unity. Quality from the perspective of service providers or program managers is efficiency and effectiveness. From the perspective of policy makers it involves optimum value for money and improvement in the mental health status of society. The objectives for accessibility have so far been on the agenda with regards mental health services in Turkey. The current situation, objectives and
strategies identified for this module are discussed in detail in Part 9.

6. Mental Health Legislation

There is a need to enact a Mental Health Law in Turkey foremost in order to safeguard the rights of individuals with mental disorders as equal citizens. These individuals are often subjected to stigmatization, discrimination and exclusion from society and continue to experience human rights violations. It is expected that enactment of a Mental Health Law ought to be in harmony with other laws and regulations and include provisions for protection of privacy and autonomy in terms of: informed consent; voluntary or involuntary admissions; voluntary and involuntary treatment; research participation; housing; employment; social security; rehabilitation; and education. The current situation, objectives and strategies identified are discussed in detail in Part 10.

7. Advocacy for Mental Health

Advocacy activities in the field of mental health involves increasing the public understanding and sensitivity those citizens with mental disorders and disabilities. It safeguards human rights, helps eliminate stigmatization and discrimination by removing social and cultural barriers and improving the mental health status of the society.

Advocacy for mental health is considered at two levels. First, advocacy aims at strengthening and protecting mental health of individuals and families in their daily lives. Second, it aims at acknowledgement, understanding and acceptance of mental disorders by the public at large. Activities at both levels serve as driving forces both for mental health policy and mental health legislation. The current situation, objectives and strategies identified for this module are discussed in detail in Part 11.

8. Training, Research and Human Resources in Mental Health

Training and employment of mental health personnel in Turkey is an important component of the national mental health policy framework. Many unresolved issues are directly related with unavailability of well-trained personnel in terms of both number and quality. There is an urgent need to train additional mental health professionals to meet the increase in population size and geographical disparities.

Comprehensive studies in the field of mental health are also required for obtaining country specific indicators and for developing evidence-based practices. Although mental health research conducted in Turkey has been able to shed some light upon mental health profile of the country, they are fragmented in nature. The current situation, objectives and strategies identified for this module are discussed in detail in Part 12.
INTRODUCTION

The terms policy, plans, programs, implementation are concepts that ought not to be confused with each other. The national policy includes series of values, principles and objectives to improve the mental health status and burden of mental disorders in the country. The main functions of the Policy are to provide a vision to improve mental health conditions of citizens in the future to help facilitate the development of appropriate measures to be implemented.

The term Plans concerns the development of an action plan by the government. The term Programs in turn provides mental health interventions using the best data available on mental health. Finally, the term Implementation is realized by coordination between all relevant sectors for putting programs into effect.

The relationship between these concepts can be clearly observed in the basic steps listed below:

Stage 1: Providing a comprehensive overview on the mental health requirements of the community;
Stage 2: Compiling all evidence that is collected in order to form an efficient policy;
Stage 3: Having interviews with and consulting to the representatives of all relevant sectors;
Stage 4: Having exchange of information with the countries, which have experience in mental health policies and practices;
Stage 5: Forming perspectives, values, principles and objectives of the policy;
Stage 6: Determining the plans that set the fundamental actions: (a) in determining the main strategies and priorities, and in (b) in providing the timetable and the resources for these action targets;
Stage 7: Identifying the main roles and responsibilities of different sectors;
Stage 8: Developing and implementing of pilot projects;

The development of the program, which is mentioned in Stage 8, is a process involving the specific stages based on the specified policy and the plans on this policy. The steps to be taken in order to develop the mentioned mental health programs are as follows:

1. Identification of issues and problems that are to be dealt with;
2. Setting the objectives of the program;
3. Selecting the most appropriate program practices;
4. Explaining the program activities;
5. Identifying the responsible organizations;
6. Setting appropriate timetables;
7. Preparing the budget;
8. Implementing the program;
9. Evaluation the program.

There are some key points in terms of the implementation of the programs that are to be taken into consideration after preparing the programs within the above process. The key points are summarized below:

1. Disseminating the NMHP;
2. Providing political support and financial resources;
3. Improving the supportive organizations;
4. Selecting pilot areas;
5. Strengthening the parties providing mental health services;
6. Strengthening inter-sectoral collaboration;
7. Enhancing the interaction between interested parties.
This section elaborates on the concepts and stages that are briefly summarized above.

**Importance of the NMHP for Turkey**

In order to develop and implement mental health plans and programs in the country, it is necessary to collect country specific data. Whereas the mental health policies prepared within the policy framework are directly linked to the general health and human services policies, they are, in turn, indirectly related to policies concerning education, social security, employment, housing and urban planning, municipal services, legislative arrangements, as well as specific policies targeting risk groups and promoting inter-sectoral cooperation.

The national mental health policy framework is of great importance for Turkey as it stands to provide efficient and equitable resources for this underestimated service sector. Both central and local programs should be prepared in line with the national policy framework. Unless there is a formal NMHP in Turkey, there can be no conformity between the ever increasing and competing demands for central and regional mental services.

**The priorities and resources within the framework of the NMHP**

Firstly, while identifying the NMHP, the priorities of the country should be clearly specified at each step. The priorities for the main strategies should be initially defined. Moreover, the mental health policy should be consistent with other policies and practices. The strategies ought to be determined by consulting with partner institutions: (i) taking into account the strengths and weaknesses of the current mental health system; and (ii) opportunities, pitfalls and priorities of the policy should be identified for each and every strategy.

Second key point is the identification of the resources. The most critical issue in terms of the execution of the strategies, for which the priorities have been identified, is the currently available mental health resources within the country centrally or in the provinces. In almost all health care systems, there is a need to have three basic resources that include: (i) human resources, (ii) physical infrastructure; and (iii) services. Within this framework complex structures including government budget, social insurances, private insurances, charities and other non-budget resources for the financing of the health services ought to be considered. Though changes can be observed on the regional level especially in terms of the financing of the mental health services, other resources such as non-governmental organizations, families and private institutions should also be taken into account. These latter groups already share the hidden burden of such costs and ought to be considered within the formal mental health service framework as acknowledged by the NMHP.

**Program Development**

Once the general objectives, main strategies and resources and the fields of implementation in national mental health policy are identified, the mental health programs that are going to be executed inside and outside the health system, including workplaces and school, are to be determined. The interventions for prevention, treatment and rehabilitation and improvement of the mental health status of the community and of the affected individuals in ought to be provided by means of program development. The Ministry of Health, as the central administration, has the responsibility to form, coordinate and evaluate the national mental health programs. Furthermore, the Ministry of Health should develop both central and regional programs. While forming these programs the following steps ought to be considered:

1. **Identification of the issues and problems**

   The first step of the development of a national mental health program is to identify specific issues and problems and set goals for the programs at hand. The issues or problems can be considered from different perspectives: for example response to an individual with a specific disorder, response to individuals in specific risk groups, response to those in need of specific protections. While identifying an issue, it is also crucial to explain how the intervention may help.
2. Setting program objectives
The second step following the identification of the problem is to set objectives for the program. The objectives should clearly indicate the aim to be reached by the program and the parties who can make use of the program. The objectives generally include improving the mental health status of a community, responding to the needs of specific groups, providing economic support and safe guarding of health costs.

3. Selecting most appropriate way of program implementation
At this stage the appropriate implementations are to be selected. The selection of the interventions ought to be evidence-based. The information on the current services, the experience gained and the requirements identified during the preliminary studies should also be taken into consideration at the time of this selection. In addition, the selection of intervention should be made in consultation with the cooperating institutions to the extent possible.

4. Explaining program activities
The special activities, which are required for the program and relevant to the selected interventions, are identified at this step. While preparing a program, all activities, including interventions should be defined. In order to facilitate this process, there may be a need for reviewing the NMHP action steps in order to decide whether the activities are necessary or not. It is necessary to ensure that the activities to be executed are in conformity with the standards concerning the national mental health services.

5. Identifying responsible organizations
There is a need to have different parties involved within a given program in order to execute the specific program at hand in an efficient way and to ensure that the accessible interventions of adequate quality standard are implemented across: (i) management; (ii) resource provision; (iii) the regulation; (iv) laws; (v) non-health sectors; and (vi) institutions that can advocate the program.

6. Setting the timetable
There is a need to have a timetable that has been prepared in line with the resources and technical capacity in order to implement each program. The plan and the program on average can last 1 to 5 years. As programs that fail to involve the community or which are managed with insufficient resources cannot reach desired success; resources should therefore be identified at the outset in order to guarantee the uninterrupted program implementation.

7. Preparing the budget
A detailed budget should be prepared as a first step in order to conduct a given program. One of the main advantages of program development is therefore to provide an appropriate and adequate budget in terms of: (i) human resources; (ii) physical infrastructure; and (iii) services. The number of people who will be subjects of an intervention in each year and the per capita cost of human resources, treatment, laboratory and physical infrastructure costs ought to be considered in preparing the annual program budget. The necessary arrangements are to be made at this step in order to ensure that current and available resources will meets program budget needs.

8. Materializing the program
The program prepared in the above seven steps will next be implemented in a coordinated fashion. All parties will agree upon a timetable for implementation.

9. Evaluation of the program
It is necessary to evaluate a given program at each step once it has been initiated. This is very important both for evaluating the effect as well as the cost of the program without delay and for providing feedback to develop future programs. Undoubtedly, a comprehensive overview should take place at the end of each program. Some of the methods for evaluating and supervising the programs are: (i) using the related standards as a benchmark; (ii) authorizing external supervisors; (iii) using the current IT systems; and (iv) consulting with those individuals who make use of the services as well as their families and advocacy groups.
Fundamental issues for NMHP and its implementation

The NMHP of a country can only be carried out by means of clearly specified and prioritized strategies and initiatives. Nevertheless, there needs to be a basic set of conditions relevant to the specific country in order to effectively carry out these interventions and strategies. In other words, there are number of important points to be taken into consideration during program implementation that have been prepared according to the above process. These are therefore summarized as follows:

1. Disseminating the NMHP
Mainly the Ministry of Health and its organization should disseminate these policies to all relevant parties and institutions.

2. Providing political support and resources
The participation of partner institutions that will be responsible for the implementation of the policy should be ensured and communication between them properly facilitated. The main aim is to provide sufficient political support and financial resources for the execution of the agreed upon policy. The leaders of the country should be aware of the fact that mental disorders constitute an important part of the burden of disease; they should be aware that all sectors irrespective of their varying commitments ought to contribute to the improvement of the mental health of individuals.

3. Improving the supportive organizations
The execution of the policy requires a group of mental and public health professionals to work cooperatively and coherently together. This group of specialists should be responsible for both carrying out the plans and programs and for ensuring common inter-sectoral practices.

It is very clear that an interdisciplinary team that works at the central level under the auspices of Ministry of Health would be very beneficial for the ultimate success of a policy. The professional groups to be involved in the team ought to include psychiatrists, child psychiatrists, psychologists, psychological advisors, public health physicians, psychiatry nurses, social services experts and workers, marriage and family consultants and occupational therapists.

A mental health specialist should be appointed at the Provincial Directorate level. In fact, it would be even more desirable to have an interdisciplinary team. In this respect, there needs to be a coordinator who works on issues related not only to mental health but to the public health and health management at the community mental health center level in the provinces that reflects the Ministry of Health goals. There is a need to have a mental health coordinator in each team working on the front line health service institutions.

4. Selecting pilot areas
The pilot area to be chosen can be part of a large city that represents a geographical region or a specific community. The information to be obtained from a pilot project ought to serve as an important indicator for the success of the policy across the country. This information ought to also be utilized for the training of mental health personnel at the level of the Provincial Directorates.

5. Strengthening the parties that provide mental health services
The individuals or institutions that provide general and mental health services should be strengthened. The mental health services is provided by various parties: (i) community mental health service providers; (ii) specialized mental health providers; (iii) professionals in the allied health sectors; (iv) advocacy groups; (v) non-governmental organizations; and (vi) families of patients and caregivers

6. Strengthening the inter-sectoral cooperation
In this regard the Ministry of Health should: (i) serve as a center for common activities carried out with other Ministries for providing, executing and evaluating the mental health services; (ii) support mental health professionals working in the Provincial Directorates in order to execute the inter-sectoral services in that specific region and to provide coordination.
7. Enhancing the interaction between the parties

Increased interaction between different institutions should be encouraged on more than one field in order to provide mental health services that could correspond to the requirements of the community. These interactions should be either on national or regional level. These interactions can be elaborated on in three different dimensions:

1. The interaction between the Ministry of Health and other sectors:
   - Partner institutions responsible for providing financial resources: Ministry of Finance, Social Security Institutions, private insurance institutions and charities;
   - Partners responsible for service provision include: health professionals, individuals providing services, organizations related to the individuals with mental health disorders and their families, advocacy groups, and non-governmental organizations
   - Other important partners include professional organizations and other supportive groups

2. The interaction between the Ministry of Health and Provincial Directorates:
   - Advantages and disadvantages of the development of the national policy, plans and programs at the central and regional level can be evaluated with the help of the interaction between the Ministry of Health and Provincial Directorates.
   - Allocating financial resources to the Provincial Directorates from central resources; funds provided should be allocated to the Provincial Directorates via a different accountable mechanism.
   - Sharing of the duties between the Ministry of Health and Provincial Directorates: The Ministry of Health should ensure the quality of mental health services provided in the future by means of ongoing technical support in addition to provision of adequate financial resources.

3. The interaction between the service providers and beneficiaries:
   - Coordination of the mental health services: firstly, this is observed between primary health care service providers; secondly, this ought to be observed between mental health team and representatives of the other allied sectors.
   - Providing support for individuals with mental disorders and their families: the organizations of individuals with mental disorders and their families ought to be strengthened in order to improve access, service quality and to overcome the negative attitudes and stigma.
   - Ensuring advocacy for mental health and mental disorders: there is a need for improving the advocacy activities in order to eliminate the stigma in the community toward mental disorders and in order to provide culturally positive perceptions to minimize stigma.

CONCLUSION

Preparing and developing the plans and programs of the NMHP is a complicated process. The requirements of many parties should be considered. Significant differences exist between countries for development of a NMHP; ultimately, the programs ought to be suitable to the specific conditions and needs salient in each country. The steps for the development of NMHP ought to therefore be adapted to country specific. The NMHP identifies the overall framework for such perspectives, values and principles to be implemented. It determines the relevant dimensions for its implementation; and identifies all the responsible parties and sets priorities. The programs, on the other hand, provide a targeted framework for the ordering of the mental health services in a rational way.

Countries furnished with a NMHP have established best practices in order to improve the mental health status of their communities in a systematic way. These countries are better prepared to provide an appropriate framework for development of plans and programs targeting the improvement of the mental health status of their citizens.
INTRODUCTION

This part briefly discusses the principles, definitions and concepts common in mental health practice. In this respect, the relevant sections are considered under the headings “Objectives of Intervention Models in Mental Health Services”; “Needs Assessment in Mental Health”; “Community-based Mental Health Services”; “Primary Health Care Services”.

In the past decade, the need for community-based mental health services is more globally understood under the scope of public health. It is generally accepted, by many national and international organizations, that policies to incorporate the concept of community-based mental health services are a major emphasis of national health care services. With this in mind, both the WHO and the European Union endorse socially equitable mental health services. In this regard, the community-based delivery of equitable mental health services requires the cooperation and coordination among various sectors. Such planning is not only relevant to clinical services but also takes into consideration issues such as the settlement, employment, social service practices in providing an opportunity to allow full integration of individuals with mental disorders in society. The provision of such services ought to be flexible enough to meet the emerging and changing needs of affected individuals throughout the course of their lives, given the long term nature of mental health problems.

Turkey is a country with a youthful population; therefore, a prospective approach that considers the demographic trends needs to be at the forefront of planning mental health services. Preventive mental health and training are important emphases for development of a national consensus among sectors. Furthermore, these approaches need to encourage linkages between mental health and general health services. Finally, it is essential to identify special risk groups for urgent delivery of services.

Although significant successes have been achieved in Turkey in recent years in the training of health care personnel, problems remain in connection with the availability of adequate number of professionals to deliver mental health services due to the rapid population growth especially with respect to children, adolescents and young adults, the increasingly aging population with improvements in life expectancy, and special issues related to trauma associated with natural disasters (e.g., earthquakes and floods), internal migration and high rate of traffic accidents, among others.

There is the need to establish a flexible partnership between primary mental health, community-based mental health services, specialized mental health and general health care services. These will need to encourage case and service management strategies on the one hand and inter-sectoral cooperation related to social life, training and improvement activities, employment and housing, on the other. Such a coherent partnership would aim to minimize risks, revise the service needs, establish and maintain access points for health care and social services, and plan for development of facilities and resources to meet such needs.

An effective audit program with an appropriate administrative structure needs to be developed with a view to allow provincial mental health managers to oversee the delivery of community-based mental health services. There is also a need to support the development of activities of daily living and participation of affected individuals in community-based leisure activities.

While preventive mental health services with its emphasis on screening, early diagnosis, appropriate triage and referral are considered under the scope of primary health care services, the consolidation of provincial network of secondary mental health care services at the local level is also urgently needed.

INTERVENTION MODELS IN MENTAL HEALTH SERVICES

There are five different intervention models in delivery of mental health services. Each model should be implemented by taking into account their strengths and limitations. The five models are briefly considered as follows:
1. **Treatment based approaches:**
This is an important scientific model that focuses on reliable identification, diagnosis, and treatment of underlying mental disorders. The therapeutic approach is evidence based, not just limited to pharmacological but includes a possible combination of psychosocial, behavioral and psychopharmacological strategies. This model is particularly relevant for the education and training of core mental health professionals.

The treatment based approach needs to be augmented for individuals with long term mental disorders because:

- Problems continue despite multiple treatments and the disorder persists. This situation demoralizes the service providers in particular in charge of a system with scarce resources;
- Treatment based approaches are costly and may not always be sustainable for resource poor care systems;
- In principle, all interventions should not be formulated in “therapy” format;
- Treatment interventions in general tend to be limited in time and space. Although the preventive treatment interventions and low-dose maintenance therapies can be cost effective and may prevent recurrence but nevertheless have important limitations

2. **Skill-based approaches:**
Skills are taught to individuals in order to learn to live independently or to establish better social relations. Rehabilitation is considered to be parallel with skill development. There are a number of limitations associated with skill-based approaches:

- People learn to use their skills in restricted or “protected” environments and may not actually put them into practice in their daily lives.
- People learn social integration in such a manner that the society provides shelter for them.
- It is more difficult to learn social and emotional skills than other skills such as taking a bus or train.
- Skills such as decision making, judgment and organizational skills are more difficult to learn than the mechanical skills. Therefore, this approach is more focused on mechanical skills given their being easier to acquire.
- Skill acquiring activities may not help these people in coping with their mental disease experience or trauma.
- There are conflicting priorities between the patient (to feel better, to earn more, to make more friends) and the personnel (education budget, family related and social skills).

Although skill building is a useful education model and increases the role of different disciplines under the scope of interdisciplinary training practices in mental health, their results have so far been limited in scope.

3. **Needs based approaches:**
These are the most commonly used approaches aimed at delivering services to meet the needs of people with mental disorders. Needs based approaches provide more flexible options within the mental health system. They not only cover treatment of symptoms and teaching of skills but also promote assistance and harmony within the community.

Unfortunately, despite its benefits, the practicality of needs based approaches depends on how and by whom the needs are identified. Conflicting priorities may arise between the service users and providers. The primary objective of mental health services is to meet the requirements of the people with mental disabilities in order to increase their activities, opportunities and relations whilst taking into consideration that their requirements should not be met in general terms.

4. **Social model of disability and access:**
The difficulty of using social skills originates from three main sources: (i) difficulties related to mental health (emotional, behavioral and cognitive); (ii) problems related to coping or adaptation skills and methods; and (iii) pre-existing social disadvantages or stigmatization related with mental health or associated difficulties.
Mental problems of the individuals, their ways of coping with stress, trauma and personal adaptation methods affect the onset of the disability of such persons. They may refuse to admit that they have mental problems due to personal or cultural reasons and may not accept any help.

Similarly, social disadvantages may result in deficiencies as much as the mental problems and/or level of adaptation. Unfortunately, low level of education, domestic violence, impaired family relations, negligence, abuse, poverty and adverse sheltering may result in early onset of mental health related difficulties. On the other hand, having mental health related problems inevitably results in consequences such as unemployment, dismissal from school, being homeless, impaired social ties, stigmatization, and refusal. All of which are very restrictive on their own. Their combination would double the difficulties.

These problems were experienced at Düzce/Kaynaşlı as it was the epicenter of 1999 Düzce earthquake. During the winter of 1999, this area between İstanbul and Ankara, which is mountainous and economically underdeveloped, was subjected to a double shock with the earthquakes of August and November. It should be noted that more severe losses were prevented through the ways the residents coped with the difficulties. Also, immediate response was given to the disaster and necessary personnel were rapidly deployed to the region. However, the psycho-social impacts of the trauma were observed in the daily lives of the residents in the region in the later months.

5. Social approaches to mental health and trauma during the disasters:
This model not only covers the physical, social and psychological factors but also the mental health related problems. This approach does not result in an exhaustive list of problems, providing less guidance for interventions. Having well-defined strategies providing for solutions in disasters is of significance for mental health and preparedness for emergencies.

Main topics are as follows:

- Trauma and disability are not independent from the physical and social environment.
- Emotional, intellectual and social barriers are the same with the physical barriers in front of these people. However, the physically disabled persons are in need of ramps, wide doors, appropriate mass transportation means. Likewise, same support is needed by the emotionally, cognitively and socially disabled. For instance; assistance related to employment, sheltering and social activity should be provided by the related assistance organizations.
- Interventions for relieving symptoms/pain and the support required for accessing such interventions require community work in order to minimize social and economic disadvantages. For instance; actual access to sheltering, employment opportunities and other leisure activities to ensure requirements are met.
- This model focuses on the social status, fields of interest and preferences of such people. The individual is considered within his/her family and social circle.
- Different interventions, aids and strategies should not be alternatives to each other without being harmonious at the medical, social and psychological levels.
- Concentration should not only be on changing the individual but also on the acceptance of the individual by the society. Any access-oriented model should provide the utmost support. Although this model is commonly used in cases of physical disability, it is rarely used in mental disorders where the individuals are isolated by the society for their resisting to change or failure to adapt.
- Services should be delivered to people under the most favorable conditions possible. They ought to understand the reason why the decisions taken individually by them are superior to the decisions taken by the others on their behalf. It is important to note that in Turkey a high quality care environment is achieved with a limited number of personnel and these personnel has limited time for the individual requests of patients.

In summary, social disabilities and access models lay the foundation for the mental health approaches during disasters. Interventions and aids facilitate the access to roles, relations and places within the community where the requirements are met. This can be interpreted in a way that the interventions are not only focusing on the individual but also on the expectations, needs and existing
facilities in the community. Such persons should follow their own decisions and set their own living standards rather than those given by the professionals.

**NEEDS ASSESSMENT IN MENTAL HEALTH**

Meeting the social needs of the persons with mental health problems is very important and plays a major role in identifying the practicability of the service delivered. Such needs are expressed in a hierarchical level:

- **Level 1:** Highest and prioritized needs - they are very sensitive and are required to be met; their deficiency at a continuous level result in sudden or maintained vital risk or immediate aggravation of the existing situation.
- **Level 2:** High level of needs - Lack of normal and regular support results in loss of control of the individual in a manner to create a risk for the individual himself/herself and his/her environment.
- **Level 3:** Need for prioritized assistance - In cases of lack of assistance for those with functional deficiencies, the individuals may not be able to handle their own works and be depending on other people.
- **Level 4:** Need for assistance - There is no need for daily special care. However, living without any assistance is limited due to ongoing mental problems and deficiencies.
- **Level 5:** Rare need for assistance - Such persons should be treated until they can live on their own without being dependent on anyone.
- **Level 6:** Problems rarely experienced can be handled by motivating the individual or isolating the problem.

The needs assessment process is composed of certain components. These components are as follows:

- Epidemiological studies covering all established data on relapse rate, prevalence and effectiveness and the level of using health services including cost-effectiveness.
- Health related criteria, demographic data and health care services indicators used by the authorities in order to identify any need for modification in terms of performance, cost and use.
- Results of various surveys
  - Local population
  - Basic health care services personnel
  - Provincial health directorates
  - Other local authorities

While developing a strategy on mental health, there is the need to integrate the quantitative and qualitative approaches. Quantitative approach examines the numerator and denominator of individuals receiving services given the needs. Qualitative approach seeks for an answer to the questions regarding the content and scope of the need. Both approaches are required; they handle different dimensions of the issue and should be used in synergistically.

There are three basic requirements for the qualitative approach: (1) Planning and execution of care; (2) conferences and working groups for the professionals and those receiving the services; and (3) establishment of focus groups.

**PRIMARY HEALTH CARE SERVICES**

According to the Declaration of Alma-Ata the definition of primary health care is as follows: "Primary health care is essential health care based on socially acceptable methods accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where
people live and work, and constitutes the first element of a continuing health care process”.

**COMMUNITY-BASED HEALTH CARE SERVICES**

The objective of community-based health care services is to provide assistance to the individuals at a level to allow them to be independent at the highest degree and to live on their own. They constitute the basis for preventive community-based mental health services and can be discussed at three levels:

- **Primary prevention**—to provide help to those individuals with high risk of onset of the disease. Prevention focus; losses, trauma; economic difficulties, unemployment; isolation, separated family members, vulnerable children and elderly.

- **Secondary prevention**—to provide early diagnosis and treatment of the disease. Treatment and prevention of relapse. Living in an environment without any stigmatization, and further expert support when needed.

- **Tertiary prevention**—to provide long term care for chronic persistent or recurring disorders. Treatment focuses on cooperation among the experts, local units, provincial directorates and primary health care institutions and on rehabilitation as well.

**Development of Community Health Care Services**

Development of community health care services is a major national mental health priority. There is a need for assessing the effectiveness and value of such services. The following criteria is used to assess for quality of community mental health services.

- **Practicability** - The feasibility and applicability of the level of services in meeting mental health requirements of the individuals living in the community.

- **Accessibility** - The ease of access to the mental health services (geographical access, minimum paperwork, acknowledgement and acceptance of the service by the masses).

- **Continuity of care** - The continuity between the past and present care practices and for flexibility according to changing and emerging needs.

- **Coordination** - The cooperation and facilitation of service needs of the individual. (Coordination among various agencies and interaction between services and relevant institutions).

- **Responsiveness to emerging demands** - The mental health services ought to be responsive to the identified risk groups and their service requirements. The services should be flexible, appropriate and easily adaptable to the required conditions.

- **Effectiveness** - The measure of the extent of achievement of identified objectives given the existing resources.

- **Efficiency** - The ability to reach the identified objectives with optimal resources and time.

- **Satisfaction of service users** - Level of satisfaction of the users from the perspective of service delivery and their level of recovery.

- **Satisfaction of service providers** - Level of satisfaction of the service providers and the measure of their positive impact on their motivation and willingness to work effectively.

**Family Medicine**

In terms of history of public health and community based approached to health, Prof. Nüsret Fışek, M.D., defines Family Medicine as “community medicine” and in this respect it can be interpreted as the implementation of a community-based mental health approach. According to Dr. Fışek, “It is a field of service which is considering the individual as a whole with his/her environment; considering health the individual’s responsibility from the fetus to death; which is preventing the healthy individuals to be ill; trying to eliminate physical, biological, social, cultural, economic and psychological factors playing a role in onset of illness; endeavoring with best efforts for creating a favorable environment for their recovery; trying to put early diagnosis of diseases to the extent possible and providing for their early treatment.”
In the best traditions of Turkish public health, the health status of an individual does not only represent the absence of disease or disability but also a state of full well-being in terms of mental and social health. The disease status of a person is closely akin to his/her health culture; in other words, when the level of an individuals’ education and enlightenment about his/her health is enhanced, that person approaches closer to the more scientifically meaningful and valid concept of health; thus there is less subjective relativity about health and disease. Again, according to Prof. Nüse Tüfek, M.D., “All planned activities performed for protecting the health of individuals and society; providing treatment for disease; ensuring the integrity of individuals with disabilities (who have either not fully recovered or unable to live on their own); improving the health status of communities are all collectively defined as health care services”. This is akin to community-based principles for organization of mental health services.

INTERSECTION OF PRIMARY HEALTH CARE AND COMMUNITY-BASED MENTAL HEALTH SERVICES

Primary health care is the first contact point of individuals with mental disorders in the community. Primary health care provides an opportunity for early diagnosis and preventive interventions that include health, nutrition, tobacco and substance use. In addition, early treatment services are provided to individuals with known diseases or disabilities through disease case management, as in asthma, diabetes and arthritis. A major objective of primary health care services is the diagnosis of principal mental disorders and their ambulatory treatment. Incidents of severe stress and trauma obviously contribute greatly in increasing the number of individuals seeking urgent mental health treatment, as in natural disasters involving the aftermath of earthquakes. Under these circumstances the burden and responsibility for the services on the care personnel increases greatly.

The absence of a coherent interface with community based mental health services enhances the problem. Emphasis of the following areas helps improve the interaction between the primary mental health care, community-based mental health and secondary locally available specialized mental health services:

- Communication - It is important not only to improve the communication between the formal primary health care and community-based service personnel, but also the communication among them and volunteers.
- Team Work - It is important to improve the coordination of services among team members (Resources and encouragement of this by the management is necessary).
- Training and Development - There is a need for long term training rather than ad hoc training sessions that address only immediate or short-term needs but do not provide longer term solutions to the needs of the community. Training and development allows that the problems are not forgotten but systematically addressed as part of a coherent strategy.
- Information - There is the need for high-quality information. Information technology (IT) and web-based strategies are important assets that can be effectively utilized in Turkey which is a geographically large country.
Mental health services in Turkey are still not accessible for most individuals based on need. The mental health services can only be more available through a systematic reform in national mental health policy with amendments to related laws, proposals for improvement of programs, tailored training of required personnel for their implementation and additional financial support. The main function of the NMHP (NMHP) in Turkey is to extend such assistance to service planners, service providers, joint organizations and, above all, service users. This section of the report will summarize the prevalence of mental disorders and their burden in Turkey, and examine how the concept of mental health is understood with some description of some stages of historical importance. Finally, this section will summarize related laws and regulations.

**Prevalence of Mental Disorders in Turkey**

The most comprehensive studies carried out regarding the prevalence of mental disorders have included the field studies by Dr. Cengiz Kılıç and colleagues on adults and by Dr. Neşe Erol and colleagues on children and adolescents conducted in cooperation with the Ministry of Health, Republic of Turkey and support from the World Health Organization (WHO). According to the results of these epidemiological studies, the overall prevalence of mental disorders in Turkey is 17.2% in adults, 10.9% in children aged between 2-3, 11.3% in children and adolescents aged between 4-18 years. The prevalence rate in women is two fold compared to that of men. Somatoform disorders, for example, are the most frequent form of such disorders in adults and these are followed by affective and anxiety disorders. The descending order of most frequently encountered conditions in children and adolescents is anxiety, depression and aggressive behavioral disorders.

The highest rate of treated disorders in Turkey include depression followed by somatoform conditions and anxiety disorders; this figure is 13.4% for adults any treated mental problem and as low as 0.3% for children and adolescents. Most adults with mental disorders are referred to psychiatrists (39.2%), other specialists (33.1%), general practitioners (20.7%), spiritual leaders (3.6%), and others (3.4%).

**Burden of Mental Disorders**

Global Burden of Mental Disorders. Mental disorders constitute 12% of global burden of disease. By 2020, it is estimated that the burden of mental disorders will have increased to 15% of Disability Adjusted Life Years (DALYs). Unfortunately, the burden of mental disorders is mostly among young adults representing the most productive segment of the society. It is projected that the burden of mental disorders will also have disproportionately increased in the future years in many countries. Persons with mental disorders face stigmatization and discrimination in the society.

Burden of Mental Disorders in Turkey. According to projected figures in year 2000 in Turkey, the burden of major depressive disorders alone among all disorders ranked 2nd with a percentage of 6.8% (DALYs) after ischemic heart disease with a percentage of 8.5%. According to the order of disability, major affective disorders ranked 1st with 14.5%, alcohol abuse 3rd, schizophrenia 5th (3.3%) and bipolar affective disorders 7th (2.9%) – with a total disability of 25.5% in the top ten ranking.

Economic and Social Cost of Mental Disorders. The total economic cost of mental disorders is highly explicit. According to Mental Health Report published in 1998, in Turkey the labor force loss attributable to mental disorders for up to 1 week v. greater week (20.9% and 11.8%) is remarkably higher than losses caused by physical disorders (15.9% and 7.5%). Indirect costs due to mental disorders bring along an increasing burden that is two to six fold direct treatment costs in developed market economies. While direct treatment costs show a tendency for decreasing in developing countries, it is observed that a great portion of the total treatment costs is comprised of indirect costs. In most countries including Turkey, families cannot afford a significant portion of these costs since there is no comprehensive mental health service fund as part of a social policy. Additionally, the affected families pay even more social costs such as emotional burdens regarding the care of disabled members of the family, decreasing quality of life as sole caretakers in the family, subsequent experiences of social exclusion, stigmatization and missing out on future opportunities for self-development due to competing responsibilities.
Brief History of Mental Health and Legislative Developments in Turkey

The first institution in the history of mental health in Turkey is the Bakırköy State Hospital for Mental and Neurological Diseases in Istanbul. Out of the hospitals and mental hospitals established to serve individuals with mental disorders during Ottoman Empire, especially Bakırköy State Hospital for Mental and Neurological Diseases which replaced Topkapı Mental Hospital closed in 1927 undertakes the most important function in this field. Dr. Raşit Tahsin (1870 – 1936) should be highlighted as a leading personality for paving the way for opening this hospital and training mental health specialists of the country in modern periods. After graduating from Gülhane Military Medical School in Istanbul, Dr. Tahsin worked for three years in Germany under E. Kraepelin, the founder of descriptive psychiatry; upon returning to Turkey, he was appointed as a physician in mental and neurological diseases at the Gülhane Military Medical School. Afterwards, Dr. Fahrettin Kerim Gökay and Dr. Mazhar Osman Uzman were sent by Dr. Tahsin to pursue specialization in psychiatry in Europe. Later on, Dr. Tahsin was appointed to Istanbul University, Faculty of Medicine, Mental and Neurological Diseases Clinic and continued contributing to the training of people to play an important role in the field of mental health. Dr. Rasim Adasal a pioneer of the development of interpretative psychiatry in Turkey was also a product of this era subsequently establishing the Psychiatry Clinic at Ankara University.

Dr. Tahsin was succeeded by his assistant Dr. Mazhar Osman Uzman (1884 – 1951). And following the First World War, Dr. Uzman became the first chief physician in Topkapı Mental Hospital. Upon the closure of this hospital, he became the chief physician in Bakırköy State Hospital for Mental and Neurological Diseases, which he also founded through the assistance of Dr. Refik Saydam, the Minister of Health at that period. For many years, the most important physicians in neurology and mental diseases of the country were trained at this institution. Ord. Professor Dr. Mazhar Osman Uzman and his team expanded training opportunities in serving a larger group of patients. However, although conditions of Bakırköy State Hospital deteriorated later becoming a depository hospital for a certain period, the situation in this historic hospital attracted attention from the public via media reports in the 1980s that led to its restructuring under the leadership of the then new chief physician Dr. Yıldırım Aktuna that endorsed the modernization of this institution.

Bakırköy State Hospital for Mental and Neurological Diseases has actually been the greatest institution rendering service and training in the field of mental health since the beginning of the Republic of Turkey. However, the gap in legislation in the field of mental health felt in the first years of the Republic was supported by the Law on Public Hygiene Works no. 1593 entering into effect in 1930. Thus the historical development of mental health in Turkey advanced parallel to the reforms introduced in public health. The most important one of these reforms is that Law on Public Hygienic Works that included regulations related to mental health beside basic primary health care services. This law also regulated the most important problems of the country also covering contagious diseases and “the establishment and administration of the hospitals for mental diseases or dormitories or institutions to register diseased persons or persons having any inborn disabilities” among the duties of the Government comparable to other duties related to health in schools and workplaces. The first paragraph of the law titled “Protection of Children and Young People”, of Chapter 6 titled Hygienic Works of Children included regulations such as applying mental examinations to children and young people during regular examinations in the schools and protecting them from family and societal abuses, alcohol and drugs use and harmful environments (Articles 164 – 167).

So as to ease the work volume of Bakırköy State Hospital, Ministry of Health, Republic of Turkey subsequently established Regional Hospitals for Mental Diseases in four regions. Established in Manisa, Elazığ, Adana and Samsun provinces, these hospitals undertook the care and treatment of mentally disordered persons referred from related provinces.

In the Republican period, the Government opened at least one State Hospital for each province and neurology departments were established in these hospitals as enough personnel was provided. Neuropsychiatrists, most of who trained in Istanbul, were then assigned to these hospitals. The referral to the Regional Hospitals for Mental Diseases was conducted from these hospitals. The Numune Hospitals, established or restructured in some provinces in 1950 after Dr. Behçet Uz became the Minister of Health, also
contributed significantly to the developments in the field of mental health. The psychiatry units of these hospitals made remarkable contributions to the training of psychiatrists in the country. Some of the Social Security Institution (SSK) Hospitals established by the Government in 1945 to serve as part of the public services opened in several provinces and thus undertook a similar function. When it came to psychiatric training, however, the Faculty of Medicine affiliated hospital under the Universities and their Departments of Psychiatry played a major role as well. The Gülhane Military Medical School, which then turned into an academy, pioneered the above described academic and institutional developments in Turkey. The Çapa Faculty of Medicine, which included Dr. Raşit Tahsin among its permanent staff upon his disengagement with Gülhane, and other faculties, such as the Ankara University Department of Psychiatry, have been the most significant institutions extending scientific education in the field of psychiatry.

During the restructuring efforts in Turkey beginning in 1960, a new initiative was taken in the field of public health under the framework of “Law on the Socialization of Health Care Services” no. 224 that entered into effect on 1 January, 1961 under the leadership of Dr. Nüsret Fişek, then appointed as Undersecretary for Health in the Ministry of Health during that period; and Health Clinics and Health Stations were established nationwide. By means of the socialization principles ensured by this landmark Law, it has been possible to render freely and equitably available services as an entitlement. This has lead to a transformation in health care services in Turkey in a novel way: that these services, which were provided in a “vertical” organizational structure before, were provided within a “horizontal” organizational structure. This process also represented a meaningful process of decentralization in the field of health care services across the country.

The Ministry of Health, Republic of Turkey, published a memorandum in 1997 in order to make primary health care services encompassing Health Clinics and Health Stations as the service centers enabling them to be widespread and more efficient. With the instructions for all health organizations in this memorandum, Ministry of Health, Republic of Turkey aimed to be cost effective and efficient by starting health care services at the primary level with the most practical approach and in conformity with the principles of social justice and parity. This way of providing general health care services was also expected to have a preventive function in terms of mental health thereby increasing the level of assurance for the people for the availability of these services that were to follow. The Ministry decided to provide mental health services from the primary health care level and to monitor individuals with mental disorders presenting at the primary care level; the Ministry also extended in-service training sessions on diagnosis and management of mental disorders for the physicians and allied personnel working at primary care level.

The coordination of mental health care services is still carried out by Department of Mental Health, General Directorate of Primary Health Care in the Ministry of Health. The General Directorate of Primary Health Care is one of seven Directorates under the responsibility of Deputy Undersecretaries. The General Directorate of Primary Health Care ensures the coordination of mental health services assigned to its jurisdiction through the Department of Mental Health, one of eight affiliated Departments. Under the Department of Mental Health there are four Branch Directorates: Preventive Mental Health, Drug Addiction, Chronic Mental Disorders and Children and Adolescents Psychiatry. Rural organizations for mental health services under the Ministry of Health are Branch Directorates for Mental Health under the auspices of the parallel Provincial Health Directorates affiliated to the Governor’s Offices in the respective provinces.

Main objective of the responsibility undertaken by General Directorate of Primary Health Care is to protect society against physical and mental diseases and to ensure sustainment of total well being of citizens. Mental health care services are of great importance among basic primary health care services. The table below describes the services directly related to mental health carried out by this Directorate, formerly called “Directorate General for Hygienic Works” and subsequently renamed following a Law enacted in 1963 and a Statutory Decree published in 1982 since the inception of the Republic. The duties specified in the table were also included in detail in the Government memorandum regarding the execution of health care services (no. 154), prepared under the framework of the Law on Socialization of Health Care and revised in 2000 so as to be tailored for new requirements and adapted to identified problematic areas. Furthermore, in the revised version of this announcement, social workers, psychologists, and dieticians were introduced under the scope of professional staff including doctors, midwives, nurses, health officers, environmental health technicians, and terms of reference for each group were defined therein.
As may be seen above, the services directly related to mental health carried out by General Directorate for Primary Health Care are mostly allocated for preventive mental health. The Department of Mental Health is also involved in the development of policy, plans and programs related to mental health, alcohol and substance use in the country. In this respect the first systematic event was a special meeting convened by the Ministry of Health on June 17, 1964 with specific objective to develop a “National Plan and Program for Mental Health”. The first important effort in mental health policy development by Department of Mental Health in the General Directorate of Primary Health Care was the larger meeting “Mental Health Program Development” again held in Ankara on June 25-27 1987. In addition to the participation of more than 120 experts from different sectors in the country, Prof. Norman Sartorius, then Head of the WHO Mental Health Division, and Prof. Sampaio Faria, then Head of the WHO Mental Health European Division, attended this meeting. It was proposed that four main projects be formed: Preventive mental health studies; improvement of mental health; psycho-social aspects of general health care services; and treatment and rehabilitation programs. These groups would, in turn, prepare reports at the end of an action plan at one year under this four part program. Unfortunately this program could not be sustained and a proposed “National Mental Health Program” could not be developed. The next significant step was the project carried out by the Mental Health Working Groups formed as part of the 1st and 2nd National Health Congresses held on March 1992 and April 1993, respectively. Last but not least, the mental
health targets identified within the scope of “Health 21” carried out under the WHO auspices was of great importance. These works were organized under the direction of the Department of Mental Health and the General Directorate of Primary Health Care in the Ministry of Health.

A statement regarding these former activities were presented in the 1st National Mental Health Conference organized in Ankara on March 2003 acknowledging and summarizing the development of mental health policies in Turkey over the preceding the last 20 years up to that year, and has been included in the annexed parts of this report (Annex 4).

The Ministry of Health, Republic of Turkey, has also made efforts to introduce a number of legislations. A summary of such legislations with respect to mental health, disabilities and social security are described by the information note no. 10831 on July 28, 2000 sent to the provinces by the General Directorate and is noted below.

**Legislation regarding Mental Health, the Disabled and Social Security**

Article 50 of the Constitution states that “children, women and physically and mentally disabled persons shall be under special protections in terms of working conditions”, Article 56 states that “it is the duty of the State to ensure everyone to sustain a healthy life with physical and mental health”, Article 61 states that “the State shall take measures for protection of the disabled and to promote their social integration.” As summarized in these declarations, the treatment, protection and social integration of individuals with severe and persistent mental disorders are identified as the duties of the State.

Under paragraph c of Article 3 of the Law on Social Services and Child Protection Agency no. 2828, dated June 24, 1983 (Amended Law June 30, 1997- KHK-572/5md) “disabled person” is defined as “a person who cannot adapt to the normative life conditions due to loss of an individual’s physical, intellectual, mental, emotional and social abilities either from birth or as a result of any disease or accident, and of individuals who are in need of protective care, rehabilitation, consultation and support services”. In terms of the services for the disabled; in article 5, “Care and Rehabilitation Centers” are defined as “social service institutions established to eliminate functional losses of the persons who cannot adapt to normal life conditions due to their physical, intellectual and mental disabilities and to equip them with skills for self-sufficiency within society or to continuously take care of persons who are not able to acquire such skills”. Moreover, the services of the agency for the disabled are defined under Chapter “Duties of the Institution” as follows:

First of all, to strengthen the family with training, consultation and social support for the purpose of raising and supporting children within the family, to carry out necessary services to ensure identification, protection, care, raising and rehabilitation of children, individuals with disabilities, and the elderly in need of protection, care and support;

To implement other duties stipulated by Laws in the field of disabilities and other social services in line with the changing needs of society and in order to establish and operate appropriate social service institutions in accordance with the general provisions of the Law;

Article 4 of General Provisions for care and rehabilitation within the society states that any arrangements shall be made or any measures shall be taken so as to ensure sustenance of the lives of vulnerable, disabled and elderly individuals in a healthy, peaceful and safe manner, to conduct care and rehabilitation services for the care of the vulnerable individuals with disabilities so that they can be self-sufficient and productive within society, and to continually care for individuals difficult and impossible to participate in treatment”. Taking the above definition as a basis, the “Law on Authorization regarding the Establishment of Administration for Individuals with Disabilities and the Amendment to Various Laws and Statutory Decrees related to the Situation of Individuals with Disabilities” no. 4216, dated December 3, 1996 had been enacted. Under the framework of this Law, the purpose is: “to authorize the Board of Ministers to enact Statutory Decrees for the purposes of amending existing Laws and Statutory Decrees or introduce new regulations with regard to the rights and problems of individuals with disabilities and for the protection of individuals with disabilities and their families, as well as for training, employment, treatment and rehabilitation of such said individuals through the establishment of an Administration for Individuals with Disabilities under the Prime Ministry.” Paragraph a of Article 3 of “Statutory Decree regarding Organization and Duties of Administration for Individuals with Disabilities” no. 571 dated March 25, 1997 defines the duties of the Administration as “to ensure
the cooperation and coordination between related institutions and organizations for the prevention of disability, training, employment, rehabilitation, social integration and other issues”. Article 8 also defines duties as “cooperation with the voluntary organizations and local authorities, to devise joint projects, and to support the submitted projects”. Furthermore, the departments of medical services, training services, vocational rehabilitation, social integration and duties thereof are also charged with these duties. The overall duty of the agency is to therefore establish commissions for “legislation” and to introduce regulations depending on these above mentioned requirements in general terms.

In terms of the regulations related to the social assurances of individuals with disabilities; the Law on Pension Fund, Republic of Turkey (5434 – June 8, 1949 –Article 72), the Law on Social Insurance Institution for Tradesmen and Craftsmen and other Self-Employed (Article 45), the Social Insurance Law (506 – July 17, 1964) all stipulate that a pension shall be granted on the condition that the insured person or persons they are obliged to care for suffer from chronic illness or disability hindering them from working and do not have any other source of income so as to benefit from health care services.

For the persons having no social assurance; “Law on Paying Pension Wages to Needy, Unprotected and Destitute Turkish Citizens over 65,” (2022 – July 1, 1976) covers the persons with severe mental disorders on the condition that the level of disability is identified. This framework is defined under Article 1 as being “in accordance with the provisions of this Law, same amount of pensions shall be granted to the persons who are not at the age 65 but proved by means of the health board report from a fully-equipped hospital that they are not able to sustain their lives without the support of others and individuals with disabilities who are not employed with a job appropriate for their situation”. It is stipulated also that these persons shall benefit from health care services free of charge.

Moreover, the Law Concerning Covering Medical Expenses of the Green Card Holders by the State who are Unable to Make Payments” (3816 – July 18, 1992) was enacted for the persons unable to benefit from health care services and Article 1 defines the purpose of this Law as “covering medical expenses of the Turkish Citizens who are not under the assurance of any social security institution and unable to afford medical expenses by the Government until the application of General Health Insurance and determining rules and procedures to follow in this regard”. Considering the fact that persons with severe and persistent mental disorders are frequently hospitalized due to lack of sufficient care or availability of sufficient treatment systems within the community, this law is highly important. Covering the medical expenses of green card holders is therefore a positive development. Article 2 of the “Law on Promotion of Social Aid and Solidarity” (3294 – May 29, 1986) states the scope of law as follows: “the scope of this law covers the needy and vulnerable citizens who are not subject to any social security institutions established under law and who do not receive any pension wages or payments (excluding 2022), and persons who may become productive citizens for the society in the event that a temporary and small amount of aid or training and education possibilities are provided”. This is known as a fund covering prescription expenses of persons with severe and persistent mental disorders and providing in kind aid to them. On the other hand, although the General Directorate for Foundations provides in cash and in kind aid, the desired objective has not been achieved as yet.

There are several legislative arrangements at the level of local provincial authorities to ensure the employment and integration of individuals with disabilities within society especially with respect to participation in integrated social and cultural activities. Examining the provisions of the Municipalities Law (1580 – April 3, 1930): the Article 18 states that the “abandoned and lost and found children, individuals who are mentally incompetent, impaired, disordered, persons collapsing in the streets, victims of accidents and disasters shall all be protected and safeguarded”, Article 81 states that “no fees shall be charged for individuals with disabilities or a discount shall be applied for the transportation to and from social and cultural services, the operation of kiosks, car parks or similar places belonging, operated or rented by the municipalities for individuals with disabilities shall be facilitated”.

Article 13 of Law on Public Hygienic Works (1593 – April 24, 1930) stipulates the care of persons with severe and persistent mental disorders in institutions and includes arrangements thereby with the statement that there should be “establishment and administration of the hospitals for mental diseases, or dormitories or institutions that shall accept individuals with mental diseases or persons having any inborn disabilities”.

Article 1 of “Statutory Decree on Organization and Duties of the Ministry of Health” (181 – December 13, 1983) expresses that the “purpose of this decree is to regulate principles related to the establishment, organization and duties of Ministry of Health: to ensure
the sustainment of life for everyone with physical and mental health; to regulate health related conditions in the country; to protect against those harming the health of individuals in particular and society, in general; to extend the health care services to the public; to centralize the planning of health care institutions; and to ensure that they provide services”.

Article 3 of “Basic Law on Health Care Services (3359 – June 7, 1987) indicates that a necessary registration and information system shall be established so as to follow everyone’s health status and related programs shall be carried out for the prevention of disabilities. Law on Socialization of health care services (224 – January 5, 1961) defines the health care services as "medical activities implemented for eliminating various factors giving harm to human health, and protecting against the effects of these factors, treatment of diseases, integrating persons with low physical and mental skills and competences with employment conditions”. The paragraph (b) of Article 29 of Decree in Force Law no. 184 regarding the Establishment of Ministry of Labor and Social Security stipulates the allocation of the following duties to this institution: “to ensure the social, medical and vocational rehabilitation and training of individuals with disabilities and to ensure that they are able to benefit from social, economic and cultural resources of the country and that they are provided with employment opportunities.” Further, paragraph (c) stipulates that the Ministry shall: “ensure cooperation and coordination between all official and private national and international institutions and organizations serving individuals with disabilities”.

The Labor Law numbered 931 stipulates that the employers should employ a specific number of employees with disabilities if some specific conditions are met. The same arrangement has also been made in the Labor Law no. 1475. Statute on the “Employment of Individuals with Disabilities” which was enforced on March 16, 1987 and amended on August 18, 1989 and November 26, 1996 explains in Article 2 of the Definitions Chapter that “individuals whose health reports indicate that they are deprived of at least 40% of their work force due to physical, mental and psychological disorders are deemed to be with disabilities in line with the provisions of the statute”. However it is also stated that the individuals who cannot work because of their disability according to their health report are excluded from this statute. In the statute it has also been stipulated that the employers where more than fifty full-time workers are recruited should recruit 2% of the total number of the employees in jobs, which is appropriate for the individual’s occupation, physical, mental and psychological conditions.

This ratio of 2% was increased to 3% with the Statutory Decree no. 572 and the amendment made to Article 25 of the Labor Law no. 1475, enforced on January 1, 2000. Furthermore, the jobs that could be undertaken by the disabled were annexed in a list and it was stated that in conditions where the disability is not involved in this list the physician should identify the jobs that could be undertaken by the individual in the health board report. Therefore, it is the responsibility of the Turkish Employment Agency to entitle individuals with disabilities with an employment opportunity and to provide occupational rehabilitation and employment consultation services.

Article 24 of the Statute on the “Duties and the Authorities of the Police Officers” stipulates that the police should not be responsible for the referral of individuals with mental disorders if there is a possibility that they can cause harm to public during such referral. In this instance, the police officer shall only be responsible for accompanying the responsible party in order to prevent any attack or harm that could occur.

Article 52 of the “Regulation on the Duties and the Authorities of the Gendarmerie” stipulates that that the gendarmerie forces should also not be responsible for the referral of the individuals with mental disorders if there is a possibility that they can cause harm to the public during their referral and shall only be responsible for preventing any attack or harm that could occur imminently. However, this responsibility is carried out by the Internal Security Forces of the Gendarmerie only in places where no police organization exists.

THE BASIC LAW ON HEALTH CARE SERVICES no. 3359, which was enforced on May 7, 1987, is the last comprehensive law enforced in Turkey in the field of the Health Care Services. This law clearly stipulates the rights, responsibilities and authorities of the government and the individuals in terms of health related issues.

As can be observed, there therefore exists no comprehensive “Law on Mental Health” among the above mentioned laws and statutes concerning the mental health, or individuals with disabilities or related to social security issues related to mental health in Turkey. Rather, there is a structural patchwork that is dispersed in various fields of legislation and is therefore hard to implement and follow. This is an area for urgent future action.
INTRODUCTION

The organization of the mental health services has an important influence on service effectiveness and for reaching National Mental Health Policy objectives. There is no single model for the mental health services. The main service area and the provision of services depend on sociocultural, political and economic structures in Turkey.

The mental health services under the scope of the primary health care services include the treatment services and prevention activities carried out by the practitioners, nurses and other health personnel working in the primary health care institutions. The primary health care services are more cost effective, accessible and considerably less stigmatized than services in other service settings.

The Current Situation

Many public and private institutions have a role in producing and providing mental health services in Turkey. The health care institutions have varying structures in terms of financing and provision of health services. The distribution of the inpatient treatment centers and beds in Turkish health care institutions reflects this pluralist character with resulting coordination problems.

The following points with regard to the organization and management of the health care services have been identified in the Draft National Health Document in the 1990s when the reform activities that have been initiated by the Ministry of Health gained impetus.

First, the health care services have multiple leadership and over-centralized management organizational structures where authority is enjoyed at the highest level. This leads to redundancy and inefficiency. The Ministry of Health works as an implementation agency and the senior directors spend an inordinate amount of time in personnel matters instead of making macro decisions. The central and rural organization of the Ministry is not in conformity with modern management approaches. The State Planning Office which develops annual implementation and 5-year development plans has formed a commission that has recently reported that Turkey harbors a serious lack of coordination within its institutions and as a result the management and resources in the health system are not utilized in an efficient way.

It is necessary to examine the institutions and organizations working on mental health services within the framework of the Turkish health system at three levels:

1. **Strategic level:** policy making and legal arrangements
2. **Tactical levels:** planning and program development
3. **Operational level:** supporting health care services

**Strategic level:** This is the level at which strategies and policies related to all health care services including mental health are identified. The main institutions at this level include TGNA (Turkish Grand National Assembly), the Ministry of Health, the Ministry of Labor and Social Security, the Ministry of Finance, the Ministry of National Defense, the Ministry of Interior, State Planning Organization and the Higher Education Board of Turkey.

Turkish Grand National Assembly is the only body that determines the legal framework of the health care services. TGNA examines and forms the proposed legislation by means of the commissions under the auspices of the TGNA (for example, the Commission on Health, Family, Labor and Social Affairs). The decisions that are made in the specialization commissions are enacted after they are discussed in the TGNA General Assembly. The TGNA carries out its supervision activities by means of the specialized commissions and the research and investigation commissions.

The other important institution in the strategic level is the State Planning Organization (SPO). One of the main service units under the auspices of the SPO is the Directorate General of Social Sectors and Coordination. This Directorate General makes decisions...
on the strategies and the appropriate investments for the health sector. The main function of this unit is to contribute to the preparation of development plans and the annual programs by conducting studies and researches in social sectors, to develop future strategies on social sectors, preparing public investment programs, following up on public projects, carrying out activities for annual revisions, directing program implementation, providing consultation on institutional and legal arrangements, ensuring coordination between the public and private institutions during the program implementation and establishing commissions that will be attended by senior authorities, and contacted or negotiated with international institutions.

**Tactical level:** This is the level at which implementation objectives and plans of principles and strategies are identified. The Ministry of Health and provincial directorates under the auspices of the Ministry are examples of the units at this level. The organs at the tactical level are responsible for the preparation and the guiding of tactical plans and programs within the framework of the identified strategies and policies.

**Implementation Level:** This is the institution that directly produce and provide services such as mental hospitals, mental health clinics in general hospitals, private clinics and office practices are examples of the entities at this implementation level. The Ministry of Health is the ultimate implementing agency which ensures the coordination and implementation of plans and programs. Ministry of Health is also the most important mental health services provider. The Social Insurance Institution (SII) which has been transferred to the Ministry of Health recently, was the second major mental health services provider of Turkey delivering inpatient services.

The Organizational Chart of the Ministry of Health includes the main service units, support units, consulting and supervision units and other affiliated bodies. General Directorate of Primary Health Care Services, and General Directorate of Treatment Services are the main service units responsible for mental health and mental illnesses services.

The main duties of the General Directorate of Primary Health Care Services have been regulated by the Statutory Law on the Duties and the Organization of the Ministry of Health. Department of Mental Health which was established under the auspices of the General Directorate of Primary Health Care Services in 1984 is the authority which directs the activities on mental health services in Turkey. Department of Mental Health includes four branch directorates and one project unit. The branches directorates are as follows:

1. Branch Directorate for Preventive Mental Health
2. Branch Directorate for Drug Addiction
3. Branch Directorate for Chronic Mental Disorders
4. Branch Directorate for Children and Adolescents Mental Health

General Directorate of Treatment Services is the management body which has the responsibility for planning, coordination and supervision of inpatient treatment centers. The mental health hospitals which provide inpatient treatment services in Turkey work under the auspices of the General Directorate of Treatment Services. The primary health care services based mental health services are organized under one general directorate and the secondary and tertiary health care services organized under another. There is limited coordination between these two general directorates.

The Guidelines for the Implementation of the Health Care Services has been prepared for rural organization of the Ministry of Health and the duties and authorities of the institutions within this organization. The aim of these guidelines is to clarify the implementation of rural mental health services that are provided at all levels of the local organization of the Ministry of Health, to ensure that the health care services are in harmony with each other and provided as a whole, and to guide and help the personnel in this regard. The administrators who are primarily responsible for the health care services at the provincial level are the governors and the provincial directors of health. The governor is the first responsible party in terms of implementation, coordination and improvement of the health care services within the province. The governors can transfer some of their authorities to one of their deputies or the provincial director of health. There is a provincial director of health and deputy provincial directors of health whose numbers are determined in the Regulation on the Bed and Cadre Standards of the Rural Organization of the Ministry of Health. The provincial director of health
is the highest health authority of the province and is accountable for his duty before the governor.

The provincial director of health ensures the fair distribution of the duties among the deputy directors. The deputy provincial directors of health carry out the assigned duties within the authority transferred by the provincial director of health. The duties of the provincial director of health have been identified in the Regulation on the Implementation of the Health care services. The provincial director of health is responsible for the planning of the health care services within the province, implementation of the plans and programs sent by the Ministry and coordination of these activities so that the health care services are implemented in line with the legislation and are of best acceptable quality. The Provincial Directorate for Mental Health is the entity responsible for the delivery of mental health services at the provincial level. The administrators who are primarily responsible for the health care services at the district level are the deputy governor and the health group president. The deputy governor is the first responsible party in terms of the implementation, coordination and improvement of the health care services within the district. The health group president is the highest health authority of the district. The responsibility of the health group president is to plan the health care services in the district, to ensure the implementation of the plans sent by the health director and to carry out the activities that will bring along the best quality health care services. The performance based payments have significantly contributed to the working and the productivity of the health personnel. The regulation on the appointment and designation that has been enforced by the Ministry of Health, has eliminated the political pressures on the members of the Ministry and provided objective criteria for the appointments and designations.

Turkey has a young population in terms of an average national age. If the necessary employment opportunities are created this youthful population can provide major advantages for growth in the health sector in terms of labor force, financing and human resources. Health care institutions in Turkey continue to have a traditional working environment. A central administrative structure exists both at provincial and district levels. Though there are some serious problems in the functioning, a sufficient infrastructure is in place and the service network of primary health care services is well distributed across the provinces.

Ministry of Health has the authority and responsibility for training, supervision and organization of health care services with its central, bureaucratic and political organization. In recent years the Turkish Medical Association (TTB) and the Coordination Board of the Specialization Associations (UDKK) has proposed that some authority and responsibility for running these institutions be transferred to the civil vocational institutions. This approach may be more consistent with contemporary systems in some more developed countries. There has been important developments in Turkey in terms of use of communication and information technologies in the health sector. The 112 emergency system has been established though with some problems about its operation. Finally, the Refik Saydam Hygiene Center has assumed the responsibility of some of the preventive health care services.

There are severe restrictions in the level of the organization of the mental health services in Turkey. These restrictions and weaknesses hinder the production and distribution of the mental health services greatly. The control of most of the health institutions and the personnel is under the responsibility of the Ministry of Health that essentially remains as a central and political institution. The health policies are based on the principle that governments and politicians act through anticipated reactions that may arise in the elections rather than in providing rational, logical and coherent solutions for the health problems of the country. The limited resources that are allocated to the health sector within the Turkish health system are directed toward therapeutic rather than preventive models.

If the bureaucratic mechanisms of the central and rural organization of the Ministry of Health in Turkey are examined, a horizontal alignment of the system is exaggerated and this generally functions in an unproductive manner. The recruitment of physicians and personnel in the public health institutions is generally regulated by the government employment laws. In accordance with these laws the main contemporary business operation concepts such as educational level of employees and quantity of their work productivity are not taken into account. There has been no serious progress in terms of the non-physician health personnel, the infrastructure investments and the suitable business operation techniques.

It is observed that the long-lasting problems about the employment of the non-physician health personnel in the mental health services are not still taken into account in the recent legal arrangements. For instance, as it is well known new laws and regulations
within the framework of the transformation in the health sector have been enacted recently. (Law and Regulation on the Pilot Project for the Family Medicine, the Circular on the Functioning of the Public Health Centers). The services and the profession groups defined in the government memorandum on the Implementation of the Health Care Services that has been revised in 2000 have unfortunately been excluded from this field by this regulation.

In Turkey, there is a huge incongruity between the number of current and future physicians and the number of well-equipped health centers where they can work in a productive manner. Turkey relies mainly on foreign country aide for the health sector, medicines and technical equipment. This results in the flowing of domestic resources to foreign countries. The self-correcting tools such as the quality control, standardization, work productivity analysis, supervision and feedback do not function well in the health sector. Turkey is one of the countries where traffic accident related injury and mortality rates are very high. The fact that Turkey is a high seismic hazard country requires some special measures and extra expenditures. In addition to this, the community is in need of therapeutic health care services as a result of the insufficient nutrition and hygiene that many citizens are exposed to.

The harmony with the European Union can bring along some rational changes in terms of health training, health care services and finance. If rational arrangements for the right operation system are made, the well-trained physicians and health personnel in Turkey can provide cheaper and better quality health care services to the European Union countries. The European and American insurance systems may deem it cheaper to treat their patients in Turkey. This can provide Turkey with a very important income and can be taken as a very important opportunity for the Turkish health system.

However, there exist some threats along with the opportunities. The biggest threat for the Turkish health system is deemed to be the health sector’s failure to have a political will and its continuing de facto situation despite the need for recognition for reforms. It has been observed that this situation has improved thanks to the health transformation activities. It is claimed that most of the well trained students in the country do not choose to be physicians any more. As a natural result of this, it is also claimed that the increasing faults by the physicians and the wrong medicinal practices constitute a great threat to the community health.

Following the identification of the main features of the current situation of the mental health services in Turkey, the objectives that are set forth for the organization of the services which constitute the main foundations of the NMHP are listed below. The current situation in the country is examined under each module heading, later the objectives on the matter and the strategies proposed for fulfilling those objectives are listed and lastly the related and responsible agencies are specified.

**OBJECTIVES**

**Objective 1: To eliminate the obstacles to accessing mental health services**

Current situation and rationale for the objective: The mental health services are mainly provided in the three major cities of Turkey. There are no mental health specialists in some provinces. This causes individuals with mental disorders and their families not to make use of these services or to travel long distances to large cities to seek care for their loved ones. The level of utilization of mental health services is therefore on average very low in Turkey - this is particularly pronounced for specific risk groups such as young children, elderly, and individuals with disabilities.

**Strategies:**

1. The mental health services should be fully integrated into the general health care services.
2. The mental health services should be readily available within primary health care services.
f3. Besides the provincial health care centers and Maternal and Child Health Care Centers, the primary health care services should be provided in the institutions which can provide protective and preventive services such as the pre-school institutions, schools and universities, Guidance and Research Centers, the workplaces, security and police departments, prisons and detention houses, nursing homes, dormitories and rest homes affiliated to the Institution of Social Services and Child Protection (SHÇEK) as well as the municipalities. The primary health care services to be provided in all these units should also involve the mental health services.

4. It should be ensured that the secondary health institutions have mental health units according to the requirements of the population of every province and district and the need of the population for the mental health services.

5. On the tertiary health care level, mental hospitals should be disseminated within regions. The current mental hospitals should be reorganized not to exceed 500 beds. These institutions should be revitalized and infrastructure developed to include child and adolescent service units.

6. The clinics and units that will be established for specific mental disorders (substance use, psychological trauma, emergency crisis response centers) should be disseminated across the country taking the characteristics and the epidemiological data related to the local population and demographic and geographical risks.

7. A more functional recording and referral system should be established for the mental health services and family practice, primary health care, as well as secondary, tertiary and rehabilitation services should be operated in accordance with productivity and cost-efficiency principles.

8. A fair access model which is based on reaching the individual who demands the mental health service within his or her own environment (homecare) and taking the service to where it is needed should be facilitated.

9. The mental health requirements of individuals with disabilities and other vulnerable groups in the community (pregnant women, young children, children and adolescents, elderly) should be assigned high priorities and these individuals should also be of importance in terms of the access to these services. The necessary plans and programs should be carried out in coordination with the related agencies. Special work groups for these individuals should be established on central and local level.

10. It should be ensured that the patients who are receiving treatments because of physical ailments (cancer, cardiovascular, stroke) ought to have sufficient and easier access to requisite mental health services.

11. An effective supervision system should be established so as to identify and eliminate the problems and the factors behind these problems.

**Relevant / Cooperative Institutions and Organizations:** Ministry of Health, Universities, Ministry of National Education, Prime Minister Administration for Disabled People, Institution of Social Services and Child Protection (SHÇEK), Private Education Institutions, Social Security Institutions, State Planning Organization, Press Organs, the Supreme Board of Radio and Television (RTÜK), Professional Associations, Non-Governmental Organizations.

**Objective 2: To enhance the present structure with regards management of mental health services both at the central and local level.**

The current situation and rationale for the objective: The policy making and implementation in mental health is organized by the Mental Health Department, which is affiliated to the Ministry of Health General Directorate of Primary Health Care Services. When this historical process is examined, it is observed that there had been very important initiatives during the period when the mental health professionals worked in the Mental Health Department. Nevertheless, more often than not individuals who have not received the required training on mental health and who are not mental health personnel have worked in the Department. Moreover, there exists no encouraging administrative and financial policies for specialists who may choose to work in these units. Given the responsibility of such individuals in caring for public mental health it is essential that more incentives and prestige be given to these positions. It is also observed that the positions in the Mental Health Branch Directorates in the Provincial Health Directorates are generally vacant or individuals without sufficient mental health qualifications work in these positions. These Branch Directorates should be supported to organize the local mental health services.
Strategies:

1. The Ministry of Health Mental Health Department should be transformed into a General Directorate.
2. It should be ensured that the units for specific mental health risks groups (Child and Adolescent Mental Health, Substance Use, Geriatric and Elderly Services, among others) are formed under the General Directorate; further it should be ensured that mental health professionals such as psychiatrists, child psychiatrists, psychologists, social services specialist are recruited to these units.
3. The Mental Health Branch Directorates at the provincial level should be strengthened and they should become functional.

Relevant / Cooperative Institutions and Organizations: Ministry of Health, Local Administrations, Social Solidarity and Collaboration Foundations, the public and private institutions in the province that are directly or indirectly related to the mental health activities.

Objective 3: To continuously monitor and assess the needs of the country in the field of mental health and to generate scientific evidence based solutions.

The current situation and rationale for the objective: There is no specific board or council dealing with mental health issues in Turkey. There is therefore a need for a council at the national level that can represent interested institutions. Miscellaneous consulting committees, their tasks and membership should be identified. It is ideal for these committees to include representatives of all partner institutions. In order to make the committees small and functional the organizations under an umbrella can represent a group of organizations.

Strategies:

1. An autonomous National Mental Health Council that includes multidisciplinary scientists from different universities, which continuously monitors and assesses the needs of the country in the field of mental health and generate scientific evidence based solutions, ought to be established.
2. Local (Provincial) Mental Health Councils that continuously monitor and assess the needs of the country in the field of mental health and generate scientific evidence based solutions and work in coordination with the National Mental Health Council ought to be established.
3. National Mental Health Database should be established.
4. All types of mental health services that are rendered to the individuals should be recorded and the access to these records in line with the ethical rules should be ensured.
5. Research on identification of the mental health needs of the country and generating solutions for them should be encouraged. Collaborative regional epidemiological studies and surveillance activities should be paid attention while carrying out the above mentioned activities.

Relevant / Cooperative Institutions and Organizations: The Ministry of Health, The Scientific and Technological Research Council of Turkey (TUBITAK), Higher Education Board of Turkey (YÖK), Ministry of National Education, Prime Minister Administration for Disabled People, Institution of Social Services and Child Protection (SHÇEK), Private Education Institutions, Social Security Institutions, State Planning Organization, Press Organs, the Supreme Board of Radio and Television (RTÜK), Professional Associations, Non-Governmental Organizations, UNICEF.

Objective 4: To emphasize the delivery of mental health services at the local level rather than the central level.

The current situation and rationale for the objective: The health care services have a multiple leaders and highly centralized management and organization structure where ultimate authority is enjoyed at the highest level. Besides the redundancy caused
by lack of coordination in decision making procedures remain chaotic. The Ministry of Health works as an implementing ministry that deals with the daily programs rather than making macro plans and directing the mental health sector in Turkey. There exists no working system for fulfilling the needs of the population in terms of the production and the distribution of the mental health services that have been identified despite a number of epidemiological studies.

**Strategies:**

1. The mental health services requirements should be identified in accordance with the local conditions (Screening activities, epidemiological studies, among others) and the organization should be done in a way to meet these requirements.
2. Besides the physical resources for providing the mental health services the financing should also be supported by the local resources.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, Universities, Social Security Institutions, Prime Minister Administration for Disabled People, Institution of Social Services and Child Protection (SHÇEK), Ministry of National Education, Private Education Institutions, Non-Governmental Organizations.

**Objective 5: To meet the urgent and special mental health requirements likely to arise during times of natural disasters, accidents, traumatic experiences, terror, immigration and crises for which our country has a high potential.**

The current situation and rationale for the objective: The fact that Turkey is a high seismic hazard country requires special measures and expenditures. It is noted that there has been 14 major earthquakes in the country with a magnitude of 7 and more on the Richter scale in the past hundred years. This indicates that in every seven years a big natural disaster is experienced in this country. Moreover, floods are experienced especially in the eastern Black Sea Region as a result of the geographical structure. In addition, Turkey is among handful of countries that have very high injury and mortality rates as a result of traffic accidents.

Even though Turkey is a middle income developing country, on average most of the people in Turkey have a low income level. The demand for technically sophisticated therapeutically oriented health care services has been increasing. Nevertheless, insufficient nutrition and hygiene and preventive health care services are still rampant. The distortions caused by rapid urbanization, internal migration from villages to cities, and the irregular urban panning, infrastructure, noise causes and pollution in the city centers all have negative effects on both general and mental health. Though the economic crisis have been brought under control in the recent years, the ongoing high rate of inflation and functional problems caused by legislative void and under financing of the health sector will inevitably lead to increasing challenges unless the current problems are addressed.

In Turkey it is generally thought that in solving the health care problems depends totally on the existence of the physician. Therefore, the numbers of non-physician mental health professionals such as psychologists, social services specialists have remained relatively low and as a result there is a huge need for non-physician mental health professionals. Furthermore, there is a serious under investment in infrastructure investments and adoption of contemporary management approaches. In Turkey, there is a also a incongruity between the number of current and future physicians and the number of well-equipped health centers where they can work in a productive manner. This problem is most evident in the mental health field. There is also an incongruity about the with limited organization regarding mental health services to be provided after disasters despite the recognition of the importance of the hazards.

**Strategies:**

1. The units which can rapidly and effectively respond to the specific mental health requirements which can arise in emergencies should be established within the mental health system of the country.
2. The affiliated crisis management centers which work in the emergencies under the auspices of the Prime Ministry and the Ministry
of Health should include the mental health services among the services that they will provide and should establish the necessary units in advance.

3. A unit should be established under the auspices of the Ministry of Health so as to coordinate the non-governmental organizations, which will provide services before, during, and after the emergencies. The coordination of the non-governmental organizations at the local level for emergency preparedness services should be the responsibility of the provincial and district crisis management centers.

4. The training and the recruitment of the non-physician mental health personnel, is identifiably low especially during emergencies.

Relevant / Cooperative Institutions and Organizations: The Ministry of Health, Universities, Prime Minister Administration for Disabled People, Institution of Social Services and Child Protection (SHÇEK), Ministry of National Education, Private Education Institutions, Social Security Institutions, the Turkish Red Crescent, Non-Governmental Organizations.

Objective 6: To allow for the introduction of the private sector in the organization of services for mental health in our country therefore not to limit the delivery of the service to solely the public sector.

The current situation and rationale for the objective: In Turkey the share of the private sector in the health services is generally small. The share of the mental health services in the private sector is smaller still. Balıklı Rum Hospital in Istanbul is the only private mental health hospital in Turkey. The private sector does not present any significant threat to the extensive primary health care network and preventive mental health services. It is important to encourage privatization on the principle that enhancing quality and diversity of available competitive services would provide a positive synergy that is likely also to enhance quality of public sector services. Therefore, reforms in public sector mental health services need to be realized to parallel the general privatization policy within the country.

Strategies:

1. The opening of the mental health services units in the private hospitals and the private rehabilitation centers should be supported. The necessary legislative and administrative infrastructure should be provided in this vein.

Relevant / Cooperative Institutions and Organizations: The Ministry of Health, Social Security Institutions, Private Health Care Institutions, Insurance Companies.

Objective 7: To establish an organizational structure in the country to be in charge of rehabilitation within the mental health system.

The current situation and rationale for the objective: Rehabilitation services approach reduce barriers for individuals with serious and persistent mental disorders and mental disabilities whose needs exceed just medical and therapeutic interventions. There is a positive trend towards a services approach that also includes disease management, as well as psychiatric rehabilitation. According to this model, first the requirements of the individual are taken into account and then services for these requirements are organized. In Turkey the burden of the rehabilitation currently rests squarely on the shoulders of the tertiary treatment services and this decreases their productivity greatly. On the other hand, the rehabilitation services currently provided tend to be very insufficient. Most of this burden is born by the family or the relatives of the mentally ill people.

Strategies:

1. Small rehabilitation units for the chronic patients should be established in the community at the local provincial level. (Day hospitals and Partial Hospitals have tended to be on site of tertiary centers but need to be integrated with community centers)
2. Forensic Psychiatry Clinics within the regional hospitals should be equipped in line with the minimum standards in terms of number of beds and security needs as they are “High Security Services”.
3. The envisaged rehabilitation units should be organized by utilizing the local resources and mobilizing the private sector.
4. The families of the patients should be provided with financial and advisory support and rehabilitation where the institutional access is not possible.
5. Organizations that can render rehabilitation services in the houses of the individuals who are in need of mental health services should be facilitated.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, Universities, Ministry of National Education, Prime Minister Administration for Disabled People, Institution of Social Services and Child Protection (SHÇEK), Private Education Institutions, Social Security Institutions, State Planning Organization, Professional Associations, Non-Governmental Organizations.

**Objective 8: To ensure for coordination among all public and private bodies and agencies delivering mental health services in the country.**

The current situation and rationale for the objective: The complex requirements of the mentally ill people can not be fulfilled by the health sector alone. There is a need for cooperation inside and outside the health sector alone. The main cooperation areas include information exchange on the philosophy of the mental health, policies, ongoing activity fields, areas of success and persistent problems. The visits are useful for developing relationships between public and private sector personnel. In additive steps, these should be supported by joint meetings, brainstorming workshops, weekly/monthly sessions, phone calls, e-mail correspondences and linked web sites if possible. The lack of coordination remains a major problem in Turkey.

**Strategies:**

1. The coordination between the units under the auspices of the Ministry of Health should be applied at the highest level.
2. It should be facilitated that the non-governmental organizations and the professional associations that have an active role in providing mental health services.
3. The cooperation between the units that are affiliated to different organizations such as youth, family and job consultation centers, universities and health care institutions.
4. When the private health care institutions begin to provide mental health services these services should be provided in synergy with the public health services and the repeated gaps eliminated.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, Universities, Ministry of National Education, Prime Minister Administration for Disabled People, Institution of Social Services and Child Protection (SHÇEK), Private Education Institutions, Social Security Institutions, State Planning Organization, Press Organs, the Supreme Board of Radio and Television (RTÜK), Professional Associations, Non-Governmental Organizations.

**Objective 9: To ensure for coordination among different professions responsible for producing services in the field of mental health.**

The current situation and rationale for the objective: The mental health services require the joint service provision by many professional groups. Most of these professional groups do not have professional laws. Moreover, these professions have their own organizational structures too. It will be useful for these professional organizations to be strengthened and to identify the mental health services they can provide in their own professions. In Turkey, non-physician professionals who have received mental health can not currently readily work in the public institutions.
Strategies:

1. Professionals from all related fields of mental health services should be sufficiently represented in all the units.
2. The ambiguities with regards to the definitions of the duties and roles of the mental health service providers/professionals should be eliminated taking the international standards as basis.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, Universities, the Professional Associations of the mental health professionals, Social Security Institutions, Prime Minister Administration for Disabled People, Institution of Social Services and Child Protection (SHÇEK), Ministry of National Education, Private Education Institutions, Private Health Care Institutions, all institutions that can provide primary health care services.

**CONCLUSION**

The organization of the mental health services has an important effect on the efficiency of the services and on reaching the objectives of the NMHP. The fact that both the organization and financing of health care services in Turkey has a pluralist characteristic results in serious coordination problems. These problems are experienced at all strategic (policy development and legal arrangements), tactical (development of plans and programs) and operational (support for health care services) levels.

The objectives that are set forth for the organization of the services which constitute one of the main foundations for the NMHP have been listed in this section. The current situation in Turkey, underlying rationale for these objectives and the strategies to be followed for fulfilling them, as well the relevant and responsible institutions are discussed in detail under the relevant components.

The mental health organization should be based on the principles of access, coordination, sustainability, effectiveness, respect for human rights and equity. A major issue for mental health service provision is the integration of services in specific disciplines.

A major objective of the NMHP in terms of the organization of the mental health services in Turkey is to eliminate the challenges faced in limitations to access in mental health services. Another target is the need is the to enhance existing administrative structures in mental health services at the central and local level. As the identification of the requirements is one of the main factors behind the success of the organization, it is of great importance to monitor, evaluate and generate scientific solutions for the mental health requirements in the country. In accordance with the contemporary mental health approaches in a number of developed European Union countries, it may be important to localize mental health services rather than keeping them at central level. Keeping the hazards associated with natural disasters in Turkey in mind as the symbolic starting point for the NMHP process, it is necessary to respond to the specific requirements that can arise from disasters, high rate of traffic accidents, traumatic events, terror events, internal migration in a systematic way.

The involvement of the private sector in the mental health services organization rather than giving this responsibility to the public sector solely has become one of the identified objectives. This involvement is in conformity with the general privatization policies in Turkey. It is envisaged that it would have an organizational structure, within the mental health system of the country. In this regard, it is essential to have cooperation and coordination between the public and private mental health care institutions within the country.
Rehabilitation is defined by WHO as a set of “interventions and actions that are planned for reducing or eliminating functional loss, deficiency and barriers caused or related to mental disorder and for improving the individual’s quality of life as far as optimally possible”. The concept of psycho-social and adaptive rehabilitation emerged in 1940s when individuals with mental disorders in society were increasingly supported within social or community settings for emotional support. This process aimed to ensure that individuals with mental disorders considered themselves as unique persons rather than patients. In psychosocial treatment and rehabilitation various models have been used in order to promote acquisition of social and vocational skills among persons with serious and persistent mental disorders in order for them to live independently in the society. Such interventions have been provided in outpatient clinics (polyclinics in Turkey), day or partial hospitals, social clubs, group homes and as part of services in patient’s own homes.

Social inclusion, work and improved quality of life by through learning and caring are the focal points of the community based mental health services for the individuals with serious and persistent mental disorders. This development in individual's quality of life can be reflected, in part, through the following measures:

- Inclusion in the community;
- Gainful employment in jobs suitable for an individual’s knowledge, skills and abilities;
- Establishment of social relationships, friendships or marriage.

The individuals with mental disorders need not be isolated from society and ought to be able to receive support and hope from caregivers in order to have a better control and improve their lives. If such vulnerable individuals are provided with the necessary support within society, they will be able to participate society in various fields including education. In this respect, educating an individual in order to meet the requirements of a specific profession is an important scope of social rehabilitation. Furthermore, the rehabilitation services can not just be limited to the services that are provided by the professionals in this field but also require meaningful support structures within society.

The rehabilitation and improvement activities mostly include overcoming illness and obstacles as well as increasing the competency in terms of adaptive and psycho-social functioning. This is a dynamic process which changes constantly and the requirements of the individual will change over time. The interventions should be chosen and tailored in accordance with the requirements and the cultural characteristics of the individual.

The Current Situation

When we look at the treatment and rehabilitation activities for the individuals with mental disorders in Turkey, it is shown that these activities are not disseminated enough to reach all patients and that they are in fact only carried out on specific project levels or by public or university hospitals. The patients are generally treated within the hospitals and there exists no systematic activity for the treatment and rehabilitation within the community promoting the universal rehabilitation principles mentioned above.

Although it is crucially vital that children with developmental disabilities such as mental retardation or autism receive special services besides medications, the special training and rehabilitation centers for these children are insufficient both in quality and quantity.

Alcohol, substance abuse and addiction are amongst the most important and serious problems of this century. Today, the primary, secondary and tertiary preventive measures are becoming more and more important in the struggle against addiction. The primary preventive measures include the school, the family and training programs and local, regional and national organizations for 15-24 year old patients. The treatment and rehabilitation for alcohol and substance addiction are included in the secondary preventive measures. Many treatment options such as individual and group therapy programs after Detox, such as family treatment, social-
worker consulting, finding jobs, self-help are included in these measures. Programs for protecting the society, friends and relatives of the substance addict individuals who reject treatment from possible harms are included in the tertiary measures.

The Ministry of Health aims at improving the quality and the quantity of service provider institutions in order to prevent the use of drugs, provide treatment and rehabilitation of the addicts in order to prevent them from encouraging others to abuse drugs, and therefore, decreasing the drug demand in the country. In this framework, in addition to the Alcohol and Drug Addiction Treatment and Research Center (AMATEM) which is affiliated to the Istanbul Bakırköy Mental Health Hospital, AMATEM centers with 30 beds have been established under the Elazığ, Samsun and Manisa Mental Health Hospitals in 1997, and AMATEM centers in the provinces of Adana and Denizli started to provide services as of 2000. However the AMATEM center under the Adana Mental Health Hospital could not fully function as a result of some problems. There is an AMATEM center which was established under the auspices of the Numune Hospital in Ankara in 2004, however it works in a different part of the region. The “Volatile Substance Addiction Treatment and Research Center” (UMATEM) which was established under the auspices of the Istanbul AMATEM so as to provide services for the volatile substance abuser children carries out successful practices. Moreover, the initiatives by the Ministry of Health with regards to the treatment with medication to individuals with substance dependence continues today.

Furthermore, there exist clinics in the regional hospitals that are allocated to the (surveillance, treatment and guarding of the forensic cases). However, the number of beds and the security measures in these clinics are not in conformity with the standards.

Besides all these groups, children and adolescents who are at risk should be dealt with separately. In particular, special service programs are needed for street children, child workers, vulnerable or disabled children, alcohol and drug abusers, adolescents committing crimes, children and adolescents who were abused and exposed to violence, traumatized individuals (as a result of disasters such as earthquakes) and children and adolescents with chronic physical diseases should also be taken under the scope of the mental health policy.

Objective 1: To improve and maintain the existing “cascaded” treatment chain in the country for the treatment of mental disorders.

The current situation and rationale for the objective: A “cascaded” treatment system has been used in the mental health for a long time, as is the case for other health problems all around the world. However, it is known that the physical venues and the personnel are not sufficient for effective structuring of this system and there are some functional problems due to reasons such as the intensive immigration.

Strategies:

1. The mental health services should be started from the primary level within the National Health System. The necessary legal and administrative arrangements should be made for this aim.
2. It is necessary to establish units that can provide mental health services based on the need to strengthen the existent units in most of the secondary health care institutions. Moreover, it should be ensured that the psychiatric crisis units are established within the emergency services of these institutions.
3. The psychiatry services, which have been established within the regional mental health hospitals and the university hospitals in response to the population distribution and regional needs, should be reorganized in terms of the necessary equipments and bed number. The medical personnel such as the physicians of internal medicine and the appropriate places for the changing demographic structure and the mental health requirements of the population should be provided also by taking the children and adolescents into account.
4. the Forensic Psychiatry Clinics within the hospitals on the secondary and tertiary line should be equipped as “high security services”. Units for the treatment of the alcohol and drug addicts, forensic cases and dangerous patients should be established and they should have high security measures, the necessary structural arrangements and the necessary number of specialized personnel.
5. A patient referral system which is functional between different lines of treatment should be established within the cascaded structure of the mental health services or the current referral chain should be improved.

**Objective 2: To adopt a patient-centered approach in treatment.**

The current situation and rationale for the objective: In our country the treatments which focus on the traditional system and the priorities of the professionals have been on the forefront for many years. The approaches where the specific requirements of the individuals are taken into account and become the focal point of the service have generally been neglected. However, it has been observed in recent times that there is a trend towards an approach where the requirements of the patient is at the center due to the nature of the mental health issues and it is better understood that this approach is a prerequisite for attaining effective results.

**Strategies:**

1. The treatment programs which are in conformity with the individuals’ view of life, values and lifestyle and which help the identification of the personal objectives and priorities should be implemented.
2. The patient should be reevaluated in a reliable way on periodical intervals during the treatment.
3. The psychosocial evaluation of the patient should be carried out during the treatment process and the strengths and the weaknesses of the patient should be identified in line with this evaluation.
4. The patient’s and family’s/friends’ satisfaction about the services should be constantly evaluated.
5. The individual or the families should be granted some abilities so as to overcome the culture, race, gender, sexual choice and age related discrimination and the stigmatization in relation with the mental illness and other disorders during the treatment process.

**Objective 3: To implement both pharmacological and psychosocial intervention methods with a view to be successful in the treatment of persons with mental disorders.**

The current situation and rationale for the objective: For the treatment of the mental disorders, the basic principle is to choose and apply the most effective treatment option in line with the specific requirements of the individuals. There are various treatment methods based on the requirements of the individuals and these methods can sometimes be combined. It is known that this contemporary treatment approach is adopted as far as the possibilities of the country allow. However, the fully effective implementation of these methods cannot be ensured due to the gaps in training, personnel and equipments. It is commonly observed that the different treatment methodologies matching with the requirements of the individuals are not implemented at an adequate level.

**Strategies:**

1. The individual should be informed on the mental disorder, the medication treatment and the side effects of the treatment. The individual should understand that most of the serious mental illnesses have a biochemical bases that an individuals is also sensitive to life events.
2. Where possible, the treatments in which psychotherapy methods are used should be of priority.
3. It should be ensured that the training on overcoming mental health problems is provided and that family members and friends are supported.
4. The information on the early indicators of psychiatric disorders and the effective pharmacological and psychotherapeutic interventions should be provided for the individual and significant others.

5. It should be ensured that the individual recognizes the physical, cognitive, behavioral and emotional indicators showing that the control of his/her emotional reactions has been distorted and he/she should be taught to overcome this.

6. A training on stress management should be given to the individual and his/her family.

7. The individual should be trained on the mental illnesses and the medication treatment.

8. The intervention plans that have been allowed by the patient before should be developed in a way that can also include further psychiatric interventions.

9. In order to attain the effective dosage and symptom control in the medication treatment, cooperation with the physician prescribing the medication should be secured.

10. The individual should have the abilities that are required for the “elongation of the attention and enhancement of the cognitive competency”, self-control and solving the inter-personal relation problems.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, Universities, Private Health Care Institutions, Professional Associations, miscellaneous Psychotherapy Specialization Associations, all institutions and organizations providing health care services.

**Objective 4: To prioritize treatment for substance use disorders considering their personal and social consequences.**

The current situation and rationale for the objective: The substance abuse disorders have the most negative effects both on the individual and the society. It is well known that in our country the problems related to the substance abuse disorders are increasing more and more especially for youth in urban settings. Therefore, the preventive activities being a priority, the treatment for the substance abuse disorders is of great importance. It is also known that there are some important components to be taken into consideration in substance abuse disorders, which are different from the other mental disorders.

**Strategies:**

1. It is necessary to establish the third line treatment services such as AMATEM and UMATEM post-treatment rehabilitation units, which are specialized in alcohol and drug addiction, according to the regional requirements. The existent services should also be enhanced.

2. The individual and his or her family and friends should be informed on the physiological and psychological effects of the substances which cause addiction (alcohol, drugs, tobacco products).

3. The individual should be trained on the interaction between mental illness and substance addiction and between substance addiction and psychotropic substances.

4. The individual should be trained on substance addiction treatment or self-help groups and other social programs that are sensitive to the interaction between substance addiction and mental health.

5. Constant participation in the substance addiction groups and social programs should be supported.

6. Personalized psycho-educational training materials should be used for prevention of substance use.

7. Individual should be supported so as to achieve full abstinence from substance and alcohol use and maintain sobriety.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, Universities, Private Health Care Institutions, Professional Associations, Press Organs, all institutions and organizations providing health care services.

**Objective 5: To develop community-based treatment and rehabilitation programs.**

The current situation and rationale for the objective: As it is well known the Community-based Treatment approach has become very
common in developed countries since the 1960s. This approach, which is an ideal one for preventing the isolation of individuals with disabilities from society and keeping them within the society they live in, is also superior to the other approaches in terms of the harmony with the humanitarian values. However, it is known that the implementation of this standard is not sufficiently insured in modern society. As a result the mentally disabled individuals can sometimes become alienated to their society and the third line health care institutions cannot get rid of the warehouse hospital image that has been “left aside” in developed countries for various reasons years ago.

**Strategies:**

1. The Law on Mental Health which is envisaged to be enacted should be formulated in a way that can allow the development and implementation of the community-based treatment and rehabilitation programs.
2. Community mental health treatment and rehabilitation teams should be established.
3. Professionals who are appropriate for the planned program for the patient such as the Mental Health Specialist, Psychologist, Social services specialist, Therapist, Nurses, Psychiatric Nurses, Hobby Therapist and the units in which these teams will provide services need to be easily accessed by the individuals and their family and friends.
4. The post-graduate and pre-graduate training programs for the professionals in the mental health team should include the community-based treatment and rehabilitation programs too.
5. The mental health teams should be provided with supervision support.
6. The society should be informed on the care, treatment and rehabilitation of the individuals with mental health disorders within the society.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, Universities, Institution of Social Services and Child Protection (SHÇEK), Ministry of Finance, Private Education Institutions, Social Solidarity and Collaboration Foundations, Private Health Care Institutions, Professional Associations, NGOs.

**Objective 6: To provide training to the employers under the scope of professional rehabilitation and to ensure employment of mentally disordered persons in the workplaces at specified rates.**

The current situation and rationale for the objective: The fact that the individuals who receive mental health treatment are generally deemed as burdens for the society is the most important factor behind the welfare of the individuals and their family and friends and the recurrence of the illness. It is an important component for the success of the rehabilitation that the patient has a job and an income that can save him/her from being a burden for the society during the rehabilitation stage. It is known that there are great restrictions and hesitations in the recruitment of mentally disabled individuals in work places as a result of the stigmatization that they suffer. Though there are some adjustments in this regard, there still exist great obstacles in the implementation.

**Strategies:**

1. It should be ensured that the vocational programs are also included in the rehabilitation of the individuals with mental illnesses.
2. The individuals should receive certificates at the end of the vocational rehabilitation programs and they should be registered in order to be placed in appropriate jobs.
3. The employers should be trained on the mental health issues and they should have a positive attitude.
4. There should be legal arrangements to avoid discrimination in recruitment of the applicants.
5. The observation should be continued in the work places.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, the Ministry of Labor, the Ministry of Finance, Press Organs, Municipalities, Turkish Union of Chambers of Commerce and Commodity Exchanges (TOBB), Chambers of Industry and Commerce and the Non-governmental Organizations, Turkish Employment Agency.
Objective 7: To provide for care of mentally handicapped persons either in their families or special nursing homes not isolated from the society.

The current situation and rationale for the objective: As the necessary institutional structures for the rehabilitation of the individuals with mental illnesses are not existent in Turkey and the institutions which have the image of warehouse hospitals are insufficient, the rehabilitation of these individuals is mostly carried out by their families. However, the families are deprived of a systematical support and the necessary equipments in this regard. The current family structure and the positive and supportive characteristics of the values in Turkey can be a part of the system within a specific systematic base for rehabilitation. Within the framework of a community-based approach special dispensatories can be established in the places where the individuals live in order to facilitate the family support.

Strategies:

1. In order to make the patients live with their families, the families should be given psycho-educational programs and they should become a part of the treatment and rehabilitation.
2. In order for the patients to live with their families or other independent houses (protective family type) they should develop some basic life skills.
3. In order to reduce the stigmatization within the society and to improve the social support systems, some training programs that can help society live with individuals who suffer from mental disorders should be given by the treatment and rehabilitation teams on local level.
4. Special dispensatories should be established for the homeless and desolated people within the society and there should be arrangements to make sure that they can live with their families.


Objective 8: To develop individual-centered rehabilitation programs.

The current situation and rationale for the objective: As the mental disorders result in a high loss of competence for the patients, the patients need almost a lifetime rehabilitation service. There is an increasing need for an approach focusing on the specific requirements of the patients in the rehabilitation services, as there are many differences from one patient to another. Therefore it is necessary to provide the rehabilitation services with an approach which is focused on the requirements of the individuals. On the other hand, as there is almost no rehabilitation service for the individuals with mental disorders as is the case for individuals with physical disabilities.

Strategies:

1. The socio-cultural conditions of the disabled or mentally ill people should also be taken into account while evaluating the strengths and weaknesses of their psycho-social functions, the support they receive and their status.
2. It should be ensured that the basic life requirements of the individual such as accommodation, food, income, health services and transportation are met in a consistent and stable way.
3. A rehabilitation plan which is based on the personal aims and priorities of the individual who have been diagnosed with a mental disorder should be developed.
4. Some initiatives should be taken in order to support the job and training needs of the individual.
5. The individual should be taught coping mechanisms and problem solving abilities so as to overcome the functional problems that he or she faces.
6. Each and every individual should be supported in order for him or her to identify their strengths and weaknesses and to develop appropriate behaviors.
7. The individual should have some abilities to evaluate the reality of the social perception.
8. It should be ensured that the individual is active in social events and enhances the natural support networks.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, Institution of Social Services and Child Protection (SHÇEK), Social Solidarity and Collaboration Foundations, Press Organs, Municipalities, the Non-governmental Organizations.

**CONCLUSION**

When we look at the treatment and rehabilitation activities for the individuals with mental disorders in Turkey, it is evident that these activities are not disseminated enough to reach all the patients and they are carried out on project level or by public or university hospitals. The patients are usually treated within the hospitals and there exists no systematic approach for the treatment and rehabilitation within the community.

Based on these findings, it is important to identify specific objectives for the treatment and rehabilitation activities for individuals with mental disorders in Turkey.

One objective is to maintain and revitalize the current treatment cascade. Another goal is the adoption of a person oriented approach in treatment. It is also envisaged to implement both the pharmacological and psychosocial intervention methods in order for the treatment of the individuals with mental disorders to be successful.

A further objective has been set forth with regards to substance abuse which is an issue becoming more and more serious for our country and the World as a whole: the treatments of substance use disorders should be of priority due to their individual and social consequences.

Developing the community-based treatment and rehabilitation services which have been adopted by the developed countries for many years is another objective. The training of the employers and the recruitment of a number of people with mental disorders, as is stipulated in the law, is another issue to emphasize.

As a result of the positive characteristics of the structure of the Turkish families, it has been recommended that the individuals with mental disorders live with their families or in dispensatories within the community. Lastly, the issue of developing individual-oriented rehabilitation program has been explored.
Children and adolescents eighteen years old and under constitute approximately 40% of the population in Turkey. It is therefore of utmost importance that issues pertaining to youth be taken into consideration within the national mental health policy framework.

Children and adolescents include present different age periods: infants, 0 to 1 years; toddlers, 2 to 3 years; preschool children, 4 to 6 years; latency or primary school age children, 7 to 11 years; and adolescents, 12 to 18 years. During these periods they have different mental health characteristics relative to adults. It is therefore necessary to have a national policy that pays tribute to almost half the population within a sustainable framework. The youthful target population also inevitably includes the families, educational institutions, teachers and health care institutions. The objectives identified are listed as below.

**OBJECTIVES**

**Objective 1: The identification of high risk groups of children and adolescents.**

The current situation and rationale for the objective: When the socio-cultural and economic conditions of Turkey are taken into account, almost all the children and adolescents can be deemed to be at some level of risk. Nevertheless, it is important to differentiate those in the highest risk groups. In this context, children and adolescents at the highest risk can be placed in nine categories: (1) physical and intellectual disabilities; (2) institutional; (3) homeless; (4) alcohol and substance use; (5) serious mental disorders with unsafe behaviors; (6) parental mental disorders; (7) neglected or abused; (8) juvenile correction or under supervision of children’s court; and (9) poverty and deprivation.

**Strategies:**

1. Focus on the children and adolescents and their requirements.
2. Public responsibility for the risk groups mentioned; an important objective in turn being the protection and rehabilitation of the children and adolescents concerned under the guidance and supervision of professionals with a scientific approach.
3. Involvement of child and adolescent mental health professionals in the future when preparing related laws.
4. Legal and administrative structure of Social Services and Child Protection (SHÇEK) being maintained as an autonomous institution being maintained.
5. Removal of the provisions of the Basic Law and Public Administration Reform about transferring the responsibility for the care of children and adolescents to the local administrations.
6. Development of epidemiological research studies to provide an important evidence base for objective identification of needs and resources.
7. Provision of resources to reduce identified risk factors and the effective and equitable planning of needs.
8. Home and community based services for children rather than institutional care. Also, the provision of financial supports and stabilization services for the families. All children under institutional care should be provided a caregiver or guardian and family care model should be adopted. Furthermore, the socio-cultural characteristics that hinder the effective working of the protective family system should be identified and alleviated.
9. A network of voluntary care services, foundations and non-governmental organizations assisting children and adolescents should be encouraged and supported.
10. Support for family planning services should be enhanced.
11. Parents’ training programs and schools should be improved and adopted in the provinces across the country.
12. Cooperation between the relevant organizations should be facilitated.
13. An insurance system covering the care of all children and adolescents should be established.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, the Ministry of National Education, Institution of Social Services and Child Protection (SHÇEK), Ministry of Labor and Social Security, Ministry of Justice, Universities, NGOs, Supreme Board of Radio and Television (RTÜK), and the Press.
Objective 2: Improvement of the quality and quantity of the services provided in child and adolescent mental health and their appropriate regulation.

The current situation and rationale for the objective: Preventive mental health services, counseling and parent guidance and treatment services should be provided in child and adolescent mental health. In Europe the number of child and adolescent mental health specialists for the population under 20 years is more than 5 per 100,000. In Turkey there are currently total of 19 child and adolescent mental health departments (16 in Universities and 3 in the State hospitals; 13 of the university clinics being located in the three major cities of Istanbul, Ankara, and Izmir). There are a total of 230 child and adolescent psychiatrists (0.2 per 100,000), 40 psychologists, 5 social services specialists, 6 pedagogues, and 11 nurses working in child mental health services. According to the Turkish National Child and Adolescent Psychiatry and Mental Health Association, there is estimated to be a need for 3000 child and adolescent psychiatrists, 4500 psychologist with education in developmental and/or clinical psychology and 3000 associate health personnel.

Only two centers have an inpatient treatment units in Turkey. Therefore, if there is an additional need for an inpatient hospitalization children are generally hospitalized in the adult psychiatry or pediatric clinics and ensuing problems are treated with not only of subspecialized treatment but aftercare services as well.

One practitioner, one psychologist and one child development specialist currently are employed in the Child and Adolescent Mental Health and Psychiatry Branch recently established under the auspices of the Department of Mental Health which is affiliated to the Ministry of Health, General Directorate of Primary Health Care Services. This Branch continues its activities in cooperation with a Coordinating Board.

The National Child and Adolescent Psychiatry and Mental Health Association of Turkey, has actively worked since 1990 as the professional association of child and adolescent mental health in the country. This association has carried out some preventive activities as well as parents and teacher training on child and adolescent mental health for physicians working in primary and secondary care level facilities, as well as implementing crisis response programs for schools, providing counseling to counseling and guidance units in schools as well as the children's court, Turkish National Television (TRT) and other media organs, the programs carried out in collaboration with the Ministry of Health, Ministry of National Education and SHÇEK; awareness raising activities on prevention of domestic violence and child abuse and neglect by means of panels and conferences. The Child and Adolescent Mental Health Association of Turkey is represented in the Coordinating Board of the European Union of Medical Specialists through the Turkish Medical Association. There is ongoing work for improving the quality of the specialization ensuring standardization in terms of curriculum development at both medical school and during specialty training.

Furthermore, within the framework of UNICEF supported projects and with the participation of the child mental health specialists, Youth Centers have been established under the General Directorate of the Maternal and Child Health (ACŞM) under the auspices of the Ministry of Health. These Centers provide services in separate buildings next to ACŞM and have personnel that can provide primary care responses for the health problems of adolescents including mental health related issues; they have the capacity to provide quality services with the in-service training support provided by university based counselors.

Strategies:

1. All services and activities for children and adolescents should have a developmental foundation.
2. The Convention on the Rights of the Child, to which Turkey is signatory, should be incorporated when planning child services.
3. The multidisciplinary coordination board established by the Child and Adolescent Psychiatry Branch Directorate in the Ministry of Health should have a regulatory function at specified intervals; the main duty of this board is to support programs undertaken by the Directorate with contribution of public health specialists, psychological counselors, children's court, Health Department of the Ministry of National Education, Juvenile Crime Department of the Ministry of Justice and the SHÇEK. Membership of the coordination board ought to be rotated at specified intervals.
4. There should be child and adolescent mental health unit within each provincial health directorate. In large cities a separate person should be appointed for the coordination of child and adolescent mental health services. In small cities in-service training on the child and adolescent mental health ought to be in place provide ongoing support.

5. The number of the child and adolescent mental health units should be increased over time across the country based on need. The establishment of the child and adolescent mental health departments in all faculties of medicine should be encouraged with increase in personnel that can provide specialization training. As a first step one position should be created per regional hospital for child and adolescent mental health specialists.

6. The number and distribution of child mental health personnel should be adjusted in accordance with the regional and provincial requirements.

7. Cooperation between institutions should be facilitated and the services across institutions should be standardized.

8. The quality of the education of child and adolescent mental health professionals should be elevated and educational standardization also ensured. Non-physician personnel who work in secondary and tertiary health care settings should at least have a masters level graduate degree.

9. The quality and quantity of service-oriented scientific research focusing on children's mental health problems in the country should be enhanced.

10. The number and distribution of child mental health personnel should be adjusted in accordance with the regional and provincial requirements.

11. It would be economic and efficient to integrate child mental health services with the primary health care as the critical number of the qualified personnel trained in mental health currently remains too low. Physicians, nurses, midwives and health workers in the community and village health care centers can be provided with in-service training and can be prepared to urgently implement new programs.

12. Preventive programs for infants, children and adolescent in mental health at the primary health care centers, schools and crèche should be enhanced targeting the youth at most risk. The prevention and risk reduction initiatives ought to take place as part of early childhood programs.

13. Child mental health training rotations by the pediatric trainees and child development students in university hospitals should be an obligatory component with a specific emphasis on prevention of stigmatization of mental health.

14. Inpatient programs for adolescents should be established in each region.

15. The inpatient clinics should involve a child and adolescent psychiatrist, a clinical psychologist, a social services specialist and a nurse. Day and partial hospitals suitable for adolescents with a flexible approach which allow transition to school and supportive services for social skills development should be established.

16. Consultation and liaison units for the children and adolescents should be established and the sufficient recruitment personnel with quality ensured.

17. Development psychological consultation and counseling services should be provided in all educational institutions and they should be taken under the scope of the primary health care services.

18. The number of private educational institutions should be encouraged to grow with sufficient capacity especially in urban centers. These services should be supervised by a commission involving experts from relevant ministries and professional organizations. The private education institutions should be supervised by both the Ministry of National Education and the Ministry of Health in a cooperative manner so as not to hinder the sensitive supervision that is required.

19. The number of the children’s courts should be adequate to meet the capacity and quality requirements across the country.

20. Media organizations should be encouraged to establish special child oriented programs or channels with some adjustment and appropriate regulation to avoid unheeded violent media images.

21. Family training, especially for mothers, should be emphasized; family and pre-marital counseling systems should be established and access to these program facilitated.

Relevant / Cooperative Institutions and Organizations: The Ministry of Health, the Ministry of National Education, Institution of Social Services and Child Protection (SHÇEK), Ministry of Labor and Social Security, Ministry of Justice, Universities, NGOs,
Supreme Board of Radio and Television (RTÜK), and the Press.

**Objective 3: The coordination and improvement of all professional disciplines related to the child and adolescent mental health and raising awareness in this regard.**

The current situation and rationale for the objective: the professionals in the field of child and adolescent mental health include: child and adolescent psychiatrists, clinical psychologists, social services specialists, adult psychiatrists, child development specialists, special training specialists, educational counselors and teachers, psychological consultation and counseling specialists, general practitioners, family physicians, nurses, and assistant health personnel. It is important to have professional groups with teams in places such as schools and for them to work cooperatively for promoting child and adolescent mental health. The requirement for the psychological consultation and counseling specialists in schools is not sufficiently realized by in the country. Some incomprehensive practices such as encouraging children with disabilities to participate in an appropriate level of sports activities remain with the belief that this may contribute to their rehabilitation and inclusion.

**Strategies:**

1. Psychological consultation and counseling services should become effective in schools; the education and quality of training of the social service specialists, teachers, school psychologists and counselors should be strengthened.
2. Units that ensure the cooperation of child mental health professionals and the press and public relations offices should be established. These units will have an important role in the relations with parent and family support.
3. Psychological consultation and counseling services in schools should be enhanced in quality and quantity in order to meet national requirements.
4. Non-governmental organizations should be encouraged and supported to provide recreational and extra-curricular activities for the children and adolescents.
5. Effective use of media for training purposes should be ensured. The preparation of training programs on the TV should be supported.
6. Community leaders should participate via Public Training Centers and the Presidency of Religious Affairs that strengthen the social support system.
7. Special units should be established for homeless children under the Social Security Department.
8. Adolescent support groups should be established under the guidance of professionals with expertise on adolescent development.
9. The role of the media and the sensitivity of the press to child mental health should be emphasized and improved.
10. Units that can provide counseling to adolescents during the military service should be established.
11. Factors that adversely effect school should be identified and preventive approaches should be developed to address them.
12. Child mental health classes should be added to the curriculum of the Faculty of Communication in different universities.
13. The number of preschool programs with qualified staff should be increased; freely available programs or those with fee scales proportionate to the income level of the family should be developed; the capacity of these programs should be increased so that as many children as possible can participate in them; these programs should be strengthened to be able to identify the high risk children at an early stage and help facilitate their development.
14. All training activities with regard to the awareness raising on child neglect and abuse should be supported and cooperation on this issue should be maintained with the non-governmental organizations.
15. The necessary arrangements should be made in order for the students from the university departments to provide vocational training and mental health education for preschool educational institutions on a voluntary or part-time basis.
16. There should be an arrangement which will make sure that the publications such as books and magazines for children, computer games and other game materials are controlled before the mass production by the child mental health professionals to ensure conformity with the social, cognitive and emotional development of children.
17. In order to create advocacy systems within society, participation of the professional and non-governmental associations should be ensured. These include associations such as the Child and Adolescent Mental Health Association, Association of Schizophrenia Families, Association for the Protection of the Autistic Children, Association of Attention Deficit and Hyperactivity Disorder and...
Specific Learning Disorder, Association for Protective Family and Child Adoption, Mental Health Association for Babies, Psychological Rehabilitation and Education Association and the other non-governmental organizations that can help to form and support advocacy systems.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, the Ministry of National Education, Institution of Social Services and Child Protection (SHÇEK), Ministry of Labor and Social Security, Ministry of Justice, Universities, NGOs, Supreme Board of Radio and Television (RTÜK), and the Press.

**CONCLUSION**

Children and adolescents eighteen years and under constitute approximately 40% of Turkish society. Therefore, it is important that these issues specific to the youth be taken into consideration under the national mental health policy framework.

Children and adolescents of differing ages with different development characteristics have different health care needs. The target population for a sustainable policy ought to comprehensively consider the needs of the children, adolescent, families, educational institutions, teachers as well as health care institutions. Three main objectives are identified in this direction. The first one is to identify high-risk youth groups; second, is to enhance the quality and quantity of the child and adolescent mental health services; and third, is to ensure the coordination and improvement of all disciplines relevant to the child and adolescent mental health services while also raising the awareness and creating advocacy systems in this regard.
**INTRODUCTION**

In countries where the mental health system has not been adequately developed, the objective of mental health financing is to emphasize the urgent need for mental health services as constituting an important component of the overall health budget. Financing is a mechanism within the mental health plans, programs for the efficient and equitable distribution of fiscal resources. Without an appropriate financing mechanism, mental health service plans remain symbolic words. In cases where the financing is provided, the resources can be used for developing adequate services, training the qualified labor force, accessing these service, and establishing the necessary technology and infrastructure for them.

**The Current Situation**

The question of how to finance the mental health services in Turkey is part of the greater question is to how to equitably finance overall general health care services in the country. This problem is, in part, related to the organization of the health insurance and health service sectors under the Government, with deficient health sector resource allocations over the years.

The formation of a general health insurance system in Turkey dates to 1983. However, the negotiations on the exact form of such a policy are still continued actively. Besides the "Law on Preventing the Harms of the Tobacco on the Health" which was enacted in 1996, there has been no specific legal arrangement in terms of mental health services in the country. Similarly, there is no budget allocation specific to mental health. The financing of the health services in Turkey is mostly covered by public financing.

Most of the financial transactions in Turkey are defined by the public budget. The consolidated budget includes two parts: first is the general budget; the second is the additional budget allocations. The general budget includes the central Government and the Ministries; all legislative and judiciary organizations and the ten General Directorates which are under the scope of the additional budget. The Higher Education Board, 53 Public Universities and three Social Security Institutions (Social Insurance Institution, Pension Fund and Pension Fund for Self Employed- BA⁄-KUR) are under additional budget allocations. The three Social Security Institutions that are planned to be merged in Turkey by law during the review phase of this report, provide health insurance for an important part of the population. As most of the health services provided by the hospitals and health institutions operated by the Ministry of Health and Social Insurance Institution, the public budget of Turkey is mostly supported by these activities.

The Ministry of Health provides primary, secondary and tertiary health care services. The law on the socialization of basic health care services was enacted in 1961. According to this law, the government has become responsible for providing preventive and therapeutic health services especially in the rural areas. The primary health care centers are the most fundamental health units at the local village level. Though the Ministry of Health derives its resources from the public budget, these resources are not sufficient to cover the operational activities of the health institutions affiliated to the Ministry of Health. The mechanism which emerged as a response to this gap is the revolving fund that is applied in 1500 institutions.

The revolving fund includes the off-budget revenues gained through the health and education institutions which are affiliated to the central government. For example, the amounts that are paid by the third parties in return for the health care services goes into the revolving fund of the state hospital and this resource is generally used for the operational costs that can not be covered by the general budget.

The Turkish Health System is financed by taxes (41%), insurance premiums (31%) and the out-of pocket expenditures (28%). The Turkish Health Care System is a combination of national health insurance and private health insurance components. The compulsory health services that are provided by the social security institutions are multidimensional in nature and scope. Though the private sector is small, it gets bigger rapidly and it functions as a complementary feature rather than a competitive one. The three social security organizations of the country include the following institutions: Pension Fund for public officers; Social Insurance Institution for the private sector employees and workers and the Pension Fund for the Self-Employed. These are also the health service provider...
institutions; however, the Social Insurance Institutions are now excluded from this group. Today, these three main social security institutions are facing increasing problems as a result of the financial imbalances. In order to overcome this problem the government has carried out a number of long- and medium-term structural reforms besides the short-term legal arrangements so as to improve the financial conditions of the retirement and health services.

When we look at the general population, which is covered by the social security institutions in Turkey, we see that a large portion of the population (87%) is under the scope of the health services program; nevertheless, a significant portion of the population (13%) is not covered by a health services program. The Social Insurance Institution has the greatest number of members. During the preparation of this report, there has been ongoing work so as to include the whole population under the scope of the health care services with the Social Security Reform Activities.

The system of financing of the health care services that is still in use in Turkey has a number of strengths. It is possible to list them as follows. First, the revolving funds of the hospitals have been supported by the government policies and therefore, the revolving fund systems have been settled especially for the developed hospitals. Through this method, the real cash flow into the health sector has been ensured and the first step has been taken in order for the hospitals to become professional and contemporary businesses. There is almost no financial reward mechanism for productive physicians and health personnel when compared to the unproductive ones. Furthermore, by means of the new legal arrangements the revolving fund has provided some limited opportunities for the support that the physicians receive when compared to the contribution. The development of this model new in Turkey can make the system more functional. The private hospital operation has been supported recently and a limited experience has been gained though with some gaps. The care and support for the old, ill and disabled people can mostly be provided by the family in a traditional way. This situation contributes to the health system in financial terms too.

There are also many financial weaknesses of the health system in general and specifically in the mental health in particular terms. The financial management of the health systems is not provided by professionally trained individuals. As a result the balance of revenues and expenditures in the health sector is often distorted. Therefore, there is a large domestic debt, and the deficits of the system have been covered by taxes and general budget funds that are not principally collected for this purpose. The limited resources which are allocated to the public health system in Turkey are spent on therapeutic medicine rather than preventive or infrastructure investments; this is in some part due to political reasons. The administration has not taken the necessary steps for solving the health financing problems in Turkey. The State subsidies have impeded this need to solve the issues at hand. Furthermore, the income level of the general population has remained low. Though there is a need resource allocation for a large population which is connected to the social security institutions that do not pay any premiums, the number of people who have a real and effective health insurance is not known. However when taken from a sectoral perspective, it is indicated that this situation has nothing to do with a rational health operation. There is a large number of non-supervised public resource subsidies for the public hospitals and institutions. On the other hand, the incentives and subsidies that are provided for the private sector are very limited. This issue affects the functioning and the development of the private hospitals in a negative way. The number of the private health institutions is very restricted. Turkey is mostly dependant on foreign subsidies for the health sector and especially for the mental health medications. This situation gets even worse with abuse of these drugs that causes the income of the country to be transferred to foreign sources. Lastly, though the young population of Turkey is deemed as being an advantage, the fact that they remain proportionately under employed or with poor productivity, this had caused this advantage to be eliminated for the time being. This current situation therefore has remained a burden for the health sector in general and for the mental health financing in particular.

The harmonization with the European Union can bring along some rational changes in terms of health training, health care services and health financing. This situation is an opportunity for Turkey. On the other hand there are a number of threats on the health sector in general and on the mental health system in particular. The problems result in the wasting of public resources, a large amount of internal domestic borrowing in the budget, thus threatening the public health sector as a whole due to the problems in the health system with inherent threats in the country’s economy beyond the objectives of this report. In the light of this information on the current status, the objectives for the financing of the mental health and the strategies to be followed are detailed below.
Objective 1: To identify the scope of health care services financing as including financing for mental health services.

The current situation and rationale for the objective: The actual total amount that is spent by Turkey for the health services by means of institutions that are affiliated to the public sector is not known. Many public institutions including the TGNA, the Ministry of National Defense, the Military Hospitals and the Central Bank provide some opportunities for the health expenditures of their personnel and their relatives. This reflects an unfair picture as these expenses are spent from the public resources, not even enjoyed by premium paying private systems.

The most common methods of financing of mental health services include tax-based funding and social security out of pocket expenditures. Individuals with mental health disorders are generally poorer and unwilling to receive treatment due to the negative past experiences and hopelessness when compared to the remaining population. As a result of this, the out of pocket expenditures by the patients or their families for the treatment of mental health illnesses are minimal compared to the amount spent on acute physical health problems.

Strategies:

1. There should be an inventory study in order to determine the expenditures specifically on mental health depending on the level of use of mental health services.
2. The power of the local administrations to finance the health services should be evaluated.
3. A specific amount should be paid for the use of health services by each individual within the scope of the general health insurance and an extra user fee should be charged for ones who prefer to receive additional services.
4. The tax rates should be updated in accordance with the cost of the health service and the ability of the service receiver to pay.
5. Mental health services should be taken under the scope of private health insurance especially for expensive and frequently repeated procedures related to mental and behavioral problems.
6. Mental health services should be taken under the scope of the insurance by means of the social security.
7. Finding ways to increase the share of advance payment can be good for the payment options if a sufficient advance payment resource can be allocated as a contribution especially for expensive and frequently repeated procedures related to mental and behavioral problems.

Relevant / Cooperative Institutions and Organizations: The Ministry of Health, the Ministry of Finance, State Planning Organization, Court of Audit, State Institute of Statistics, the Ministry of Interior, Ministry of National Defense, the Private Institutions.

Objective 2: To identify the existing sources for financing of health and their use.

The current situation and rationale for the objective: Co-funding of the budgetary and off-budget resources of the health sector, resulted in a multi-leader and multi-staged system which can be identified by factors, such as: who is providing the health services in Turkey? Who is paying the cost? How much is it? and What is the quality of the services? The fund pools of the Ministry of Health and the Universities have some main and sub components. The main component is the share that is taken from the general budget and is known as the consolidated budget. The sub component focuses on utilization of the revolving funds and the mobility of some specific funds, foundations and additional funds. Furthermore, these two components are basically conflicting factors within the context of the provision and financing has different effects on the health policy.

Strategies:

1. In order to understand the mental health financing system in Turkey, the current systems and their available resources should be mapped.
2. The infrastructure and the administrative support activities, especially the implementation policy, services and the necessary infrastructure costs should be calculated for the mapping.
3. The main categories should be identified and listed for the mapping.
4. The fund resources should be identified depending on the type of funding and the sector or organization providing this fund.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, the Ministry of Finance, State Planning Organization, Court of Audit, State Institute of Statistics, the Ministry of Interior, Ministry of National Defense, the Private Institutions

**Objective 3: To identify the financing source base for mental health services.**

The current situation and rationale for the objective: Understanding the reasons behind the insufficient funding is an important starting point for developing a resource base. The factors causing this are as follows: the negative economic conditions in Turkey; the mental health problems and the insufficient awareness; the unwillingness or impoverishment of individuals with mental health disorders or their family members and friends paying the cost of treatment; and the fact that the policy makers do not attach equal importance or priorities to investments for the prevention and treatment of the mental health disorders compared to the investments on general health services.

The tax and fund revenues subsidize 41% of the allocated resources for the health sector. The real reason behind collecting these taxes and funds, which are independent from the premiums collected by the social security institutions, is not for supporting the therapeutic health sector but making investments for the development of the country. Most of the money that is allocated includes the low productivity personnel expenditures and the therapeutic medicinal practices.

**Strategies:**

1. Fund should be allocated for innovative projects.
2. The mental health services should not be separated from the general health services.
3. It should be ensured that the financing of the preventive healthcare services is encouraged.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, the Ministry of Finance, State Planning Organization, Court of Audit, State Institute of Statistics, the Ministry of Interior, Ministry of National Defense.

**Objective 4: To identify the way of allocating the collected funds.**

The current situation and rationale for the objective: The sharing of funds should be in line with the policy and planning priorities. Though the regional distribution can be based on the per capita funds; here, the differences in terms of prevalence of mental disorders are not taken into account. The prevalence of the low-income group is higher than high-income group. The current mental health resources are more developed in some regions than the others. In terms of accessibility for the mental health services, the individuals who live in distant and rural areas have a disadvantage when compared to the ones who live in the cities.

**Strategies:**

1. The mental disorder prevalence in the lower income group, region and accessibility factors should be deemed as a part of the planning process for developing distribution strategies on national and local levels.
2. Decentralization and the transfer of the authority to the local authorities should be ensured.
3. A necessary cost effectiveness analysis should be carried out for the specific problems for the different sub-groups that are identified in the planning process.
Objective 5: To link the budget to management and responsibility.

The current situation and rationale for the objective: Budget is the financial outcome of the plans for reaching the identified objectives. The planning ought to direct the budgeting process. However, it is generally observed that plans and budgets are developed independently and the objectives cannot be reflected in the budget sufficiently. For this reason it is important to consider that the budget has four main functions that include: policy, planning, control as well as responsibility.

There are four types of budgets: global budgets, line-item budgets, performance-based budgets, zero-based budgets. Although the mental health service planners do not have an option to identify budget type, it is important to understand the positive and negative aspects of all these considerations. A budget should not be limited to the services and it should be linked to the priorities in the plans and policies. The priorities should involve points such as policy development, planning and advocating for plans and programs.

Strategies:

1. A special mental health fund should be established.
2. A budget should not be limited to the services and it should be linked to the priorities in the plans and policies. The priorities should involve points such as policy development, planning and advocating the plan.
3. Even if the mental health fund is a small-scaled one it should have a structure that will improve the quality, generate projects and support the researches and training activities.

Objective 6: To purchase effective and efficient mental health services, when needed.

The current situation and rationale for the objective: There are three obligatory relations between the investors and the service providers: reimbursement, contract and integration. Though the integrated models in which the investor is the service provider and within which there is no fragmentation between the investor and the service provider, the different combinations of the models are used in Turkey and models can change even within the country. Taking the conditions of the service into account, these models can be used in turn or in a complementary way.

Strategies:

1. The purchasing should be done at the level of general budget when necessary; for example, the services can be purchased for an identified group.
2. Capitation based service purchasing payments should be made when necessary; for example, a specific sub-group of the society has the right to purchase services.
3. Service cost payments should be made when necessary; for example, the amount paid for the service provided.
4. Services should be purchased from the non-physician mental health services when necessary.
CONCLUSION

A comprehensive Health Transformation Program is being implemented in Turkey. According to this program the Ministry of Health aims at being the planner and the supervisor of the overall health sector rather than managing and directly providing the health services. The key component of this program is a national health insurance plan that is effective for all citizens and that integrates all working social security institutions.

The recommendations that are given in this chapter are derived from two important studies: the National Disease Burden and Cost Efficiency Research which was co-organized by the Ministry of Health and the Başkent University; the National Health Accounts Research which was co-sponsored by the Ministry of Health, Harvard University and the Hacettepe University. These researches are important for the evidence-based decision making processes and are in compliance with each other being the two components of a large research on the optimal healthcare services in Turkey. The first one identifies the general problems and challenges and the second one sets forth the financial opportunities to overcome these problems.

The first thing to be done in terms of the financing is to have an understanding of the important requirements. This consensus will provide a harmony for advocacy of mental health services and this in turn will affect the development of policies, financing and laws. The financing is closely linked with mental health policy, advocating for mental health services and improved social expectations.

The point to be focused on by the mental health system in a developing country such as Turkey is the establishment of a mental health infrastructure including the legislation, planning and preparation of budgetary allocation for important issues. The main aim of the financing is to add the laws, policies, personal rights and mental health services which will be a part of the long-term infrastructure of mental health services across the country. Once this resource is attained then the financing can be carried out in a more systematic manner.

In conclusion, identifying the scope of financing of the health services which includes the financing of mental health, identifying the existent resources and the way to utilize them, identifying the resource base for mental health services, identifying the way to share the collected funds, linking the budget with health administration and responsibilities, and purchasing effective and productive mental health services when necessary remain major objectives.
INTRODUCTION

All individuals who are in need of primary mental health services have the right to have access to them. The mental health services should be affordable, fair, accessible, voluntary and of good quality. For a member of the family, the quality means elimination of symptoms and improvement of the quality of life for an individual with a mental health disorder. Quality, in turn, means provision of a variety of supports and protection of the integrity of the family. The quality also means effectiveness and efficiency for a service provider or a person who is responsible for a given program. For a politician, the quality plays an important role in improving the mental health status of the community and means guaranteeing the value and responsibility of the money that has been spent. All of these are valid criteria that require to be fulfilled both for the mental health services at the starting phase which has limited resources and for the mental health services which have large resources and concrete foundations.

The improvement of the quality is a criterion indicating whether the possibility to reach the desired result has been increased or is not in compliance with evidence based practice. This definition is comprised of two components: First, includes individuals with mental health disorders and their families; second, includes the professionals, service planners and administrators.

The quality of the treatment is not only important for correcting past violations such as in human rights but also for the effective and efficient treatment by psychiatric institutions. Improvements in quality under conditions of scarce services also stands to contribute to building an important foundations for the future.

The quality improvement phase has a cyclic characteristic. It is necessary to constantly improve treatment quality, to supervise services continuously and to include the quality improvement strategies in the management services once the policy, standards and authorization procedures are formed. Sometimes it may be necessary to review the policy, standards and the authorization procedures. This will help adopting the policy, standards and procedures in line with the results that are reached during this important quality improvement process.

The Current Situation

The quality is an issue related to structures which have concrete foundations and good resources rather than systems. The health care institutions and universities in large urban centers have caused Turkey to become a country with discrepant institutional practices with widely different levels of quality. This leads to poor confidence and the public’s undermining of the system by not conforming to meaningful referral procedures and results in overcrowding of tertiary care centers in major cities. There is a common understanding in Turkey that the health services in general and mental health services in particular are not at the desired level with important discrepancies between regions. Also include the imbalance in terms of qualified service providers among mental health professionals.

The objectives for improving the quality of the mental health services in Turkey and the strategies for these objectives are presented below.

Objective 1: To adopt a policy that considers service quality in addition to service quantity in delivery of mental health services.

The emphasis over quantity rather than quality of services in Turkey is an important concern. The quality of service delivery is often neglected or underestimated given the great demand. Nevertheless, service quality has important short, medium and long term implications for cost effectiveness of services, prevention of stigma associated with mental illness and overall human rights considerations. In Turkey, the quality is superceded as a result of efforts to provide the a saturated level of services with minimal resources. Both quantity and quality needs to be balanced according to optimal international standards.

Strategies:

1. The Ministry of Health should pay special attention to the optimal WHO international standards and the quality ought to be envisaged as a central theme in the development of the mental health law.
2. The consultation board in charge of the quality and standards in mental health services ought to be established with participation of representatives of the mental health sectors.
3. The financial systems to ensure quality improvement of mental health services ought to be established.
4. Improving service effectiveness should be a basic tool for the improvement of the quality and the cost control.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, the Ministry of Finance, State Planning Organization, Court of Audit, the Ministry of Interior, Ministry of National Defense, Higher Education Board of Turkey (YÖK), Universities, Turkish Standards Institute, Institution of Social Services and Child Protection, Ministry of National Education, and non-governmental organizations.

**Objective 2: To identify standards for implementation of mental health services as a quality improvement criterion.**

The main step for implementation of mental health services in terms of quality improvement include a series of standards. In this respect it is necessary for the planners and administrators to exchange opinions with professional organizations and to prepare a quality improvement standards document. This document should involve all components of the mental health services identified by specific sectors. The criteria for measurement of each standard should be identified. The evaluation of the services should include measures of the quality of all components of mental health services. Currently clear measurement of standards for quality improvement of mental health are lacking in Turkey.

**Strategies:**

1. A working group with a total quality management approach should be established in order to identify the service and quality standards for the mental health service practices.
2. The draft standards document should be prepared and open discussed by inclusion of relevant parties.
3. The quality document should include concrete criteria amenable to evaluation.
4. The standards document for provision of mental health services, should include training related to professionals and service institutions.

**Relevant / Cooperative Institutions and Organizations:** The Ministry of Health, the Ministry of Finance, State Planning Organization, Court of Audit, the Ministry of Interior, Ministry of National Defense, Higher Education Board of Turkey (YÖK), Universities, Turkish Standards Institute, Institution of Social Services and Child Protection, Ministry of National Education, and non-governmental organizations.

**Objective 3: To identify the authorized individuals assigned to ensure quality improvement in mental health services.**

This is the third step following the identification establishment of standards for the evaluation of services prior to receiving legislative approval. Such an authorization makes quality improvement an important cornerstone for licensing of mental health service providers. As quality improvement issues have not received the necessary attention in Turkey, gaps in the identification of quality standards and their implementation continue to beset the country.

**Strategies:**

1. The authorization of quality improvement of mental health services should be put under a clear legislative authorization by the Ministry of Health.
2. It is important to prepare the necessary legal groundwork for this in cooperation with the appropriate agencies as this is currently lacking.
3. It should be ensured that all sectors in the mental health system should be encouraged to embrace and fulfill the authorities and responsibilities they have as a part of such a quality management strategy.
Objective 4: To ensure sustainability of quality standards as applied to mental health services.

The quality improvement is an uninterrupted process to enhance the continuing impact and efficiency of the mental health services. After the quality mechanisms have been implemented they can be updated at five yearly intervals by reviewing service objectives. The review of quality mechanisms is necessary for updating these mechanisms according to the most effective improvement methods. In order to reach this result the service managers should be trained in quality improvement and management methods. The information gathered from the quality improvement process for service provision and management should be integrated within the policy in terms of ongoing development of standards and authorization procedures.

In order to increase the speedy implementation of quality improvement initiatives, the administrators and the mental health professionals should receive constant training on quality mental health treatment.

The mental health services should be supervised in order to evaluate the quality of the treatment. It is important to improve the treatment quality as well as the standards and authorization procedures for supervising the services.

Strategies:

1. Information should be collected routinely under the current information system and performance indicators established.
2. There should be meetings with individuals with mental disorders, their families, caregivers, and advocacy organizations to obtain input on this process.
3. Service quality supervision including service planning objectives should be annually implemented.
4. Quality standards should be monitored by means of a review system in which timely attainment of goals are continually accounted.
5. Mental health quality improvement standards should be reviewed and changes fully authorized in a flexible way prior to implementation.

Relevant / Cooperative Institutions and Organizations: The Ministry of Health, the Ministry of Finance, State Planning Organization, Court of Audit, the Ministry of Interior, Ministry of National Defense, Higher Education Board of Turkey (YÖK), Universities, Turkish Standards Institute, Institution of Social Services and Child Protection, Ministry of National Education, and the non-governmental organizations.

CONCLUSION

Quality improvement is a key indicator for reaching desired results and implementation of evidence based practices in mental health services. Quality improvement is a cyclical process; it is necessary to constantly improve treatment standards according to evidence based best practices, to supervise these services, and to include quality improvement and authorization strategies for management and improvement of service implementation within the policy objectives. It is also necessary to continuously review quality standards and authorization procedure adopted in line with the quality improvement system thus in effect.

The main objectives for the quality improvement therefore includes a detailed understanding of the importance of improving the quality of the mental health services delivered to the public. It is necessary to identify standards by including all responsible parties and by ensuring that are continually reviewed.
INTRODUCTION

Mental health law provides a legal framework for the care of individuals with mental disorders in society. Such a law would offer increased access, protect human rights, improve housing and living conditions, education and employment for individuals with mental disorders. Such a legal framework would also play an important role for overall improvement of mental health and preventive services. This is therefore a necessary step for reforms and implementation of National Mental Health Policy (NMHP) for Turkey.

Mental health law is necessary to safeguard the rights of individuals with mental disorders facing stigmatization, discrimination, exclusion and human rights abuses. As mental disorders impair decision making and insight individuals often may be unable to seek services. In addition to emotional and behavioral problems, impairments in cognitive function add important burdens on elderly and individuals with development disabilities.

Adoption of mental health law on its own can not safeguard the rights of individuals with mental disorders. Laws currently in effect in some countries in fact include provisions that still contribute to human rights violations.

Despite such limitations, mental health law nevertheless is a necessary step forward in strengthening the NMHP objectives and ensuring humane integration of individuals as valued citizens in society. In safeguarding human rights, improving mental health services and ensuring the humane settlement and integration of individuals with mentally disorders in society. The mental health law therefore forms an integral part of the proposed NMHP framework.

Principles of protecting persons with mental disorders and improving mental health services; standards for equitable opportunities for individuals with disabilities; human rights declarations such as Caracas and Madrid; the UN Convention for the Rights of the Child and standards such as the WHO World Mental Health Care Law – Ten basic Principles serve as an important background for determination of an appropriate content for mental health law in Turkey. These human rights principles and international declarations are not legally binding in themselves but reflect a commitment to international agreements.

The United Nations resolution 46/119 includes a series of principles on safeguarding the rights of persons with mental disorders, and was unanimously adopted in 1991. Both principles for protection of persons with mental illness and the improvement of mental health care highlighted the fundamental rights regarded as inviolable by the international community for proper treatment of individuals with mental disorders. These principles cover the following areas:

- Identification of mental disorders
- Protection of confidentiality
- Development of service and treatment standards including treatment with or without consent
- Human rights of individuals with mentally disorders in mental health institutions
- Protection of persons among minority groups
- Provision of optimal resources for mental health institutions
- Role and responsibilities of society and cultural factors
- Establishment of research mechanisms for study and development of safeguards in terms of human rights of individuals with mentally disorders who offend
- Development of guidelines for security officers with respect to judicial acts on safeguarding the rights of individuals with mental disorders.

In order to allow a better understanding and easier implementation of the UN declarations, in 1996 WHO published guidelines on “Safeguarding the Rights of Mentally Disordered Persons”. These guidelines include a valuable checklist to facilitate rapid assessment of human rights conditions at national as well as local and regional levels. Another document for implementation of UN principles is the Mental Health Care Law – Ten Basic Principles. These ten basic principles are as follows:
1. Promotion of Mental Health and Prevention of Mental Disorders
2. Access to Basic Mental Health Care
3. Mental Health Assessments in Accordance with Internationally Accepted Principles
4. Provision of the Least Restrictive Type of Mental Health Care
5. Self-Determination
6. Right to be Assisted in the Exercise of Self-Determination
7. Availability of Review Procedures
9. Qualified Decision-Maker
10. Respect of the Rule of Law

International associations for mental health professionals try to safeguard the rights of individuals with mental disorders through their own guidelines promoting development of professional attitudes and implementation standards. An example of such guidelines is the Madrid Declaration, adopted by the World Psychiatric Association in 1996. Among other standards, this Declaration puts an emphasis on treatment based on collaboration of individuals with mental disorders and treatment systems; any treatment without consent is considered under special and rare circumstances.

The Current Situation

The legislative gap in health care in the first years of the Turkish Republic was filled by the important Law on Public Hygiene Works no. 1593 entered into force in 1930. This Law is still in effect in Turkey. The historical development of mental health in Turkey advanced parallel to the reforms introduced in public health. The most important one of these reforms is that Law on Public Hygienic Works that included regulations related to mental health beside basic health care services. Regulating the most important problems of the country also covering contagious diseases, this law regarded “the establishment and administration of hospitals for mental diseases or dormitories or institutions to register diseased persons or persons having any inborn disabilities” among the duties of the Government just like other duties related to health in schools and workplaces. First paragraph titled “Protection of Children and Young People”, of Chapter 6 titled Hygienic Works of Children included regulations such as applying mental assessment of children and young people during regular examinations in the schools and protecting them from abuse, alcohol and drugs misuse and harmful places (Articles 164 – 167).

Article 50 of the Constitution states that “children, women and physically and individuals with mentally disabilities shall be under special protection in terms of working conditions”, Article 56 notes that “it is the duty of the State to ensure everybody to sustain their life with physical and mental health”, Article 61 notes that “State shall take measures for protection of individuals with disabilities and enable their social integration.” So, care, treatment, protection and social integration of the persons with severe mental disorders are identified as the duties of the State.

Under paragraph c of Article 3 of Law on Social Services and Child Protection Agency no. 2828, dated June 24, 1983 (Amended Law June 30, 1997- KHK-572/5md) “a disabled person” is defined as “a person who cannot adapt to normal life conditions due to the loss of his/her physical, intellectual, mental, emotional and social abilities at certain levels from birth or as a result of any disease or accident and who is in need of protection, care, rehabilitation, consultancy and support services”. In terms of the services for individuals with disabilities; in article 5, “Care and Rehabilitation Centers” are defined as “social service institutions established to eliminate functional losses of the persons who cannot adapt to normal life conditions due to their physical, intellectual and mental disabilities and to equip them with skills for self-sufficiency within the society or to continuously take care of persons who are not able to acquire such skills”. These are:

To strengthen the family with training, counseling and social support for the purpose of raising and supporting the child within the family, to carry out necessary services to ensure identification, protection, care, raising and rehabilitation of children, individuals
with disabilities and elderly.

To execute other duties stipulated by Laws in the field of disabilities and other social services in line with the changing needs of the society and to establish and operate appropriate social service institutions in accordance with general provisions;

Article 4 of General Provisions for care and rehabilitation within the society states that any arrangements shall be made or any measures shall be taken so as to ensure sustainment of the lives of vulnerable, disabled and elderly in a healthy, peaceful and safe manner, to conduct care and rehabilitation of the vulnerable disabled so that they can be self-sufficient and productive within the society, and to continuously take care of the ones who are impossible to treat”. Taking the above definition as a basis, “Law on Authorization regarding the Establishment of Administration for Disabled People and Amendment to Various Laws and Statutory Decrees related to the Situation of the Disabled” no. 4216, dated December 3, 1996 was enacted. Under the framework of this Law, the purpose is stated as follows: “The purpose of this law is to authorize Board of Ministers with enacting Statutory Decrees for the purposes of amending existing Laws and Statutory Decrees or introduce new regulations with regard to the rights and problems of the disabled for the protection of the disabled and their families, training, employment treatment and rehabilitation of them through the establishment of Administration for Disabled People affiliated to Prime Ministry.

Paragraph a of Article 3 of “Statutory Decree regarding Organization and Duties of Administration for Disabled People” no. 571 dated March 25, 1997 defines the duties of the Administration as “to ensure cooperation and coordination between related institutions and organizations on prevention of disability, training, employment, rehabilitation, social integration and other issues”. Article 8 defines duties such as “to cooperate with voluntary organizations and local authorities, to devise joint projects, and to support the submitted projects”. Furthermore, departments of medical services, training services, vocational rehabilitation, social integration and duties thereof are determined.

The overall duty of the agency is to establish commissions for “legislation” and to introduce regulations depending on the requirements in general terms.

In terms of the regulations related to social assurances of the disabled; Law on Pension Fund, Republic of Turkey (5434 – June 8, 1949 –Article 72), Law on Social Insurance Institution for Tradesmen and Craftsmen and other Self-Employed (Article 45), Social Insurance Law (506 – July 17, 1964) stipulate that a pension shall be granted on the condition that the insured person him/herself or the persons that they are obliged to care are impossible to heal or have a disability hindering them from working and do not have any other source of income so as to benefit from health care services.

For the persons having no social assurance; “Law on Paying Pension Wages to Needy, Unprotected and Destitute Turkish Citizens over 65,” (2022 – July 1, 1976) covers the persons with severe mental disorders on the condition that the level of disability is identified. This framework is defined under Article 1 as “in accordance with the provisions of this Law, same amount of pensions shall be granted to the persons who are not at the age 65 but proved by means of the health board report from a fully-equipped hospital that they are not able to sustain their lives without the support of others and the disabled who are not employed with a job appropriate for their situation”. Those people can benefit from health care services free of charge as well.

Moreover, Law Concerning Covering Medical Expenses of the Green Card Holders by the State who are Unable to Make Their Payments” (3816 – July 18, 1992) was enacted for the persons unable to benefit from health care services and Article 1 defines the purpose of law as “covering medical expenses of the Turkish Citizens who are not under the assurance of any social security institution and unable to afford medical expenses by the Government until the application of General Health Insurance and determining rules and procedures to follow in this regard”. Considering the fact that persons with severe mental disorders are frequently hospitalized due to lack of sufficient care and treatment systems within the society, this law is highly important. Covering the medical expenses of green card holders is a positive development.
Article 2 of “Law on Promotion of Social Aid and Solidarity” (3294 – May 29, 1986) states the scope of law as follows: “the scope of this law covers the needy and vulnerable citizens who are not subject to any social security institutions established under law and do not receive any pension wage or payment (excluding 2022), and persons who may become beneficial and productive citizens for the society in the event that a temporary and small amount of aid or training and education possibilities are provided”. This is known as a fund covering prescription expenses of persons with severe mental disorders and providing in kind aids. On the other hand, although Directorate General for Foundations provides in cash and in kind aids, the desired objective has not been achieved yet.

There are several legal arrangements at local authorities level to ensure employment and integration of the disabled to social life especially to social and cultural activities. Examining the provisions of Municipalities Law (1580 – April 3, 1930); Article 18 states that "abandoned and found children, insane, impaired, disordered, persons fainting in the streets, victims of accidents and disasters shall be protected and safeguarded", Article 81 that "no fees shall be charged from the disabled or a discount shall be applied for transportation and social and cultural services, the operation of kiosks, car parks or similar places belonging, operated or rented by the municipalities by the disabled shall be facilitated".

Article 13 of Law on Public Hygenic Works (1593 – April 24, 1930) stipulates the care of persons with severe mental disorders in institutions and includes arrangements thereof with the statement of "the establishment and administration of the hospitals for mental diseases or dormitories or institutions to accept diseased persons or persons having any inborn disabilities".

Article 1 of “Statutory Decree on Organization and Duties of the Ministry of Health” (181 – December 13, 1983) expresses that "the purpose of this decree is to regulate principles related to the establishment, organization and duties of Ministry of Health to ensure the sustainment of life for everybody with physical and mental health, to regulate health related conditions of the country, to struggle against the persons harming the health of individuals and the society and extend health care services to the public and centralize the planning of health institutions and ensure that they provide services".

Article 3 of “Basic Law on Health Care Services (3359 – June 7, 1987) indicates that a necessary registration and information system shall be established so as to follow everyone’s health status and related works shall be carried out for the prevention of disability. Law on Socialization of health care services (224 – January 5, 1961) defines the health care services as "medical activities executed for eliminating various factors giving harm to human health, and protecting against the effects of these factors, treatment of diseases, integrating persons with low physical and mental skills and competences with employment conditions".

The duties stipulated in paragraph (b) of Article 29 of Decree in Force Law no. 184 regarding the Establishment of Ministry of Labor and Social Security "to ensure the social, medical and vocational rehabilitation and training of the disabled and that they benefit from social, economic and cultural resources of the country and that they are provided with employment opportunities" and paragraph (c) "to ensure cooperation and coordination between all official and private national and international institutions and organizations serving for the disabled” are allocated to this institutions.

The Labor Law numbered 931 stipulates that the employers should employ a specific number of disabled employees if some specific conditions are met. The same arrangement was made in Labor Law numbered 1475, as well. The “Statute on the Employment of the Disabled” which was enforced on March 16, 1987 and was amended on August 18, 1989 and November 26, 1996 explains in Article 2 of the Definitions Chapter that "the individuals whose health reports indicate that they are deprived of at least 40% of their work force due to physical, mental and psychological disorders are deemed disabled in line with the provisions of this statute", however it is stated that the individuals who cannot work because of their disability according to their health report are excluded from this statute. In the statute it was stipulated that the employers of the workplaces where more than fifty full-time workers are recruited should recruit 2% of the total number of the employees in jobs, which is appropriate for the individual’s occupation, physical, mental and psychological conditions.

This ratio of 2 % was increased to 3 % with the Statutory Decree no. 572 and the amendment made to the Article 25 of the Labor Law.
no. 1475, which was enforced on January 1, 2000. Furthermore, the jobs that could be undertaken by the disabled were annexed in a list and it was stated that in conditions where the disability is not involved in this list the physician should identify the jobs that could be undertaken by the individual in the health board report. Therefore, it is the responsibility of the Turkish Employment Agency to entitle the disabled with a job and to provide occupational rehabilitation and employment consultation services.

Article 24 of the Statute on the Duties and the Authorities of the Police Officers stipulates that the police officers should not be responsible for the referral of the individuals with mental disorders if there is a possibility that they can cause harm to public during their referral; in such a case, the police officers shall only be responsible for accompanying the responsible bodies in order to prevent any attack that could occur and Article 52 of the Regulation on the Duties and the Authorities of the Gendarmerie stipulates that that the gendarmerie forces should not be responsible for the referral of the individuals with mental disorders if there is a possibility that they can cause harm to public during their referral and shall only be responsible for preventing any attack that could occur; however, this responsibility is carried out by the Internal Security Forces of the Gendarmerie only in places where no police organization exists. As can be observed, there exists no comprehensive “Law on Mental Health” among the laws concerning the mental health, disabled individuals and social security issues in Turkey. Rather, there exists a structure, which is dispersed in various fields of legislation and is therefore hard to implement and follow.

THE BASIC LAW ON HEALTH CARE SERVICES no. 3359, which was enforced on May 7, 1987, is the last comprehensive law enforced in Turkey in the field of the Health Care Services. This law clearly stipulates the rights, responsibilities and authorities of the government and the individuals in terms of health related issues.

The strength of health system in terms of laws and human rights is that Ministry of Health has a more central bureaucratic and political structure than any of the developed western countries. On the other hand, there are emerging views and practices advocating the transfer of these powers and responsibilities to non-governmental organizations. This is a promising initiative for Turkey, which needs harmonization with contemporary systems.

On the other side, mental health system has its own weaknesses. First of all, lack of an integrated mental health law is a restraint. Provisions related to mental health are spread in other various laws. Non-governmental organizations and the society in general do not have the intellectual and cultural infrastructure necessary for assuming power and responsibility in fields they should be organized. In addition to this, there is a tendency to rely on the government as a mediator for each and every problem. In developed western countries, education, planning and audit in medical field are mostly carried out by non-governmental professional organizations, not by Ministry of Health. Moreover, this is one of the obligations for Turkey in EU accession process. However, the situation is vice versa in Turkey. There is a strong central bureaucratic system unwilling to transfer its powers in the field of health. On the other hand, most non-governmental organizations are not prepared to assume such powers and responsibilities as a conception. Another restriction is that forensic medicine services and related legislation, human rights and patient rights legislation have not been adopted yet.

Mental health legislation and objectives related to human rights and strategies to follow for attaining these objectives are detailed as follows. For each objective the rationale for identifying such an objective is provided and the current situation in Turkey is discussed.

**Objective 1: To eliminate inhumane, humiliating and unstandardized treatments and care, to enforce a mental health law that will be in harmony with United Nations Conventions and international law standards.**

There is no comprehensive “mental health law” dealing with all aspects of mental health among existing Turkish laws regarding protection of patient and individual rights, rather there are provisions spread all over in various laws, accordingly enforcement and surveillance of these provisions are difficult.
Strategies:

1. A conference should be held for all related counterparts to make proposals regarding mental health before the enforcement of the law.
2. Works on drafting the law should be consistent with European Social Charter
3. The law should be in conformity with international principles and standards
4. Principles for human rights and social justice should be adhered to.

Relevant / Cooperative Institutions and Organizations: Turkish Grand National Assembly, Ministry of Health, Ministry of Justice, Ministry of Social Works and Labour, Bar Association, Professional Associations, and Non-Governmental Organizations.

Objective 2: To have the Law on Protecting Psychiatric Patient Rights approved by the Turkish Parliament.

There is need for an independent law regulating the specific rights of psychiatric patients similar to the ones in developed countries. This law should clearly state the rights of psychiatric patients and these rights should be considered in every practice in mental health system.

Strategies:

1. Laws of other countries on patient rights should be reviewed.
2. Works carried out especially by Non-governmental Organizations, Professional Chambers and Professional Associations regarding patient rights should be supported.
3. The mentioned Law on Protecting Psychiatric Patient Rights should be drafted and passed the parliament together with the coordination of all sectors under the leadership of Ministry of Health.

Relevant / Cooperative Institutions and Organizations: Turkish Grand National Assembly, Ministry of Health, Ministry of Justice, Ministry of Social Works and Labour, Bar Association, Professional Associations, and Non-Governmental Organizations.

Objective 3: To update the legislation on mental health.

The complicated legal situation in Turkey an elaborated in the introduction of this section is well documented. This confusion not only results in conflict of authority but also decreases the effectiveness of mental health practices. Therefore, all relevant legislation pertaining to the Ministry of Health and related mental health law components including the Law on Protecting Psychiatric Patient Rights should be revised. Furthermore, the Statute on the Duties and the Authorities of the Police Officers and other relevant laws currently in force regarding the referral of psychiatric patients by security forces without consent have serious problems especially in urgent referral of patients. There are major uncertainties about how to enforce the provisions stipulated in Turkish Penal Code no. 5237, Code of Criminal Procedures no. 5271, Law no. 5402 on Probation and Child Protection Law no. 5395 regarding mentally disordered persons and drug addicts by the institutions.

Strategies:

1. Upon the enactment of two basic laws mentioned above, legislations of primarily Ministry of Health and all ministries should be revised and accordingly amended.
2. Necessary legal amendments should be done so as to eliminate conflicts of authority regarding the immediate referral of mentally disordered persons.
3. Decisions inherent in the no. 5237 TCK, no. 5271 CMUK, No. 5402 Search and Freedoms Law ve no. 5395 Child Protectin Laws should be taken up by the appropriate institutions to define and correct uncertainties and inconsistencies

**Relevant / Cooperative Institutions and Organizations:** Ministry of Health, Ministry of Justice, Ministry of Social Works and Labour, Bar Association, Professional Associations, and Non-Governmental Organizations.

**Objective 4: To enact legislation allowing full implementation of the UN Convention on the Rights of the Child.**

Thirty two percent of the country population is below 18 years old. Mental health requirements of the children and adolescents of this age groups differ from that of the adults. Therefore, the rights of children belonging this age group should be protected under distinct legislation. As a developing country, Turkey experiences problems about child abuse in families and institutions, child labour and limited health services for children, which are all on the forefront of the community via media exposes.

**Strategies:**

1. The UN Convention on the Rights of the Child and other international conventions, and their provisions as supported and rejected by Turkey should be revised; and the issue should be addressed collaboratively by all sectors and mentioned amendments should be made under the auspices of Ministry of Health.


**Objective 5: To enact legislation with respect to mental health professionals approved by the Turkish Parliament either as a single piece of legislation or a framework law.**

Professional laws include official decisions regarding regulations and sanctions approved at governmental level so as to protect the rights of professionals in a given field or the rights of consumers of services provided by that professional group. In this sense, various professional groups serving in the field of mental health such as psychologists, psychological consultants, social workers, psychiatric nurses, speech and hearing therapists do not currently have a professional law guiding their practice. Rules for taking up, pursuing or being excluded from the profession, roles and responsibilities thereof are not clear. Protection of professional practices and standards through such a law is vital in terms of the social responsibility born by these professions in society.

**Strategies:**

1. The mentioned professional laws or the framework law should be drafted and enacted on the basis of the views proposed by professional organizations which are the representatives of all related professions and international standards under the leadership of Ministry of Finance.

2. The relevant professional organizations should be encouraged to carry out the work for determining the quality standards and accreditation criteria of training programs dedicated to train professionals.

**Relevant / Cooperative Institutions and Organizations:** Ministry of Health, Ministry of Justice, Ministry of Social Works and Labour, Bar Association, Professional Associations, and Non-Governmental Organizations.
CONCLUSION

Turkish Mental Health Law to be drafted under the framework of international standards should deal with various aspects. The law should not only protect the rights of mentally disordered persons but also target the development of mental health and prevention of mental disorders. The law should be based on the application of alternatives proposing treatment that will be least restrictive on the freedom of the persons and have least impact on their status and concessions within the society with regard to proceeding with their job, taking day off and dealing with their own personal issues. The law should guarantee the confidentiality of all clinical information regarding individuals with mental disorders. The principle for allowing the treatment by informing and taking the consent of the patient should definitely be included in the law. If the patient does not show consent for hospitalization, this should be specifically stated and apply for only under special conditions. Such conditions should be elaborated in the laws and the procedures to follow in case of hospitalization without consent should be identified. Apart from rare conditions such as being deprived of the capacity for showing consent and the necessity for a treatment to improve mental health and/or prevention of considerable deterioration of the mental health and/or avoiding harm by patients to themselves and others, the patients showing no consent should not be regarded as being willing to have treatment. In the countries where treatment without consent is provided, rules regarding such treatment should be put forth and appropriately followed. The law should include a provision stipulating the assignment of an independent research official who will function as a regulatory mechanism. The law should not be confined only to mental health and health-related issues. Necessary importance should be attached to include issues like housing, education, employment, general health and prevention of mental disorders in the general framework.

Main objectives for the enactment of the necessary mental health law and Law on Psychiatric Patient Rights and re-regulation of relevant legislation are stated as follows: to eliminate inhumane, humiliating and unstandardized treatments and care, to enforce a mental health law that will be consistent with UN Conventions and international law standards; to have the Law on Protecting Psychiatric Patient Rights pass the Parliament; to update the legislation on mental health; to enact a legislation allowing for full implementation of the Convention on the Rights of the Child; to have the law regulating professions in mental health pass the Parliament either as a single piece of legislation or a framework law.
INTRODUCTION

Most countries attach less importance to mental health and mental disorders than physical health. The impact of mental disorders and disabilities are seriously underrepresented in most societies. Studies have shown that advocacy stand to increase sensitivity to mental disorders and improve the care of individuals with mental disorders as well as their families.

The concept of advocacy for mental health provides fundamental human rights to those suffering with mental disorders by also eliminating stigmatization and discrimination. The protection and improvement of mental health in society can only be possible through systematic organization of a set of activities in order to elimination social and cultural barriers. Historically, it may be observed that at the inception of advocacy efforts worldwide individuals and the families faced immense problems on their own. As they came together and established non-governmental organizations support of professions and government began to play an increasing role. The process, in turn, has helped to improve planning, implementation and evaluation of mental health services.

Mental health advocacy occurs at two levels. First, it aims at strengthening and protecting the mental health of individuals, families, interest groups and society in general. Second, it aims at increasing awareness, understanding and acceptance of mental disorders in society. Activities carried out at both levels represent a driving force in terms of mental health policy as well as development of legislation to improve the mental health care in the country. Therefore, advocacy is one of the essential components of a NMHP. In summary, advocacy for mental health covers the activities that allow understanding of the importance of mental well-being -- one of the major indicators of quality of life for the society.

The Current Situation

Despite recent important legal regulations to encourage full participation of individuals with mentally disorders within society, regulations remain incomplete or improperly enforced. Epidemiological studies reveal that individuals with mental disorders do not have sufficient access to mental health services. The uneven distribution of services in the country is remains a major barrier. The course of illness worsens on account of inability to access timely treatment, disability increases on account of increased recurrence. Finally, individuals face financial constraints, stigma and cannot benefit from basic rights such as education and employment.

As a result of changes in traditional family structures and weakened social support systems due to rapid urbanization in Turkey, individuals with severe an persistent mental disorders and their families suffer are poorly supported in urban areas. Similarly, the quality of life is decreased by social exclusion of individuals, long term hospitalizations, and insufficient community based care services. Many such individuals do not participate in advocacy activities. Although more recently there has been a substantive increase in the number of non-governmental mental health organizations in Turkey, such organizations, e.g., Association for Schizophrenic Patients and Their Families, Association for Attention Deficit Hyperactivity and Learning Disorders, Association for Mental Health in Babies, Association for Mental Health in School, Protective Families Association, Association for Adoption do not have widespread chapters across the provinces to be able to make a countrywide impact.

Objectives proposed for advocacy activities regarding mental health and strategies to follow for attaining them are detailed as follows. For each objective the rationale for identifying such an objective is provided and the current situation in Turkey is discussed.

Objective 1: To facilitate the work of non-governmental organizations to promote advocacy activities and provide human rights to the individuals with mental disorders as well as their families; and to help eliminate stigmatization and discrimination.

Current Situation and rationale for the objective: Current situation about mental health advocacy detailed in the introduction above applies to this first overall objective and sets the rationale for the objective.
Strategies:

1. A database on non-governmental organizations founded by individuals and families with mental health concerns should be developed and such organizations should be made widely available through opening chapters or branches nationwide.
2. Brochures defining the mission and vision of the non-governmental organizations and elaborating upon their activities should be listed and readily available in print; web pages should be designed and announced to the public so that the individuals and their families become members of these organizations.
3. The representatives for non-governmental organizations should be elected to participate in meetings held in the fields of health, education and employment, and should be allowed to participate actively in such meetings.
4. Non-governmental organizations should be strengthened in technical and financial terms.
5. Different non-governmental organizations should be encouraged to carry out joint activities on mental health related issues.
6. Non-governmental organizations that are founded or to be established by service users in the future should be encouraged to carry out joint activities with professional organizations for mental health.


Objective 2: To carry out advocacy activities aimed at improving personnel rights and working conditions of professionals delivering mental health services.

The current situation and rationale for the objective: Provision of mental health services differs from that of others since it requires showing intense empathy. Thus, it is necessary to protect and improve the health of the service providers so as to increase the quality of services rendered by them. In order to make regulations in legal and institutional terms, the number of professional organizations should be increased and the professionals should act jointly with their own national non-governmental organizations such as associations and chambers. Although mental health and illness specialists, practitioners, psychologists, social workers, counselors, child development specialists and nurses all have their respective associations, it is known that the concept of professional organization has not been fully recognized yet and does not cover each and every professional in a democratic manner. Moreover, cooperation and understanding of joint action among professional organizations are limited.

Strategies:

1. A healthy database on professional organizations delivering mental health services should be established.
2. Being a member of professional organizations should be promoted through various means.
3. Brochures defining the mission and vision and elaborating the activities and direct contact information of each professional organization should be printed and handed out; web pages should be designed and announced to the public so that the individuals and their families become members of these organizations.
4. Election of representatives for professional organizations should be encouraged for participation in platforms where the decision-taking process related to legal personnel rights of mental health professionals is taking place.
5. Professional organizations should be supported in technical and financial terms.

Relevant / Cooperative Institutions and Organizations: Ministry of Health, Turkish Psychiatric Society, Turkish Psychologists Society, Social Workers Society and associations founded by mental health service users and providers such as Child and Adolescent Social Services and Child Protection Agency, Ministry of National Education, Ministry of Social Work and Labour, Non-Governmental Organizations, Press and Information Agencies, Social Aid and Solidarity Foundation, local authorities.
Objective 3: To raise awareness of politicians and decision-makers on advocacy.

The current situation and rationale for the objective: So as to make legal regulations and service programs peculiar to the needs of mental health service users and providers, first of all the politicians and decision-makers should be informed regarding the issue and carry out advocacy activities. And in Turkey, where the importance of mental health and mental health services was recognized after Marmara earthquake, the politicians should be equipped with evidence-based information in this regard.

Strategies:

1. Advocacy areas having priority in mental health should be identified.
2. It should be determined who will carry out advocacy activities: for whom; where; with which content and methods; and for what cost.
3. Policy-makers and decision-makers should gather with service users at the same platform and try to understand their needs and raise awareness.

Relevant / Cooperative Institutions and Organizations: Board of Directors of political parties, NGOs driven by service users and service providers, all institutions and organizations delivering service in the field of mental health, press and information agencies.

Objective 4: To raise awareness of all the segments of the society on advocacy.

The current situation and rationale for the objective: There are information gaps with regard to mental disorders in Turkey. It is known that patients and their families cannot appropriately make use of their rights. However, it is possible to raise awareness about the fact that the more the society as a whole become sensitive, the better it will become in serving the needs of the patients and the families to receive services.

Strategies:

1. Mental health prevention, rights of individuals with mental illness and disability, and help-seeking should be included in curricula starting from the primary school.
2. Training programs should be organized to raise mental health awareness on high risk groups (pregnant women, children and adolescents, elderly, disabled).
3. Media and public information sources should be included in mental health training and encouraged to include positive messages in broadcasts. Necessary arrangements should be made to allow such programs to be broadcast in prime time.
4. Training programs dedicated to eliminate stigmatization in the workplace and schools should be facilitated.
5. Scientific research regarding mental health should be shared by the authorities and publicly disseminated in a meaningful way.

Relevant / Cooperative Institutions and Organizations: Ministry of Health, Ministry of National Education, Institution of Social Services and Child Protection, NGOs driven by service users and service providers, all institutions and organizations delivering service in the field of mental health, Press and Information Agencies.

Objective 5: To ensure sustainability of advocacy activities in the field of mental health.

The current situation and rationale for the objective: In addition to widening the advocacy activities for mental health to each segment of the society, necessary measures should be taken to ensure the sustainability of such activities.
Strategies:

1. Measurable indicators for the success and sustainability of advocacy messages should be identified and used for their evaluation.
2. Symposia or similar platforms should be held where mental health advocacy activities are periodically reviewed under the leadership and coordination of professional organizations and non-governmetal organizations.

Relevant / Cooperative Institutions and Organizations: Ministry of Health, Ministry of National Education, Institution of Social Services and Child Protection, NGOs driven by service users and service providers, all institutions and organizations delivering service in the field of mental health, Press and Information Agencies.

CONCLUSION

The concept of advocacy for mental health is developed with the aims of allowing individuals with mental problems to benefit from fundamental human rights, and elimination of stigmatization and discrimination. In spite of recent legal regulations for active participation of individuals with mental disorders in society, these regulations are still not properly enforced. Epidemiological studies revealed that individuals with mental disorders do not have sufficient access to mental health services and that the main reasons for this include financial constraints, lack of education, improper or no treatment, stigmatization, discrimination and human rights violations.

Objectives of facilitating the functioning of and cooperation among non-governmental organizations to promote advocacy activities, human rights and to eliminate stigmatization and discrimination are needed. Other areas include: carrying out advocacy activities aimed at improving rights and working conditions of professionals delivering mental health services; raising the awareness of politicians and decision-makers on advocacy; raising the awareness of all the segments of the society on advocacy; and ensuring the sustainability of advocacy activities in the field of mental health.
INTRODUCTION

Health policies are an integral part of medical education. In as much medical education plays an important role in developing careers of physicians, health policies play a parallel role in determining the health system of a country. Health systems in turn shape medical education models change society through emerging forms of practice and contribute to formulation of new policies. Services are in turn affected by requirements of social and the economic systems. Economic conditions are undoubtedly important in determining health policies, however, it should be remembered that life expectancy is not always related to the level of economic welfare of that country, but how well that welfare is distributed and thus reflected in terms of overall health status of society. In systems which follow the free market economy approach, it is observed that the patient - doctor relationship is profoundly affected by these forces. Yet an unchanged for patients in all systems is the requirement for courage, hope, confidence and positive patient - doctor relationship. Hence, medical education and practices should not only have a scientific infrastructure but also include humanism and communication.

A NMHP ought to be developed on the basis of determining pathways follow in designing health education programs, analysis of health needs of society, and research on prioritized problems.

Separation of mental health education from mainstream medical education has a negative impact on development of physicians. According to WHO mental health education should have a wider role in medical education curricula. There are three major reasons for this: First, it is important to underscore the relationship between physical and emotional and intellectual integrity. Second, mental health education provides skills for understanding patient – doctor relationship. Third, the prevalence of mental health problems encountered among patients are better examined. As a result, the World Psychiatric Association has launched a core program for mental health education as an integral part of medical education in order to respond to the need for a wider role for psychiatry in medical education.

A major goal in education of physicians is that it ought to be continuous enhancing the ability to make critical judgment on evaluating information in line with newly gained evidence-based practice. A further objective is that such education should be community oriented and country relevant. In this respect community based medical education programs are better able to prioritize health problems in the country. To attain this goal, there is a need for cooperation and coordination between medical schools and the Ministry of Health, professional organizations and the public interest groups.

WHO believes that medical education should also have social validity, i.e. knowledge and skills should be utilized in helping to solve health problems in the community. Four main criteria have been identified in this regard:

1) Prioritization: Medical education should be in parallel with the elimination of health problems in a country, prioritizing health problems. For example, if in a community the child mortality due to contagious diseases is high then child health and contagious diseases ought to be prioritized.

2) Quality: Quality in medical education is not solely related with pure technical competence; students should be able to understand and apply primary health care principles as well as preventive, developmental, therapeutic and rehabilitative perspectives.

3) Cost-efficiency: Students should be aware of the importance of appropriate and adequate use of expensive technology and medications.

4) Equity: Students be aware of distributive use of services and resources in the community

Medical education should also focus on the education of mental health professionals, psychologists, social workers, child development and educational and counseling specialists, and psychiatric nurses. There is a need for adequate numbers of professionals to complete team work for provision of mental health services. Since all mental health professions mentioned above include varying roles and require different skills, principles regarding the education of these professions cannot be summarized here. There views regarding the mental health or allied professionals from both medical and non-medical fields are detailed in Annex 7.

Like in every field of science, revealing scientific findings on mental health depends on research. It is well-known that research
Information is largely produced in developed countries and later utilized in other parts of the world. However, there is a need for local and country specific information regarding these problems, which can change due to cultural differences.

**The Current Situation**

There are major discrepancies in the number of mental health professionals and their distribution in Turkey. Furthermore, there are limitations on educational standards of these professionals in the mental health fields. With regard to medical education, the number of faculties of medicine and medical students is on the increase. Medical education across different schools in Turkey has also advanced significantly with the establishment of departments of medical education. Problem-oriented training programs are being introduced and traditional programs devised. Nevertheless, the increase in number of students had also kept pace with these reforms. Last 15 years’ data show that the number of medical students accepted to faculties of medicine is 5000. Medical education needs to be further restructured considering the basic problems experienced in Turkey and utilizing problem based learning methods.

Employment of physicians and health personnel at these institutions under the Ministry of Health is regulated by laws regarding civil servants. These laws do not consider basic and contemporary managerial concepts, the quality and quantity of work produced and work efficiency.

With respect to education of other groups of mental health professionals it is notable that the number of professionals with masters and doctoral degrees have remain few. There are also constraints about employing educated professionals; further, they often receive limited education in preventive and clinical mental health services, and are employed on a limited basis in mental health service delivery settings. Considering the importance of preventive mental health, it is surprising that there is no human resources policy that ensures further contributions of professional groups such as psychologists, social workers, counselors, and child development specialists, and nurse practitioners.

Objectives proposed for human resources and education in mental health and strategies in order to attain these objectives are detailed as follows. For each objective the rationale for identifying such an objective is provided and the current situation in Turkey is discussed.

**Objective 1: To train mental health professionals in various disciplines in requisite numbers and at optimal quality levels.**

The current situation and the rationale for the objective: There are qualitative and quantitative problems in Turkey regarding the education of professionals such as physicians, social workers, psychologists, and nurse practitioners to be employed in mental health field. There is a need for an increase in both the quality and the capacity of academic programs in charge of educating mental health professionals according to universal standards.

In order to emphasize the importance of community based mental health in Turkey, an interdisciplinary community mental health graduate program was launched for the first time at Ankara University that educated 60 specialists to date. It is obvious that there is a need for academic programs providing various mental health professionals with at higher level education on psychological trauma, especially at high risk in Turkey. One of the first examples in this regard is the graduate program launched at Kocaeli University.

**Strategies:**

1. To establish scientific programs educating mental health professionals in various disciplines in terms of both quantity and quality to meet national needs
2. To establish optimal standards for programs educating mental health professionals.
3. To establish institutional and professional accreditation standards that needs to be identified for specific disciplines educating mental health professionals.
4. To regularly evaluate the accreditation of programs by an independent agency.

5. To intensify education with respect to mental health actors in the education of general practitioners providing primary health care services by strengthening education within curricula in the faculties of medicine across the country and to standardize this process.

6. To provide skill sets for the mental health professionals in preventive and clinical aspects of mental health practice in line with national needs.

7. To strengthen programs in universities by development of sufficient academic staff, recruitment of graduate students being revised until such revitalization can be completed. For institutions that lack academic staff, education is to be provided in appropriate institutional settings with the sufficient number of staff.

8. To establish supervised practice as a requisite in post graduate education preceding any independent professional practice with standards set for this.

9. To increase the quota for student recruitment in mental health field for graduate programs in universities with to address needs.

10. Arrangements for internship upon graduation in specific professions related to mental health practice should be established.

11. To launch specific programs in universities by considering social requirements for programs educating professionals, e.g., Alcohol and Substance Abuse, Speech and Language Therapy, Occupational Therapy, Family and Couples Therapy, among others.

12. To establish specific graduate programs on community based mental health services across the country to address need.

13. To widen the scope and number of graduate programs specializing on psychological trauma to address need.

14. To provide mental health professionals with in-service training including psychological trauma prioritized in this context; general health professionals providing primary health care services should be educated on this topic.


**Objective 2: To make plan for human resources in mental health and provide employment opportunities at various levels to urgently alleviate shortage of professionals in the field.**

The current situation and the rationale for the objective: Services provided by medical and non-medical personnel have an important role in the provision of mental health services. Although there are no sufficient and reliable data on the percentage of psychiatrists working in the private sector, it may be assumed that less than 10% of psychiatrists are employed in inpatient treatment institutions operating in the private sector. Furthermore, the number of psychiatrists in solitary office practice is not known. The numbers of psychiatrists, child psychiatrists, clinical psychologists, child development and education specialists, and social workers working in the clinical settings remains low compared to European Union levels. Aside from the numerical shortcomings, a major problem is the vastly uneven distribution of mental health professionals according in disparate regions.

**Strategies:**

1. An adequate number of mental health professionals according to regional and provincial requirements should be employed.

2. Considering the fact that mental health services should be provided with an understanding of team work, health professionals such as physicians, clinical psychologists, social workers, occupational therapists, speech and language therapists, psychiatric nurses, among others, should be fully employed for development of such interdisciplinary such teams whenever feasible.

3. Clinical psychologists, social workers, counselors, child development specialists providing primary health care especially for mental health should be employed and given effective roles.

Objective 3: To stimulate research in the country on mental health indicators.

The current situation and the rationale for the objective: As mentioned earlier research on mental health remains inadequate, ad hoc, small scale, and often financed by individual budgets. An integrated research policy is needed that will allow the understanding of local factors in promoting research funding for systematic study of mental health problems.

Strategies:

1. Research priorities of Turkey in the field of mental health should be identified as a framework by a higher interdisciplinary scientific institution such as TÜBİTAK (Scientific and Technological Research Council of Turkey) and TÜBA (Turkish Academy of Sciences).
2. In order to prevent these researches from being small scaled ones, considerable financial support should be provided for competitively funded research projects through a comprehensive project support system.
3. An institution similar to National Health Institute in the US can be considered as an important peer review model to augment existing national institutions supporting scientific research in Turkey. This model should allocate a strategic roadmap and financial support to promote a mental health research agenda.
4. Special importance should be attached to epidemiological and mental health services research and they should be planned regularly at least every 5-years.
5. Researches for the development, adaptation and update of psychological and psychiatric measuring instruments should be encourage refraining from unnecessary repetition and redundancy with the coordination of these studied being organized nationwide.
6. Mental health professionals should be encouraged to conduct interdisciplinary research.
7. European Union and other international resources for mental health basic, epidemiological and services research should be more effectively sought out with development of international partnerships.

Relevant / Cooperative Institutions and Organizations: Ministry of Health, TÜBİTAK (The Scientific and Technological Research Council of Turkey), TÜBA (Turkish Academy of Sciences), Ministry of National Education, Higher Education Council, Universities, and Ministry of Finance.

CONCLUSION

The main factors for an adequate provision of mental health services involve the education and employment of trained personnel that will produce these services and support the research agenda. Regarding education, it is observed that each and every mental health professional group faces unique challenges. These include problems such as uneven regional and provincial distribution of psychiatrists as well as other mental health professionals with particularly low number of child and adolescent mental health specialists given the needs.

Most mental health research in Turkey depends on individual effort that has been relatively small scale. In summary the objectives are: to train mental health professionals in adequate numbers and quality; to plan for human resources in mental health and to provide employment for various mental health professions based on objective assessment of needs; to conduct research in the country on mental health indicators.
This report constitutes the National Mental Health Policy (NMHP) as announced by the Ministry of Health developed in accordance with international standards and by taking into consideration the prevalent conditions in the country. It is expected that the NMHP, which is requested by the World Health Organization (WHO) from each member country will effectively allocate resources for mental health services and serve as a framework for development of legal arrangements, strategies and programs in related sectors.

WHO stipulates six main components of NMHP: (1) Decentralization; (2) inter-sectoral cooperation; (3) comprehensiveness; (4) Equity; (5) sustainability; and (6) community participation. The NMHP declared by the Republic of Turkey in this report is structured by strictly following these six main components.

A series of activities have been conducted in line with the project objectives. Three separate mental health conferences were held with the participation of the representatives of the relevant sectors with a view to share their considerations. In the conferences to which representatives of all sectors related to mental health were invited, valuable information was collected on the objectives, strategies and resources of these sectors, international initiatives were discussed and examined by the local experts and their feasibility in terms of the needs of the Turkish Republic elaborated on. Written considerations of the professional organizations acting in the field of mental health in Turkey on the NMHP were compiled. Additionally, contacts were made with certain non-governmental organizations. Visits were paid to representative mental health institutions; presentations made in national and international conferences; relevant research examined; and relevant information on the mental health practices of the Ministry of Health and the Provincial Health Directorates obtained. During these proceedings attention was continuously focused in developments in the earthquake hit region. In addition to all these, statistical data and records at the archives of the Ministry of Health on mental health were obtained to the extent possible.

WHO Service Guidance Package provides practical information to assist countries in development of national mental health policy. These WHO modules were adapted to country specific conditions. The current situation in the country is examined under each module heading, objectives noted, and strategies described for fulfilling these aims. Finally, related and responsible agencies involved were listed under each section.

WHO Service Guidance Package modules under each sections heading allow separate examination of each policy domain. The relevant sections, however, are interwoven and complement one another and ought not to be regarded separately. For example, treatment and rehabilitation services cannot be considered separately from legislation, human resources and training cannot be considered separately from organization or financing.

It is observed that there is a tendency to give more emphasis to some modules over others. Although such a tendency can be understood, the reader is cautioned to avoid putting such unique emphasis on any one section but encouraged to pursue a holistic approach by assessing the modules duly and equally.

Please find below the 43 main objectives for the eight modules which are examined between Parts 5-12 of the report and adapted to the conditions in Turkey. The current situation in the country, underlying rationale for the objectives, and the strategies to be followed for fulfilling each one are discussed in detail under the relevant section.

**Module 1: Organization of Services for Mental Health**

**Objective 1:** To eliminate the obstacles in terms of access to mental health services.

**Objective 2:** To enhance the present structure with regards management of mental health services both at central and local provincial levels.

**Objective 3:** To continuously monitor and assess the mental health needs of the country and to generate scientific evidence based solutions.
Objective 4: To encourage and ensure delivery of needed mental health services at the local level.

Objective 5: To meet the urgent and special mental health requirements likely to arise during times of natural disasters, accidents, traumatic experiences, terror events, migration and other crises situations prevalent in Turkey.

Objective 6: To allow the introduction of private sector in the organization of mental health services and not to limit service delivery solely to the public sector.

Objective 7: To establish an organizational structure in charge of rehabilitation within the Turkish mental health system.

Objective 8: To ensure the coordination among all public and private agencies delivering mental health services in the country.

Objective 9: To ensure the coordination among different professions responsible for mental health service delivery.

Module 2: Treatment and Rehabilitation Services

Objective 1: To improve and revitalize the existing mental health treatment cascade

Objective 2: To adopt person centered treatment approach

Objective 3: To implement combined pharmacological and psycho-social intervention methods.

Objective 4: To prioritize treatment for substance use disorders considering their personal and social consequences.

Objective 5: To develop community based treatment approaches and rehabilitation programs.

Objective 6: To provide employer training under the scope of rehabilitation in the workplace and ensure gainful employment of individuals with mental disorders.

Objective 7: To provide family and home based care services for individuals with mental disorders.

Objective 8: To develop person centered rehabilitation programs.

Module 3: Child and Adolescent Mental Health Policy

Objective 1: To identify children and adolescents at high risk for mental disorders.

Objective 2: To improve both the quality and quantity of available child and adolescent mental health services

Objective 3: To establish and improve the coordination of disciplines providing child and adolescent mental health services and raise awareness of child and adolescent mental health.

Module 4: Mental Health Financing

Objective 1: To identify the scope of health care services financing including financing for mental health services.

Objective 2: To define the existing financing source for health services,

Objective 3: To define the financing source base for mental health services.

Objective 4: To identify the way of allocating the collected funds.

Objective 5: To link the mental health budget to management and responsibility.

Objective 6: To purchase effective and efficient mental health services, when needed.

Module 5: Quality Improvement for Mental Health

Objective 1: To adopt the policy of considering the significance of service quality in addition to service quantity in delivery of mental health services.

Objective 2: To identify implementation standards on mental health as a quality criterion.

Objective 3: To identify the persons authorized to ensure quality of mental health services.

Objective 4: To ensure sustainability of quality standards applied to mental health services.
Module 6: Mental Health Legislation

Objective 1: To develop a mental health law based on human rights consistent with the UN conventions and standards of international law.
Objective 2: To have the Law on Protecting Psychiatric Patient Rights pass the Parliament.
Objective 3: To update legislation related to mental health and enact an overarching Mental Health Law.
Objective 4: To enact legislation allowing for full implementation of the UN Convention on the Rights of the Child.
Objective 5: To have the law regulating the practice of mental health professionals pass the Parliament either as a single piece of legislation or a framework law.

Module 7: Advocacy for Mental Health

Objective 1: To facilitate the both the functioning and cooperation among non-governmental organizations for mental health advocacy regarding the human rights to individuals with mental disorders and to reduce stigmatization and discrimination against them
Objective 2: To carry out advocacy activities for improving personnel rights and working conditions of professionals delivering mental health services.
Objective 3: To raise awareness of politicians and decision-makers through advocacy.
Objective 4: To raise awareness of all the segments of the society through advocacy.
Objective 5: To ensure sustainability of advocacy activities in the field of mental health.

Module 8: Training, Research and Human Resources in Mental Health

Objective 1: To train adequate number and quality mental health professionals.
Objective 2: To plan for additional mental health staff and enable their employment to meet the identified needs.
Objective 3: To support in country research on mental health risk indicators.

Main Recommendations for the NMHP

Main objectives and goals and the main points covering the structure of the NMHP can be briefly summarized as follows:

There is a need to integrate the best practices model to improve mental health services within the important network of primary health care centers in the provinces. These institutions remain as the first contact point locally and can provide early diagnosis and treatment services. If Family Medicine model is introduced, family physicians will be in charge of the primary health care services and their scope of responsibility will be extended to address mental health needs of the population. The primary health care institutions will continue to play an important role in monitoring and control of the treatment in cooperation with secondary and tertiary health care institutions. In this respect, it is of significance to provide appropriate training to the physicians and other health care professionals in particular practicing at the primary health care institutions regarding the diagnosis and treatment of common mental disorders.

There is a need to conduct extensive community screening of common mental health problems for purposes of early identification and treatment.

It is important to strengthen cooperation, consultation and communication among all institutions in charge of delivering mental health and social services in Turkey. Lack of cooperation and communication continues to be a major obstacle. Emphasis ought also to be given for establishing within sector and inter-sector cooperation.
The patients and their families should be at the core of a fully harmonious and accessible system in mental health services. There is an urgent need for to pass legislation to formally endorse rights of individuals with mental disorders and mental disabilities with a view to overcome stigmatization and ensure societal inclusion.

Evidence-based mental health services ought to be provided universally. In this respect, it is important to work with a core group of experienced clinicians to review evidence based practices applicable for Turkey and to promote further in-country research in this field. Mental Health Care Teams under the Ministry of Health ought to be formed at the provincial level to support the service structure. Mental Health Care Teams ought to also develop implementation plans specific to their own region. Mental Health Development Council should be established with a view to oversee the quality of mental health services and make recommendations on measures to be undertaken in concert with the Ministry of Health.

There is an apparent need to develop new programs on mental health for the community. The patients and the community should be protected more in order to avoid any interruption in access to the actual services. New or revised mental health legislation should be developed to meet such requirements.

There is an urgent need for additional investments with regards mental health and social services in all provinces. Such investments should cover matters such as increasing bed capacities at the hospitals at one side and establishing adequately reliable teams allowing for 24 hours access to services in cases of emergencies and/or regular contact with those suffering from crises. Services for the individuals with severe and persistent mental disorders should be close to the homes, families and communities.

Adequate level of mental health services and management is only possible through health care providers equipped with the required level of information and support. At the era of information technology, cost-effective computing and web technologies ought to be made available. Establishment of hotlines or support services ought to also continue to play a major role in meeting demand for support services.

For the implementation of the conditions are to be assessed both from the perspective of consumers, i.e., patients and families, as well as individual providers. It is important to conduct research at intervals as well as to provide incentives and information rewarding successful programs. Performance indicators are to be determined to improve the outcomes of the programs to be implemented. This necessitates identification of a vision on how the service be structured. There is the need to assess the overall community effectiveness of mental health and psychosocial services and to analyze these outcomes.

The main objective of the NMHP is to establish a community-based mental health system, providing accessible services for all, mobilizing the community resources to assist the families and minimizing the effects of stigmatization and discrimination by the society.

Mental health services should offer both preventive interventions and treatment programs integrated and coordinated with the general health care services and social services. It is important for the Ministry to make a declaration of its political will on NMHP in terms of implementing specific recommendations with short, medium and long term outcomes.

As the project group, we propose the following as the strategic priorities of Turkey in the field of mental health.

- To deliver evidence-based, cost-effective, quality, and adequate level of mental health services complying with global standards; to provide community-based services making use of state-of-the-art technologies; to provide services based on principle of equity and access for all the citizens given the wide geography and rapidly growing population of the country. To give emphasis to family based primary mental health services covering the needs of preschool children as well as school age children and adolescents and to establish the required coordination among all the relevant sectors in this regard.
A fundamental point necessary for successful implementation of the NHP is the need for a clear declaration of the political and bureaucratic commitment by the respective authorities. The support of the government ought to be sustained in all matters related to legislation and implementation of the recommendations listed herein. Success of NMHP mainly depends on this commitment, insight, determination and support.

We have observed a misleading conceptualization with regards to mental health services development process in Turkey -- that such services somehow remain as the concern of only a limited number of fields. As is clear from the scope of the NMHP report, there are several sectors, agencies, professional groups involved with vested interest in the field of mental health services. Various sectors, agencies and professions are listed under the heading "relevant agencies and institutions" through the end of each of the objective for our modules. Therefore, everyone has a certain level of shared responsibility in mental health services. What is important at this point is not to have a divergence from the responsibilities but to undertake full responsibility by each and every related party. In other words, there is the need to assume the motto that at this juncture what matters is what each party does for the country overall than what they do for their own professional identity.
As is clear from the report, the priority is the equal distribution of the burden of mental disorders across all relevant segments of society. The objective is to deploy the responsibility by these segments in a coordinated manner to the extent possible. In this respect, the government should ensure that NMHP is enforced by all relevant parties. This is one way of complying with the cost-effectiveness principle: in other words the government has an obligation for delivering quality services for the greatest number of citizens in need with the least cost and most efficiency. As is to be observed, majority of our recommendations in the NMHP report safeguard this principle.

This report has been prepared by taking into consideration the current situation in Turkey and the relevant national and international literature. The NMHP in Turkey would require future revisions in the light of emerging conditions. It is urged therefore the NMHP framework herein ought not to be considered as an outcome but rather as the start of a process. Future works should overcome certain deficiencies of our study due to several limitations and ought to follow the same level of scientific caution and approach. Nevertheless, the NMHP should always remain a live document.
REFERENCES

A


B


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APPENDICES
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<tr>
<th>Name - Surname</th>
<th>Agency</th>
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<tbody>
<tr>
<td>Dr. Ismail Toprak</td>
<td>General Director for Primary Health Care Services</td>
</tr>
<tr>
<td>Dr. Tahir Soydal</td>
<td>Deputy General Director for Primary Health Care Services</td>
</tr>
<tr>
<td>Associate Prof. Arif Verimli</td>
<td>Bakirköy Mental Hospital Chief Physician</td>
</tr>
<tr>
<td>Dr. Niyazi Yurtsever</td>
<td>Adana Mental Hospital Chief Physician</td>
</tr>
<tr>
<td>Medical Specialist</td>
<td>Manisa Mental Hospital Chief Physician</td>
</tr>
<tr>
<td>İzzet Hamkaya</td>
<td>Samsun Mental Hospital Chief Physician</td>
</tr>
<tr>
<td>Dr. Nejat Akyol</td>
<td>Elazığ Mental Hospital</td>
</tr>
<tr>
<td>Dr. Ömer Deniz</td>
<td>Ankara University Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. İşık Sayılı</td>
<td>Gazi University Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. Erdal İşık</td>
<td>Ankara University Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. Yıldırım Beyatlı Doğan</td>
<td>Cumhuriyet University Department of Family Medicine</td>
</tr>
<tr>
<td>Prof. Erol Sezer</td>
<td>Ege University Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. Soli Sorias</td>
<td>Ankara University Department of Public Health</td>
</tr>
<tr>
<td>Prof. Recep Akdur</td>
<td>Istanbul University Cerrahpasa School of Medicine Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. Engin Eker</td>
<td>Istanbul University Cerrahpasa School of Medicine Department of Neurology</td>
</tr>
<tr>
<td>Prof. Alaattin Duran</td>
<td>Ankara University Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. Saynur Canat</td>
<td>Ankara University Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. İsmet Kırkpınar</td>
<td>Ankara University Department of Pediatric Psychiatry</td>
</tr>
<tr>
<td>Associate Prof. Z. Emine Kılıç</td>
<td>Ankara University Faculty of Letters</td>
</tr>
<tr>
<td>Specialist Psychiatrist</td>
<td>Department of Psychology</td>
</tr>
<tr>
<td>İlgın Gökler</td>
<td>Hacettepe University Department of Neurology</td>
</tr>
<tr>
<td>Prof. Kubilay Varlı</td>
<td>Çukurova University Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. Nurgül Özpooyraz</td>
<td>Akdeniz University Department of Psychiatry</td>
</tr>
<tr>
<td>Prof. Sunar Bırsöz</td>
<td>Pediatric Psychiatry Specialist</td>
</tr>
<tr>
<td>Prof. Atalay Yörüköglü</td>
<td>Bakirköy Mental Hospital Clinic Chief</td>
</tr>
<tr>
<td>Medical Specialist Nihat Alpay</td>
<td>Bakirköy Mental Hospital Clinic Chief</td>
</tr>
<tr>
<td>Associate Prof. Duran Çakmak</td>
<td>Ankara Numune Hospital Chief of Psychiatry Clinic</td>
</tr>
<tr>
<td>Associate Prof. Nesrin Dilbaz</td>
<td>Şişli Etfal Hospital Chief of Psychiatry Clinic</td>
</tr>
<tr>
<td>Associate Prof. Oğuz Karamustafalıoğlu</td>
<td>SSK Dişkapi Hospital Chief of Psychiatry Clinic</td>
</tr>
<tr>
<td>Associate Prof. Haluk Özbay</td>
<td>Hacettepe University</td>
</tr>
<tr>
<td>Associate Prof. İbrahim Yıldırım</td>
<td>Department of Psychological Counselling and Guidance</td>
</tr>
<tr>
<td>Prof. Nesrin H. Şahin</td>
<td>President of Turkish Psychological Association</td>
</tr>
<tr>
<td>Medical Specialist Hakan Erman</td>
<td>Turkish Association of Child and Adolescent Mental Health</td>
</tr>
<tr>
<td>Prof. Ayla Aysel</td>
<td>Turkish Association of Child and Adolescent Mental Health</td>
</tr>
<tr>
<td>Prof. Nilüfer Voltan Acar</td>
<td>President of Turkish Psychological Counselling and Guidance Association</td>
</tr>
<tr>
<td>Associate Prof. Hüsnü Erkmen</td>
<td>President of Anxiety Disorders Association</td>
</tr>
<tr>
<td>Prof. Zehra Arkan</td>
<td>President of Substance Addiction Association</td>
</tr>
<tr>
<td>Dr. M. Sezai Berber</td>
<td>Turkish Medical Association Central Council</td>
</tr>
<tr>
<td>Dr. Taner Gökcınar</td>
<td>Ankara Provincial Health Director</td>
</tr>
<tr>
<td>Psychiatrist Ayşen Kurtuluş</td>
<td>Ankara Provincial Health Directorate</td>
</tr>
<tr>
<td>Dr. Erhan Önal</td>
<td>Ankara Provincial Health Directorate</td>
</tr>
<tr>
<td>Dr. Osman Orsel</td>
<td>Ankara Provincial Health Directorate</td>
</tr>
<tr>
<td>Dr. Hülsü Safımlıoğlu</td>
<td>Yalova Provincial Health Director</td>
</tr>
<tr>
<td>Fatih Topkaş</td>
<td>Head of the Department of Mental Health</td>
</tr>
<tr>
<td>Dr. Toker Ergüder</td>
<td>Department of Mental Health</td>
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<tr>
<td>Dr. Şehnaz Tumay</td>
<td>Department of Mental Health</td>
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<tr>
<td>Dr. Mesut Yıldırım</td>
<td>Department of Mental Health</td>
</tr>
<tr>
<td>Dr. Naciye Aral</td>
<td>General Directorate of Curative Services</td>
</tr>
<tr>
<td>Dr. Esin Temel</td>
<td>Representative of the General Directorate for Mother and Child Health and Family Planning</td>
</tr>
<tr>
<td>Dr. Hülya Altinyollar</td>
<td>Directorate General for Primary Health Care Services</td>
</tr>
<tr>
<td>Psychiatrist Hayrunisa Saldıroğlu</td>
<td>Ministry of National Education Gen. Dir. of Special Education and Counselling Services</td>
</tr>
<tr>
<td>Recep Çalık</td>
<td>Ministry of National Education Department of Health</td>
</tr>
<tr>
<td>Dr. Tevfik Çelikbilen</td>
<td>Turkish Red Crescent Society</td>
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<tr>
<td>Serap Aslan</td>
<td>Turkish Red Crescent Society</td>
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<tr>
<td>Medical Specialist Cem Bilgiç</td>
<td>General Directorate for Youth and Sports</td>
</tr>
<tr>
<td>Nihan Kircali</td>
<td>State Planning Organization</td>
</tr>
<tr>
<td>Gökhan Deniz</td>
<td>Ministry of National Defence Department of Health</td>
</tr>
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<td>T. Yaprağ Günday</td>
<td>Ministry of Justice General Directorate of Prisons and Detention Houses</td>
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<td>Prof. Gülşen Tezkiye</td>
<td>SSK Deputy General Director for Health Affairs</td>
</tr>
<tr>
<td>Dr. Canan Sargin</td>
<td>United Nations Children’s Fund (UNICEF)</td>
</tr>
<tr>
<td>Bekir Metin</td>
<td>World Health Organisation - Ankara</td>
</tr>
<tr>
<td>Prof. Hamdullah Aydın</td>
<td>Gülhane Military Medical Academy Clinic of Psychiatry</td>
</tr>
<tr>
<td>Representative</td>
<td>Ministry of Health Office of the Legal Advisor</td>
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## APPENDIX 2

### PARTICIPANT LIST FOR NMHP DEVELOPMENT EFFORTS

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<td>Recep, Prof. Dr.</td>
<td>Minister of Health</td>
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<tr>
<td>Adam</td>
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<td>Fatih University School of Medicine</td>
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<td>Akçayoğlu</td>
<td>İbrahim</td>
<td>World Bank Ankara Office</td>
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<tr>
<td>Akdur</td>
<td>Recep, Prof. Dr.</td>
<td>Ankara University School of Medicine Department of Public Health</td>
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<td>Hacettepe University School of Nursing</td>
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<td>Bakırköy Mental Hospital</td>
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<td>Ankara University School of Medicine Department of Psychiatry</td>
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<td>Ėm, Uzm. Dr.</td>
<td>General Directorate for Youth and Sports</td>
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<td>Mustafa</td>
<td>Bakırköy Mental Hospital</td>
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<tr>
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<td>Nazmi, Prof. Dr.</td>
<td>Hacettepe University School of Medicine Department of Public Health</td>
</tr>
<tr>
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<td>Samsun Mental Hospital</td>
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<td>Fatih M., Prof. Dr.</td>
<td>Hacettepe University School of Medicine Department of Child Psychiatry</td>
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<td>Ünal</td>
<td>Serhat, Prof. Dr.</td>
<td>Hacettepe University School of Medicine Department of Internal Diseases</td>
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<td>Ünal</td>
<td>Fathi, Prof. Dr.</td>
<td>Hacettepe University School of Medicine Department of Child Psychiatry</td>
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<td>Kubilay, Prof. Dr.</td>
<td>Hacettepe University School of Medicine Department of Neurology</td>
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<td>Nilüfer, Prof. Dr.</td>
<td>Turkish Psychological Counselling and Guidance Association</td>
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<td>Dilek, Doç. Dr.</td>
<td>Hacettepe University School of Medicine Department of Pediatric Neurology</td>
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<td>Ministry of Health Ankara Provincial Health Directorate</td>
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<td>Yeşilyapak</td>
<td>Binnur, Prof. Dr.</td>
<td>Turkish Psychological Counselling and Guidance Association</td>
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<td>Yıldırım</td>
<td>İbrahim, Doç. Dr.</td>
<td>Hacettepe University Faculty of Education Department of Psychological Counselling and Guidance</td>
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<td>Mesut, Dr.</td>
<td>Ministry of Health General Directorate for Primary Health Care Services</td>
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<td>Atalay, Prof. Dr.</td>
<td>Ret. Prof. - Hacettepe University Department of Psychiatry</td>
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<td>Niayaz, Uz. Dr.</td>
<td>Adana Mental Hospital</td>
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<td>Nevzat, Prof. Dr.</td>
<td>Gazi University School of Medicine Department of Psychiatry</td>
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<td>Turkish Psychology Association</td>
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<td>Rüstem, Dr.</td>
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(Participants are alphabetically listed in terms of their surnames)
Upon the call from Prof. Recep Akdağ, the Minister of Health, Prof. Rüstem Aşkın organized a meeting on “Improving Mental Health Services” at the Ministry of Health on June 10-11, 2004 with the involvement of the Ministry of Health Scientific Advisory Board for Mental Health, Professional Organizations in the field of Mental Health, representatives of universities and voluntary colleagues.

Psychiatric Association of Turkey was represented by President Assoc. Prof. Haluk Özbay, Vice President Assoc. Prof. Mustafa Sercan and Secretary General Prof. Berna Uluğ, whereas the Association of Child and Youth Mental Health was represented by President Prof. Bahar Gökler and Prof. Füsun Çuhadaroğlu and Turkish Psychologists’ Association by Prof. Nesrin Hisli Şahin. Representatives from the Ministry of Health Scientific Advisory Board for Mental Health who were present at the meeting were as follows:

1. Prof. Rüstem Aşkın, Selçuk University Meram School of Medicine Department of Psychiatry.
2. Prof. İşıklı Sayılı, Ankara University School of Medicine Department of Psychiatry.
3. Prof. Zehra Arkän, Gazi University School of Medicine Department of Psychiatry.
4. Prof. Selahattin Şenol, Gazi University School of Medicine Department of Child and Adolescent Psychiatry.
5. Prof. Bahar Gökler, Hacettepe University School of Medicine Department of Child and Adolescent Psychiatry.
6. Prof. Sayınur Canat, Ankara University School of Medicine Department of Psychiatry.
7. Prof. Ferhunde Öktem, Hacettepe University School of Medicine Department of Child and Adolescent Psychiatry.
8. Prof. Musa Tosun, Bakırköy Mental Hospital.
9. Prof. Şahnrur Şener, Gazi University School of Medicine Department of Child and Adolescent Psychiatry.
10. Prof. Neşe Erol, Ankara University School of Medicine Department of Child and Adolescent Psychiatry.
11. Associate Prof. Duran Çakmak, Bakırköy Mental Hospital.
12. Associate Prof. Nesrin Dildız, Ankara Numune Hospital Psychiatry Clinic.
13. Associate Prof. K.Oğuz Karamustafaloglu, Şişli Etfal Training and Research Hospital.
14. Associate Prof. Hüsnü Erkmen, Bakırköy Mental Hospital.
15. Associate Prof. İlhan Yargıç, Istanbul University Istanbul School of Medicine Department of Psychiatry.
16. Associate Prof. Hamdi Tutkun, Gaziantep University Department of Psychiatry.
17. Assistant Prof. Ali Savaş Çilli, Selçuk University Meram School of Medicine Department of Psychiatry.
18. Medical Specialist Mustafa Namli, Elazığ Mental Hospital.
19. Medical Specialist Rabia Ay, Eskişehir State Hospital.

As a result of the discussions held in the meeting, a list of improvement proposals comprised of 27 articles on the improvement of mental health services in Turkey were submitted to the Minister of Health. Upon the proposal of the Minister of Health, a monitoring board of five members was established in order to monitor the implementation of improvement proposals. It is decided that two representatives from the Ministry of Health and one from each Professional organization will be present in this board.

PROPOSALS PRESENTED TO THE MINISTER OF HEALTH DURING THE MEETING ON IMPROVING MENTAL HEALTH SERVICES

PROPOSALS PRESENTED TO THE MINISTER OF HEALTH DURING THE MEETING ON IMPROVING MENTAL HEALTH SERVICES

A. INCREASING THE NUMBER OF BEDS
1. To establish psychiatry services having sufficient number of beds in proportion with the population in each provincial state hospital and large district hospitals and appoint sufficient number of psychiatrists and health professionals,
2. To modernize existing or future psychiatry services for acute psychiatric care,
3. To establish outpatient mental health centers that are affiliated to mental hospitals in large provinces and to the psychiatry clinic of state hospitals in small provinces and large districts,
4. To facilitate the establishment of outpatient and in-patient psychiatric care institutions at public and private hospitals, to update the related legislation urgently,
5. To increase the number of services where forensic psychiatric patients who need care and treatment under the order of a court will be kept,
6. To identify and classify hospitals and other units that will provide mental health services,
7. To establish child and adolescent psychiatry clinics on the basis of regions at first and then of provinces.

B. INCREASING THE NUMBER OF MENTAL HEALTH PROFESSIONALS
1. To increase the number of Adult, Child and Adolescent Psychiatry Specialists,
2. To increase the previous resident number of 8 to 12 per clinic for adult, child and adolescent psychiatry specialty training and to increase the number of resident personnel at universities,
3. To provide Child and Adolescent Psychiatry specialty training at training hospitals and to provide chief personnel cadres,
4. To urgently establish cadres of the Ministry of Health at universities for Child and Adolescent Psychiatry specialty training until training starts at training hospitals,
5. To maintain the specialist cadres at training hospitals that are planned to be abolished for a transition period of three years in line with the requirements of hospitals,
6. To provide sustainability by way of working at the same branch and certification for auxiliary health professionals and employees trained in the field of psychiatry,
7. To redefine the duties of psychologists at hospitals,
8. To increase to the sufficient level the number of mental health personnel such as psychologists, social workers and psychiatry nurses and to standardize in-service training.

C. LEGISLATION
1. To perceive the Law on the Protection of the Rights of Psychiatric Patients separately from the general health legislation due to its different nature,
2. To determine the daily patient care time and capacity by taking the norms of the World Health Organisation and the European Union into account in order to improve the quality of patient care,
3. To establish the Child and Adolescent Psychiatry Branch under the aegis of the Ministry of Health Department of Mental Health,
4. To establish the NATIONAL MENTAL HEALTH INSTITUTE,
5. To specially price the emergency and psychiatric intensive care services ad to increase the contributions of the personnel of the said unit to the revolving fund,
6. To devise rational prescription rules,
7. To facilitate the issue of green cards for chronic mental patients and to provide permanent visas to this end,
8. To organize the 2005 World Health Organisation National Focal Points meeting in Turkey,
9. To encourage participation in congresses and training meetings and to provide participation through assignment,
10. To abstain from appointing non-doctor personnel at any health institution than a psychiatry specialist.

D. SERVICE
1. To establish rehabilitation centers affiliated to mental hospitals or clinics,
2. To bring the transfer arrangements of mental patients to a level in accordance with the contemporary law, to functionalize the mental health section directorates and the follow up for chronic patients,
3. To establish care houses for psychiatry patients in need of protection,
4. To have basic pharmaceuticals accredited by the WHO present at psychiatry services and primary health care institutions and to provide them to needy people for free.

PREVENTIVE MENTAL HEALTH
To form working groups on issues posing a risk to public mental health such as substance addiction, child neglect and abuse, violence, homicide and disasters.

**NMHP**

A strong mental health policy is one of the most significant elements of an efficient health system. Mental health policy should be developed as an integrated part of the national health policies of the countries lacking a separate mental health policy and a mental health program. The NMHP is defined with the contribution of the relevant sectors in line with the current status, objectives and philosophy of the country.

The systematic studies carried out in the last two decades until December 2002 that aimed to develop NMHP in Turkey are reviewed in this article in a chronological order. The objectives and strategies of the Ministry of Health in Turkey set forth in the studies mentioned above are listed in this article.

**Systematic studies on mental health policies in Turkey**

It is known that Turkey did not have a NMHP until the end of 2002. However this problem is not unique for Turkey. According to the “Mental Health Policy and Services” paper of the World Health Organization (WHO) published in the 2001 World Health Report, nearly 40% of the countries do not have a specific mental health policy, 33% of the countries do not even have a mental health program and even worse 33% of the countries do not have a specific policy on drugs or alcohol which are closely related with mental health issues. The vast majority of the countries implementing national mental health policies developed the policies in question in the last decade. Moreover 33% of the countries do not report that they allocate a specific amount of fund to mental health services in the budgets. Similarly 33% of the countries allocate less than 1% to the mental health services from the public health budget. And this figure is less than 5% in the rest of the countries.

Republic of Turkey celebrating the 80th anniversary of the Turkish Republic accelerated the researches and studies to design a NMHP. Such studies dated back in Turkey and even the origination of this objective can be followed to the very early years of the republic. Mental Health Division Directorate was established in 1967 under the body of the Ministry. Although it is not documented, it is known that Ministry of Health in Turkey convened on 17 June 1964 to initiate preparations for a “National Mental Health Plan and Program” for the first time. Moreover it is known that the experts worked in this field and submitted reports to the National Health Councils that convene periodically. The Turkish Ministry of Health must have possessed many reports in its archives that would attract the interest of researchers. This article summarizes the systematic studies conducted by the Turkish Ministry of Health in the last two decades after the establishment of the head of the department. Therefore the early efforts are just briefly mentioned in this article.

**Head of the Department of Mental Health**

The more systematic studies of the Ministry of Health were initiated 20 years ago. General Directorate of Basic Health Services was established in 1983 within the framework of the restructuralization of the Ministry. Following this progress the division directorate was restructured into the Head of the Department of Mental Health. One year later the Mental Health Division Directorates affiliated to the Provincial Health Directorates were transformed into the regional structure for mental health services. The Head of the Department of Mental Health focuses on preventive measures, and the main objectives of the Department are listed as follows:

- Improvement of mental health service system;
- Improvement and extension of preventive mental health services;
- Integration of mental health services with general health services and Access to treatment services in every district and province;
- Public awareness in the role of mental health in a healthy life;
- Protection of the public from harmful habits.
Mental Health Program Development Meeting

The head of the Department of Mental Health focused on the baseline study since there was no specific mental health program and basic information to develop such a program. The Department held its first important meeting on 25-27 June 1987 in Ankara. It was the “Mental Health Development Meeting”. Over 120 local experts from different sectors and Prof Norman Sartorius, from the WHO Head of the Mental Health Department and Prof Sampaio Faria, from the WHO Head of the European Mental Health Department were participated in this meeting. The meeting was organized according to the outcomes of the preliminary studies carried out by the Head of the Department of the Mental Health in its central and regional organization on mental health issues. The Ministry asserted that they were decisive to create a new national mental health program to develop preventive mental health services. It was stated that mental health issues could never be handled within the limits of only a single medical branch namely psychiatry. Four working groups were organized and worked on the below mentioned areas. They identified the main problems and recommended solutions:

- Development/improvement of mental health services
- Prevention of mental diseases
- Treatment and rehabilitation of mental diseases
- Psycho-social aspect of the general health services
- Improvement of data collection systems
- Development of researches
- Improvement of legislation

The striking issues found in the reports of the working groups are listed below:

- Mental health services should be integrated with the primary care services.
- Post partum leaves (paid and unpaid) should be increased due to preventive mental health related issues.
- Multi sector based programs aiming at mentally disabled children, children committed crime or children having tendency to commit crime should be given priority and prepared as soon as possible.
- Mental health hospitals should be improved, transformed into qualified special hospitals. Psychiatry services should be established in general hospitals and there should be an efficient cooperation chain between psychiatry services and health units.
- Mental health services cannot be abstracted from the general health services. The services should focus on “the mental health of the individuals forming the society” rather than to focus on “the patient administered to the hospital”.
- Mental health services should be organized as follows: mental health services should start in the primary care in health units, and then continue with the secondary care through teams that involve psychiatrist, psychologist, social worker and nurse and should be supported by voluntary teams (family, teacher etc). Mental health services should be designed bottom to top on the basis of regions.
- Issues that will bring success in the short term with limited amount of funds should be focused on.
- Epidemiology of mental disorders should be researched through joint research projects concluded in cooperation with the universities and the Ministry with the support of the WHO.
- Mental health education should be given priority both in terms of the professionals and public.
- National mental health program should be developed and preventive measures should be taken to ensure the maintenance and guarantee of the program against political pressures.
- The most important problem in Turkey is the lack of an efficient and functional unit to develop and implement national mental health programs. Therefore the Head of the Department of Mental Health should work efficiently and effectively.
- A research group should be established to identify the requirements and collect data.
- Vocational and continuous education and training should be given priority. Preventive health services should focus on children. The number of child psychiatrists should be increased.
- The Ministry should coordinate with the relevant institutions to organize such services.
- The problems observed in the family structure due to rapid social transformation, population increase, cultural problems, economic issues and migration should be taken into consideration.
Turkey does not have any specific mental health program for the prevention and treatment of the vulnerable groups in the society such as children, adolescents, women and elderly. The applicable diagnosis and treatment approaches and the legislation are insufficient. There is need for an urgent amendment.

As a result of the meetings it was suggested that four main groups be organized (preventive mental health services; improvement of mental health, psycho-social aspects of general health services; treatment and rehabilitation works) and work on their reports within a period of one year which was divided into four components. However the proposed studies could not be completed and “National Mental Health Program” could not be developed. The issues identified by the working groups guided the studies of the “National Mental Health Coordination Board” established in April 1993.

1st National Health Congress

The health problems of Turkey were discussed in the 1st National Health Congress organized between 23 and 27 March 1992. The working groups of the Congress worked on the specific health issues in details and the results were stated in a report by the experts. The “Mental Health Working Group” of the Congress discussed the current situation from the perspectives of group rendering mental health services and the group receiving mental health services. In this working group twelve experts assessed the main problems from the perspectives of the system, group rendering services and the group receiving services. The group stated recommendations on their report.

The recommendations reflecting the current situation and main problems stated by the Working Group in their report can be summarized as follows:

1. Recommendations related to organization and practice;
   - To increase efficiency of the Head of the Department of Mental Health under the body of the Ministry and Division Directorates of Mental Health affiliated to the Provincial Health Directorates.
   - To extend and improve psychiatry clinics in every general hospital and to equip such clinics with qualified personnel and equipment.
   - To relieve the care and safekeeping burden of the special (mental health) hospitals and to have such hospitals to focus on treatment, training and research.
   - To extend the out patient treatment facilities, to provide rehabilitation services to the chronic patients in their homes and to provide free of charge medication.
   - To integrate therapeutic and preventive mental health services and to have the specialized personnel in the hospitals work in cooperation with the primary care institutions.
   - To have balanced distribution of specialized personnel throughout the country and to cooperate with the local governments.

2. Recommendations related to coordination and legislation;
   - To establish National Mental Health Coordination Board in the shortest extent possible.
   - To establish a unit providing consultation services to the Ministry on a continuous basis.
   - To enact the mental health legislation as soon as possible and to enforce necessary arrangements related to criminal psychiatry and patient rights.
   - To review the tasks and duties of the mental health personnel and to improve the conditions in line with the international developments and national facts; to develop certification programs for the training of the personnel.
   - To include psychiatry services into the private health and insurance systems.

3. Recommendations related to data collection, research, monitoring and evaluation;
   - To collect statistical data and mental health indicators that are necessary in every level of mental health services.
   - To reach consensus on diagnosis so as to collect healthy data.
To establish a databank under the body of the Ministry and to seek support from the other institutions and sectors for the establishment and maintenance of such databank.

4. Recommendations related to training and advertisement;

- To review the training and education programs of mental health professionals (psychiatrist, psychologist, social worker, nurse), general health service practitioners (physician, nurse, midwife, assistant personnel) and the personnel of the other relevant sectors (managers, teacher, personnel in charge of religious affairs, security officers, etc)
- To improve the theoretical and practical education programs, to increase the quality of the education and to focus on continuous education and training.
- To realize the amendments necessary for the development of specialization branches such as Child Psychiatry that are significant for the development of preventive mental health services and to allocate more room to social psychiatry in education and services.
- To inform practitioners who render primary health care services in the field of mental health (A training program was organized within the scope of a joint project carried out by the Ministry and the WHO. Erol et al. gave lectures on psychosocial development of children between the ages 0 and 2 to the primary health care professionals.)
- To maintain institutional cooperation
- To inform public about mental health via mass communication means, to take necessary measures against misconducts, to render special training and advertisement services (booklets, films, etc) to risky groups, to train the public to prevent non-medical services with the support of the role models of the public

2nd National Health Congress

The 1st National Mental Health Congress was held in March 1992. One year later the 2nd National Mental Health Congress was organized between 12 and 16 April 1993 by the Ministry of Health. The second Congress was organized to monitor and widely support the outcomes of the first congress. The draft law on health reform was discussed and working groups were formed to elaborate on main health issues. 16 experts were worked in the Mental Health Working Group and the measures to be taken were listed under the titles of action plan and implementation plan:

- To strengthen the central and regional organization and the institutional structure (The National Mental Health Coordination Board should work effectively and continuously. Regional Mental Health Coordination Boards should be established. The outpatient facilities should be extended)
- To improve the working conditions of the psychiatry clinics in hospitals
- To open emergency psychiatry units in general hospitals (the emergency psychiatry services, including crises management, should be integrated with the emergency services)
- To draft the mental health law (main rules should be defined concerning the administration of patients, patient rights and protection of the public from the individuals having a tendency to commit crime)
- To conduct epidemiological studies throughout Turkey and to identify mental health indicators (the profiles of mental diseases should be defined) (the profiling of the mental diseases was completed and published by the Ministry)
- To reach a consensus on the diagnosis of mental diseases (the mental diseases classification of the WHO should be used)
- To train and educate the health personnel on basic and preventive mental health (the preventive and general mental health training should be included to the family practice program, the physician and other health personnel working in health units should be trained on mental health, the non medical personnel to render secondary mental health services should be trained on mental health before assigned to their posts)
- To raise awareness of the public on mental health issues and to train the public accordingly.

Both of the National Mental Health Congresses underlined the gaps and lacking points of the country in the field of mental health
plans, programs, policies and practices and emphasized the measures to be taken. The National Health Policy of Turkey was prepared at the end of the congresses to be submitted to the Turkish Parliament. As an outcome of the studies carried out during the congresses reports were prepared. And mental health issues (Objective 28) were included among the objectives listed in the draft policy. The draft in question listing the principles and objectives in line with the current situation, became null and void before enacted by the Parliament. The principles and objectives listed in the draft are summarized below:

Principles

- Preventive and therapeutic mental health services should be combined and integrated with basic health services.
- Therapeutic mental health services should be given extensively in general hospitals as well.
- The care and safekeeping services rendered to the mentally ill people should be combined with the social services.
- The risk factors related to mental health should be elaborated on and advised from a community based perspective.
- Human resources for mental health services should be developed.

Strategies (until 1995)

- Social mental health implementation plan should be prepared.
- Primary care out patient services should be organized to provide rehabilitation services at home.
- Psychiatry clinics should be established in general hospitals.
- Care and safekeeping services should be given by social services.
- Risk factors such as malnutrition, birth and early childhood traumas, kinship marriages, migration, natural disasters, and economic problems should be elaborated on and action plans should be developed.
- Crisis respond centers should be established.
- Social psychiatry should be integrated with all levels of education.

World Health Organization initiated an incentive in 1995 to review health strategies and be prepared to the 21st century due to the accelerated global changes. As it is known the health status of communities is not static. Health services aim to raise the health status and this is a common for all the countries. The WHO encourages all the countries to work on plans to evaluate and improve health services. A recent example is the “Health for Everyone” approach accepted by the General Assembly of the WHO. This is an outcome of the vision adopted in the General Assembly of the WHO in 1997 and initiated in Alma Ata conference in 1978. Turkey also voted for and adopted the program. Actually Turkey engaged in this program as a result of the WHO 47th European Regional Committee Meeting that mainly focused on the “revision of the approach health for everyone” and held in September 1997 in Istanbul.

Health 21 studies

The previous studies and researches brought everyone to a new turning point. It was emphasized that the countries should have completed the action plans parallel to their priorities to reach health objectives in the 21st century. Health for everyone approach was officially accepted under the title of “Health 21” with the slogan of “21 Objectives in the 21st Century” in the 48th European Regional Committee Meeting of the WHO in September 1998 in Copenhagen. It was also expected that public health infrastructure, experiences and capacity would play a key role in the adoption of this new agenda by the countries. Being a party to this program would be an opportunity to Turkey to assess the current status of health services in the 21st century in Turkey and to plan necessary arrangements to improve the health level of the community.

Three out of 21 Objectives are related to mental health directly or indirectly. These objectives are given below:

Objective 6: To improve mental health
Objective 9: To minimize injuries due to violence and accidents
Objective 12: To decrease the harm caused by alcohol, drugs and tobacco
These objectives are explained in the part titled “Healthy Community” together with the objectives of “healthy life”, “health of adolescents” and “health of elderly”.

The Health 21 book of WHO describes objective 6 – to improve mental health – as follows:

The psycho social well being of individuals should be improved and comprehensive mental health services should be provided to the individuals until 2020.

Particularly:

1. The prevalence of the mental health problems that adversely affect health should be decreased and individuals should be provided with new abilities to cope with stress.

2. Significant reduction should be attained in the rates of suicide especially in the countries having high rates of suicide. The rate of suicide should be decreased at least 1/3.

Objective 6 can be met provided that:

- More attention is paid to preservation and protection of mental health lifetime especially in the social and economically vulnerable groups of the community,
- Living and working conditions of individuals are revised and rearranged that the individuals feel harmony, establish and maintain social relations and cope with stress.
- Health personnel and other professionals are educated and trained on early diagnosis and treatment of mental problems.
- Combination of community based and hospital based services are given to individuals suffering from mental health problems in a qualified way and that crises management, minorities and vulnerable groups are given special attention.
- Human rights of the individuals suffering from mental health problems particularly chronic disorders are respected and that their life quality is improved.

Areas recommended for the indicators are given below:

- Suicide rates
- Incidence and prevalence of mental disorders such as schizophrenia, major depression, alcohol psychosis, post traumatic stress disorders.
- Statistics on the accessibility and use of mental health services

Turkish Ministry of Health pioneered not only to the activities carried out in the last two decades in Turkey, but also to the Health 21 activities and carried out necessary arrangements. Sector specific studies were officially started on 23 December 1999 by the Ministry and political commitment was exposed by the Minister. The benefits expected from the study are as follows: (1) to guide the decision making organs to improve the health level of the community; (2) to identify the priorities in resource allocation and distribution; and (3) to develop inter-sector cooperation and to improve public participation.

National Health 21 Policy Development Inter-sector Working Group was introduced on 5 July 2000, and the group convened with a large participation between 31 July and 1 August 2000. The objectives and the strategies to reach such objectives were defined in this meeting with the participation of all relevant institutions and agencies (SPO, relevant Ministries, other public and private institutions, vocational organizations, universities, non governmental organizations, etc) in line with the level of health and current situation of health services in Turkey. Five different working groups were established in this meeting and sub groups were also formed. One of these groups was “healthy Community” group. And one of the sub groups of Healthy Community group was assigned
with the task to adopt the objective 6 – namely to improve mental health – to Turkey. Reports were prepared for each objective including the baseline information, aims and objectives, strategies, main activities, responsible authorities and monitoring activities.

These reports were standardized for each objective by the editor group of the Ministry and objectives having priority for Turkey were defined. All the process took two years. The document titled “Health for Everyone: Objectives and Strategies of Turkey” based on the “National Health 21 Policy” suggested by WHO and adopted by 191 countries in the world was announced to the public on 25 December 2001 by the Minister of Health.

In accordance with this document published by the Ministry of Health 10 national objectives were defined for the first 25 years of the 21st century. The main objective this program was defined in the document as to improve the health indicators in Turkey, to prolong the life expectancy, to improve the life quality and to minimize the differences of health status between the regions and groups.

Main objectives of National Health 21 Policy are as follows:

**OBJECTIVE 1:** To reduce contagious diseases
**OBJECTIVE 2:** To reduce non-contagious diseases
**OBJECTIVE 3:** To minimize the results of accidents, violence and disasters
**OBJECTIVE 4:** To improve the health of infants and children
**OBJECTIVE 5:** To improve reproduction and sexual health
**OBJECTIVE 6:** To decrease risk factors
**OBJECTIVE 7:** To improve the health of adolescents, elderly and disabled
**OBJECTIVE 8:** TO IMPROVE MENTAL HEALTH
**OBJECTIVE 9:** To improve environmental health
**OBJECTIVE 10:** To develop a national health system

Objective 8 - “To improve mental health”
This objective was described as to improve the psycho social well being of individuals and to provide special care to the individuals suffering from mental health problems until 2020. The sub objectives were listed as follows:

- To complete the integration of mental health services to the health center services until 2005
- To double the application rates to the health centers and consultancy centers providing mental health services until the year 2020
- To decrease some mental disorders such as anxiety, depression, substance use, insomnia and somatization 20%.
- To prevent the increases in suicide attempts

**STRATEGIES**

**General Strategies**
- The physicians providing services in primary care should be trained and supported to distinguish psychiatric disorders;
- The nurses rendering services in the primary care should be trained on psycho social situations (It is known that the Ministry completed some successful studies in line with the first two strategies. These strategies stated again to ensure the continuation of such similar studies);
- Public awareness should be created. The public should be informed of the fact that preventive mental health services are significant for the general health and that mental health services can be sought whenever necessary without any hesitation
**Special Strategies**

- The health centers should monitor the psycho social development of the children between the ages of 0 and 6 besides their physical conditions;
- The patients diagnosed with chronic mental disorders should be monitored in their homes within the scope of the primary health services;
- The parents and teachers should be trained on children raising and training and early diagnosis of mental problems within the perspective of preventive mental health services;
- The psycho social development of children should be monitored in every level of educations starting from the kindergarten. Counseling and psychological guidance services should be rendered and sufficient amount of qualified personnel for such services should be raised and employed;
- The individuals should be trained on coping with stress through training programs specific for stress management.

The objective “to improve mental health” was described in the document as stated above. There is no doubt that relevant objectives and strategies related to mental health were also mentioned under the scope of the other 9 objectives. Some examples of such objectives are given below:

- The rehabilitation services to be rendered after accidents and disasters should be developed and extended (3.a.7)
- Necessary arrangements should be made to protect the individuals and the community from violence and aggression elements of all publications and broadcastings (3.b.9)
- The number of the cigarette smokers, alcohol addicts, drug addicts and volatile substance addicts should be decreased (in specific ratios) until 2010. (6.1, 6.2, 6.3, 6.4)
- The counseling and treatment units should be developed and extended. These units should be easy to access by the addicts. (6.b.10)
- The centers providing guidance, social services and rehabilitation services to adolescents, elderly and disabled should be improved both in terms of quality and quantity, and such centers should be extended (7.a.1)
- The adolescents should be trained on cigarette, alcohol and drug abuse, reproductive health, nutrition, contagious diseases, self recognition, self confidence and mental health through organized, non formal and peer education models. (7.b.1)

Development of National Health System: To provide accessible, applicable and available good quality health services to all the sections of the community and to extend and maintain the services to overcome the regional and social differences. (Objective 10)

As it is understood that one of the 10 significant objectives defined by the Ministry in line with Health 21 is directly allocated to mental health, and that issues related to mental health are considered within the scope of the 4 objectives out of these 10. The report also underlines that the next step is to include these objectives into the development plans of the countries and to integrate these objectives with the action plans of all relevant institutions and agencies and to implement the action plans in question.

**CONCLUSION**

As it is known the WHO expects every country to have a NMHP. This expectation is emphasized in Atlas Project of the WHO which aims to identify resources for mental health issues. Atlas Project states that the countries are not prepared to cope with the mental health problems rising in the world since they do not have policies, programs, and resources allocated to this specific field. As it is summarized in this article Turkish Ministry of Health showed significant efforts to progress in this field. Within this framework a study has been initiated to provide a basis for the NMHP to be announced by the Turkish Ministry of Health, which is in line with the current situation of Turkey and in harmony with the international standards so as to reach the objectives listed in Health 21. This study has been started as a result of the 1st NMHP Congress held between 12 and 13 December 2002 in Ankara. It is aimed that the NMHP of Turkey guides the legislative amendments, strategies and programs to be developed in all sectors and practices as it is expected from every country by the WHO so as to use the resources allocated to mental health services in a productive manner.
The problems identified and the root causes proposed by the participants to the round table meetings held during the NMHP Conferences are briefly summarized in the following tables. Data obtained through the below given questionnaire from the agencies and individuals are also included in these tables.

### QUESTIONNAIRE FOR THE DEVELOPMENT OF NMHP

- **Name and Surname:**
- **Agency:**
- **Title:**
- **Business Address:**
- **Phone No:**
- **Fax No:**
- **E-mail address:**
- **Date:**

**Question 1.** Please provide some information on your own activities and works. How can one benefit from the data and practical experience of your agency in the development process of NMHP?

**Question 2.** What are the “Best Clinical Practices for Improving the Quality of Mental Health Services” that you find beneficial to be considered?

**Question 3.** What your recommendations are with regards the development of well-trained human resources in the field of mental health in our country in the future? In your opinion, what is the way for the most fair and equal distribution of these resources in our country?

**Question 4.** Would you like to deliver a presentation or join as a panelist to any of the panels to be organized during the 2nd NMHP Conference to be held in Ankara on 10-12 March 2003 on the role of your relevant field and the implementations of your agency in the field of Mental Health Policy?

If “yes”, would you please write down a summary of 250 words of your proposed presentation?

**Question 5.** Would you please list the individuals, agencies, associations, foundations or other organizations which you propose to have a contribution in the NMHP studies and to which we may sent this “questionnaire”? Would you please provide us with their contact information, if any?

**Question 6.** Would you please list your other suggestions and recommendations which are not included in the questionnaire and deemed to be significant in the NMHP? (You may use the backside of the page).
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>PROBLEMS</th>
<th>ROOT CAUSES</th>
</tr>
</thead>
</table>
| Research         | Shortcomings in the support given to the researches in the field of mental health | Lack of a mental health policy  
|                  | Failure to take evidence-based studies as the basis in every stage of mental healthcare | Lack of medical education and professional training in the field of mental health |
| Education & Training | Failure to have ethical arrangements for the mental health professionals |                                                                        |
|                  | Lack of public awareness                                                  |                                                                            |
|                  | Neglect of psychological and social development dimensions in education and training | Lack of inter-disciplinary work (Lack of coordination between Ministry of Health and Ministry of National Education) |
|                  | Lack of Parent Training                                                   |                                                                            |
|                  | Lack of information, skills and attitude of the primary health care professionals | Shortcomings in Pre-graduation and continuous professional education |
|                  | Shortcomings in the training of teachers and instructors                  |                                                                            |
|                  | Failure to provide appropriate training to the physicians and the other professionals working in the field in line with their requirements both before and after graduation; |                                                                            |
|                  | Lack of training programs for the professionals in the specialties such as speech therapist, hobby therapist, rehabilitation counseling, family and marriage counseling. |                                                                            |
| Financing        | Non-reimbursement for treatment and drug expenses by the private health insurance schemes | Shortcomings in legal arrangement;                                     |
|                  | Failure to encourage the professionals working in risky environments      | Lack of financing and policy  
|                  | Lack of health assurance                                                  | Lack of organization in health systems                                    |
|                  | Inadequate budget allocated for mental health                            |                                                                            |
|                  | Negative impact of economic crisis on the individuals and families       |                                                                            |
|                  | Unemployment                                                             |                                                                            |
|                  | Inadequate share for health in the budget (2.4 %)                        |                                                                            |
| Quality Assessment | Lack of assessing the efficiency and outcomes of the services delivered | Failure to put emphasize on research in health related policies            |
| Preventive services | Communication with and control over the media, and misdirection of the public by the media | Lack of information;  
<p>|                   | Having limited programs (sports, art, etc.) to assist the individuals in their self-development | Lack of control;                                     |
|                   | Inadequate level and unplanned nature of preventive measures              | Limitations in pays, expectations; lack of knowledge and skills and shortcomings of the teams |
|                   | Negligence of mental health of pregnant women                            |                                                                            |
|                   | Negligence of mental health of infants                                   |                                                                            |
|                   | Failure to deliver primary mental health services                         |                                                                            |
|                   | Younger age of onset for tobacco, alcohol and substance use               |                                                                            |</p>
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>PROBLEMS</th>
<th>ROOT CAUSES</th>
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<tbody>
<tr>
<td>Lack of social skills training</td>
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<tr>
<td>Experiencing major problems secondary to sexual dysfunctions</td>
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<td>Increase in marriage-related and sexual problems</td>
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<tr>
<td>Lack of early intervention in traumatic events</td>
<td>Lack of crisis respond teams</td>
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<tr>
<td>Lack of preventive mental health programs</td>
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<tr>
<td>Domestic and overall violence problem</td>
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<tr>
<td>Failure to consider the preventive services as a step in the treatment process</td>
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<td>Lack of support systems to the risk groups</td>
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<tr>
<td><strong>Culture</strong></td>
<td>Decrease in social support systems as a result of rapid social changes</td>
<td>Rapid social change</td>
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<td>Youth with no goal in life</td>
<td>Corrupted values, dilemma experienced by the parents</td>
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<tr>
<td>Stigmatization of psychiatric patients both in the society and other branches of medicine,</td>
<td>Toplumda ruhsal sorunlara karşı olan tutumlar</td>
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<td>Considerable use of individuals claimed to have supernatural powers as the first resort by the individuals with mental problems</td>
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<td>Shortcomings in family planning</td>
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<tr>
<td>Consanguineous marriages and consequential incidence of developmental disorders</td>
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<tr>
<td>Involvement of family elderly and neighbors in the treatment process and related problems.</td>
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<tr>
<td>Covering of sexual abuse as a taboo and thus increase in its incidence</td>
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<tr>
<td>Increasing trend of suicide and depression in particular in the Southeastern Anatolia region</td>
<td>Traditions, family pressure and cultural features</td>
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<tr>
<td>Lack of confidence in the physicians</td>
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<tr>
<td><strong>Organization</strong></td>
<td>Lack of inter-agency and interdisciplinary cooperation</td>
<td>Having a variety of social security institutions such as Social Security Ins., Pension Fund for Self Employed, Pension Fund;</td>
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<tr>
<td>Shortcomings in the referral chain</td>
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<tr>
<td>Lack of control over the functions of the pharmaceutical companies</td>
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<td>Lack of proper recordkeeping for the patients in the field of mental health</td>
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<td>Lack of community mental health centers</td>
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<td>Lack of collaborative work among different professional groups</td>
<td>Lack of legal arrangements (absence of a law on national mental health)</td>
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<td>Having inadequate number of beds</td>
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<tr>
<td>Lack of on-the-spot mental health services after the disasters</td>
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<tr>
<td>CATEGORY</td>
<td>PROBLEMS</td>
<td>ROOT CAUSES</td>
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<tr>
<td>Failure to have access to mental health services</td>
<td>Unequal distribution of services; Shortcomings in reimbursement systems; Myths and malpractices; Economic problems (Not having an insurance scheme or not having mental health services under the insurance cover) Failure to demand mental health services due to lack of information; Lack of individuals and agencies to deliver mental health services in terms of number, knowledge and organization; Stigmatization and prejudice by the society to mental health problems; Failure to integrate mental health services with the primary care</td>
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<tr>
<td>Failure to have sustained service delivery by the trained professionals</td>
<td>Considering being a GP as a temporary status</td>
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<tr>
<td>Uncertainties with regards function and role description of education and health service providers</td>
<td>Shortcomings in the laws, regulations and legislation</td>
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<tr>
<td>Lack of cooperation with the Counselling and Research Centers, Psychological Counselling Center, Health Training Center, Public Training Center and Youth Centers</td>
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<tr>
<td>Decision-making based not only on the needs of the field of health but rather political preferences of the individuals.</td>
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<tr>
<td>Lack of control over implementation and training</td>
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<tr>
<td>Inadequate level of personnel in the field of Pediatric Psychiatry, psychology and social services</td>
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<tr>
<td>Shortcomings in the delivery of mental health services</td>
<td>Lack of support and information of the parents in bringing up and training of children; Lack of outpatient treatment and rehabilitation services;</td>
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<tr>
<td>Lack of social services and social support systems in the field of mental health</td>
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<tr>
<td>Lack of coordination among the service provider agencies</td>
<td>Problems related to team work; Having a variety of requirements due regional discrepancies and failure to plan the services in accordance with such requirements; Failure to provide pre and post graduation training to the physicians and other professionals working in the field in line with the arising requirements.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Lack of rehabilitation in chronic mental disorders</td>
<td>Lack of laws and legislation; Lack of rehabilitation and homecare services;</td>
</tr>
<tr>
<td></td>
<td>Limitations in the rehabilitation of children with disabilities and developmental disorders</td>
<td>Demand for service by the individuals in particular from the low income level group</td>
</tr>
</tbody>
</table>
BRIEF RECOMMENDATIONS

1. In order to improve the level of community mental health, there is the need to prioritize the continuous education of families, physicians and the entire health care and mental health care personnel related to the field.

2. The main goal in the overall country should be improving awareness, accessibility, equality, standard and quality in the field of mental health services. There should be the involvement of general health insurance scheme, national mental health mobilization and non-governmental organizations.

3. Standards for infrastructure, service and education and training aiming at accessible, standard, comprehensive mental health services which are measurable in terms of efficiency and output and which improve quality of life of individuals should be identified and restructured as a priority.

4. There is the need to prioritize preventive mental health services (by taking into account the various institutional structures—education, health, non-governmental organizations— in the community).

5. The authorities of the professional organizations should be strengthened in order to improve the qualifications and competency of the professional groups in the field of mental health.

6. There is the need for cooperation with the Department of Religious Affairs and raising the awareness of the religious leaders in the field of mental health by taking into account of the impact of cultural and religious features.

7. Community based measures should be taken against events like traffic accidents, resulting in mental traumas.

8. With a view to improve the quantity and quality of mental health services, measures should be taken to have enough number of pediatric psychiatrists as much as the adult psychiatrists; and with a view to allow for team work, required programs should be provided for the training of clinical psychologists, pedagogical psychologists, psychological counselor, social workers and psychiatric nurses and the number of qualified personnel in the mentioned fields should be increased.
<table>
<thead>
<tr>
<th>Goals / General Objectives</th>
<th>Main Methods / Strategies</th>
<th>Recommendations for implementation, program or arrangements applicable/required to be applicable in Turkey</th>
</tr>
</thead>
</table>
| Standardization in Education and Training | To prioritize mental health education in the general medicine education  
To provide continuous post-graduation education in the field of mental health  
To assess the education provided, identify its conformity with the needs, to assess the actual practice of education, to evaluate the outcomes and re-plan the education if required.  
To ensure standardization in acquiring of knowledge, skill and attitude, their development and measurement | Pre-graduation training for the general practitioners, nurses and midwives  
Effective use of certification system in the education and training of personnel  
Extensive implementation of post-graduation continuous education  
Evidence-based education |
| Standardization in service delivery | To deploy mental health service units at all levels  
To increase practice of Total Quality Management in the health institutions  
To develop self-control systems in the service provider institutions  
To have the relevant bodies perform audit of the services  
To develop an information network, registration system and treatment and follow-up program on the delivery of mental health services at the regional and country level as starting from the local level  
To increase inter-disciplinary works  
To act in line with the capacities of the relevant institutions  
To establish special centers for certain specific mental health problems  
To deliver certain mental health services in the emergency services of general hospitals  
To have the professional laws of the mental health personnel enacted (psychologists, social workers, etc.)  
To plan and actually implement the equal distribution of mental health services country-wide  
To identify mental health working teams and their job descriptions | To have quality practices in place (ISO Practices)  
To assign mental health professionals to the vacant posts in the institutions and to assign the service providers to the posts in line with their training, to reorganize regional hospitals  
To restructure patient referral system and outpatient follow-up (Form RS 1020).  
To consider early diagnosis and treatment at all levels  
To develop a common information network throughout Turkey in the field of mental health in terms of the effective use of existing resources and to share the necessary data over this network  
To integrate mental health services to the primary care services  
To put emphasis on the preventive mental health studies Alcohol and Drug Addiction Treatment and Research Center (AMATEM), Substance Abuse Center (TADOC)  
Modular mental health services (excitation, suicide attempt, intoxication) |
| Standardization in use of the service | To enhance use of total quality management in the health institutions  
To have audit of the services by the relevant institutions  
To assess the quality of the mental health services used by the public  
Law on Patient Rights | To communicate mental health services delivered to the public through the media  
To ensure access to social security system and services by the entire population |
<table>
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</thead>
</table>
| Access to mental health services by all the individuals in the community | To deliver equal and accessible mental health services to all individuals in the community  | To conduct epidemiological studies  
To develop on-site treatment and daytime hospital models  
To improve the functions of healthcare centers  
To establish in-patient units in the state hospitals  
To improve mental health services delivery system at the provincial level by considering region-specific conditions and living standards and to assign adequate capacity of personnel |
| Improvement of rehabilitation services                       | To provide service opportunities for chronic psychiatric diseases  
To provide rehabilitation opportunities for special groups (geriatric patients, mentally disabled, homeless, etc.) | Turkish Armed Forces Rehabilitation Center  
Home follow-up programs  
Drug supply programs to chronic patients  
To establish daytime care centers |
| To raise awareness on the concept of “Mental Health” (mental health, mental disorder, units to refer, etc.)  
To have a common terminology in the field of mental health: for example to avoid confusion in the use of mental health and diseases, psychiatric and neurological disorders, psychiatry, etc. | To use a common and clear terminology in the public training activities  
To have personnel trained and qualified on mental health to deliver primary care mental health services | To establish parents schools |

**QUALITY IMPROVEMENT IN MENTAL HEALTH**

<table>
<thead>
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</tr>
</thead>
</table>
| To allow for diagnosis of major mental health problems at the primary care level | To direct pre and post graduation training towards these objectives  
To provide for updated and standard education and training at all levels  
To prepare training materials  
To use standard assessment scales in diagnosis | To improve evidence-based education |

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## ORGANIZATION OF MENTAL HEALTH SERVICES

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<th>Main Methods / Strategies</th>
<th>Recommendations for implementation, program or arrangements applicable/required to be applicable in Turkey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopting a regional approach</td>
<td>To identify needs in line with the conditions in the region and to organize according to such needs</td>
<td>To develop programs on the basis of regional risk groups</td>
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<tr>
<td>Delivery of in-service training on mental health to the professionals working in all levels and emergency services</td>
<td>To provide better understanding of mental health to all health professionals during their formal education</td>
<td>To integrate mental healthcare to in-service training programs</td>
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<tr>
<td>Training of professionals to deliver mental health care services</td>
<td>To effectively include mental health professionals in the existing organization To establish teams</td>
<td>To do planning</td>
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<tr>
<td>Coverage: Extending the scope of social security system to the entire population</td>
<td>To make primary care mental health services functional in workplaces, schools, etc.</td>
<td>To enact the laws and regulations for putting the works in the field into practice</td>
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<tr>
<td>Functional communication between primary care and other levels (improvement of the referral system)</td>
<td>To allocate the professionals To employ adequate number of other mental health professionals To make home visits To make screening Records of health institutions Case-finding studies</td>
<td>To have the Ministry of Health develop personnel policies To have at least one psychiatrist in every province To have access to the cases Schools Workplaces Mosques Trade Unions Offices of Headmen Community Training Centers Driving Classes</td>
</tr>
<tr>
<td>Accessible mental health services</td>
<td>To deliver primary care mental health services to the teachers, students and parents at school To deliver primary care mental health services to the employees in the workplaces</td>
<td>Activities of the Department of Religious Affairs for Preventing Suicides Parent Schools To train Psychological Counselors (Counselor Teacher)</td>
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<td>Well-established organization for preventive mental health services</td>
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<tbody>
<tr>
<td>Primary Prevention:</td>
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<td>To establish teams having functional communication and cooperation</td>
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<td>Maintaining state of</td>
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<td>To encourage initiatives supporting mental health</td>
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<td>well-being</td>
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<td>Redefinition of and</td>
<td>To improve the functioning of healthcare centers</td>
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<td>extending scope of</td>
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<td>primary care</td>
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<td>Adoption of family-</td>
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<td>To extend the training on family therapy</td>
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<td>based approaches in</td>
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<td>To support family counseling</td>
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<td>delivery of mental</td>
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<td>health services</td>
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<td>Having a definition of</td>
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<td>profession for mental</td>
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<td>Establishment of</td>
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<td>psychiatric clinics in</td>
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<td>the general hospitals</td>
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<td>Reorganization of</td>
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<td>regional hospitals</td>
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<td>Systematic record-</td>
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<td>keeping of the patients</td>
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<td>receiving mental health</td>
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<td>services and accessibility of such data by the relevant institutions.</td>
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## Goals / General Objectives

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Identification of groups to be rehabilitated</td>
<td></td>
<td>To apply quota in the employment of disabled and discharged convicts</td>
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<tr>
<td>Establishment of institutions in the field of rehabilitation</td>
<td></td>
<td>To authorize primary care health institutions on the referral and follow-up of individuals subject to mental disorder treatment at the primary care institutions Turkish Armed Forces Rehabilitation Center To establish separate rehabilitation centers for the mentally retarded</td>
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<tr>
<td>Training of personnel in the field of rehabilitation</td>
<td>To deliver short term training programs to the volunteers from different professions</td>
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<tr>
<td>Integration of rehabilitation services as a part of the general health system</td>
<td>To have closer cooperation with the local governments and social organizations such as foundations and associations To have long term follow-up and control mechanisms in rehabilitation</td>
<td>Community and family based practices To provide job opportunities for those under rehabilitation through employment policies To start rehabilitation services after the treatment without any delay</td>
</tr>
<tr>
<td>Development of rehabilitation programs</td>
<td>To have evidence-based practices in place</td>
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<tr>
<td>QUESTIONS</td>
<td>ANSWERS</td>
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<tr>
<td>Are the financial resources allocated to general and mental health care services at an adequate level?</td>
<td>In general terms they are not; however more importantly the existing resources are not used efficiently and effectively. They are in particular inadequate for community based mental health services.</td>
<td></td>
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</tbody>
</table>
| If inadequate, what are the underlying reasons?                           | Due attention is not given to mental health.  
There is not enough level of mental health advocacy.  
There is lack of information and awareness in the public with regards mental health.  
There is no NMHP.  
No resources are allocated for research.  
No adequate financing is provided for preventive services (low income level).  
There is lack of coordination in the delivery of services.  
There is no database to control resource distribution.  
Services are not planned according to identified needs (priority setting).  
There is irrational use of drugs.  
Certain drugs are not prescribed by the specialist. |
| Are there groups failing to receive any service as a result of these deficiencies? If yes, who are they? | Children and adolescents  
Individuals with mental health problems  
High risk group (street children, homosexuals)  
Very-low income group  
Those failing to have access to service  
Elderly and the needy  
Those requiring on-site and home care  
Those living in rural areas and far from settlement areas |
| What are the existing financial resources?                                | General budget  
Social Security Institutions (Social Security Institution, Pension Fund, Pension Fund for Self Employed)  
Out-of-pocket expenditures  
Incentives like tax deduction provided for the resources allocated by the volunteer individuals, organizations, associations and foundations for mental health  
Social Assistance and Consolidation Foundation  
Local governments, municipalities |
| What may be the additional financial resources?                           | To make significant allocation from the general budget to mental health services  
To impose a special tax on alcohol and tobacco and to use a share of this amount in fight against addiction and preventive mental health  
International resources  
Non-governmental organizations  
Municipalities and special provincial administrations  
Obligatory mental health insurance  
To audit health carnets  
To initiate general health insurance scheme |
<table>
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<tr>
<th>QUESTIONS</th>
<th>ANSWERS</th>
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| Are there limitations to the contributions by the individuals to the expenditures? What is the extent of this contribution and limitations? | To decrease the contribution pay in drugs and have no contribution pay liability for the children, adolescents and chronic patients (provided that the new mechanism prevents waste of resources)  
To include the drugs used in the treatment of nicotine addiction in the list of social security and insurance reimbursement in return for a certain contribution pay.  
To ensure effective use of drugs and their prescription over a certain quantity  
To provide regular free of charge drug delivery to the chronic patients in return for a report |
| What should be the priorities in expenditures? | Preventive interventions  
Interventions with high impact over a low cost  
Pediatric mental health services  
Establishment of psycho-social rehabilitation institutions and their services  
Treatment  
Education and Training  
Research |
| What are your recommendations for the coordination and efficient and effective distribution of financial resources? (Separately for rural and urban areas, major cities and various service delivery unit levels) | To have national mental health policies, plans and programs in place. To implement the same fully and as based on scientific evaluation.  
To develop mental health services other than the hospital services.  
To strengthen local governments in the delivery of health care services and to decrease the influence of the center.  
To develop family counseling services  
To ensure inter-agency organization and coordination in the planning and use of financial resources  
To delegate the local governments the responsibility to provide care for the psychiatric patients |
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<th>Recommendations for implementation, program or arrangements applicable/required to be applicable in Turkey</th>
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| Identification of risk groups | **Children required to be safeguarded**  
Disabled children  
Children working in streets  
Children subject to violence and abuse  
Children and adolescents with mental problems  
Children with chronic diseases  
Children and adolescent using tobacco, alcohol and substance | To have adequate cooperation with ŞHÇEK  
To cooperate with the Ministry of National Education for skill building in recognition of mental problems  
To enhance special education institutions in terms of both quantity and quality  
To make juvenile courts functional  
To improve consultation liaison programs  
To have institutional programs for transition to community care |
| To train personnel in the field of child and adolescent mental health | **To train appropriate personnel for the proper diagnosis and treatment of the mental problems in children**  
To establish child and adolescent mental health care departments in every medical school | |
| Protection of child and adolescent mental health | **To improve the capacity of primary care in protecting the infant, child and adolescent mental health**  
To establish regional child and adolescent mental health care centers | To give priority to child and adolescent mental health in the pre and post graduation programs in medicine  
To provide in-service training programs on child and adolescent mental health care in the institutions |
| Supporting mental health activities at schools | **To organize developmental-based psychological counseling and guidance at schools** | To consider psychological counseling and guidance services at schools under primary care  
To extent delivery of comprehensive psychological counseling and guidance programs and services  
To provide personnel and family training under the scope of school based risk prevention programs  
To have qualified and trained professionals employed at the psychological counseling and guidance units of the schools |
| | **To provide psychological counseling and guidance programs also outside the schools** | Life skills training  
Scope of the training  
Problem-solving  
Decision-making |
<p>| | <strong>To ensure participation of adolescents in the planning and implementation process of the training</strong> | |
| Strengthening of social support in the community | <strong>Effective use of the media for training</strong> | To produce training programs for the state TV stations |</p>
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</table>
| Preventive mental health: Maintaining state of primary well-being | To implement programs discouraging use of tobacco, alcohol and substance  
To extend sports and physical activities  
To identify mental health care needs of the regions and to prepare the programs accordingly  
To raise public awareness on protection of mental health, use of the services and prevention of stigmatization  
To ensure cooperation and coordination of all agencies working in the field of mental health | AMATEM  
To establish pressure groups against the use of tobacco and alcohol and advertisements and for the improvement and full enforcement of the laws  
To improve sports facilities and allow for access to mentally disordered patients  
To authorize the hospitals in identifying the needs of the hospitals and prevention programs  
Use of the media |
| Increasing number of inpatient mental health care institutions and their equal distribution | To establish properly equipped psychiatric services at the state hospitals.  
To increase number of regional hospitals and to narrow down the region  
To identify workload of mental health professionals and identify the required number of personnel accordingly | To enact and enforce legal arrangements with regards organization of mental health |
<p>| Follow-up of the treatment of the patients with mental disorders after discharge | To organize the primary care health personnel for this function | To establish a mechanism allowing for flow of information between the primary and tertiary care |</p>
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<td>Rehabilitation: Decreasing loss of skill of the mentally disordered, providing them skill training and employment at appropriate fields</td>
<td>To establish and institutionalize a rehabilitation system to be identified in line with the needs of the patient and to adopt a holistic approach in rehabilitation</td>
<td>Legal arrangements</td>
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<tr>
<td>Extending delivery of psychiatric diagnosis and treatment services</td>
<td>To have at least one psychiatrist in every province To establish psychiatry clinics at all state hospitals and all other hospitals with at least 100 bed capacity To increase the number of psychiatric nurses, psychologists, social workers, psychological counselors To enhance psychiatric service quality at the emergency services</td>
<td>Pay policies Problems arising from specialist and bed allocation between different institutions Single management Reorganization of regional hospitals Mental health care training to the emergency service personnel Underlining psychiatry in the specialist education of emergency medicine</td>
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<td>Legal arrangements</td>
<td>To define the professions</td>
<td>Job descriptions for psychologist, psychological counselor, social worker</td>
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<td>Preventive and protective services</td>
<td>Family training Train the trainers Training of primary care professionals To raise public awareness with impressive training materials</td>
<td>Programs on addiction Community training programs on other mental problems</td>
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<td>Organization</td>
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<td>Rehabilitation: chronic patients, mentally disabled</td>
<td>Foster families Rehabilitation institutions Daytime hospitals</td>
<td>Salary payment to and control over the families Support programs for the families of psychotic patients To ensure coordination among the health, education and social security institutions for the mentally disabled</td>
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<td>Establishment of institutions and units to deliver family mental health care services for prevention, treatment and rehabilitation</td>
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1. TURKISH PSYCHIATRIC ASSOCIATION

WE SHOULD HAVE A SUSTAINABLE PSYCHIATRY POLICY

We, as the Turkish Psychiatry Association, strongly believe that we are in need of a “road map” with a legal and economic infrastructure, an organizational schema, with its own principals of increases in the quantity and quality of services, an understanding of personnel, management fundamentals and its short-medium-long term targets, with its own supervision and correction mechanisms and implementation plans and programs.

It is obvious that the said road map, as stated in the draft report, will be a “National Psychiatry Policy (NPP)”. One can only by means of the right map attain the target without losing their way; however, there will be no destination without an ongoing journey. The NPP, which is to be prepared for the provision of improvements in the field of psychology and for reaching and preserving the contemporary standards, has to conform our country (be the right map) and the journey has to go on.

Cooperation among the runners of the journey in terms of thought, effort, motivation and activity is a sine qua non for the preparation, implementation and sustaining of the NPP as an appropriate road map is. Therefore, we call for the implementing parties of such a policy to be program and implemented on the national scale, i.e. non-governmental professional organizations as well as the governmental organization, to actively take part in the process of implementation and sustaining of the program beginning from the preparatory stage. We, as the TPD, would like to reemphasize our desire to be actively involved in this process.

SITUATION OF PATIENT BURDEN

The budgetary share of health is considerably low in Turkey. Thus, psychology is also given an extremely low budgetary share. However, a big deal of this insufficient resource is spent on in-patient health services and chemical treatment. The portion of the population without any kind of social security cannot afford the cost of treatment. Conclusively, the family merely shoulders the fiscal burden of the individuals having psychological problems but not any kind of social security. The emotional burden of individuals and families is also higher than the normal since chemical treatment is attached greater importance and rehabilitation is ignored. Patients cannot find a psychological treatment facility to apply for health service in their vicinity as psychiatric in-patient facilities, which are obligatory for the treatment of acute psychotic tables, are insufficient in number and unequal with respect to distribution and treatment standards. The country experiences a “psychological tourism” either obligatorily or optionally.

Visits are generally shorter than the reasonable period of treatment because of the insufficiency, with a few unnecessarily longer visits due to the lack of treatment standards. As a result of insufficient visit duration and insufficient treatment, psychotic patients swing from the usual psychological system to the forensic psychiatric period.

Working burden of the hospital staff in general and psychiatrists in particular continuously gets heavier and professional satisfaction decreases day by day due to the inevitably low service quality because both psychiatrists and members of auxiliary medical personnel such as clinical psychologists, social workers, psychiatric nurses and even servants are unqualified and insufficient in number. Briefly; the burden of psychological patients is shouldered by the patient, his family, the social security institution whose the patient is a member, and the psychiatry personnel, and this burden cannot be shouldered any more when the above bearers get deprived of support.

ATTITUDE TOWARDS PSYCHIATRIC PATIENTS AND THE SITUATION OF SOCIAL SUPPORT SYSTEMS IN TURKEY

Within the social traditions of our country there has been no room for excluding psychiatric patients and feeling disturbed by living together with those patients as long as they do not behave aggressively. The psychiatric patients who lack family support are customarily looked after by villagers or the residents of quarters, which are small settlements with a preserved traditional structure of social ties.
Asylums, i.e. big hospitals where psychiatric patients are imprisoned and isolated from the rest of the society, have a history of two centuries in Turkey. They were introduced with the installation of Western institutions. They did not reach a sufficient scale in time for the majority of the psychiatric patients in the country. The practice of western “big hospital” and the traditional approach have gone hand in hand for the last two centuries. Today big hospitals in the country mostly are on the way of turning into modern medical institutions due to the facts that efficient antipsychopathic treatment could be accomplished via medicines within the last fifty years, that the big hospitals turned to be insufficient for “patient isolation” because of increasing population, that new hospitals cannot be established due to economic problems as well as the efforts for adaptation to the developments in the west.

Our country has never witnessed the “imprisonment in institutions (Institutionalization)” of a majority of patients; thus, it is impossible to speak of any violation of human rights in the national scale. However (perhaps for this reason), the concept of patient rights has started to be lately (since the last decade only) discussed in the field of psychiatry in our country. The bat-type practice of “patient institutionalization”, which walked hand in hand with the traditional practice, ended twenty years ago when patients were taken out of hospital. Today there are still some patients that are kept in hospital, except Forensic Psychiatric cases; however, the aim of this practice is not to isolate the individual from the society or to protect the society from the individual. Those patients are kept in hospital with the consideration that they can be given harm outside since they do not receive any family or social support. They number to just point 3 per cent of the total number of psychiatric patients.

There are still not any institutions to give psychosocial support or to carry out rehabilitation within the society, except the treatment of bedded acute patients. Big hospitals are going on shouldering a significant amount of the burden but the mental health services could not been integrated into public health services yet.

One of the most important developments is that traditional systems of social support (big family, neighbourhood, country relations, etc) are disappearing simultaneously with urbanization. Because psychiatric patients get deprived of support, psychotic patients gradually turn into poor homeless people and the number of patients wandering in the streets without any support increases as those support systems cannot be substituted by modern institutions. Stigmatization, discrimination and exclusion become more frequent.

**LAW ON MENTAL HEALTH AND HUMAN RIGHTS**

Turkey does not have a law on mental health. One will not find a legal justification of the practice when the freedom of psychiatric patients is required to be limited due to their illness. This situation both leaves an open door for violation of patient rights and leaves psychiatry personnel without any legal support.

Psychiatric patients are commonly used as a means of popular broadcasting by mass media, where the privacy of psychiatric patients is violated. Legal regulations are also required in this respect. In the 96th page of the draft is stated the commitment of keeping secret although it is his right. Necessary legal actions should be taken in order to prevent the screening of patients in psychiatry clinics or the use of obviously psychotic people for shows on TV channels.

The Turkish Psychiatry Association has established a commission to prepare a draft bill which holds our respective requests: “The Draft Bill on the Protection of Psychiatric Patients’ Rights”. Final arrangements are carried out on the document. The draft is going to be submitted to the Ministry of Health. The draft states some suggestions for rules on the definition and juridical security of rights of the patients who are mental problems and need to given limited freedom, and for the protection of patients’ privacy by third persons and the mass media.

As stated in the preparations of the report, in case of a delay to take place in the legislative assembly despite our diligent efforts, a regulation to be issued by the Ministry of Health and adopted by all of the social parties will remove the existing vacuums in this field although it is not expected to be as effective as a law.
The draft projects states that “The existence of the law on mental health does not imply that the protection of psychiatric patients’ rights is absolutely guaranteed. On the contrary, the law on mental health holds some statements that lead to violation of human rights in some countries.” This statement is undoubtedly true. A recent amendment in Turkey has legalized forced feeding in strikes in contrast with universal principals and documents of medical and human rights. In the document on psychiatry policy references should be made to universal values, human rights documents and the documents of World Medical Association (WMA) and World Psychiatry Assembly (WPA); it should be emphasized that local arrangements cannot be considered higher than the above documents, as well.

The current draft project makes frequent references to a great many United Nations, WHO, WMA, WPA documents. It should be identified within the scope of the project of which documents our country is one of the signatory parties. For instance, our country adds abstention for some articles of the Agreement on Children’s Rights. Moreover, signing those agreements is not enough alone; they should be translated and published so that we can be aware of these stages. Our association can take the responsibility of translation and publishing of some of those texts; for example, “A Guideline For the Protection of Human Rights of Psychiatric Patients” published by WHO in 1996.

QUALITY IMPROVAL

Quality improvement in mental health services is extremely important. However, quality improvement efforts is better to be considered within integrated organization of services instead of being handled as the single target with a view to the fact that the proportion of psychiatric patients who cannot benefit from services is significantly high.

With reference to quality promotion, the final copy of “the Bylaw on Medical Specialization” provides a more appropriate infrastructure for inspection of educational institutions than before; however, there is not a particular arrangement for inspection and quality improvement regarding the health facilities which do not provide education.

Although efforts are being carried out in terms of standardization in prognosis and treatment in the field of health by the Ministry of Health, not any efforts are spent on service standardization of health facilities.

The Turkish Psychiatry Association is currently having prepared treatment guidelines for psychiatric disorders. The first one concerns “Psychological Disorders” and is going to be published within this month. Preparations are going on for the treatment guidelines on “Psychotic Disorders” and “Anxiety Disorders”.

VIEWS AND SUGGESTIONS REGARDING THE ORGANIZATION OF MENTAL HEALTH

Mental health services are provided by considerably different facilities and units within coordination in our country. The structuring within the Ministry of Health is composed of Psychiatry Department, which is affiliated to the General Directorate of Basic Health Services. Activated and efficient from time to time thanks to personal efforts of some heads of department, this structure, which is generally not functional, should be changed. The change of department into the General Directorate of Psychiatry gains great importance for the effect of policies and programs to be followed. That general directorate must be directed by a psychiatry specialist. The general directorate should be supported by a sufficient number of psychiatrists, psychologists and other staff, and all of the facilities providing psychiatric service should be coordinated. Affiliation of all of the units providing psychiatric service within the Ministry of Health to the general directorate may yield the opportunity for more effective working.

An autonomous National Psychiatry Council should be established to work with the secretariat of the General Directorate of Psychiatry. The Council to be formed by representatives of Ministries of Health, National Education, Labour, Universities, Turkish Psychiatry Association, Juvenile and Teenage Psychiatry Association and Turkish Psychologists Association, the Institution of Social Services and Child Protection (SHÇEK), shall provide the planning, coordination and standardization among all of the facilities with psychiatric functions within the country.
Similar structuring should be provided in urban centres. Psychiatry Centres under Directorates of Health should have a sufficient number of psychologists, social workers and nurses headed by a psychiatry specialist, if possible, or a generalist. Educational and protective services for the community, transfer of patients to the second stage facilities and regional hospital as well as rehabilitation facilities, post-treatment follow-up, home visits should be carried out by those departments under the General Directorate of Psychiatry. The departments should have ready allocations for pharmaceuticals and transfer of patients without any social security.

Local Psychiatry Councils formed of the representatives of ministerial institutions and facilities providing curative services in provinces should be structured to coordinate psychiatric services as in the centre.

Patients should be made comfortable during transfer to/between facilities starting from the smallest unit in the end. Responsible medical and security personnel should be defined beforehand, the personnel should act urgently in the event of transfer, each facility should have ready an allocation for the patient transfer by ambulance or other appropriate vehicles, and the personnel should have the necessary education to take necessary medical actions during transfer.

**VIEWS AND SUGGESTIONS REGARDING THE QUANTITY AND QUALITY OF PSYCHIATRY PROFESSIONALS**

In Turkey are 1 psychiatry specialist, 1 psychologist and 1 social worker per a hundred thousand population. Furthermore, regional and institutional distribution of these medical personnel is considerably unequal. Our target for the next 10 years should be to increase those numbers five times at least.

There are 784 psychiatry specialists in Turkey, 359 of whom are employed by the Ministry of Health. The number of specialists to be increased should be fairly distributed. Existence of 1 psychiatry specialist at least in all provincial centres and in each district with a population over 100 thousand should be targeted for the next five years.

An increase in the number mostly depends on the adoption of encouraging measures. Additional financial promotions for psychiatry specialists and improving the employment and cadre potential for psychologists and social workers in diverse facilities are the most significant ones of those measures. Systems of additional promotions to be given to the personnel working in the facilities without a specialists and premiums to be determined according to the number and working area or specialists may provide assistance. Duty and job descriptions of professionals should be well defined. In particular, the laws to clear the working areas should be urgently developed.

Standard educational programs and boarding systems should be developed for institutions which provide education for psychiatry professionals. Necessary action should absolutely be taken for conduction of this service through Professional organizations. Efforts of the Turkish Psychiatry Association for boarding and standardization should be supported; efficiency of Professional organizations in other fields should also be promoted.

Programs with a content of education on test and scale applications and psychotherapy practices for psychologists should be periodically arranged.
VIEWS AND SUGGESTIONS REGARDING THE HEALTH FACILITIES TO PROVIDE PSYCHIATRIC TREATMENT AND CARE SERVICES:

1. Primary Health Care Facilities

A. Health Posts and Health Centres
There are many health posts in provinces and districts of Turkey, the number of which is determined according to the population served. In addition, protective health services (vaccination, etc), pregnancy monitoring, deliveries, mother-infant care services and primary curative services are provided in these health posts, which are also available in some selected villages and the total number of which is currently 5833. In these facilities where different numbers of doctors, nurses, midwives and other personnel provides services, are there registrations of the population inhabiting the service area and periodical controls of pregnant woman, in particular, new mothers and children are regularly conducted in the appropriate way. As for some other villages, there are Health Centres where deliveries and mother-infant health services are usually carried out by midwives, the only personnel of those centres.

Despite their widespread distribution and well-planned job descriptions, these units are not mostly preferred for curative services. This may result from the facts that the appointed personnel frequent changes, especially generalists avoids working in these centres and the local people are not satisfied with the service provided in these centres, etc. Studies conducted in Ankara by Kılıç et. al. (1994) and in Erzurum by Kırpinar et. al (1997) reveal that individuals having psychological problems firstly visit specialists despite distance and higher cost.

Expectations
These centres, if well-organized, have the potential of being the fundamental units of psychiatric practices and protective mental health services, identification of risk groups, initial treatment of patients and their transfer to specialized staff and units, follow-up of patients within the society, continuation of their treatments and social educational activities. Regular home visits by midwives presents an almost ideal model in terms of monitoring the whole population and pregnant women, in particular.

Recommendations
Reinforcement of health posts with sufficient number of staff to be appointed for a long time is the major problem. Monetary, social and other promotions in personnel rights to encourage being a generalist and working in health posts should be realized urgently. The personnel working in these facilities should be equipped with a good psychiatry education in terms of mental health before and after graduation.

Information pertaining to the patients who have received treatment in secondary and the third stage health facilities and who are decided to be followed up and receive ongoing treatment should be submitted to these units in the form of well-arranged registrations annexed with calls for following steps; and the follow-up results should be sent to the treating facilities in the same form.

Treatment/transfer algorithms with short scales and questionnaires to be used by generalists and midwives during public controls should be prepared for prominent mental problems, distributed to those units and put into implementation.

The nursery schools and caring units within SHÇEK should be urgently improved with the priority given to the employment of large numbers of specialized staff.

B. Other Facilities Providing Primary Health Care Services
Apart from health posts, there is a large number of primary health facilities where generalists are employed. Institutional surgeries of several institutions (National Education, Communications [PTT], Police, Municipalities, etc) in urban cities and corporation surgeries in industrial organizations handle the initial examination, transfer and prescription of patients. Introduction of the obligation to employ a physician in all state and private organizations with more than 100 personnel should be introduced, these physicians
should be subject to compulsory periodical training programs concerning mental disorders and they should deal with the treatment and follow-up of patients turning back from secondary services. These physicians can render educational and protective mental health services through identified programs to the corporation personnel and their dependents.

Employment of sufficient number of psychiatrists, psychologists and generalists in the facilities which are known as Medico-Social and exist in most of the Universities and Higher Schools should be made obligatory. Teenagers and adolescents at university in particular constitute a major risk group for protective mental health services.

Dispensaries of various institutions and SSK as well present similar characteristics. Consultancy and guidance services to be given in schools which are affiliated to the Ministry of National Education should be improved. The employment of this staff, numbering to 1 in schools with a high number of students can provide an opportunity for individual consultancy and the educational activities throughout the school. As for the major cities, it is appropriate that psychiatrists and psychologists are employed to work in units (Consultancy Centres) under the Ministry of National Education and in coordination with this staff.

2. In-patient Facilities
The bed capacity for psychiatric patients is almost 1/6 of the portion suggested by WHO. This capacity is distributed to hospitals of the MoH, SSK or other state organizations, Foundation Hospitals and university hospitals. Since the MoH specialization hospitals do not include separate rehabilitation clinics, some of the beds are occupied by chronic psychotic patients. Decreasing the number of beds for psychiatric patients should be out of the plan with consideration to the current situation. However, a balanced distribution of in-patient facilities throughout the country should be the basis. It should be noted that both the quality and the functioning of in-patient facilities are deteriorated by the lack of rehabilitation facilities.

A. Psychiatry Clinics within Public Hospitals:
These units, which should be taken as the basic facility in the organization of mental health services, are diversified with respect to the institutions they are affiliated to and their distribution to the countrywide. Currently in Turkey there are inpatient psychiatry clinics in most of the 751 MoH State Hospitals working and the SSK and Military hospitals. Almost 2450 of 6190 psychiatry beds of the MoH are held by state hospitals. Some of these hospitals are known as training hospitals, which provide specialization training in some branches. Others have different numbers of beds and personnel.

There are great inequalities between hospitals with respect to the number of beds and specialists. For instance, in a 100-bed-hospital may be more than 10 psychiatrists while only one psychiatrist may be assigned in one out of 7-8 cities (Eastern Anatolia).

Hospitals of the Ministry of Health (MoH) charge for services as well as they provide free services for Civil Servants, members of the Pension Fund and Bağ-kur (the Social Security Agency for Artisans and the Self-employed) and their dependents in addition to pensioners, widows and orphans, members of SSK (the Social Insurances Agency) - if directed, on condition that their treatment fee is charged from their institution. Funds which are allocated by the MoH for Green Card holders in certain hospitals in each city are used for bedded treatment of those patients. Citizens who fall within the scope of the Law no. 2022 are provided with limited services free of charge. The Social Contribution Funds operating under Provincial Governorships can extend limited contributions for the treatment of people with no insurance.

While some of SSK’s public hospitals function as training hospitals, other hospitals in many cities and districts lack psychiatry clinics. Most of these hospitals employ Neurologists with the title and clinic of nerves specialization (Asabiye) and some out-of-date legislation creates obstacles before the formation of psychiatry units. These hospitals only serve SSK members and their dependent relatives.

Hospitals within the Universities with Medical Schools have Psychiatry Departments with different numbers of beds, academicians, assistants and other personnel. Providing training for in-patient and outpatient therapies, these institutions present a wide range in terms of cadre and equipment.
A number of hospitals owned by the Armed Forces (TSK), 2 of which are training hospitals, employ psychiatrists, some of whom are reserve officers. These hospitals provide services for members of the Armed Forces and their dependents.

Furthermore, public hospitals owned by some foundations, institutions (PTT [Mail-Telephone-Telegram], the Police, Municipalities), unions (tradesmen) also provide psychiatric services.

Most of the private hospitals lack psychiatry clinics due to the drawbacks of the legislation.

**Expectations**

Initial treatment of psychiatric patients should be conducted in the said clinics. The clinics should be attended by sufficient numbers of psychiatrists, psychologists, social workers and trained nurses and staff. The number of beds in clinics should be determined according to the total number of beds in each respective hospital and the population served. Services to be given in the clinics should be based on the elimination of acute symptoms, distinctive prognosis, the adjustment of pharmaceuticals and their doses and the provision of the improvement to enable adaptation to the next therapies and follow-up. These clinics should unexceptionally have intensive care units and appropriate reaction areas for emergent psychiatric practices. The outpatient units should be appropriately equipped for pharmaceutical and psychotherapy practices. The clinics should have the necessary equipment and staff to carry out consultation-liaison services of the hospitals in general.

Social workers and nursing staff of these hospitals should receive training for home-care and follow-up practices; the functioning personnel should be institutionalized.

**Recommendations**

Psychiatry clinics must be opened in the short term in all public hospitals which provide training, at least in one of the public hospitals in provinces and all districts with a population over 100 thousand. At least one of the state hospitals in each provincial district of densely populated cities should have a psychiatry clinic.

In the long term psychiatry clinics should be put into service in all state hospitals with a bed capacity over 100 throughout the country. Psychiatry clinics should be opened in all training and regional hospitals and in hospitals with more than 100 beds if nursing services of institutions such as SSK will continue in the same way.

Private psychiatry hospitals should be encouraged. Regulations exerting obstacles before the introduction of psychiatry clinics in both private hospitals and institutional hospitals such as SSK should be reviewed to be based on facilitating elements. Foundation of small units for bedded treatment of slight psychiatric cases should be encouraged in private hospitals.

A sound cooperation network should be established among MoH, university and other institutional clinics. The cooperation should include such issues as personnel appointment, supervision, patient transfer system, training and work planning. Institutions without a psychiatrist, in particular, should be encouraged with persuasive measures (additional premiums) to be supported by other facilities. The inter-clinical cooperation and assignments should be conducted by the Local Psychiatry Council in each province.

Except for the funds allocated from the general budgets, fees charged from individuals and institutions in turn for the services provided by MoH and University hospitals constitute Revolving Fund revenues. Other institutions (SSK, TSK) mostly operate through allocations from the general budget. The budgetary share of mental health services should be increased. Periodical notification of public hospital directors by higher bodies concerning the importance and supporting of psychiatric services is deemed as necessary. Employees’ premium from revolving funds should be promoted for mental health professionals via improvements in quality and quantity.

**3. Psychiatric Specialization Hospitals:**

In turkey there are 1 SSK and 5 MoH Psychiatric Specialization hospitals, one of which is training hospital. Bakirköy Psychiatry and
Neurology Hospital is a facility which provides specialization training and services in the field of neurology and neurochirurgery as well as psychiatry. Each clinic should employ a chief, a chief assistant and specialists together with different numbers of assistants and other staff. AMATEM, a prominent department of the hospital, provides treatment for alcohol and drug abuse and comprises one of the biggest forensic units in Turkey. Other regional hospitals (Adana, Elazığ, Samsun, Manisa) and the SSK hospital in Erenköy have lower bed capacities and only psychiatrists working.

Although MoH hospitals are envisaged to care for patients from certain provinces, patients from all regions are accepted in practice. Specialization hospitals have certain criteria about patient acceptance and do not provide service for all patients. Although the foundation of centres similar to AMATEM in Bakırköy hospital, which are specialized in treatment of alcohol and drug addiction in other regional hospitals was initiated, they have not yet reached the desired level of functioning. In addition, regional hospitals have specific clinics for observation, treatment and protection of forensic cases. However, these clinics do not comply with standards in terms of bed capacity and security. The forensic psychiatry clinics within these hospitals should be equipped as "high security units". A major portion of the bed capacity of regional hospitals in general is occupied by chronic patients whose therapies are completed but who are needed to be kept in hospital since they are not subject to a suitable social support system. Some of these patients have been staying in hospital for 30-40 years, and the hospital administration is troubled with the inability of sending out the patient. While the financing and patient profiles of the referred hospitals are similar to other public hospitals, patients from a lower socio-economic level constitute the majority, which yields more significant financial problems.

**Expectations and Suggestions**

The insufficiency of the number and bed capacity of specialization hospitals indicates that a non-institutionalization policy of some kind as followed in other countries is not necessary. Following are the necessary actions:

- Transfer of chronic, resistant patients with a high level of disability, who are kept in the said hospitals, to the rehabilitation facilities to be established;
- Restructuring of hospitals as units specialized in specific complications and treatments;
- High security units with appropriate structural arrangements and sufficient number of specialized personnel, which are founded for the treatment of alcohol and drug addiction, forensic cases and dangerous patients, in particular;
- These hospitals should work in integration with community-based psychiatric services. A small number of new specialization hospitals with a bed capacity of 500 maximum, which may be established in the demanding parts of the country.

Patients sent from primary facilities and public hospitals will be preferred in entry to these hospitals. Conditions and procedures of patient transfer should be stipulated by well-defined directives. Required specialized staff should be employed for patients whose therapy is completed but who are needed to be monitored within the society. In addition, those patients should be put in close cooperation with the facility and personnel that are responsible for their local follow-up and treatment.

**4. Nursing and Rehabilitation Practices and Facilities**

In Turkey there are not special centres for chronic patients who need long-term treatment and whose treatment are impossible. The majority of these patients are kept in regional hospitals, whose main function is short-term treatment and they paralyse the working of these facilities.

In order to provide these patients with nursing and rehabilitation services, high- and small-capacity facilities should be opened in some regions of the country and in each urban centre, respectively. These facilities should employ sufficient number of psychiatrists, psychologists, social workers, occupational therapists, nurses and other staff so as to enable the continuation of therapies.

In order to prevent facilities from turning into "stock facilities", i.e. from being an extension of old practices, they should make to contain sufficient number of workshops and recreation areas, and their prospective patients must be transferred pursuant to a medical board report to be obtained from curative institutions. Appropriate development and inspection systems should also be created for the sake of effective working in these rehabilitation facilities.
Small-scale nursing and rehabilitation facilities to be founded in urban centres should be affiliated to Municipalities. The Law on Municipalities allows such practice.

Mentally retarded individuals are known to be in great number in our country; their exact number is not known, though. Currently, nursing and rehabilitation of individuals with acute mental retardation, especially, is burdened on by families, apart from a few facilities. Special centres should immediately be established with sufficient equipment and personnel to deal with heavy mental retardation cases in several areas. Educational and training institutions should be opened and special facilities should be encouraged for less significant mental retardations.

Specialized institutions should be founded for the rehabilitation of special cases such as Post-Traumatic Distress. Through a structuring to organize the services before, during and after disasters should the possible mental problems following possible disasters be mitigated.

The Law no 2022 grants limitedly free health care and very low wages to patients whose ailment or disability is proved by a hospital board report. If the conditions of healthiness and wage levels are promoted, many families may volunteer to care for their patients at home.

Volatile Substance Abuse constitutes a recently prominent psychiatric problem of the youth. Satisfactorily equipped and staffed units should urgently be established under the authority of MoH and/or ŞÇEK for these young people.

OTHER POINTS ABOUT FINANCING
A policy change in the direction of local administrations’ inclusion (municipalities and local governments) in the institutional process is required.

Involvement of public insurance organizations in the institutional process in the field of mental health may be put on the agenda as part of a program presenting financial remedies (e.g. SSK). Efforts should be spared on arrangements of private health insurances to include treatment and rehabilitation of psychiatric problems.

POLICY
Each policy should have a fundamental idea and aim. The fundamental aim of mental health policy should be the protection of mental health in good condition and the availability of appropriate and quality health services for psychiatric patients in the simplest way. High quality services should be available at a payable amount. Citizens who cannot afford the cost of services should be supported by a suitable social security system. All facilities should be available for both treatment and rehabilitation of disability. Precautions should be taken so that temporary administrative changes will not distort continuation. Policy planning and program applications should contain internally coherent inspection and feedback mechanisms and objective correction principles. Targets, financial resources and expenses related to overall policy plans and programs and their stages should be defined beforehand. Inspectional order should be ready during application.

Planned arrangements should be tested within a pilot study. Public information and awareness should be provided with reference to mental health via all kinds of educational channels. An awareness to prevent the stigmatization of psychiatric patients should be the focus. Programs should be prepared and implemented to prevent suicides. Through an arrangement, psychiatric patients should be enabled to continue their treatment and monitoring within the community in accordance with the conditions of the country, except periods of acute attack. Non-governmental organizations and professional organizations should be given an active role in rehabilitation and common mental health. MoH should undertake the coordination of services rendered by wide range of structures from policy determination to implementation. Views and Notes About the Draft Report on Development of National Psychiatry.
2. CHILD AND ADOLESCENT MENTAL HEALTH ASSOCIATION

This report is prepared for the development of Child and Adolescent Mental Health Policy within the project of NMHP Development carried on by the Ministry of Health and the Harvard Group. Children and adolescents need to be considered separately in some areas in policy studies. About 40 percent of Turkey’s population are children and adolescents in the 0-18 age group. Childhood (0 to11) and adolescence (12 to18) have several subperiods (ages 0-1, 2-3, 4-6, 7-11 and 12-18); their individual characteristics and health needs differ from each other and from adulthood. The policy programs for the needs of this group, which is almost half of total population, have to be considered separately from adult mental health programs.

The framework of a policy on the Child and Adolescent Mental Health should be comprehensive and sustainable. Necessities should be identified, protective and preventive programs should be focused on, the issue of equality should be paid attention in the distribution of services and priorities should be identified in utilization of financial resources.

The objective of the policy is to sustain the mental health services by integrating them into the primary health care objectives, to increase healthy development in terms of mental health, to develop systems for advocating mental health, to determine the risk factors threatening mental health and to take preventive and protective measures, design appropriate systems for the diagnosis and treatment of diseases.

The Child and Adolescent Mental Health Services should be established as a separate unit under the Ministry of Health within the organizational structure of the government and the individuals to provide counselling to this unit should be identified.

Firstly, the requirements should be determined for the organization of service provision. Then the type and level of the positions and service units and the number of staff required for meeting these requirements should be estimated. The effective management and supervision of the services provided is necessary for achieving positive results. It is necessary to attach the due importance to the mental health within medical training and to the development of continuous training programs.

A good policy program should also set forward some certain principles with regards financing and the use of available resources. It is a well known fact all over the world that positive results depend on the effective use of the resource rather than the amount of the resource.

THE FRAMEWORK OF MENTAL HEALTH POLICY FOR CHILDREN AND ADOLESCENTS

Policy development needs to be based on the true conditions prevailing in Turkey. For this purpose, data obtained from previous scientific research should be taken into account and evaluated. This is the only way to recognise the facts pertaining to the country, to establish needs and so develop policies to satisfy those needs. Results of programs put into effect in countries with similar conditions to ours should also be studied and evaluated. In this context, the main points for a policy program based on data can be summarized as follows:

- When mental health services are not provided in full, the expenditure for treatment and care that will be needed in the future is higher. For that reason the policies and programs developed in the field of mental health should be extensive and capable of ensuring the continuity of mental health services.
- The evidences show that mental health problems emerging in adulthood have early signs in childhood. Therefore early diagnosis, prevention and early intervention programs are very important for children and adolescents.
- Another point derived from research projects is the necessity to deal with children when the mother is psychologically disturbed, especially depressed. This will bring relief to the mother, as well as diminish the risk of the development of childhood psychological problems. It should not be neglected that child and adolescent mental health is interwoven with adult mental health.
Data derived from research show that psychological problems observed in children and adolescents have some specific and differentiating characteristics from those experienced by adults, needing specially designed mental health programs.

In the absence of a well designed policy there is danger of wasting resources by spending on fragmentary and ineffectual programs, leading to inability to develop an effective system.

The Turkish people in general have only lately become conscious of the importance of mental health and especially of child and adolescent mental health; there is great need to provide and present correct information to the public, the families and the educational staff.

The concept of “health” is understood in our country, including those employed in health services, only in the framework of treatment of illnesses, in fact it is very important to make groups providing health services such as doctors, psychologists and social service specialists, as well as the general public realize that health, including mental health, is primarily the continuation of the state of “being healthy”.

In relation to above, the curriculum of medical schools should be revised to give more emphasis on mental health and illness, on protection and prevention. When protection and prevention is the subject, the primary care physicians also need to be trained about mental health of children and adolescents.

There are many people in the civil population of Turkey who are eager and willing to be of service to children and young people. In policy making, apart from treatment, it is important to include this voluntary human resource in preparing supportive programs for mental health.

Turkey is understaffed in the field of mental health. While working to increase the staff, plans should also be developed to maximize the efficiency of the presently available manpower.

As noted above, the development of efficient policies depend on having more data on the present situation and the assessment of services; more research is needed to provide this data.

The mental health programs for children and adolescents must have a vision in accordance with the socio-cultural and economic conditions of the country.

Although various studies in the field of mental health are presently being continued in several regions of our country, they are entirely unorganized. There is need for coordination and integration of the studies.

II. THE BASIC AIMS AND THE VISION OF MENTAL HEALTH POLICY FOR CHILDREN AND ADOLESCENTS

1. Organization and Finance
   - Providing evidence-based, high quality and continuous services, on the rights of children, on special needs of children, adolescents and their families, and in accordance with ethical principles.
   - Integration of mental health services into the primary care services.
   - Prevention of patient overload in the big city and university hospitals by establishing efficient chain of patient transfer between the primary, secondary and tertiary health services.
   - Collaboration among various institutions and forming multidisciplinary teams.
   - Ensuring that psychological services are performed by appropriately trained people.
   - Providing mental health services in all contexts such as the home, the workplace, the school, etc.
   - Establishing priorities for the well planned use of financial resources, and, equal distribution of services as much as possible
   - Allocating resources for preventive services and services supporting research and healthy development.
   - Supervision and evaluation of services.

2. Promoting psychologically healthy development
   - Bringing up the children as individuals valuing themselves and others will provide significant gains in their future life both for themselves and the society. For this reason, informing the public and providing consultancy about the criteria of healthiness (commitment, self confidence, personal autonomy) as of early infancy is necessary.
   - Providing training to the families and especially to the mothers is important. Mental health of babies and children cannot
be considered separately from the mental health of their mothers, for this reason integration with the preventive mental health programs for mothers should also be provided.

3. Protecting health
- Mental health policy should not be limited to the provision of treatment services, researches and works towards increasing the factors enabling better mental health and resilience should be paid attention.
- Moreover the support systems in the society (for example sport halls) should be examined and their number should be increased.

4. Diagnosis
- Adopting the developmental approach in diagnosis and treatment
- Taking into consideration the culturally specific characteristics of children and adolescents in our country, establishing their profile of normal development and building up the most relevant assessment tools for development and diagnosis

5. Treatment
a) In Primary care
- Identifying the groups under risk and providing them with protective and preventive programs, thereby decreasing the rate of developmental and psychological disfunctions in children and adolescents
- Diminishing the social risk factors for children and adolescents.

b) In Secondary care
- Ensuring that treatment is carried out correctly and appropriately, avoiding unnecessary treatment expenditures.

III. ORGANIZATIONAL STRUCTURING

In any field, organization is the prerequisite for the ability to generate policies. The evaluation of the field of mental health in our country reveals obvious deficiencies. In government administration, the only department representing mental health is the Department of Mental Health, under the General Department of Basic Health Services in the Ministry of Health.

For organizational structuring, the first priority is to assess this department and reorganize it with recruiting a multidisciplinary staff of psychiatrists, psychologists and social workers, able to have a professional attitude to mental health policies and willing to work effectively. There is need to create a separate unit for Child and Adolescent Mental health under the Department of Mental health. At the beginning, the administration of this unit can be assigned to an experienced specialist from a university with an appropriate approach to policy aims, as it is the case in many other Departments of the Ministry of Health. Taking into consideration the cultural structure of our country, this person should be a child and adolescent psychiatry specialist.

Up to the present, the field of Child and Adolescent Mental health has not been represented in the Ministry of Health as a distinct field. In our country the services in this field are given by the "Society for the Mental Health of Children and Adolescents" which is a nongovernmental organization. The activities of this non-governmental organization, which has been working actively since 1990 and has been the professional agency for the specialists of child and adolescent mental health and disorders in Turkey, covers protective and preventive mental health studies, education of parents and teachers, giving postgraduate training on child and adolescent mental health to medical doctors employed in the primary and secondary care settings, applying crisis intervention programs designed for schools, acting as consultant for the guidance centers of schools, juvenile courts of law, TRT and other media institutions, the Ministries of Health and Education; working to heighten public awareness by organizing various panels and lectures on such issues as violence, child abuse, and incorrect therapy applications.
The Turkish Medical Association, as a representative of the field of medicine, is represented in the Coordination Board of the European Union of Medical Specialists and in the process of our Country’s admission into the European Union, this Association works for improving the quality of the specialisation curriculum for “Child and Adolescent Psychiatry”, for the achievement of standardisation (the National Board of Qualification has been established and qualification examinations are being planned). Taking into account fourteen years of experience and service, the Society should be assigned as consultant to the Department of Child and Adolescent Mental health which needs to be established in the Ministry of Health.

The establishment of a Coordination Committee for the Department of Child and Adolescent Health in the Ministry will also be helpful. Such a board will support the work of department staff and will also facilitate receiving proposals from other specialists. Members of the Coordination Board can serve for fixed periods (such as four years). The Committee should include child and adolescent psychiatrists from the universities, psychologists experienced in field studies (preferably a developmental psychologist and a clinical psychologist), specialists in the fields of public health, social services, education, psychological consultation and guidance, a lawyer experienced in the field of children’s rights and juvenile courts of law, also representatives from the Health Department of the Ministry of Education, from the Department of Juvenile Delinquents of the Ministry of Justice, and, from the Institution for Social Services and Child Protection.

There are also Youth Centers affiliated with the Department of Mother and Child Care of the Ministry of Health, a project carried on with the participation of specialists from the Society for Child and Adolescent Mental health and supported by UNICEF. These Centers are located near the Clinics of Mother and Child Care in a separate building; the staff is consisted of a multidisciplinary team which can respond to any health problem at primary health care level and which is equipped with the support of university consultants and in-service and continuous trainings and can provide high quality services. The Unit for Child and Adolescent Mental health should also collaborate with these Centers.

This central organization has to be duplicated in a modified form in the provinces. A mental health unit should definitely be formed under all Provincial Health Directorates and there should also be a special staff employed for child and adolescent mental health in the large provinces. In smaller provinces, the staff of the Mental health unit should be given adequate postgraduate training on child and adolescent mental health, to enable them to function in this field also.

IV. ORGANIZATION OF THE SERVICES

There are two vital points to be noted on planning services: All kinds of activites and services for children should be within the framework of principles outlined in the United Nations agreement on the Rights of Children which our country is also a party. We mentioned before that children and adolescents are a continually developing group; as each subgroup of ages (0-1, 2-3, 4-6, 7-11, 12-21) have their own developmental characteristics and individual needs, the services have to be prepared from a developmental approach.

A. Factors causing difficulties for services

In developing countries there are socio-economic characteristics which create difficulties for the application of mental health services, and especially for services designed for children and adolescents. To improve the effectiveness of services it is necessary to be conscious of the existence of such factors, to identify them and take necessary measures.

Since economic difficulties also restrict the resources for health services, the available resources are usually devoted to fight potential life threatening and acute conditions such as infectious diseases and their treatment. Moreover, since the administrators and the public usually do not have a conscious attitude to health, preventive services are either disregarded, or preventive measures for mental health have to take a backplace when infectious diseases have the priority. Whereas, a much larger health expenditure is needed in later years to treat psychological illnesses, arising from psychological risk factors that could have been dealt with and
prevented in early ages. For this reason, the improvement of mental health services depend on the rational use of resources, rather than on the development level or wealth of the country.

Another point is the priority given to adult mental health in psychological services, or failure to develop programs specified for children and adolescents, because children are regarded as minor models of adults.

Because the staff of health services are not sufficiently conscious of the importance of mental health in children and adolescents and because they have insufficient medical training in this field, the families are not oriented at the appropriate time. Cases which could be treated with early intervention (such as autism) are directed to mental health service only after the condition becomes permanent or chronic. In most regions there are no mental health services; the families have to go very long distances to reach the available service. This means facing with some other difficulties such as tight financial resources, lack of time, problems in taking leave from work).

Another point is the stigmatising of people with psychological disorders; although, it is not as much as it used to be, it is still a problem in our country. On the other hand, with the help of the media, an increasing number of families have become conscious of the importance of psychological problems of children and look for services.

B. Planning for services

1-Establishing needs

The policies to be implemented should primarily answer the health needs of the public. For this reason it is important to make a good assessment of prevalent conditions and needs as a basis for planning the services.

As in all public health matters, epidemiological studies are very important for the mental health of children and adolescents. The epidemiological studies in this field are limited in Turkey. Some measurements for children and adolescents were used in a study conducted by the Ministry of Health, but it would be better if this study was done in more detail taking into account regional characteristics. In most studies made in our country the children and adolescents are assessed by the tools developed in other countries. Some of these have been adapted, some have not. In establishing needs it is important to know what is “normal” for children and adolescents in this culture and measure the development with the norms of this population; therefore normative studies should be planned and the ongoing ones supported.

2-Planning the Staff

At present the psychological services for children and adolescents are offered by child and adolescent psychiatrists, and in a few clinics by clinical psychologists specialised in this field. Specializations in the fields of educational psychology, social services and guidance has not yet been able to reach effective functional and numerical levels compared to Western countries. The number of the child psychiatrists and psychologists trained in this field are much lower than is needed. As of 2003, the total number of child and adolescent health specialists, including those in training is 75. The ratio of specialists to the population under the age of 20 is 5 to 100,000 in the West; this ratio is only 0.2 per 100,000 in our country (child psychiatrist rate is 1 to 500,000). It is urgently needed to increase the available government job placements for child and adolescent psychiatrist. For this objective the Ministry of Health should use all its resources, if necessary getting into touch with the Ministry of Finance to increase the number of posts for specialist training. There are three child psychiatry clinics affiliated with Ministry of Health. These clinics are located in the three largest provinces, within state hospitals under the control of the Ministry of Health. However, these hospitals are unable to offer specialisation training for the reason that they do not have a training child psychiatrist. Providing necessary chief staff to these training hospitals will also result in an increase in the training of specialists. However, even if the specialization in this area is promoted, it is difficult to reach the sufficient number of specialists required in the near future. Thus, it will be important to increase
the number of clinical psychologists, developmental psychologists, educational psychologists, psychiatric nurses and social workers, and to provide these professional groups with adequate training programs (injob training, certificate programs or master’s degree programs).

3-Planning of Service Units

Of the total number of the child and adolescent psychiatrists, 80 percent are occupied in three largest cities, they are employed in 19 university (16) and state hospital clinics (3). Of the 19 clinics, 13 are in the three major provinces, Ankara, Istanbul and Izmir; the remaining 6 are affiliated with universities in Kocaeli, Bursa, Trabzon, Antalya, Adana and Gaziantep. There are also 2 more units for adolescent mental health in Ankara located in the adult psychiatric clinics, and 1 adolescent mental health unit in Istanbul located in the Institute for Child Health. Beyond these, there is a minimal number (3) of self employed child psychiatrists.

The major reason why medical specialists are concentrated in large cities is the absence of available posts in state hospitals elsewhere. In this context, it will be helpful to assign one child psychiatrist, retrievable in future, to regional state hospitals for each 500,000 population between the ages of 1-21.

Because presently there isn’t sufficient number of qualified staff in this area, possibly the most economic and efficient solution would be the integration and planning of mental health services into the primary care services. Our country has the Health Centers system, one for every 10,000 population which has been continuing to serve efficiently and functionally both for preventive and for treatment purposes for many years. Other first step institutions, the dispensaries (attached to Mother and Child Care Organization and the Social Security Institute), medical doctors working for schools, business and industry, and dispensaries of local governments can be included into the mental health services. For primary care services, it would be helpful to work in collaboration with the Youth Centers established by the General Directorate of Mother and Child Care. If necessary, the child and adolescent mental health services can be carried on integrated into the Mother and Child Care centers. The staff in these centers consist of a paediatrician a psychologist, two general practitioners and a nurse who have undergone a training programs in the field of child and adolescent mental health. The staff of the Health Centers is formed of a general practitioner, nurse, midwife and health officer, who can also be given in job training to prepare them for the application of certain mental health programs.

In the child psychiatry clinics which form the secondary care system, it is absolutely necessary to form a multidisciplinary team; apart from the child psychiatrist, it should include at least one clinical psychologist and a social worker.

There is only one center with an inpatient unit. In the rest of the clinics, when it is necessary to hospitalize patients they are placed either in the adult or the paediatric inpatient units. Both placements create difficulties in the process of treatment. Each region needs to have an separate inpatient unit for adolescents (because of their developmental characteristics and of stigmatization) apart from psychological hospitals for the adults. These units can be placed within general hospitals. The multidisciplinary staff of these units should again include a child psychiatrist, a clinical psychologist, psychiatric nurses and a social worker.

Another important service in child and adolescent mental health is given by the special education centers. However, no standardization has been achieved in the service quality of such institutions, and despite the payments given by state many of them fail to provide the expected quality in services. This sector is administratively under jurisdiction of the Ministry of Education; but in fact they provide a kind of health service to children with developmental problems or with some serious psychiatric disorders such as autism. It is important that The Ministry of Health should get the cooperation of the Ministry of Education to ensure the quality of special education services and these centers should be supervised by child mental health professionals.

4- Effective administration of services

Effective use of staff: On each step, the job description and job range of the staff giving child and adolescent mental health services
should be clearly defined; the staff should not be asked to work beyond their professionally defined duties.

Supervision of the service: There should be clear instructions about the application of the preventive, protective and treatment services; how the services are given should be closely supervised, the effectiveness of results should be evaluated.

Research: Research should be a part of every step of the mental health services; the nature and quality of the research should be adequate to contribute to new policies and programs designed for the future. The tranformation of research results into new application should be considered part of the services and should be supervised. The research in primary care should especially aim to identify the protective and risk factors and the groups under risk. The preventive and protective mental health programs should be designed with those risk groups in mind, and, studies should be done to increase and support protective factors. It is imperative that research should honor the ethical principles related to children and adolescents.

Strengthening Referral Chain: Transfer of patients from primary care to the secondary should be well planned so that services given are not duplicated; this will ensure considerable savings in manpower and resources.

Establishing interdisciplinary links: The child and adolescent mental health teams should definitely establish relations with paeditrians, with adult psychiatrists, and with other specialist groups that serve children and adolescents, such as orthopaedists, dermatologists, physical therapists, gynaecologists, urologists and dentists. They should also establish cooperation with juvenile courts of justice, half-way houses for delinquents, orphanages and regional schools.

Personnel and patient satisfaction about the services: the services should be organized in a way to increase satisfaction and team leaders should be trained about total quality study if necessary.

V. IMPROVING THE QUALITY OF SERVICES

In planning services, it is important to keep in mind that children are not minature adults; they have special needs depending on their age group and their specific problems.

An important prerequisite of improving the quality of services is to get qualified staff. It is a 'must' to have professional education above B.A. level in order to work with children and adolescents.

The staff employed in the primary care should definitely be given continuous education programs designed for the protection of child and adolescent mental health. For this purpose, it is possible receive support from universities and the Turkish Medical Association. The continuous education programs for staff employed at secondary and tertiary care should also be increased. For medical doctors, child and adolescent mental subjects should take its place in the undergraduate curriculum leading to M.D. degree and the child psychiatry specialization training should be standardized. Works towards these two ends have been initiated and are continuing. Courses on child and adolescent mental health and disorders have been incorporated into the National Core Curriculum program being prepared for undergraduate training. For non-medical staff, it is necessary to increase the number of other training programs at various levels such as certificates, M.A. or Ph.D. It should be a requirement for nonmedical staff employed in the secondary and tertiary care to have MA degree.

Another important point is related to the way in which the services are offered. The services should be organised to increase patient satisfaction. This would prevent the patient from going from doctor to doctor and the resulting duplication of services given to the same patient.

The transfer of patients between different steps of care is another point which should be carefully organized and supervised. For sustained care, it is important to establish the links between institutional and public based services. The patients to be treated in
The primary care step should be identified, the related treatment algorithms set up, the conditions under which patients have to be transferred to hospitals should be established, the patients should be given a written statement on the reasons why they are directed, and, if possible, clear information on which hospital they should apply to. When the patient leaves the hospital to return to his own region, information on what treatment was given and the medical opinion should be given in written form, to be handed to the primary care medical unit.

The services should be continually assessed, evaluated and there should be enough flexibility to make necessary adjustments; in fact, effective administration of services is another factor leading to sustained quality.

VI. FINANCE

A. Obtaining Funds

The proposed restructuring of child and adolescent mental health services need to have sustained financement. Other sources of funds beside the Ministry of Health should be searched. For example there are quite a number of health insurance companies, but none of them include mental health expenses of children and adolescents in their programs. A possible source may be obtained by trying for the inclusion of mental health services into health insurance schemes for the 0-21 age group. However, it is also necessary to work for those families without any social security. It must be remembered that the future of this country depends on a young generation brought up in good mental health. Another possible source is to develop projects on services to be given and present them to international institutions that can provide funds (such as UNICEF, UNFPA, NIMH and the development programs of the European Union). Also it should be borne in mind that support can be received from voluntary civil organizations. In our country there are more than 20 voluntary civil organizations which serve to children and adolescents. Achieving coordination between them will help integrate their work and add to available financial resources and also manpower.

B. Organizing the Use of Resources:

How the funds are used is possibly a more important issue than the amount of funds available. For effective use, the first objective should be to establish priorities. It will be wiser to give priority to subjects that will prevent much larger expenditures in the future, rather than disperse funds on seemingly low cost, diverse projects. For example, programs designed to protect mental health and prevent psychological illnesses will result in considerable savings on treatment expenditures, for this reason such programs should have priority in allocation of funds.

Another important point is to organize funds so that ongoing programs can be sustained. In planning how the funds will be spent, needs that arise from the stage of development have to be taken into account. The programs proposed by the funding institution may not always be the ones that require priority in the conditions of the country; in such cases, discussions between two sides would lead to agreement on adjustments for the most effective use of funds. It is also necessary to make a fair allocation of funds among regions with a view to their needs.

In treatment services, financial resources can be used more economically by the wider application of treatment algorithms to prevent unnecessary use of medication, and, by developing focused treatment plans. Also, promoting therapy approaches other than the drugs (psychotherapy, family therapy, play therapy, behavioral therapies) and increasing the number of sufficiently trained staff will be important for saving resources in the long run.

VII. THE EXTENT OF SERVICES

1. Providing the conditions for growing up in good mental health

Being psychologically healthy means, first of all, valuing one's self as an individual and also valuing others. Bearing in mind that
children and adolescents constitute the future of the country, bringing up healthy children is expected to be the foremost state policy.

The basis of mental health in children is formed from babyhood, through the ties that the mother establishes with her child. One of the first steps for bringing up psychologically healthy individuals is to make mothers and mothers to be more conscious of this fact. For this purpose, there should be better educational programs designed for mothers and they have to be made widely available.

It is important that the public in general be also informed about the mental health of children and adolescents part from mothers. Educational programs can be given through the media; also parent education programs should be made available for parents who want to focus on bringing up healthy children.

Another indication of mental health is the personal adaptation skills. Such skills should be taught to children in the process of growing up. The family and the school are both responsible for this. The schools have to apply programs that help children to acquire social and adaptational skills. In this context, the “Life Skills Training” program proposed by WHO can be a model to be used. This program has been integrated into school curricula of many developing countries and focuses on decision making and problem solving, creative and critical thought processes, communication skills, raising consciousness, and on emotional and stress management. The aim of this application is to support psychological well being, to heighten the ability of children to take more responsibility for their own lives and make them feel more effective.

2. Protection of mental health

An important subject from the point of view of mental health policy is protection of psychological well being, and, measures to be taken against its disturbance. Such preventive measures appear to require a lot of effort, but it is a minor investment compared to the expense of treatment which might be needed in future. In every community there is stress, but there are also some factors which help psychological well being against stress. Programs should be planned to research, identify, support and increase resilience factors that support and protect mental health in both individual and community levels. Some of the efforts may be to give more support to the family, to make the social support systems more effective and to develop measures to control the rate of social change.

Along with protective factors, there are also risk factors which weaken some individuals against psychological illnesses. In order to prevent the psychologically healthy individuals from getting mental disorders it is very important to do research to identify such risk factors and develop policies and programs to eliminate them.

The problem of stigmatization is related to mental health and illness in almost all communities. The pressure generated by the fear of being labeled prevents the psychologically disturbed person from looking for treatment; it is also an impediment against sustained well being of individuals, in particular adolescents, who have been treated and regained their mental health. Developing programs to fight stigmatization will have an important part in policies for the mental health of children and adolescents.

3. Diagnosis

The diagnostic criteria relevant for children and adolescents are still being discussed all over the world. Most of the time mental symptoms of children are like the aberrations of the normal developmental characteristics. Cultural factors also play a role in the variations observed in different disorders. In order to understand the nature of the disorders better and to achieve clearer definitions, psychological illnesses have to be evaluated with a developmental approach. For this purpose, a profile of normal development that takes into account culturally defined characteristics has to be built up for the children and adolescents of our country, and assessment tools suitable for development and diagnosis have to be developed. This is another important point which needs to be included in the planning of mental health services. In addition, the culturally defined characteristics of various psychiatric disorders have to be identified and the diagnostic variations should be made clear.
4. Treatment

a. In primary care: The individuals and groups under risk of experiencing psychiatric disorders can be identified. By developing protective and supportive programs for children and adolescents, the rates of psychiatric disorders can be decreased. In addition, treatment algorithms should be developed for psychological problems of childhood and adolescence.

b. In secondary care: The patients should be assessed, diagnosed and treated by the developmental approach. Also in this step, construction of treatment algorithms and development of strategies for focused treatment will save time and resources. An effective supervision of the use of medication, prohibiting the use of psychotropic medicines unapproved for children, and supervision of pharmaceutical firms on this subject may help prevent unsuitable and unnecessary therapies.

There is also a need for increased capacity for clinical research. However, such studies should deal with the problems and needs of the country rather than duplicating studies already done in western countries.

5. Rehabilitation

Children with conditions such as mental retardation and autism have to be given special education along with medication. There is great need for special education centers to be opened by the state. It is also imperative that psychologically disturbed children be protected from all kinds of abuse.

Apart from these, children and adolescent groups with some specific needs have to get special attention. The foremost of such groups is homeless children, alcohol and drug users, the disabled, the juvenile delinquents, the sexually and physically abused, those traumatised by calamities such as earthquakes, and, adolescents with chronic physical disorders. The policy programs for mental health should cover developing special mental health programs for such groups.

6. Building support systems and advocacy

It might not be enough to leave mental health only to the responsibility of the Ministries; there should also be defensive systems to support the policies and programs they have developed. In order to build up defense mechanisms in communities, it might be useful to include NGO groups such as the "Society for the Schizophrenics' Families", "Society for Autistic Children", "Society for Hyperactive and Attention Deficient Children and their Parents" to participate in program development. It is possible that other voluntary organizations can also contribute to building defense mechanisms.

3. SOCIAL WORKERS ASSOCIATION

Regarding National Mental Health Policy the following points have been commonly agreed in the meetings:

- The mental health services should be included in basic health services.
- Clear, measurable, achievable, realistic and contemporary targets should be determined.
- Mental health care should be considered as not only a clinical subject but also a subject that concerns the whole society. Therefore, preventive-remedial services should be focused on.
- A community based and preventive approach should be adopted.
- The quantity and quality of mental health professionals (psychiatrists, psychologists, social service experts, nurses, midwives, etc) should be improved.
• It should be considered that basic professional personnel (i.e. psychologists and social workers) have not got a professional law yet. Therefore, a professional law should be laid down and
  o professional capacity and competence,
  o professional supervision,
  o professional control,
  o professional roles and functions
  o necessity of having legal validity
  of professionals should be recognized.
• The related sectors (health, education, social service, justice, etc.) should determine standards that conform to the content and quality of the services and interrelation of those sectors should be defined.
• Necessary measures should be taken regarding the insufficient number of social service experts in the field of mental health (the number of social service experts in the field of mental health was 20 in 2000).
• A multi-disciplined and multi-sectored approach should be developed.
• The training process of the personnel before and after graduation, should be reconstructed and in-service training should be sustained. In addition, the institutions and organizations that provide psychological and social training should add psycho-social subjects to their programs.
• The research and educational activities in this field should be supported.
• The collaboration among Non-Governmental Organizations, Local Administrations and concerned public institutions and foundations should be increased.
• There should be a coordination between professional rehabilitation services and mental health services.
• There should be a collaboration with Social Services Child Protection Institution for the planning and rendering of the services to the risk groups.
• The professionals should collaborate with families.
• A “road map” for legal infrastructures, organizational and personnel schemas, short/mid/long-term targets, and for organizational and controlling mechanisms should be formed.
• The financial burden of those who are not covered by a social security, and in need of mental health care services should be shared by the society.
• The content of “development and education aid” given by Institution of Social Insurance, and Department of Retired should be expanded and should include those who are not covered by a social insurance and in need of mental health care. The law numbered 2022 should be revised.
• The rehabilitation standards should be revised.
• As the burden of those who need mental health care is on the patient himself, his family, concerned social security institutions and the personnel, necessary precautions to increase the satisfaction of all should be taken.
• Rehabilitation guides regarding the disability groups should be prepared.
• Necessary precautions should be taken in order to prevent the imbalance that may occur due to the change in administration.
• Programs regarding rehabilitation, preventing disability, enabling skill acquisition, etc should be determined and related institutions should be established.
• Within the framework of professional rehabilitation, integration with the society should be obtained.
• The mental health service should conform to the education level of the consumer and should be in favor of the consumer.
• Human rights and privileges should be taken into consideration and legal concerns should be improved.
• Legal sanctions against “discrimination”, “rejection”, and “stigmatization” should be formed.
• Non-governmental organizations, and professional organizations should actively take part especially in the field of rehabilitation and community mental health services.
• Individuals should be provided with the sufficient level of social functions, the productivity and quality of life of individuals should be improved in order to lessen the burden on families.
• The services to be given by the concerned institutions in case of emergency (earthquakes, natural disasters, wars, immigrations, etc) should be defined and expert teams should be formed.
• Collaboration among institutions should be improved.
• Technological webs should be properly used.
• The public awareness should be an ultimate target. There should be a wide collaboration with media.
• The quality should be improved.
• Argumentative service models should be developed. Common approaches of the professionals should be determined.
• The helping understanding of Non-Governmental Organizations and Social Services should be sustained.
• The exhaustion, attrition of the personnel working in the field should be taken into consideration.
• The exhaustion, attrition, negligence, and exploitation of children under the protection of the institution should be taken into consideration.
• Public institutions and organizations should revise their in-service training programs.
• Due to the insufficiency of programs against crisis, the following should be dealt with in detail:
  o war versus child, adult, woman
  o violence versus child, adult, woman
  o wrong applications in education system versus child and adult
  o Estrangement in juveniles
  o Children, juveniles, disabled, and the old under the care of an institution
  o Adult suicides
• A financial and human source for the establishment of Mental Health of Children and Adults Department should be formed.
• Professional personnel should be directed to work in their professional field.
• High risk groups should be defined and services to be rendered to those groups should be planned.
• The groups under high risk are as follows:
  o Those who attempted suicide
  o Street children
  o Alcohol and drug addicts
  o Those who have behavioral disorders
  o Those from lower socio-economic level
  o Working adults
  o The disabled
  o Children under the protection of the institute
  o Those who are traumatised or exploited
  o Women
  o The old
  o Those whose previous generations have mental disorders
  o Those who are chronically ill.
• The data collecting methods and information process centers should be improved.

SUGGESTIONS

• The law of Basic Health Services and the law of Mental Health should be passed. In the process of putting the law into practice the following should be taken into consideration:
  o Human rights and social justice principles
  o The rights of patients
  o Professional ethic values
  o The rights of professionals
• Regulations should be updated.
- The amendment in the law numbered 1219, dated 1928, on the Application of Medical Branches is important. The Ministry of Health has proposed a law within the EU adaptation process. This law aims at defining professions in the field of health, and determining responsibilities, duties and qualifications of the professionals. The difficulty in finding personnel in this field results in the necessity for the personnel to work at the highest level.
- The law of Social Services Child Protection Institution, numbered 2828
- The law numbered 2022

- Mental health should be considered within preventive-protective services
- The defensive and preventive services, rehabilitation, psycho-social support, treatment, guidance, and training services should be in coordination with other sectors.
- An integrated approach rather than a patient-based approach should be adopted.
- Precautions for increasing the quality and quantity of the professionals working in this field should be taken.
  - The number of departments giving social service education in the universities should be increased.
  - "Psychiatric social service" education program should be included in post-graduate programs.
- The required conditions for the improvement of the professionals’ satisfaction should be provided.
- The information systems should be improved in order to access data more easily.
- Cooperation between non-governmental organizations and volunteer individuals should be supported and public awareness should be created.

**CONCLUSION AND EVALUATION**

It is a known fact that there is an imbalance in income distribution in our country. For this reason, it is a necessity to include population groups such as children, the old, handicapped, women, family, etc. into the social security scheme. Those population groups should be supported by the states and their development, education, and health security should be sustained within the principle of Social State.

There should be a coordination between doctors, nurses, midwives, social service experts, and psychologists within the First Step Health Services and Social Workers for the Protection of Children for providing preventive/protective/defensive services. In this context, Family Courts, Children’s Courts and Law of bankruptcy should be considered.

It is also necessary to establish a single center under the name “National Mental Health Institute, Union or Agency etc.” in which targets, strategies, functions, research and measurements will be assessed and the binding legal framework will be identified with the participation of all sectors.

In recent days, the local administrations are planned to be given authorities. Therefore, it becomes necessary to decide what to expect from the localization of the services.

As conclusion, an approach that supports an integration and coordination of general health services and social service systems by focusing on the people consuming those services should be supported.
SERVICES FOR CHILDREN

According to the 2000 census the children between the ages of 0-18 constitute 38.3% of the whole population in Turkey. According to the data of 2003 by the State Statistics Institute there are almost 26 million children in the country. The ratio of the children who are vulnerable and are under nursing is 0.08 % (20,000). Poverty being an important factor in terms of the services that are provided for children, the children under the risk of social risks other than the poverty is also provided with services. The Institution of Social Services and Child Protection is responsible for these services as it is a coordinating body for the implementation of the Convention on the Rights of the Child in Turkey.

The concept of “vulnerable child” has been defined as follows in the paragraph b of the Article 3 of Law numbered 2828; “The child whose physical and moral development or personal security is at stake and

1- who is an orphan or has lost one of his/her parent,
2- whose both parents or one of them is not identified
3- who has been abandoned by his/her mother or father or both,
4- who is neglected by his/her mother or father and is untended and vulnerable to all kinds of social threats and bad habits such as prostitution, mendicancy, alcohol or drug abuse. ”

As can be clearly seen, though the vulnerability is greatly influenced by poverty, there can be some vulnerabilities other than the poverty.

The services for children can be listed under the following topics:

- Institutional care services,
- Protective family services,
- Child Adoption services,
- The family care services by means of aids in cash or in kind,
- The services that are provided via the child and adolescent centers,
- Care and rehabilitation services for the disabled children,
- Crèche and daytime dispensatory services.

The nursing houses and orphanages which set the basis for the institutional care have been defined in the paragraph e of the Article 3 of Law as follows: Nursing houses; “are the boarding social service institutions which are assigned and liable to ensure that the vulnerable children between the ages of 0-12 – for girls older than 12 when necessary- have a healthy physical, educational and psychosocial development, a healthy personality and good habits.” The orphanages “are the boarding social service institutions which are assigned and liable to protect and care for the vulnerable children between the ages of 13-18 and to help them to acquire a profession and to be useful for the society.” According to the Regulation on Protective Family the protective family “includes the families or people who take the reasonability of caring for the child for a fee or not, can take the place of the real parents and ensure that the child lives within a family environment for short or long term under the supervision of the Provincial directorates.” The Child Adoption “is linking the child with a family legally and socially by means of an agreement which is not based on a cognation”. If the reason for the vulnerability of the child is the poverty, the same aid in cash or in kind can be given to the original family and the care can be given to the child within this family. The Child and Adolescent Centers are boarding or daytime social service institutions that are established for the temporary rehabilitation of the children and adolescents who are abandoned or working in streets or are in danger of social threats for reasons such as conflict between the parents, negligence, diseases, bad habits, poverty, abandoning etc. The Care and Rehabilitation Centers for the Disabled Children are the social service institutions that are established for overcoming the functional loss that is experienced by the individuals who can not carry out their daily activities as a result of their physical, intellectual and mental disorders; for helping them to acquire skills that will make them self-sufficient within the society or giving care to the individuals who can not acquire these skills on temporary basis.
The physical, emotional and sexual abuse within or outside the family—can be in relation with the poverty or not—can make them vulnerable. The children of the separated families, the disabled children, the refugees, very young mother, the children in conflict with the law, the poor children and the children with the chronic diseases are in this risk group.

The above-mentioned services that are provided by the SHÇEK are as follows:

As of January 2004, 9 thousand children have been provided with care services in 84 nursing houses with a capacity of 8056 beds within the framework of the Protection and Care Services. 9500 children have been provided with care services in 107 orphanages with a capacity of 8973 beds.

According to the Article 24 of the Law numbered 2828 the decision on protection is valid until the child is 18. However, if the original cause of protection is eliminated the decision can become invalid until the age of 18. This limit age can be 20 for the children in the primary education and 25 for the university students if the vulnerability is still existent. The girls, who are 18, who do not continue their education and have nowhere to go, are protected as is stipulated in the law. The children who are under protection till they are 18 are recruited in the public institutions in line with the Law numbered 3413. 23385 children have been recruited between the years 1988-2003 in line with this Law. The girls who get married during their protection period receive dowry money. (1.5 folds of the highest public officer salary).

The school age children under the protection and nursing of the nursing houses and orphanages continue their education in schools near the institution they stay in. Furthermore, if the children between the ages of 13–18 can not continue their education for some reason they receive vocational training (Training Course on Tourism, Training Course for Apprenticeship etc.). 1347 of the children under the protection decision receive In Cash and In Kind Aid Service and original family care, and 8537 children receive this In Cash and In Kind Aid Service and original family care without any protection decision.

Another service provided by the SHÇEK is the Child Adoption Service. Though the stating date in not known 7281 children have been adopted till 2003. Every year, almost 3000 families are on the list to adopt a child in Turkey. The average number of children who are adopted every year is 450.

The protective family services are not adopted greatly in Turkey. Therefore 552 children were staying with a protective family in 2003.

23872 children have received services in 38 institutions of Child and Adolescent Centers between 1997-2003 (State Planning Organization, 2004 Program). The “Early Child Development Project” initiated under the cooperation of UNICEF, the Ministry of National Education and the Institution of Social Services and Child Protection has been implemented in the schools of the Ministry of National Education and the Community Centers of the Institution of Social Services and Child Protection and approximately 10 thousand children have attended to this project.

The Crèche and Daytime Dispensatory services are carried out for giving care to the children between the ages of 0-6, protecting and improving their physical and mental health and helping these children to acquire basic values and habits. According to the data of December 2002; 16495 children are provided with care in 1160 institutions affiliated to the SHÇEK and established by private or legal persons. 481 of these children receive services free of charge for poverty reasons. Moreover, services are provided for 592 children in 9 officially established SHÇEK crèches.

The ratio of the children who attend the Pre-school educational institutions in Turkey is 8.8%. The SHÇEK have started the “Chain of Love Project” so as to isolate the vulnerable children between the ages of 0-6 from their natural environment for a specific period of time and to train them in a different environment, to provide them food and care, helping their physical, mental, emotional and social development, and helping them to acquire basic values and habits. With the “Chain of Love Project” the children between the ages of 0-6 in the nursing houses can make use of the Public and Private Crèches and daytime Dispensatories. Within the framework of this project 1915 children received this service between the years 1997-2002.
Within the framework of the project for the children of the female offenders and prisoners living in the prisons (Uçurtmayı Vurulanlar Project) in daytime, the children can enjoy the services of the Public and Private Crèches and Daytime Dispensatories. 93 children enjoyed this service between the years 1998-2002.

Professionals such as the social services specialist, psychologist, child development specialist, teacher/trainer, physiotherapist and the assisting personnel provide all services within these institutions. On 26.06.2002, “Hello 183 woman, child and social services counseling line” has been established by the Circular numbered 17 in order to prevent the child negligence and abuse. By means of this line 2738 phone calls have been dwelled on as cases since October 2002. Besides the above-mentioned child services some social services are provided in children’s courts and correction houses too.

**The problems**

As the proportion of the need for social services in Turkey is not known, the proportion for the children is also not known. The 0-18 age group constitute 26 million people and the children are the most affected group in terms of the economic and social problems in the country. If these facts are taken into account, we see how comprehensive the SHÇEK’s services are (which reach to almost 40,000 children with all its services).

It is observed that the services that are provided for the vulnerable children by the Institution of Social Services and Child Protection are focused on the institutional care. This model does not meet the physical, emotional and mental needs of the children and fails to make them socialized.

The fact that the children are provided with care in large groups, there is not a sufficient number of personnel to care for the children individually, the venue where the care is provided is too large, the siblings are separated and the different age groups can not come together in the care given by these organizations influences the development of the child negatively. The lacking qualified personnel, (social services specialist, child development specialist, psychologist etc.), the lacking coordination between the existing personnel, the fact that the specialization is not given the necessary attention, the lacking equipment constitute the important problems of the institutional care.

The fact that the quality and the quantity of the personnel in the institutions are insufficient and therefore the existent qualified personnel can not work at the desired level, makes it difficult for the children to be protected from the disadvantaged of this care model.

As the number of the personnel is insufficient, the workers have to work in many different fields, which are not their profession, for maintaining the functioning of the institution. This causes a role conflict and the personnel not giving the necessary care to the child.

The temporary care model and the fact that the activities for monitoring and supporting the children under the protection of the institution and their families are not sufficient causes the children to be under the protection of the institution for too long and delays the child to mix with the society.

The fact that the personnel can not follow up the failures and problems about the education of the children who are under the protection of the institution causes the children to lack out of the education. The counseling to be provided for the re-merging of the family in order to overcome the educational problems of the children is insufficient. The necessary attention is not paid to the activities that will support the individual development.

There are also some problems caused by the institutional care in the orphanages for the 13-18 years of children. Especially the services on the adolescence problems are not sufficient.

The fact that there are no services to be provided for the family after the child being taken under protection, the necessary counseling
and support services are not provided causes to fail in terms of overcoming the problems of the family and the increasing of the problems. The fact that the children are grown up in provinces distant from their families is one of the reasons behind this issue. Furthermore, the children's changing many nursing houses and orphanages and the siblings being placed in the nursing houses and orphanages in different provinces distort the unity of the family.

It is observed that the economic weaknesses of the families are one of the main reasons for the institutional protection. As the aid in cash and in kind is much more smaller than the cost of the institutional care the original families do not generally prefer the aid in cash and in kind.

There is not a clear number with regards to the child abuse however it is understood from the cases coming to the SHÇEK that the domestic sexual abuse is at a significant level. This issue is very important as it is an indicator for the awareness raising in our country. Furthermore, the people who are close to the family (teachers, doctors, neighbors etc.) avoid reporting that the children is being abused as a result of our cultural structure or do not know where to report this.

The services by the SHÇEK for the children working in the prostitution sector are limited to the provinces of Ankara and Istanbul. The number of the services is limited. The failure to roll out these services all around the country makes it hard to reach the children who are deemed as a commercial tool.

A family type increasing in Turkey is the single parent family or the separated family. These families are generally too poor as they are generally deprived of the psychosocial support systems. The fact that the requirements are not met sufficiently and on time causes the child to become vulnerable. The preventive and protective services such as aid in cash and in kind or free crèche and counseling services are not sufficient for these families.

Though the recruitment of the adolescents over 18 years old is facilitated by the Law numbered 3413 this law can sometimes be abused.

The rehabilitation and care services for the disabled children are similar to the care provided in barracks as it is provided to very large groups at one time. This prevent the disabled children to be rehabilitated in a healthy way.

The children who are in conflict with the law and are under 15, are placed into the nursing houses or orphanages by means of a decision on measure. This causes the child to be deprived of the programs and works for the therapy to be given to him/her in order to change his/her attitude. According to the law numbered 2253 the Ministry of Justice should provide rehabilitation services for the treatment of the children, however the children who are in conflict with the law are placed into the nursing houses or orphanages. The child is not rehabilitated in the rehabilitation centers which are suitable for his conditions and requirements.

The gender discrimination for the children and the priority that is given to the boys prevents the girls from enjoying their rights and this is a well known fact.

It is observed that the services of the Institution of Social Services and Child Protection are focused on the therapeutic service models. The gaps in the structuring of the preventive and protective services causes the problems to become chronic, makes it hard to reach the solutions, wasting of the resources and decreasing of the motivation of the personnel and therefore the works can not reach to the desired level.

**Recommendations**

There is need for research for vulnerable children in Turkey. It is especially useful to determine the problems of children living in different regions through field studies in order to unfold solution ways.
In order for a child under institutional care to return to a family as soon as possible, it is important to launch professional works related to the family and its close environment and to provide necessary guiding services. For children that are impossible to return to their original family, adoption services should be provided; various awareness-raising and incentive works should be carried out in cooperation with other public and private institutions so as to make protective family services widespread; payments made to protective families should be realistic considering the cost of care of the child within the institution. And the families of children under institutional care only due to economic reasons should be supported in cash and kind and necessary arrangements should be made to allow them living with their families.

Children aged 0-18 who are obliged to undergo institutional care in each province should be provided services together with their siblings; frequent change of nursing homes or orphanages by children should be prevented; frequent change of personnel especially in nursing homes should be avoided; and small-scaled institutions (group houses, independent houses in a neighborhood etc.), which exist in very few numbers in our country, should be made widespread.

Children under institutional care should be provided with every kind of outdoor social activity (cinema, theatre, children's libraries, shows, festivals, camps, etc.) in order for them to be under least influence of institutionalization and live within the society.

In these small institutions to be restructured, children should be ensured to live by assuming the responsibilities required by house life (acquiring life skills under the responsibility of an adult undertaking the role of a mother or a sister model) regardless of their age group.

Legal arrangements that will eliminate the guardianship problems about the children under institutional care should be made. Necessary works should be carried out for the public guardianship law to pass the Parliament in order to protect the rights of children under institutional care.

Law no. 3413 should be revised and taking the children under institutional care only for benefiting from this law should be prevented; and regulations eliminating the unwillingness of children about proceeding to their education due to employment guarantee for children under institutional care should be made.

Services that will solve the adolescence problems of children aged 13-18 staying in orphanages should be delivered. They should be allowed to integrate with the society.

Vocational courses for the children aged 13-18 staying in orphanages and not continuing their education due to several reasons should be delivered out of the institution.

Projects for preparation and settlement of the vulnerable young persons leaving the institution after 18 in the society should be widespread.

Qualities and quantities of existing Child and Youth Centers for street and working children should be increased; child should be detected before working and living in streets; and the protective/preventive systems providing the necessary guidance, counseling and support services should be strengthened.

Measures against the negligence and abuse of children under age 15 should be taken.

Child and Youth Services should be appropriately classified according to the features and characteristics of children and made widespread. Child and Youth centers each specialized on different groups like neglected and abused, working in streets, living in streets, having psychological disorders etc. should be opened.

Treatment services required by the children in negligence and abuse cases should be provided. In this framework, counseling and rehabilitation services should be developed.
Awareness-raising programs on rights and responsibilities of parents and children should be carried out; there should be legal arrangements that make the participation of families that are thought to neglect their children in such programs mandatory.

Necessary legal arrangements should be made so as to allow full practice of the provisions of Convention on the Rights of the Child. Child-mothers (children becoming pregnant and/or mothers as a result of extra-marital intercourse before age 18) should be informed during their pregnancy, provided with the services they require, and supported so as to embrace mothership and claim their children, accordingly the familial integrity without need to register the children in a nursing home should be ensured.

The care of disabled children in orphanages and nursing homes should be provided in rehabilitation centers as much as possible also taking the type and degree of the disability into account. Existing inpatient rehabilitation and care services should be delivered in small groups.

Cooperation with Ministry of Justice should be continued for the young persons under institutional care or the ones referred from judicial authorities to Provincial Directorate of Social Services on cautionary judgment and the ones in conflict with the laws; child supervision works should be structured in a way to be executed by qualified personnel and made widespread.

Cooperation with Ministry of Justice should be made for the children under 15 who committed a crime or have a tendency to do so; and institutions for the rehabilitation of such children should be established.

Bearing in mind the fact that child refugees and immigrants as well as children exposed to a natural disaster are in the special needs group; with regard to services for asylum seekers, refugees and natural disaster victims, the education, guidance and support programs for children should be prepared in cooperation among institutions.

Media should be made sensitive to the problems of children and refrain from negative broadcasts or publications. In order to eliminate negative views of the public against the Institution of Social Services and Child Protection, promotional works should be carried out about the services provided and the awareness of the public about the nursing homes and orphanges should be raised.

4. TURKISH PSYCHOLOGISTS ASSOCIATION

Views And Evaluations of The Turkish Psychological Association Regarding The Report on the NMHP

Recently a new understanding has emerged in the field of mental health and mental disorders in relation to the advances in behavioral sciences. Individuals have gradually been more aware of the burden and prices of mental disorders. As the recent findings in the field are examined, the relations between thoughts, feelings and physical illnesses gain more clarity. With this new understanding, it is adopted that genetics and environment are not separate and conflicting aspects but each has mutual effects on the other. As the widely accepted definition of the World Health Organization reads, “health is a situation of complete wellbeing in physical, psychological and social terms.” These aspects of the concept of health cannot be said to have a hierarchical order of magnitude, and the lack of one of these aspects distorts the state of complete wellbeing.

In most countries a community - based approach begins to settle in the field of mental health. Accordingly, mental disorders are integrated with general health services and preventive efforts. However, the resources allocated for mental health fall far behind the allocations for physical health. Similarly, the scope and efficiency of psychological services are insufficient with comparison to the individual and social obstacles resulting from mental health problems. It is believed that policies which comprise mental health practices in a systematic and integrated way will bring about positive consequences (Brundtland, 2001).

Basic principles of effective mental health services are diagnosis, early treatment, rational application of therapy techniques, a widespread serve network, the participation of users of the service, cooperation with families, social participation and integration with primary health services (WHO, 2001 b).
Improvement of mental health at the social level is a complicated responsibility which entails decision making in several fields. Mental health services and strategies should be planned internally and coordinated with other social services such as social security, education, etc. The role of governments in mental health practices should be policy development and implementation.

In recent years mental health, as a field, has lured gradually more interest in Turkey. The natural disasters and other traumatic incidents suffered by the society, in particular, have revealed the importance of mental health included within the scope of general health. Within the framework of the NMHP (NMHP), appropriate legal regulations are needed to be put into implementation to enable the professional groups working in the field to have a precise definition of their roles, functions and operational scope and to realize their capacity. In this context, below is presented the report of the Turkish Psychological Association (TPA), which gives a brief summary of the professional status of psychologists in Turkey.

**ROLE, TRAINING, COMPETENCE, NUMBER AND PROFESSIONAL ORGANIZATION OF TURKISH PSYCHOLOGISTS IN THE FIELD OF MENTAL HEALTH**

**Their Role in the Field of Mental Health**

The epidemiologic studies conducted in our country have revealed that one tenth of children and teenagers and one sixth of adults suffer from a mental disorder that can be diagnosed no later than a year (Erol, Şimşek 1998, Kılıç, 1998). According to the study, the prevalence of problematic behavior is about 11-12% in children and teenagers, with 17% having problems of various severity. Teenagers have stated more problems than their parents and teachers do. As for the data regarding adults, the ratio of individuals who have suffered from any kind of mental disorders in the last 12 months is 17.2%. The incidence rate of mental disorders among females is twice as much as it is among males (Kılıç, 1998). Despite such prevalence, families with children of 2-3 age group have not applied for mental health services while the respective ratio for the 4-18 age group is 0.2%. Although 5% of teenagers have stated their need for help, the utility ratio of health posts and juvenile and teenage mental health centers is found to be 0.3%. Also the ratio of adults seeking / applying for treatment due to mental / neurological reasons during last 12 months is seen to be 4.7% (Erol, Kılıç, Ulusoy, Keçeci, Şimşek, 1998). These findings reveal that most children, teenagers and adults cannot have access to the assistance they need. It is of primary importance that the awareness of individuals concerned with the problem be increased. However, social awareness of the problem is not sufficient. Studies should be conducted to find out how services should be provided and whether the existing services are functional and sufficient enough to meet the demand. We hope, through the realization of “National Mental Health Policies” that are special to Turkey most infants, children, teenagers and adults who seek assistance will be able to receive the help they should as their right.

The psychologist, one of the major specialists in the field of mental health, contribute to the field with research, evaluation, treatment and educational operations. Psychologists who are specialized in such sub-fields of psychology as clinical, developmental, social, school, health, industrial-organizational, traffic, forensic, sports psychology constitute an important part within mental health services. Psychologists work on the phases of individual growth within the life circle starting from prenatal period and ending with death. They deal with the definition, explanation and measurement of natural behavioral changes in relation to age. They study the universal characteristics of and cultural and individual differences in growth. They examine usual and unusual behavioral changes.

Psychologists work as researchers and practitioners for prevention of disorders and sustention of health. They study the biological, psychological and social factors having an impact on health and illness. They develop curative health strategies. In addition, the problems of health personnel are also one of their concern. They are employed in health organizations, public sector, hospitals and medical centers or security services.

They examine and treat individuals with intellectual, behavioral and emotional disorders. Their field of interest ranges from short-term developmental crisis during developmental periods (such as the rebelliousness in puberty and devaluation of self in adulthood) to the treatment of severer problems such as phobia, depression or schizophrenia.
Research is one of the most essential functions of the psychologist. Planning and implementation of research, development of scales and tests to be used in research or evaluating the effectiveness of education, treatment and operation via adaptation, standardization and validity studies which are in accordance with national requirements are their major functions.

As for neurologists, diagnosis and treatment of disorders in the central nervous system is their matter of concern; moreover, they work together with the patient for the diagnosis and rehabilitation of behavioral disorders. Clinic neurologists work in neurology, pediatrics, brain surgery and psychiatry clinics.

Psychologists are also employed in schools to provide consultancy and assessment services for students. Furthermore, they work on the arrangement of environmental conditions that are necessary for mental health and learning. They care for children who are in need of special education and they develop and evaluate programs; they work in cooperation with teachers with respect to class management. They also provide consultancy in psychological and educational issues for families, students and school personnel.

**The Importance of Psychologists' services in the Field of Mental Health**

In a country with high rates of mother mortality, infant mortality, poverty, unemployment, intense migration and frequent natural disasters, traffic accidents, Turkish people feel an urgent need for mental health personnel. The risk of depression is twice as much among the unemployed as it is among the employed individuals. It has been found that children living in poor houses have three times more mental health problems with comparison to children living in average houses. It is to our knowledge that most of the above-said problems are sources of mental illness. As mental health personnel, we should search for the ways of eliminating lack of hope and help and replacing them with hope and resolution consciously, systematically and in an organized manner, if possible.

It is essential that all professionals concerned with the “NMHP” and mental health unite their power, clarify their roles and responsibilities and work in cooperation. Identification of the common aim and requirement and fulfillment of the responsibilities to be committed by each professional group will yield synergy. On the other hand, it is important that consciousness about responsibility be spread and rights be taught among professional organizations and the whole community; unification with NGOs should be realized, as well.

During pregnancy, infancy and early childhood; pregnant psychology, family support programs, programs for supporting psychological growth (aiming toward the prevention of behavior which causes mental disorder and toward the intensification of family-child interaction by strengthening individual skills to cope with problems of social and environmental conditions) are of major functions of psychologists. It is essential that they reveal and support the protective factors in the lives of parents and children before the emergence of problems and that prevalence of problems and risks be reduced. The principle, taken as the method, is to reveal and support the strong characteristics of the family and, by this way, to contribute to the formation of a healthy environment which is emotionally, socially and culturally supported. (Erol, Şimşek, Ertem, 1997, Erol, 1999). One of their aims is to emphasize the interaction and relationship between infant and its caregivers on the basis of family-oriented approaches rather than individual-oriented ones. Training programs to develop the quality and competence of service providers are needed in preventive service models.

**Educational Institutions and Titles**

Within the framework of university laws, which have been in power for a long time in Turkey, 4-year bachelorate programs admit students after a central entrance examination. Departments of Psychology at Faculties of Letter or Faculties of Science and Letters can also provide 4-year bachelorate programs within the same framework and their graduates receive the title of “PSYCHOLOGIST” in accordance with the respective legislation.

Some Departments of Psychology also provide Postgraduate (MA) and Ph.D. programs and the psychologists are named “PSYCHOLOGY SPECIALIST” and “DR. PSYCHOLOGIST”, respectively, after having completed their respective education. The branch of specialization may occasionally be used in the title; for example, the titles of “CLINICAL PSYCHOLOGIST” or “DEVELOPMENTAL PSYCHOLOGIST” may also be used on legal basis.

The number of psychology departments at the established public universities in Turkey, which have a history of more than 25 years, is 6 (Istanbul University, Ankara University, the Middle East Technical University, Hacettepe University, Boğaziçi University and Ege
In addition to the 6 established departments, 14 more departments were opened in other cities relatively later, 7 of which are at public universities (Samsun Ondokuz Mayıs University, Mersin University, Bursa Uludağ University, Diyarbakır Dicle University, Muğla University, Abant İzzet Baysal University ve Sivas Cumhuriyet University) and 7 at foundation universities (İstanbul Koç University, İstanbul Bilgi University, İstanbul Haliç University, İstanbul Maltepe University, İstanbul Ticaret University, İstanbul Okan University ve İstanbul Doğuş University). So, there are 20 established psychology departments as of the end of 2003. However, some of these departments (e.g. Ondokuz Mayıs [19th May] University) cannot provide regular education even in undergraduate courses due to the lack of academicians. Some departments (at Muğla University, Abant İzzet Baysal University and Sivas Cumhuriyet University) could not yet admit students although they are officially in operation. Total student quota of the said departments was 395 in 2003 while it was 287 for foundation universities, both of which sum to 682 in total.

Educational Standards

Length of education and titles also differ between Turkey and the standards of Western countries. For instance, graduates of bachelorate programs are not granted the title of psychologist in developed countries. However, the level of psychology education provided in bachelorate programs in those countries is lower in terms of psychological content than in Turkey, and the program is largely comprised of optional intellectual and recreational courses in developed countries. Therefore, professional titles are acquired after postgraduate study in those countries, as in many other professions (medicine, law, etc). While the total credit of psychology courses to be attained by an undergraduate psychology student at the end of 4 years constitutes almost 75% of the total credit needed for graduation, whereas it is around 40-50% in developed countries although there are some differences. Moreover, with the limited postgraduate and doctoral programs in Turkey taken into account, directly applicable knowledge and skills are tried to be taught during undergraduate study, e.g. in sophomorical courses. Thus, a psychologist with a BA degree is equipped with far more professional knowledge in Turkey when compared to graduates of bachelorate programs in developed countries.

Above all, most of the graduates of bachelorate programs in Turkey take initiatives to improve themselves early in their career due to the extremely limited postgraduate study facilities. Within this context, they receive in-service training provided by professional organizations, associations and private organizations and which are based on skill acquisition. This is true for many young psychologists working in public or private sector. Such in-service training may sometimes be organized by the public sector itself, e.g. Ministry of Health. The TPA has also arranged several courses and working groups in its centre and branches and granted the participants a certificate or participation certificate. This further improves the professional equipment of Turkish psychologists when compared to the graduates of undergraduate psychology programs in developed countries.

In addition to carrying out actual operations as the professional organization of psychologists in Turkey, the TPA exerts great efforts for the promotion of psychologist education to meet European standards. A 5-year psychology education comprising of a 3-year undergraduate program followed by a practice-weighted 2-year postgraduate study is envisaged in accordance with the European model. Related preparations are being carried out in respective state institutions within the EU harmonization process.

Specialization

In Turkey, postgraduate psychology programs open and admit the number of students defined under the initiative of departments; they are limited in number and cannot meet the demand. The 6 psychology departments at our established universities are the major ones with postgraduate and Ph.D. programs. However, postgraduate programs do not sustain general continuity and some branches do not give entrance examination for years. This mainly results from cadre problems and related burden of undergraduate courses to obligatorily be instructed by academicians. However, the lack of encouraging factors and motivation may be occasional reasons for the situation. For example, the monthly wage of a full time professor currently working at a psychology department at any Turkish public university is nearly 1000 USD equivalent, which is one fifth of its US corresponding! Working conditions at universities and other encouraging facilities cannot sufficiently motivate the academicians in Turkey. On the other hand, new postgraduate programs are being initiated in foundation universities.

Psychology departments at Turkish universities provide postgraduate education in 6 branches as standard. These are experimental,
social, growth, clinical, industrial-organizational psychology and psychometry. However, specialization in psychometry seems to actually cease in recent years due to the lack of specialists. Official specialization in other major fields such as school psychology and Neuropsychology is currently not possible in Turkey.

In a field of direct practice on human, which most necessitates specialization for application, that is clinical psychology, student quotas remain insufficient with comparison to the demand. Another important reason for quota insufficiency in this field is difficulties faced in the provision of suitable clinical conditions for internship and practice. Some psychology departments can occasionally initiate postgraduate programs in the field of clinical psychology just to provide education for the psychologists who are employed in those departments, but in a way not in conformity with scientific realities. Thus, it can be seen that clinical psychologists are “educated” by few psychiatrists and on the basis of visits and case meetings in those departments, which lack any clinical psychologist of seniority.

Employment Statistics
The answer to a question about the current number of psychologists in Turkey is not an easy one. The TPA has 1883 permanent members as of late 2003. However, this number does not reflect the number of actually working psychologists because membership to association, which was established 27 years ago, is optional and not compulsory for occupational performance as in occupational chambers.

Although there are not available precise data, with a view to the potential active-working age groups, previous department quotas and rates of success, increasing quotas and new departments of the last 15-20 years, almost 10,000 people must have graduated from psychology departments during the last three decades. Most of them are graduates of the last decade. However, not all of the graduates are involved in professional life for any reason and many work in sectors other than psychology or in sectors such as teaching, management, etc. The number of graduates currently working as psychologists must be about 2500, according to a 25% proportion. However, this ratio may be smaller. Almost 20% (max.) of those 2500 can be said to be admitted to the same departments or a postgraduate program abroad despite gradually improving quota possibilities. It amounts to nearly 500, covering all specialists involved in the field of psychology. Therefore, there are almost 2000 graduates currently working as psychologists in all sub-fields and nearly 500 psychologists with an MA degree (some Ph.D.) in Turkey. For instance, the total number of academicians at our psychology departments is 100, included in the above 500. In other words, there are 2-3 psychologists (graduate or postgraduate) for each 100,000 population, and they work in psychology clinics, crèches, industrial organizations, prisons, etc.

The exact number of clinical psychologists in Turkey is not available for the same reasons. However, with a view into the fact that most postgraduate programs are initiated in the branch of clinical psychology in line with the requirements, the most probable realistic estimation would be about 300 clinical psychologists to work in Turkey. This number includes academicians working in universities and Ph.D. psychologists. Most of them have specialized in the 6 programs listed above; however, some studied abroad.

Almost 33% of TPA members are registered in Istanbul branch, 51% in head office in Ankara, 14% in İzmir and 2% in Bursa. However, nearly half of the members are registered in head office in Ankara, as an example, but they operate in various cities of Turkey. The majority of psychologists are employed in big cities as psychiatrists are. In some cities there are just 1-2 psychologists working while there are not any psychologists in some others. Certainly, the TPA can have exact knowledge about its registered members only; however, there are psychologists operating without a registration at the TPA.

Professional Organization and Problems and Ethical Issues
The largest professional organization of psychologists in Turkey has been realized under the umbrella of the TPA. Throughout its 27-year history, the Association has carried out significant operations on such issues as the personnel rights of and publication and course support for its members; it has reached a particularly prestigious position before both state institutions and the public sector. It conducted a comprehensive field study following the big earthquake in 1999 and provided psychological support and psycho-education for hundreds thousands of citizens who were hit by the disaster.
The problematic aspects of education and employment statistics summarized above are accompanied by the lack of legal regulations concerning the scope of profession. Thus, Turkish psychologists still work without clear definitions about their working area, their duties, rights, authorities and responsibilities because of the lack of a professional law. They are deprived of an internal supervision of the professional quality and standards, which they would be subject to through professional organizations. Thus, the community that the psychologists provide services to is also vulnerable to ethical matters etc. Functioning as the actual professional chamber of psychologists in Turkey, the TPA has taken several initiatives to enable the legislation of a professional law throughout its 27-year history; however, its efforts have not turned to be fruitful yet. There is not a professional law regarding psychologists as well as some other medical professions. On the other hand, the formation of a legal framework for the operations of psychologists, which will be required by EU, is gradually being more probable within the scope of legal regulations enacted by the Republic of Turkey for the sake of harmonization with the EU. The Association has carried out all preparations in cooperation with EFPPA and submitted the required applications to the related government authorities.

As of the end of 2003, the TPA has put forward the professional ethics and related rules of procedures and it keeps them ready to put into effect when it becomes a chamber after the ratification of a professional law.

**The Need for a Professional Law for Turkish Psychologists**

Professional laws are official decisions comprising the regulations and sanctions which are adopted at the governmental level in order to protect the right of professionals of an occupation or the rights of users of the services provided by that professional group. Psychology is an independent professional scope where the information obtained within the science of psychology are integrated with certain skills and abilities and where certain practices are carried out to provide changes in human attitude and behavior together with resolutions for problems.

Despite the facts that, psychology study in Turkey started in 1930s and that hundreds of psychology graduates from İstanbul, Boğaziçi, Ege, Ankara, Hacettepe and the Middle East Technical Universities are working in various public and private organizations in the country, the profession and its field of specialization does not have a standard description for the time being. Each organization creates its own description in parallel with the nature of that organization and with the degree of its familiarity with the field; or they use the description include in “the Statutes for Management of Inpatient Facilities”, which was prepared in 1983 and which does not reflect contemporary developments and new branches of specialization in the field of psychology and remains extremely limited with respect to psychological specializations in relation to health, such as “clinical psychology”, “neuropsychology”, “psychopharmacology” and “health psychology”. This situation causes not only obscurity and conflicts between the expectations of the ones working as psychologists and their chiefs, but also significant national inefficiency because the individuals cannot fully put into practice their knowledge, skill and energy after having been equipped with a considerable amount of field knowledge during their four-six years study. Furthermore, people who have graduated from other fields with a few additional psychology courses but without a degree in psychology are appointed as psychologists due to the said obscurity, and the users of their service are face to face a potential risk. As long as professional standards to be regulated by laws are introduced, one should expect the risk of professional abuse by people who are of the field but whose competence for independent professional execution is not approved (as in the case of freelance attempts of a person who has not specialized in clinical psychology and not fulfilled other requirements, or as in the case of a psychologists trying to work in the specialized field of Clinical psychology although s/he has specialized in a different field such as industrial-organizational psychology).

Since the practice of psychological knowledge includes such decisions and actions to affect the individual and social life of a person, the legal protection of standards in psychology education and practices and professional ethics is of vital importance in terms of the social responsibility of the profession.

Moreover, we should conform certain standards and principles in order to ensure that Turkish psychologists can also work in the states of European Union, to which we have applied for membership. To this aim, it should be given priority that psychology is taken as a standing science and occupation, not a “supplementary medical profession”, and that the required standards for psychology education and practices are defined and put into legal framework.
Taking into consideration the above mentioned problems and the requirement for the implementation of contemporary standards in
the field of psychology as well as other fields, especially while we are attempting for the Western world; a “Professional Law” to
define the conditions and basics of services provided in various fields of specialized psychology is required. It is an essential
prerequisite for psychologists to execute their profession effectively to the benefit of the society, within an integrated national mental
health system to be structured through a NMHP.

5. TURKISH PSYCHOLOGICAL COUNSELING AND GUIDANCE ASSOCIATION

OVERALL OPINIONS OF TURKISH PSYCHOLOGICAL COUNSELING AND GUIDANCE ASSOCIATION WITH REGARD
TO NMHP

Making efforts to develop a nationwide mental health policy constitutes a remarkable initiative. Psychological counselors, widely
serving for schools and for many other institutions as well, are the professionals who are equipped with the qualifications required
for first step mental health services. The profession of counseling psychology, possessing the triple functions of prevention,
 improvement and treatment, provides the mental-health-related services. The report concerned deals with the education as a structure
that requires cooperation for mental-health-related works. The psychological counselors working under this system are the members
of a profession that will provide the best available support for mental health services.

In the various chapters of the report, the necessity of inter-institutional cooperation, the psychiatric services only accessible for
limited number of people and the necessity of nationwide accessibility in this regard are repeatedly pointed out within the context
of the efficiency of psychiatric services.

Inter-institutional cooperation is insistently repeated and underlined in many modules throughout the report (Modules 1, 2, 3, 5
and 9: p.5, 15, 19, 27, 37, 38, 52, 81). Education is among these institutions under which the said cooperation can be put into
practice by means of psychological counselors and the other mental health personnel readily available at most of the schools. Despite
the fact that psychological counselors can be employed in various business fields such as education, health and industry, they
primarily and mostly serve under education system. Gelso and Fretz (1992) describes the major issues of counseling psychology
as focusing on the people not having serious disorders, emphasizing positive mental health and strong characteristics of persons
regardless of the degree of disorder concerned, opting for relative and short term intervention, being interested in individual and
environment interaction rather than individual and environment only, and focusing on educational and vocational environments along
with the educational and vocational development of persons. All these definitions underline the aspects of counseling psychology
that are related with promotion of mental health and prevention of probable problems.

The low accessibility of psychiatric services is pointed out in the Module 1 (p. 11). Similar statements on this fact can be spotted
in some other publications (Göka and Duman, 2002). One of the ways for promoting accessibility of mental health services is to
utilize schools. Among the sub-branches of counseling psychology and guidance that are educational, vocational and personal –
social guidance, especially the third one – i.e. personal – social guidance - is closely associated with mental health. This can be
supported by the fact that the total number of students having applied to guidance research centers (RAMs) to get social psychology
counseling services in 2001 – 2002 education year is over 10 thousand. The number of people who accessed out-of-school services
is 1151. At the schools, on the other hand, 665,618 students and 27,646 external applicants were provided with social psychology
counseling service (Saldıroğlu, 2003).

Childhood and youth periods are very important. In Turkey, people under 18 constitute more than 38 % of the total population
(Modules 2 and 9; p. 19, 79). Most of these people are currently schooled. The total number of psychological counselors presently
serving at both state and private schools is 6,420. The number of psychological counselors working in 127 RAMs is 805 (Turkish
Ministry of Education, 2002). This total number of counselors is considered to be significant in the context of supporting the other
mental health services in order to provide first step health services. The number concerned may also gain significance within the context of balanced distribution of these services among various institutions.

Some actions that are considered to be included within children and adult mental health policies (drawing attention of mass media to some issues such as suicide among the youth, substance addiction, violence etc.) may also be performed at schools. The data on the rates that indicate youth problems in our country are given in the following paragraphs. Psychological counselors currently employed within the education system are to have key roles in solving out these problems that pose a major threat against mental health.

The sensational media reports that have been released on the issue of violence so far indicate that the violence among youth in Turkey is going up. Nevertheless, there is neither a nationwide study with respect to allegedly widespread school violence nor research results of significant number that support or refute this argument (Sümer and Aydın, 1999). On the other hand, some school – violence – related studies conducted by Üçlemuş (1993, 1996) may be interpreted as the indications of the attention drawn to said issue. As for substance abuse, it is not quite possible to give precise data with regard to the number of addicts and prevalence level. In his study directed towards elementary school and higher education students, Yılmaz (1996) tried to ascertain alcohol and drug addiction rates among this age group. According to this study, the rates of alcohol and drug use were 03 % for girls and 0.4 % for boys in elementary education; and 0.3 % for girls and 1.6 % for boys in higher education.

In our country, suicide attempts and committed suicide rates are rather low when compared to rates recorded in Europe (Sayıl and Devrimci-Özgüven, 2000). The study that was conducted on suicide by Sayıl and Devrimci-Özgüven (2000) reveals that 31.9 per 100.000 persons above the age of 15 who attempt to commit suicide are male and 85.6 are female; while 9.9 per 100.000 persons above 15 who commit suicide are male and 5.6 are female. Most of the people who attempt to commit suicide in Turkey are from the age group of 15 – 24, which is same for Europe as well. Those who actually commit suicide are generally over 40 in Europe, whereas in our country the age is 15-24. The risks of suicide for men and suicide attempts for women are considered relatively high in our country, too. The study conducted by Biliç, Bekaroğlu, Hocaoğlu et al (2002) in Trabzon province revealed that the figures on attempted and committed suicide are 31.5 and 2.6 per 100.000 people, respectively. The study also revealed the finding that the highest frequency for attempted and committed suicide are observed among the young, single and unemployed persons. In this regard, these society segments may be considered as risk groups.

In a study conducted on university students, it was revealed that the frequency of eating disorders (Anorexia and Bulimia Nervosa) was 6 % for female and 2 % for male students (Alpargun, 1995). According to another study performed by Tuncer (2002) on children from 9–17 age group in Turkey, obesity rate among boys is 11.2 % and 9.4 % among girls. These rates are higher among children from high level socio-economic group. According to researchers, obesity rate is observed to have been going up in Turkey. As for HIV/AIDS, the data published by the Ministry of Health in 2003 reveal an incremental trend of said disease among the youth. 217 HIV/AIDS cases, as officially reported among the young people at and under 24 years in the data of the Ministry of Health (2000), went up to 300 in accordance with the data derived in 2003. Due to the fact that these numbers represent the ones who were provided with official diagnosis and treatment, actual figures are thought to be quite higher.

Module 2 deals with skill-based works, one of the intervention approaches related with mental health, social disempowerment and model of access (mental health difficulties, coping, preceding disadvantages and stigmatizations) (p.23-24). These activities can be organized most efficiently and prevalently at schools.

Module 3 covers prevention issue under sub-titles related with mental health services that are expected to be positive (p. 39). One of the functions of counseling psychology is prevention (PDR-DER, 2000).

Module 5 mentions about the institutions that are to cooperate with fundamental health service staff. In this context, cooperation between fundamental health service staff and Guidance Research Centers (RAMs) could be established. Also RAMs could be considered as institutions to be cooperated with under the scope of primary health services.
Module 9 takes up schools as one of the society based services (p. 87). It is significant that the necessity to cooperate with schools is continuously acknowledged in some parts of the report, although statements like the preceding sentence are not given place quite a lot in the report.

In the Module 11, defending and introducing the argument are covered (p. 115). In this regard, psychological counselors serving under the body of the Ministry of Education or in other institutions and RAMS may cooperate with the Ministry of Health.

As for the recommendations of the working groups, the lack of coordination between the Ministry of Health and Ministry of Education on the problems determined in the first conference and the envisaged problems was considered as a major reason, which is a fully right indication. Under the sub-titles of preventive services and culture, some problems that are able to be solved through education are pointed out. Some problems that can be solved by the help of psychological counselors have been given in the paragraphs above.

It is extremely significant that the recommendations of the second conference handle the school under the scope of first step services. Taking as a point of departure the courses to be given place in the education process in accordance with the recommendations, we may also add the preventive and developmental approach-related courses into the training programs of psychological counseling and guidance. In the conference concerned, the importance of school in terms of accessing to the relevant cases, the necessity of providing teachers, students and parents with first step mental health services, promotion of wellness, the importance of parental education and the necessity to foster the mental-health-related works at schools were the other major issues that were strongly emphasized. All of these concepts are included on the agendas of psychological counselors.

THE ROLE OF SCHOOLS IN MENTAL HEALTH WORKS

LeCapitaine (1999) suggests that personal and psychological development should be taken as an education mission and schools should function like clinics. The author considers emotional, ethical, social, multicultural, cognitive, aesthetic, professional and individual developments as the fields of personal and psychological development, both of which he deems critical elements. Some schools attempt to take preventive actions with respect to drug use, arise of disputes etc. only when these problems tend to increase. Today, only a few schools are able to provide the normal with positive, real, age-appropriate developmental and preventive services for their personal and psychological development. Despite the fact that the major concern of school guidance service is the prevention rather than treatment, in practice, less time is to be allocated for the preventive works due to the urgent needs of students with problems (Daws, 1973). However, school guidance services need to establish programs which have the potential to ensure practical and efficient ways and which are accessible by all the children and youth.

The supportive issues in terms of mental health in education are fostering academic achievement, healthy cognitive, social, emotional development and power of coping, intervention to variables that impede success and development and providing students, parents and school personnel with social and emotional support. The scope of services directed towards students can be summarized as supporting the healthy development through some ways such as paying interest in educational and psychosocial problems like adaptation to school, learning and attention problems, inter-personal disputes, negligence and abuse and conditions to lead to stress; teaching social skills, responsibility, self-management, protection of health; and exposing creativity of individuals. Some of these services can be provided in education system by direct ways such as primary prevention, promoting wellness, improving school environment, developmental guidance activities and exchange and monitoring programs. Psychological counseling and guidance services within the education system are included in some general mental health activities such as taking students as the center of interest, focusing on the development, attaching importance to primary prevention, developing comprehensive guidance programs and fulfilling participation and cooperation tasks (Saldıroğlu, 2003).

The professions associated with mental health have been making efforts to prevent probable problems that can be faced about this issue. Preventive works can also be performed within education systems and be helpful in reaching the most efficient outcomes through cooperating with the other institutions. Counselors and school psychologists constitute the key staff to serve for mental health at schools. The schools are the most appropriate places to initiate such efforts. One of the most important reasons for this
is that preventive works generate the most efficient impact on children and youth. Henceforth, the services become more efficient when pre-school period and the early stages of primary education are considered as the major focus. This assumption is based on the fact that the roots of capabilities are embedded within the early years of development and the psychological structure developed in early years is resistant to alteration to take place in following years. Problem development may also begin from this early point (Shaw and Goodyear, 1984). It should be a sound way to initiate life-time effective preventive works from the childhood and youth ages which have logical effects on the whole life (Albee et al, 1992: quoted in Albee, 1999).

Recently, on dealing with the tasks of counseling psychology, some concepts have been increasingly acknowledged such as promoting health (Cowen, 1997a; Kolbe, 1997; Mrazek and Haggerty, 1994), providing acquisition and enhancement of social and emotional capabilities (Albee, 1996; Cicchetti et al; 2001; Cowen, 1994; Zins, 2001); enhancing positive development for children and youth or ensuring positive youth development (Catalano, Berglund, Ryan, et al. 2002; Cowen, 2001, Larson, 2000, Vera, 2000); promoting wellness (Cicchetti et al., 2001; Cowen, 1996; Munoz, Mrazek and Haggerty, 1996), subjective well-being (Diener, 2000) and empowerment (Cowen, 2001, McWhinter, 1991; Zimmerman, 1995, Perkins and Zimmerman, 1995); enhancement of resilience (Cicchetti et al., 2001, De Civita, 2000; Cowen, 1997b, Kolbe, 1997); establishing positive psychology (Seligman and Csikszentmihalyi, 2000) and positive emotions (Fredickson, 2000, De Civita, 2000).

Going through the tasks of counselors briefly mentioned above, it is observed that all these tasks serve to protect, optimize and develop mental health. This point of view, which has been getting worldwide support recently, has also been acknowledged a lot in our country, as well.

**SOME OPINIONS AND PROPOSALS WITH REGARD TO THE ROLE OF PSYCHOLOGICAL COUNSELING AND GUIDANCE SERVICES IN THE WORKS ON NMHP AND THE LAW ON MENTAL HEALTH**

First of all, all mental-health-related professions, including psychological counseling and guidance, should be defined precisely; relevant chambers of the professions should be founded and accreditation works should be completed. Some appropriate mental health service centers can be founded where the public accessibility is ensured within private sector. The qualifications of the staff to provide mental health services in these centers may be specified in detail. Taking into account the limited number of people to provide such services as a clinic psychologist, psychiatrist and as member of other psychiatric professions and considering the low quantity of the people getting these services, we inevitably face the necessity to work in cooperation with the other groups of professions to ensure cost-effectiveness. Besides, efforts can be made in providing higher quality psychological counseling and guidance services by taking into account some certain mental problems that can be prevented at relatively low cost.

Evidence can be acquired to determine why the work with youth is necessary through performing inquiries on the problems of youth. Saldıroğlu (2003) points out an inquiry held by the Ministry of Education on the problems among the youth. Cooperation with RAMs can be organized for primary health services under province-based structures. Seminars have already been organized for the parents through schools in order to provide the public with education about mental health. The quantity and quality of these activities may be enhanced. Health care professionals working within provincial regions and the psychological counselors serving at schools can cooperate in this regard. Academic staff working in the psychological counseling and guidance departments at universities, like other professionals actively serve to provide mental health services, can initiate some works to educate the public on mental health issue. They can also make these works widespread through local government and mass media facilities.

The mental health care personnel working at schools and in workplaces can be strengthened as a result of the necessary cooperation among various sectors. Developmental and preventive efforts of mental-health-promoting qualities at schools can be fostered. Inter-professional cooperation can be administered in this regard. Adding over 7500 counselors currently serving in Guidance and Research Centers located in schools to the number of other mental health care personnel, a very sound and reliable figure comes out in terms of providing mental health services at various levels and stages. Inclusion of psychological counseling and guidance services within first step health care services will lead to an integrated mental health service provision.
Psychological counseling and guidance field can be utilized for the psychosocial support directed towards children and youth. Psychological counselors, being educated primarily for this aim, constitute a major profession group, an instance of which was clearly witnessed in the psychosocial project implemented for Marmora earthquake victims.

In the event that a committee or council on National Mental Health is founded, it will be proper to appoint a representative from Turkish Association of Psychological Counseling and Guidance to that committee or council. The persons from psychological counseling and guidance field should take part in the organization of mental health services not only in educational institutions but also in health, social assistance and youth centers. Psychological counselors can also serve on rehabilitation and readaptation issues. Psychological counseling and guidance is a profession that aims to promote mental health in education. Supporting healthy development and preventing mental problems constitute the major activities of psychological counseling and guidance field. Putting in use every resource available for ensuring nationwide mental health is of great importance. To this end, psychological counselors should be taken as well-trained and ready-to-serve sources.

In conclusion, as a profession that provides psychological service, psychological counseling has significant quantity of contribution potential available for the efforts that are exerted to develop a national policy of mental health. In order to fulfill this responsibility, psychological counseling has been making imminent progress getting faster day by day.

6. ASSOCIATION OF MENTAL HEALTH NURSES

COMMUNITY MENTAL HEALTH NURSES

The mentally healthy behaviours of individuals favorably influence next generations and this interaction continue from generation to generation. Therefore the protection, development and maintenance of mental health of the community are inevitable for the creation of a healthy future.

Mental health is defined as any individual’s balance and harmony with himself and his environment. Within the framework of this definition, the basic principle of Community Mental Health (CMH) services is the fair delivery of medical care to each individual in the community and the assurance of easy access to these services. This principle covers the delivery of community-oriented services rather than individual-oriented ones, the implementation of primary health services, the maintenance of integrating patient care, the participation of all members of the community to care process, the extension of cooperation among medical disciplines and rehabilitation services to cover the entire community.

The objective of CMH services is to protect and provide the maintenance of mental health of the individual and the community, and to diagnose, cure and rehabilitate mental disorders and mental retardation.

Target 28 of national health policy provides for the implementation of a system of mental health services integrated with medical and social services at all levels by the year 2000. Therefore it is widely accepted that the mental health of individuals, families and the community should be evaluated within a medical system focused on the community, within the framework of national health policies and resources and within the framework of a multidisciplinary study and an integrating approach, a system, harmonization theories which are in line with ethical principles, and that the solutions of national, cultural, developmental and vital crises, stress, harmony and mental health problems should be considered in the light of primary, secondary and tertiary measures.

It is not possible to ignore the importance of teamwork in the delivery of such a wide-ranging service. This team includes psychiatrists, psychologists, psychiatric nurses and social workers. When this opinion and the cases in other countries of the world are taken into account, it is inevitable that nurses take part in CMH services, and Mental Health and Psychiatric Nurses, members of this team, may assume important responsibilities for the initiation and maintenance of CMH services.
CMH nursing started to develop as a field of specialty within the discipline of nursing. Taking integrating approach on its basis, CMH nursing is a specialized field of nursing which seeks to prevent mental disorders and to cure and rehabilitate them.

According to American Nurses Association (ANA), a Mental Health and Psychiatric Nurse may assume the following responsibilities:

- Creating a favorable environment for treatment
- Assisting the patients in dealing with life problems
- Determining the care requirements related to the treatment of patients
- Offering medical training
- Contributing to the development of patients in social activities, entertainment, social skills
- Taking part in psychotherapy of patients
- Dealing with social activities related to the mental health of the community

Chronic mental patients, aged people, addicts, homeless people, AIDS patients and street children are among the risk groups that CMH nurses should provide an efficient care.

When the service is targeted on such a large group, it is inevitable to consider the number of psychiatric nurses in our country and their competency and skills. According to 1998 data, the total number of nurses working in our country is presumably 40575, and the patient-to-nurse ratio is 71 patients per nurse. According to data collected from Nursing Vocational Schools, the number of nurses specialized in psychiatric nursing is approximately 185. This figure includes the nurses who have either a master or a PhD degree.

Since nursing education is offered at university level in our country, an academic development has been achieved in psychiatric nursing as well as other fields of nursing. However, because the number of these nurses is not adequate as mentioned above, they do not have the opportunity to work in the field of mental health or in psychiatric hospitals. Therefore unspecialized nurses have to work in the field of mental health. In order to compensate the inadequacy in the number of psychiatric nurses, unspecialized nurses can be offered training and certificate programs organized by the Ministry of Health, nursing vocational schools in universities and concerned associations so that they will be competent to provide adequate and qualified service. These nurses can work in CMH centers, mental health institutions, health centers, mental health rehabilitation centers, geriatric institutions and clinics, psychiatric polyclinics, addiction centers, schools and daycare centers.

It is not possible to deny how important it is to protect mental health of individuals in the 21st century which started with wars, migrations, natural disasters, economic problems and diseases which threaten human health. This protection is inevitable for the creation of healthy future generations. It is obviously seen that people who assume great responsibilities in the field of mental health cannot work in a single discipline. The achievement of this responsibility requires teamwork and organized fulfillment of this work. Nurses who are a part of this team will be the professional members providing service in cooperation with other members of the team thanks to their education based on integrating approach. As members of the team, nurses will assume tasks and contribute to the delivery of efficient mental health services to the community.

7. ASSOCIATON FOR PUBLIC HEALTH SPECIALISTS

It is of great importance for the Association of Public Health Specialists to participate in directly or make contributions to the works regarding the solutions of Turkey’s health problems. We regard the intensification of the efforts in Turkey to deal with health problems as a highly positive approach. Therefore, we would like to thank you for giving our Association the opportunity to make contributions to the establishment of a policy on mental health in Turkey. It is obvious that Turkey does not have a clear/established policy on mental health and that a policy which is based on the community and takes account of preventive medicine and early diagnosis should be developed. It is known that the mental health services that have already been offered are mostly based on treatment/medication
and rehabilitation. Therefore we regard the initiation of such a work within your directorate as a concrete development. However, if you provide us basic information on “Marmara Earthquake Emergency Reconstruction Project” mentioned in your letter, we will be able to make more concrete and realistic recommendations on this issue. Do you expect us to make recommendations or make active contribution to the project? The clarification of this point will shape the contribution of our Association to your works. But yet the viewpoints and approaches of our Association to the problems of public health in Turkey are summarized below:

Mental health is an integral part of complete well-being of individuals. However, health sector dealt with the physical aspect of health until the second half of the twentieth century. Mental and social health problems were regarded as secondary problems which could be negligible and as the field of interest of sectors other than the health sector. Yet, these three dimensions of health are closely related to each other and have mutual impacts on each other. Freud summarizes mental health as to be able to love and work. Mental health may be defined as the harmony of social, physical and emotional aspects of life as well. Furthermore, the behaviors of any individual towards the other people and his/her choices about the life are directly influenced by mental health. Mental health does not only mean not to have a mental disease; it also concerns how an individual feels, his/her feelings about the people around him/her and his/her capacity to fulfill the requirements of life. Mental health should be protected and developed at both individual and social levels in order to achieve this ideal in today’s societies in which self-realization and success in life gains more and more importance. However, since health sector which is the key factor in solving the related problems have limited interest to mental health problems, medical professionals except for mental health professionals exclude this issue from their profession and avoid the diagnosis and treatment of mental health problems of the community as well as individuals, the education opportunities on mental health are restricted both during and after graduation, mental health professionals form professional barriers, patients do not have the opportunity to benefit from treatment services and receive the appropriate and adequate treatment, which is called “treatment gap”. Moreover, the professional conflict among these three disciplines and in particular the fact that most of the mental health professionals, especially mental health specialists, handle the problem within the four walls of clinics have adverse impacts on the solution of community mental health problems. Hence, according to the data obtained from the World Health Organization, today only a small part of 450 million people who have mental problems in the world receive the appropriate and adequate treatment. This is the case in Turkey as well.

The number of mental health specialists employed in the Ministry of Health was 398 in 2002. The number of the members of the Turkish Psychiatry Association is 850 and that of the Turkish Psychological Association is 1650. The distribution of mental health professionals in the country is unbalanced like that of other health professionals. It is observed that a considerable number of mental health professionals work in big cities. This situation is among the factors that hinder accessibility to mental health treatment. Moreover, taking account of 2000 census results in Turkey, there is one mental health professional almost per 25,000 people. When the frequencies obtained from the Research on Mental Health Profile of Turkey are adapted to current Turkish population which reaches to 71 million, it is observed that approximately 10 million people have mental problems. Accordingly, there is one mental health professional per 3500 patients. It is possible to conclude from this data that any country including Turkey cannot solve the problems related to mental health by just deploying mental health professionals or mental health specialists.

Following this brief assessment, the public health approach of “Association of Public Health Specialists” and the services that need to be offered in order to solve the mental health problems of Turkey are set out below:

- The mental health problems of the country should be detailed. While detailing these problems, discrepancies in terms of gender, urban-rural life and region should be taken into account.
- The resources of the country that can be exploited in the field of mental health should be set out (information, financial resources, labor force, materials…).
- The legal regulations in the country concerning mental health should be evaluated in terms of scientific information, human rights and patient rights. It should be determined whether there are discriminatory practices against the persons suffering from mental problems.
- A NMHP should be established, making use of the data obtained. When establishing the policy, the requirements,
priorities and resources of the country should be taken into consideration, and the participation and contribution of all related sectors, including non-governmental organizations, should be ensured. (When ensuring the participation of these sectors, the support of persons working efficiently in the field of mental health in Turkey should be consulted)

- The strategies required in order to implement the NMHP should be defined. In these strategies on mental health, the preventive aspect of the issue, that is, the preliminary factors in the society, families and individuals (the basic factors) and the priority of fight for mental problems should be emphasized.

- The programs that are in conformity with the strategies should be devised. These programs should take account of gender and different age groups. The mental health problems in the East and South-East are different from those in the other regions. Specific programs should be drawn up for these regions. The basic approach of the programs should be to incorporate preventive and therapeutic mental health services into basic medical services and to offer such services in primary medical institutions. While offering mental health services to physicians and nurses working in primary medical institutions, social service professionals should be appointed to existent positions and new positions should be created to provide the psychologists with the opportunity to work in primary medical institutions.

- The mental health programs should be tested in various regions which reflect the heterogeneous structure of the country, the obtained results should be evaluated in accordance with objective criteria, and the programs should be implemented throughout the country after making the required changes.

- The mental health curriculum offered during the training of medical workers at the university level should be revised, the ratio of these courses within the overall education should be established, deficiencies in this field should be defined and the standardization in education should be ensured. The basic educational level of the psychologists who are to offer services based on knowledge and ability with physicians and nurses in primary medical institutions should certainly be revised, and they should be provided with more opportunities of practice. Medical professional working in all levels of the medical system should be given in-service training aiming at multiplying their sensitivity and developing their level of knowledge and skills. Medical professionals, in particular those working in primary health sector, should be trained on how to prevent from mental health problems and on the issues of diagnosis, treatment and rehabilitation, and the continuity of these training programs should be ensured.

- The community is today much more interested in mental health issues. However, their knowledge may be deficient or they may have wrong beliefs on mental health. The researches and works which aim raising the interest and awareness of the community should be conducted.

- Cooperation with audio-visual media and press is of great importance. In Turkey 69.7 % of women and 61.1 % men have an education at primary school level or at a lower level. Hence, frequency of reading newspapers, magazines and books is not very high. However, almost all of the society watches television regularly, and a great many of them listen to the radio. Therefore, particularly television and radio are important resources of medical education in the field of mental health. However, it is observed that television or radio program makers working in the field of medical or mental health issues have limited knowledge and that the news presented to the public are prepared carelessly and deficiently. Certain work on this problem should be conducted as well.

- In the whole world the period of hospital care of patients suffering from a mental problem, including the schizophrenics, has recently been diminished. Patients suffering from a mental problem are expected to continue their social life after a short term care in the hospital. The hospitals with higher bed capacity are closed or their bed capacity is lowered. It is recommended that therapeutic and rehabilitating mental health services should be offered in the psychiatry clinics within general hospitals in order to avoid the prejudices and discriminations against schizophrenics in the society. The infrastructure of the patients should be ready when they are expected to continue their life in the society. Without these opportunities, it is impossible for the patients to adapt to social life. Moreover there should be regular consultation services among primary, secondary and tertiary medical institutions.

- Specific importance should be attached to adolescent age groups when offering mental health services. A functional educational health program targeted at this age group should be enforced and implemented in cooperation with the Ministry of Health and the Ministry of National Education.
The problems in Turkey, in particular the ones concerning the primary medical services, are not related to the structuring of service, but to the administrative problems concerning the presentation, quality and control of the service. Moreover, it has been recently observed in Turkey that the health sector is politicized. The administrations handle, as a part of their internal policy, medical issues with superficial and populist approaches disregarding the quality of programs, and prevent medical service from attaining a permanent structure which is able to achieve self-control and develop in accordance with the requirements of the society. The politicization of health sector hinders the nomination of persons who are capable conducting works to raise medical level of the country. Moreover, this current situation causes educated people and specialists to be away from administrative posts. In addition, the deficiencies in employee rights and remuneration in Turkey restrict the application of medical personnel to administrative posts. In brief, it is possible to conclude that the problems of health sector are not brought about by the medical system itself, but by the decision-makers and administrators who are not able to or who do not implement this system. Hence, it is difficult to establish and implement permanent mental health policies in the country as far as the current situation is maintained. As the Association of Public Health Specialists, we declare clearly in our official web site and in the press release of our members that we do not support the “Health Transformation Program” established by the government. We believe that the changes intended to be realized in the health sector aim at avoiding the economic burden of medical services; however, the most important point disregarded by the political will is that “Health is an inborn human right and the State/government is responsible for ensuring that this right is enjoyed by every individual in the country.” Practices such as allowing merely the specialist of a branch to administer drugs of his/her branch in order to restrict the costs of expenditures on medicaments are certainly incompatible with scientific facts and the efforts to enhance the scope of health and mental health services. These practices provide us important clues about the future condition of health system. As the Association of Public Health Specialists, inspired by the thought that health should be regarded as a fundamental human right, we believe that the medical requirements of the society, which is impoverished gradually, cannot be satisfied by the policies that privatize the medical services, grant the administration to local authorities, and disregard preventive approaches/services, reducing health to diseases and treatment. Hence, the efforts of this government, which is to be in power at least during the next three years, to establish a mental health policy disregarding the implementations will a be loss of time, labor and financial resource. Therefore, we believe that the policy which has been envisaged should take account of the above-mentioned points and even fight against these problems.

It has been known for a long time that Turkish administration is dominated by an excessively centralist structure. It is clear that there is a need for practices that are set out in accordance with local requirements. However, a political will, which is capable of making changes in benefit of the society, has not been in power so far. The draft law on local authorities devised by the government envisages an arrangement which requires a great many of services including health services be offered by the municipalities. However, local authorities have already been suffering from economic burden. How will local authorities assume functions of the administration if they fail to repay their debts as it was the case in the middle of 1990s and at a stage where works on the consolidation of mutual debts with the Treasure are being conducted? How will the local authorities in small towns deal with such a complex issue as health with their limited resources? It is known that the impacts of political decisions are more intense in settlements in the peripheral. How will these decisions influence the services offered in medical institutions at regional level? Turkey does not have adequate financial resources to find out the answers to these questions by the method of trial and error?

Consequently, as the Association of Public Health Specialists, taking into consideration that local elections are over, we believe that it is reasonable to observe the legal arrangements implemented by the government, express our responses to these arrangements and make the required orientations in benefit of the society via democratic ways and wait for the results. It is clear that these legal arrangements and their implementations should be monitored. We believe that at this stage a monitoring committee which knows Turkey very well, follow and deal with the developments in the country should be established, and that new policies and programs should be shaped taking account of subsequent developments. I wish you success in your works on behalf of the Executive Board of the Association of Public Health Specialists.
8. NMHP (JOINT REPORT) OF THE SOCIAL PSYCHIATRY ASSOCIATION OF TURKEY AND SUICIDE PREVENTION SOCIETY

A country can develop and improve itself only if health conditions are improved, services are accessible throughout the country, and higher level of quality is provided. A society, where health remains a problem can not be successful in development. Our country has failed to reach this kind of a success in health yet. There exists the need to consider the mental health issue from a community mental health perspective and formulate a contemporary mental health policy embracing the current health system as a whole.

Inevitable dominance of concepts such as "protectionalism" and "sociality" shaping the type and organization of services in psychiatry practices becomes more sensible every other day. The understanding of social psychiatry mainly associated with "care by or in the society, shifting of caregiving centers from hospitals to the society" has undoubtedly been accepted as the main service understanding of the day. Today the question to be asked is "what kind of a mental health policy for this community".

The answer to the question "what kind of a mental health policy for Turkey" can be given by collective efforts of various agencies, organizations, groups and individuals that should be started immediately. This requirement has become even more urgent for Turkey, as a candidate country for the EU.

It is time that self-repeating approaches be replaced by innovative regulations and recommendations in policy-making attempts.

As the Social Psychiatry Association of Turkey, we believe in the necessity to review fundamental principles first, and then to provide guidance for implementation. This report has been promulgated in three chapters for this purpose. The first chapter deals with the basic principles that should be considered when defining contemporary mental health policies. The second chapter provides recommendations for implementation within the framework of a suitable mental health policy for Turkey. Finally, the last chapter defines a strategy for implementation of these recommendations.

The fundamental criteria of the WHO and EU should be taken into consideration in attempts when making a NMHP for Turkey. The sine qua non indicators of the general approach are as follows:

1. In hospitalized treatment of mental problems, the criterion should be to reintegrate the patient to the community as quickly as possible.
2. Small-scaled hospitals should be choice of selection, based preferably on psychiatry clinics of general hospitals.
3. An organizational structure should be created for treatment of mental disorders in institutions that are located as closest to the patient as possible. (Sectorization)
4. Services should be comprehensive enough to meet various needs of the individual. Not only the disease-related findings and symptoms, but also social availabilities of the person should be considered.
5. Services should be multi-dimensional covering rehabilitation services and preventive mental health works besides hospitalized treatment.
6. Services should cover not only psychiatrists, but also other mental health professionals. There should be a multidisciplinary approach including psychologists, social workers, psychiatry nurses, hobby therapists, hospital managers, etc.
7. A multi-sectoral analysis is needed for an effective mental health policy. Cooperation is essential with the Ministries of Health, National Education, Interior, municipalities, etc.
8. A service program should be formulated in integration with the general health policies of the country.
9. The necessary laws and regulations on mental health should be revised, restructured and implemented considering the importance of mental health within the framework of contemporary conditions.
10. It should be admitted that works can be run more smoothly with the collaboration of non-governmental organizations.
11. Planning should be made for professionals to be employed in this field, public education programs should be designed and
implemented to avoid stigmatization, discrimination and exclusion of the mentally ill.

12. Suicidal behaviour having the potential of becoming one of the most crucial problems of the future and preventive attempts against suicide should be included in the NMHP with the attention that it deserves.

B

How to structure the program to be prepared in line with these fundamental principles:

1- First, existing resources should be defined. (psychiatry, psychologist, social worker, psychiatry nurse, hobby therapist, etc.) Gaps should be identified in line with the needs, and initiatives should be taken to overcome these gaps.

2- Epidemiological research should be planned and projected to meet the funding requirements as may be needed for determining the patient population in the country as well as epidemiological characteristics of service-receivers.

3- Service providers in mental health should be identified; not only psychiatry clinics, but also other institutions such as polyclinics, rehabilitation centres, nursing homes, if any, correction houses, etc. should be identified.

4- Awareness programs should be organized for the purpose of changing attitudes of the entire health personnel and the general public against stigmatization, discrimination and exclusion in mental health.

5- Necessary initiatives should be taken to launch educative programs for all personnel to be employed in mental health care at all university and teaching hospitals based on the graduate education program of Ankara University, Health Sciences Institute, Department of Interdisciplinary Social Psychiatry.

6- In-service training programs of the field personnel should be standardized and applied as continuous training programs.

7- Commissions should be set up and activated to start and run these works.

Agencies, institutions and individuals with experience and knowledge in the respective field should be admitted to commissions for the purpose of speeding up the process.

For instance; the Turkish Psychiatry Association having taken a long distance in preparing laws and regulations on mental health may be assigned to set up the commission in charge of these activities.

8- The most suitable city or cities should be selected for “pilot project” considering the basic principles.

9- All works should be projected, budgeted and funded properly.

C

In conclusion, rather than self-repeating meetings, practice should be a priority; latest situation should be reviewed semi-annually with commission reports.

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9. CHILD DEVELOPMENT AND EDUCATION SPECIALISTS ASSOCIATION

In developed countries, it has been a priority and focus point to protect and strengthen the family structure particularly in the last fifty years. The foundation of social life is the family, which can only be carried on to the future by children and youngsters. Therefore, it is “child health” that lies on the ground of a healthy society. It is necessary to appreciate well the facts that there is a large population of youngsters in Turkey and that it is vitally important to have a healthy, productive and qualified young population for the future since these are the most critical aspects of the development potential of societies. Hence, it is important that proper measures are taken to prevent children and adolescents from getting trapped by dramatic events as their peers in developed countries and that practicable ways of solution are reached by accurate diagnosis of problem fields.
It is crucial that our children, who are the adults of the future, have access to services with proper content delivered by properly qualified people so as to have a healthy development. For healthy generations, cognitive, motor, language, social, emotional and self-care developments of children should be properly evaluated and policies should be followed for solution of their problems.

The need for cooperation between professional groups in mental health care is stressed in various chapters of the NMHP Report. Considering the fact that Child Development and Education Specialists, who constitute the only professional group supporting the developmental stages of the child and adolescent and finding solutions for their problems at the graduate and post-graduate levels both in theory and practice in the last four decades undertake important roles in raising healthy future generations in the system, it is quite evident that they should be involved in the seven modules constituted around the social mental health policies (organization of mental health services, treatment-rehabilitation services, mental health policy for the child and adolescent, funding of mental health services, quality improvement, legal arrangements, education-research-human resources for advocacy in the field).

The history of Child Development and Education goes back to 1968, which is the year of establishment of the department in Hacettepe University becoming more recognized in four decades with the establishment of this department in other universities by graduates of under-graduate and post-graduate programs of Hacettepe University.

Specialists of this branch are educated with theoretical and practical courses on child mental health (developmental psychology, family planning, mental health and adaptation problems, dynamics of family and life, communication, psychological counselling introduction to counselling, pediatric health and diseases, family counselling in education, development and education of sick children, etc.) and take active role in public and private institutions serving to raise awareness of families and the society in this field.

Child Development and Education Specialists define level of development of all children between the ages 0-18
a) With normal development,
b) In need of special education (at home, special education institutions or undergoing integration),
c) Under risk (vulnerable - institutionalized, living at streets / working, refugee, criminal, neglected / abused, child mothers, contradicting with laws / poor)
d) Under hospital care,
   (1) During infancy
   (2) Preschool, school
   (3) Adolescence
and follow their development in all areas (mental, language, motor, self-care, social and emotional), prepare proper supportive educative programs that would match their development level, make arrangements for educational environment, apply and follow programs, monitor whether the program provides an input to the child, family and other related parties and make alterations accordingly.

• Provide consultancy to parents (before, during and after pregnancy), to people, authorities and agencies involved in matters relating to child development and education and cooperate with them.

**CHILD DEVELOPMENT AND PROBLEMS OF EDUCATORS**

• As many other professional groups, child development and education specialists still need definition of their profession and approval of professional laws. It is for this reason that their field of interest may from time to time overlap with that of other professionals leading to vagueness in definition of powers, rights, duties and putting our colleagues in a difficult position since violations of rights and responsibilities cannot be prevented.

• Law-makers generally do not have sufficient level of knowledge on professional groups in question, and sometimes do not have a single idea about some professions, resulting in their failure to seek proper employment in public agencies and institutions due to qualifications listed in laws. For instance, although there remains no university department
graduating pedagogues since 198, public authorities keep on announcing vacancies in their pedagogue staff paying no attention to child development and education specialists educated to work with infants, children and adolescents in ages between 0-18 with normal development, under risk or in need of special education (Child development and education specialists are excluded from the structure of juvenile courts, family courts as referred to in the child protection law.).

- Child development and education specialists, who are competent to deliver services at various agencies and institutions, are often mistaken with preschool education specialists and kindergarten teachers, who work with children in the age group of 0-6, because of the word “child” attached to the name of the profession. However, all individuals under the age of 18 are referred to as child by the WHO, Unicef as well as in the Civil Law. So, child development and education specialists graduate from undergraduate programs of universities intended for normal and vulnerable infants, children and adolescents in the age group of 0-18 and their field of activity is not only limited to preschool and normal children as confused most of the time.

- This profession is not sufficiently known in our country since there are only three departments having graduates in child development and education leaving the needs of the country unmet.

- Since staffing is not subject to standardization, other professional specialists may be appointed to posts in public authorities and agencies.

- Since the job description of child development and education is unknown to other health professionals although they are involved in health sector, they are not assigned to posts albeit their competence in development and follow-up screenings in primary care and are positioned to secondary care only in limited cases.

- Although Turkey ratified the “Convention on the Rights of the Child”, the posts requiring attention of child development and education specialists, being one of the basic profession needed to meet conditions of the conventions, still remain underoccupied.

- The specialists of this profession have limited access to special branch education and academic career.

THE ROLE OF CHILD DEVELOPMENT AND EDUCATION SPECIALISTS IN THE NMHP

Within the framework of the NMHP of the Ministry of Health, Child development and Education specialists may carry out the following tasks for determining problem cases in children’s mental health care in aspects relating to their specialization as explained above.

- To follow the social-emotional development of children at the Counselling Research Centers, special daycare and nursing homes, kindergartens and public and private care and rehabilitation centers under the Ministry of National Eduation, to determine any problem cases and provide guidance to the family and the child in leading them to ‘Child mental health care’ units.

- To carry out developmental screening for children of families applying to Mother-Child Health and Family Planning Centres of the Ministry of Health, to detect problem cases and provide guidance to the family in having access to related authorities.

- To be involved in team work for detecting problem cases in mental health at the nursing homes, community centres and family counselling centres under the Institution for Social Services and Child Protection of the Primeministry.

- To function as advisor to juvenile courts and juvenile correction facilities of the Ministry of Justice, to contribute to works for solution of conditions threatening mental health status of children and families.

- To take role in awareness raising activities intended for families and the society on matters relating to children’s mental health in cooperation with the press and the media.

- To be involved in works aimed at supporting development of children.
RECOMMENDATIONS FOR CHILDREN’S MENTAL HEALTH CARE WITHIN THE SCOPE OF THE NMHP:

• Problems relating to Children’s Mental Health should be clearly identified since mental health problems may differ in different regions due to reasons such as life style and living conditions.

• More importance should be attributed to Children’s Mental Health within the general health services evaluating resources that may be used for protection of mental health in the society.

• Legal regulations should be reviewed in Children’s Mental Health making use of relevant scientific research and applying to expert opinion.

• Preventive and protective services should be intensified on Children’s Mental Health. A proactive approach to problems is extremely important in making proper timing, improving quality of services and achieving positive outcomes.

• Within the framework of preventive and protective works, attempts intended for risk-groups and adolescents should be prioritized in shaping of a service plan.

• Services intended for children’s mental health care should be provided by professionals competent in mental health care services and free of charge to make sure access by everyone starting from primary care.

• Preventive and developmental attempts should precede therapeutic services in mental health care resulting in effective programs in this area.

• Cooperation with local governments and non-governmental organizations is essential in children’s mental health.

• A multi-disciplinary approach should be planned in the area of children’s mental health with involvement of various professional groups.

• Data obtained nationwide should be used for setting up and implementing a policy for children’s mental health.

• Programs prepared in line with strategies for children’s mental health should be tried in different regions with an ultimate goal of reviewing the outcomes.

• Situation review should be made after various attempts on children’s mental health in different regions seeking for the necessary revisions in the program to be extended to a national scale.

• The press and the media should be used for raising social awareness on children’s mental health.

• The program developed on children’s mental health within the framework of National Mental Health should be thoroughly monitored and the results closely evaluated.

• Child development and education specialists, who have been going through difficulties in finding employment in the health sector although they are part of the health system, should be given posts in mental health care, mother-child care and primary care. They may be used as back-up personnel in other health institutions, where there is limited staff available paving the way for more effective services intended for children and adolescents.
HOW SHOULD BE THE CONTEMPORARY MEDICAL EDUCATION?

Today, it is an accepted fact that all health policies should be associated with medical education. The mental health policy cannot be dealt with separately. This chapter discusses how mental health education should be incorporated in the contemporary medical education.

The purpose of medical education is to educate physicians to make sure a healthy living for people. A physician to be educated for this purpose should
- deliver public health services,
- serve as an advisor/educator,
- have the skills and knowledge to make research,
- be familiar with the priority health problems of the country, as well as social, cultural and economic structure of the society and have an influence of health policies.

Situation in Our Country: There is an increasing trend for growing number of faculties and students of medicine in Turkey. Education provided in faculties of medicine has undergone a remarkable progress with establishment of specialties and contribution of medical congresses. Problem and community-based horizontal and vertical learning programs are tried and new ones are prepared. The only thing that remains unchanged is the increasing trend in number of students. According to data of the last 15 years, the number of students admitted to faculties of medicine is roughly 5000. By the end of 2002, 49% of education models applied in faculties of medicine is integrated, 37.5% mixed (integrated + 30% active, classical + 7.5% active), 14% classical and 5% completely active. Classical education model is far from meeting the demands of the health requirements of the day due to its approach to basic health problems and the learning/teaching methods it employs. Medical education should be restructured by taking into consideration the fundamental problems encountered in the health sector.

The main objective of medical education should be to provide skills of life-long self-learning, judgemental capacity for knowledge and evaluating knowledge in line with an understanding of evidence-based medicine.

Medical education should be “community-based” and “community-oriented”. A community-oriented medical education addresses the priority health issues of a country. A community-based education, on the other hand, takes as the basis primary and secondary care services of the country. To reach these goals, there is the need for a coordinated approach with involvement of the Ministry of Health, as the service provider, professional organizations and education authorities (faculties of medicine).

The World Health Organization shares the opinion that medical education should have validity on a community scale, or in other words the knowledge and skills used in the education process have validity in solution of health problems of the community. Four criteria have been laid out for validity:

Priority: Medical education should be relevant to health problems, and it should be taught how to identify priority health problems. If there exist child deaths due to communicable diseases in a particular community, priority should be given to child health and communicable diseases in education with a secondary attention to cardiovascular surgery.

Quality: Quality is not solely related to technical competence in medical education. The students are expected to appreciate primary care services, grasp and apply integrity of protection/improvement/treatment/rehabilitation. Furthermore, each physician to be is expected to have learnt urgent interventions and health education matters sufficiently.

Cost-efficiency: Each physician to be should appreciate the importance of how to use resources. It should not be the expensive technology, but relevant technology; not abundant but sufficient medication to be of choice. They should be provided with the skills and knowledge on matters such as family planning, health child raising, tuberculosis treatment, etc.
Equality: The type of service needed everywhere and for everyone should be defined, prioritizing the needs in education. Faculties of medicine are expected to determine what kind of service is needed where and for whom.

Community-based validity should be attributed the same level of importance by both the service-provider and education authorities. Faculties of medicine are recommended to make use of these four criteria in the education process and perform revisions in their education methodology by on-site and timely evaluations. This would contribute to overlapping of education with needs of the community. A monitoring form may be comprised for the education program making sure the use of the above criteria in planning, implementation and influencing phases of education.

The method to be used for medical education should be active learning. Two fundamental methods are needed for active learning: The first is problem-based learning (PBL) that is construed upon suspicion and research. This way, a small group studying a written script under control of a mentor “learns how to learn” by discussing and improving their self-learning methods. The second is the community-based learning (CBL) that aims at learning health problems of the community and producing solution ways. In this method, students must be guided into an area where they would actually see how community-based approach is applied to deal with health problems throughout the education process.

Relation of Medical Education With Health Policies

Medical education is in interaction with health policies. However, it is essential for efficacy of education that this is achieved in mutual interaction. Health policies have an important role in shaping up the health system of a particular country. Health systems, on the other hand, do have an effect in outlining medical education models. Medical education models should contribute to making of new policies by causing a change in the community by means of the ultimate forms of practice. Service-providing units that make health policies are affected by the needs of the community as well as economic systems. However, one with the highest influence in policy-making would be the determinant in shaping up the health system and education models. Medical education models should contribute to making of new policies by causing a change in the community by means of the ultimate forms of practice. Service-providing units that make health policies are affected by the needs of the community as well as economic systems. However, one with the highest influence in policy-making would be the determinant in shaping up the health system and education models. Of course, economic conditions do have a major effect in formulating health policies, but it should be remembered that longevity of people in a given country is mostly associated with how welfare is shared and reflected on community health in that country rather than the given level of welfare in that particular country. Patient-physician relation is seriously affected in countries of free-market economy. However, one thing that remains unchanged for patients in all systems is the need for courage, hope, thrust and a good patient-physician relation. It is for this reason that medical education and practices should incorporate science with humanism and inter-personal communication.

The flow-chart to be followed in formulating health policies, defining health systems and designing medical programs should be based on an analysis of the community’s health needs, inquiry of priority problems and cost-effectiveness as main factors of program design.

After goals of education are clearly identified on the grounds of health needs, education programs are set up by considering the availabilities of education. On the second phase, a community and problem-based, hospital-backed active learning process is started. The process transforming into service in the third phase gets once again in the starting phase following control and evaluation by the community. With uninterrupted dynamism, integrity and continuity is ensured in education and service. This way, it is possible to evaluate the effect and validity of the existing health policy on medical education and community health laying the ground for new health policies.

What Should Be The Role and Characteristics of Mental Health Education in the Global Medical Education Programs?

Alienation of psychiatry from other disciplines of medicine has a negative effect on evolution of medicine and psychiatry in general. Health improvement, preventive and protective services have gained importance in both areas. This point should be emphasized in medical education programs. WHO accepts the fact that psychiatry should have a dominant position in medical education programs.
There are three main reasons for that: First, psychiatry accepts integrity of the body with the mind as a general approach, which is important for the general practice of medicine. Secondly, psychiatric skills such as building good relations with the patient and making mental state evaluation are the ones that should be learnt by all physicians. Thirdly, there is a high incidence of psychiatric problems amongst patients seen in all disciplines of medicine.

With respect to the need for including psychiatry in medical education with a dominant position, the World Psychiatric Association prepared a core program for education in mental health and diseases. The mental health education should have the following education targets within the scope of medical education:

I) Knowledge Targets:
- Psychiatric symptoms and syndromes should be learnt in a biopsychosocial approach;
- Psychological dimension of diseases should be learnt;
- Psychosocial issues such as stigmatization should be discussed;
- Matters relating to written informed consent and patient rights should be well appreciated;
- Legal aspects of forced hospitalization or treatment should be known;
- Patient-physician confidentiality should be observed;
- Professional ethical rules should be learnt;
- Research methods should be learnt.

II) Skills Targets:
1) Skills relating to patient-physician relation,
   - Active listening
   - Empathy building
   - Nonverbal communication skills
   - Starting, managing and ending an interview
   - Problem solving skills
2) Information gathering skills
   - Getting patient history
   - Assessing functionality level of the family and their level of support to the patient
3) Informing skills
   - Informing the patient about protecting his/her health
   - Informing about the possible diagnosis
   - Informing about tests
   - Informing about side effects of treatment and therapeutic methods
   - Informing about the prognosis and course of the disease
   - Skills of breaking bad news
4) Reporting skills
   - Making verbal or written reports to colleagues about patients
   - Reporting to relatives or care-givers of patients
   - Reporting to public
   - Providing health education to public
5) Treating skills
   - Adapting the patient to treatment
   - Ability to treat common psychiatric conditions
   - Differentiating side effects of treatment from symptoms of the disease
6) Learning skills
   - Self and independent learning skills,
- Acquiring skills of having a progressive perspective in clinical conditions

7) Team work skills
- Cooperating with other physicians, other health personnel, NGO’s of patients and patient relatives, community centres
- Building relations with individuals in the community to develop mental health

III) Attitude Targets:
A. Attitude targets relating to general medicine
- Appreciating the importance of psychiatry as a discipline of medicine
- Integrating the humanistic, scientific and technological aspects of psychiatry knowledge,
- Improving mental health and appreciating the significance of preventing mental diseases,
- Having the capacity of putting forth these attitudes towards patients by internalizing them besides expressing verbally,
- Having the capacity of critical thinking, improving the capacity of raising structural criticism against themselves and others,
- Tolerating vagueness and being open to listening others’ views,
B. Attitude targets relating to patients and patients’ relatives:
- Respecting patients and appreciating their emotions,
- Understanding the importance of good patient-physician relation,
- Being aware of remarkable impacts by the family and circle of the patient.

Education Methodology: Mental health education should be provided in an active and problem-based model. Education should be based on protection and improvement of mental health against diseases encountered in primary care, should employ interactive methods such as discussion of case studies, role plays and group works, and should encourage lifelong independent learning. Students must be sent out to the field to recognize most common diseases in the community within the framework of general principles of medicine; if not possible, standard patient system should be improved to enable students learn how to approach and deal with mental problems by simulations.

Education Process: What defines the education process is the content, structure, duration, methodology and evaluation of education as well as education-service relation. In medical education, the education process is not only limited to education provided at faculties of medicine. In this context, mental health education should be planned as undergraduate, specialization and continuous medical education.

Scope of Education: Undergraduate education should be planned according to the mental health needs of every country keeping in mind the above explained education targets. It would be wise to extend mental health education in years throughout the undergraduate education process in continuity. In this context, concepts of health and disease should be introduced during the first year providing modes of biopsychosocial approach. In the years to follow, there should be more focus on patient-physician, physician-physician and physician-other health personnel relations discussing proper attitudes with learning advisors. There should be continuity in developing communication skills and physician identity starting from year 1.

There is the need of emphasizing priority public health problems in preparing mental health programs within medical education. The following criteria may be of guidance in identifying the priority problems:

1. Prevalence: what is the extension of the problem?
2. Clinical logic: what is significance of the problem in terms of clinical problem solving?
3. Prototype value: does the problem have value in creating a model on it?
4. Emergency: what is the level of requiring urgent intervention?
5. Treatability: do the benefits obtained by protection, treatment or rehabilitation override sides effects or adverse events?
6. Interdisciplinary input: is this a problem or a situation making possible input by different disciplines?
Since specialization education is provided by not only the faculties of medicine, but also hospitals of the Ministry, there is the need for a close collaboration between faculties of medicine, Government Specialization Hospitals and professional organizations for mental health care—which actually are two, namely the Turkish Psychiatry Association (the professional organization of adult psychiatrists) and Child and Adolescent Mental Health Association of Turkey (the professional organization of pediatric psychiatrists)—to ensure standardization of the education program. In the program development process for specialization education, it should be the preliminary task to define problems and identify general requirements in setting the content of education and learning criteria. In addition, it is worth highlighting the need for ensuring equal level of specialization education in mental health and diseases and harmonization with the standards of the EU that we are striving to become a part of. The most remarkable problem in terms of standardization is the lack of education personnel sufficiently equipped for this purpose. One way of overcoming this problem is to apply methods presenting alternatives to students of working in different units in rotation throughout their specialization process. When planning this rotation, regional needs should be considered. It would be crucially important to adopt these principles as the education policy for mental health and to include them in health programs.

Another phase in mental health education is to achieve continuous education. Continuous education programs may be in the form of in-service training courses delivered to keep mental health specialists updated in their professional development or to familiarize them with new treatment techniques. This would include training on mental conditions that may be diagnosed and prevented in primary care and on tasks that may be performed by the community for preserving and improving mental health. Furthermore, these programs to be developed would also contribute to other education programs by making the necessary modifications to adapt them to non-mental health care personnel according to their needs.

**Evaluation of Education:** The undergraduate education should not only be evaluated with pass/fail criteria, but should include the following evaluation steps:

- Student performance should be evaluated while doing,
- Education process should be evaluated,
- Program should be evaluated,
- Student's feedback should be taken,
- Instructor's feedback should be taken.

In specialization education, evaluation should be based on standardized assistant reports according to knowledge, skills and attitudes observed during the education process. Continuous education can only be possible by practice-based evaluations. For this reason, student performance should be checked in predefined intervals to sustain use of professional competence and credit system should be functional including the obligation of each physician to attend continuous education programs.

It is essential to evaluate the outcomes of applied programs to appreciate effectiveness and efficiency of both education and existing policy programs. Policy programs and education provided can be deemed as successful as long as the practices meet mental health needs.

**Conclusion:** The way the mental health education is given affects how the physicians of the future would deliver mental health care services to public by their priorities. The mental health policies to be developed would take as a basis the mental health needs of that particular community. If medical education is shaped accordingly, the physicians to be educated in the system would deliver services meeting policies and targets laid down for education. Consequently, education, in this way, would result in efficiency in functionality and validity of mental health policies.
THE NEED FOR CHANGING MODELS FOR EDUCATION OF PSYCHOLOGISTS IN TURKEY

In our country, 4-year undergraduate education may be provided at Psychology Departments of universities affiliated to Faculties of Letters or Science-Letters that admit students according to results of a central student selection and location examination. After this 4-year education they are given the title “psychologist” in accordance with the relevant legislation. In Psychology Departments, education may be extended to Graduate (Master’s) or Doctorate levels in some fields and those meeting the requirements of these education programs are referred to as “Specialized Psychologist” and “Doctor Psychologist”, respectively. Sometimes, the field of specialization may be legally used in the title such as “Clinic Psychologist” or “Developmental Psychologist”.

In Turkey, 6 of the psychology departments date back to more than 25 years in reputable universities (Istanbul University, Ankara University, Middle East Technical University, Hacettepe University, Bosphorus University and Ege University). In addition, there are 7 respectively newer state universities (Samsun Ondokuzmayıs University, Mersin University, Bursa Uludağ University, Diyarbakir Dicle University, Muğla University, Abant Izzet Baysal University and Sivas Cumhuriyet University) and 7 foundation universities (İstanbul Koç University, İstanbul Bilgi University, İstanbul Haliç University, İstanbul Maltepe University, İstanbul Commerce University, İstanbul Okan University and İstanbul Doğuş University) that serve with 14 psychology departments. In other words, there are 20 functional psychology departments as of the end of 2003. However, even undergraduate education cannot be delivered in an uninterrupted fashion in some of these departments due to lack of faculty members (Ondokuzmayıs University). Some have not been able to start recruiting students although founded officially (Muğla University, Abant İzzet Baysal University and Sivas Cumhuriyet University). The total student quota of the above named state universities for 2003 is 395, and that of the foundation universities 287 with an overall total of 682. Student quota of universities is determined by the Higher Education Board in consultation with universities.

There are differences between the standards applicable in Turkey and the US on titles and duration of education. Unlike Turkey, graduates of 4-year psychology departments are not entitled to use the title psychologist despite of the fact that psychology education is mostly based on psychology programs in universities of the US. Because of the applicable credit system, psychology students take not only introduction to psychology, but also some courses of general culture (mathematics, biology, anthropology, etc.) during their first year of education; and start the main sub-fields of psychology during the second year. During the third year, basic courses continue on one side, and elective psychology lessons are taken on the other. The fourth year is mostly based on electives. This structure is almost the same as the psychology education programs in the US. The main difference lies in the weight of elective psychology courses. In the US, students may take courses of a minor branch completing their missing credits with leisure courses. However, in Turkey there is a very intensive psychology curriculum during the third and fourth years, some of which are structured in a practical approach as if they are master’s level courses. As a result, graduates get their BSc diplomas equipped with relatively more knowledge and skills when compared to their counterparts in the US. However this level of competency does not automatically give them a master’s degree. Similarly, unlike the US, graduates of these departments may legally use the title “psychologist” following graduation.

This is mainly due to limited capacity of graduate level education in our country. There are attempts to compensate for this gap by the above defined in-service training following graduation.

As a matter of fact, graduate level education programs, which may be opened with the discretion of psychology departments of universities are very much limited in number falling a lot behind the actual need. According to projections of the Turkish Psychologists Association, graduate (master’s) level education in psychology may only be provided to 20% of university graduates albeit growing capacity in recent years. The 6 psychology departments of our reputable universities are the main departments providing graduate and doctorate levels of education but generally graduate programs cannot be long lasting sometimes not opening entry exams in some fields for years. The main reason for that is the staffing problems of these departments, which result in a loaded schedule for faculty members. Another factor is the lack of motivation for faculty. Education facilities may have their own limitations (such as lab, etc.). Graduate level of education is provided in 6 fields at the psychology departments: experimental, social, developmental,
clinical, industrial / organizational psychology and psychometrics. Yet, specialization education in psychometrics has almost stopped due to lack of specialists. Specialization education is not provided in country at all in important fields such as school psychology, neuropsychology, etc. Programs planned for cognitive psychology or psychobiology were added on top of the list of these fields.

Student quota is insufficient in fields such as clinical psychology that requires direct intervention on human patients and a relatively more intensive specialization. According to estimations of the Turkish Psychologists Association, only about 300 specialists were trained in this field so far. Another reason for insufficiency in student vacancies is the difficulty encountered in providing clinical conditions for internship and practice to specialization students. Although an extreme example, some psychiatry departments at some universities may open graduate programs on clinical psychology for the aim of educating psychologists they employ in their departments although the level of education is mostly irrelevant to scientific facts. This way, clinical psychologists are educated by psychiatrists using case discussions and visits.

Doctorate degree in psychology is even more limited in this country, mostly for academical posts, which are mostly occupied by people educated abroad.

Turkish Psychologists Association is the professional organization that has been aware of the fact that the 4-year psychology education, basically a US-based model, cannot be supported by graduate level education as in the US with a proper understanding of the need for standardization in this field given that Turkey is a candidate country to the EU, which makes standardization an inevitable factor awaiting for our country when this membership becomes real. The Association, which has not yet managed to become a chamber due to legal obstacles, has been working actively in this field to uphold the Turkish standards to the level applied in the EU. In line with the European model, the 3-year basic undergraduate education is to be complemented with a 2-year graduate education making a total of 5 years in psychology education.

This is a model that was started by the “EuroPsyT” project group as a basis for (education of psychologists as required in Europe) European Diploma in the future and was created in European countries within the scope of an ongoing project since 2001. the project is being funded by the European Union and the “Leonardo da Vinci Program” of the Union. EFPA (European Federation of Psychologists’ Associations) is one of the partners of this project being conducted with participation of 15 partners from 10 EU countries. This initiative was possible within the framework of Sorbonne (1998) and Bologna (1999) conventions ratified by the European Ministers of Education for the purpose of creating a common education structure throughout Europe enabling transfer of students when necessary. This way, it is aimed to alleviate differences existing in psychology education of different European countries. (Detailed information and the framework program may be obtained at the project web site: www.europsych.org )

According to this model, there applies the condition of a one –year full-time supervised work on top of this 5-year education entitling to a master’s degree at the end of an independent study in major fields including clinical psychology. The Turkish Psychologists Association running an advisory process with EFPA has a while ago brought up the issue for discussion with psychology departments of universities and has started the procedure for filing the necessary application to the Higher Education Board. However, some of the academic staff having been accustomed to applying the 4-year American model for many years and educated accordingly both in Turkey and the US, initially approached the 3+2 model with suspicion raising concerns that this system might distort the existing system even further since it already has its own limitations.

Yet, for our country having made all of her plans according to the target of becoming full member to the EU, this model proves to be an important opportunity to overcome the impass (failure to provide sufficient level of specialization to psychologists and considering the graduates inadequate to be employed in the field) in education of psychologists within the availabilities of this country.

Reputable psychology departments give master’s level education resulting in 4+2=6 years of education. The second year of the master’s level is the thesis year. In other words, master’s students actively take courses for five years including the undergraduate
education. This thesis work is comprised in the last year of the 3+2 model. When the courses of the last two years focus on a specialized field, the students would get better chances of having a better integrated learning with this model. According to the current model, the students elect courses of various sub-branches of psychology during the last year of their undergraduate education with a concern to fill in their credits resulting in superficial learning of various topics. On the contrary, the European model gives a chance to all psychology students deciding to continue with the master’s level of education in this field after completing their third year according to their success status and/or exam and preferences (provided that there is flexibility according to available conditions of the department and needs of the country). This kind of a system results in a much better education with target-oriented compulsory courses, elective courses and internship. Graduates of the 3+2 model may seek employment as specialists under supervision at different institutions. Those willing to perform independent work may get prepared with a 1-year internship to be organized either within or outside of the university system under supervision. Considering the fact that psychology literature is mostly in English language, a 1-year preparatory language education should be imposed as a prerequisite for those planning to continue with the 2-year master’s program.

Regarding applicability of this system, psychology departments may raise concerns considering limitations of academic staff and other education availabilities. Undoubtedly, there will be the need to strengthen the staff and education availabilities. However, considering that major problems are experienced in the current system except for reputable universities, some departments of state and foundation universities may have to stop admitting students according to this model until they are totally ready. Given that the general purpose is to raise quality of service by graduates, this weakness may be acceptable for some time.

There is no doubt that arrangements of the professional organization on competency, accreditation and continuous education would harmonize this education of the new model with the demands of the working life. The necessary political will and legal arrangements (the Law and Regulations of the Higher Education Board, professional rules for psychologists, etc.) are extremely important for this purpose, which must be completed urgently. Keeping in mind that almost 2500 psychologists (500 with specialization) are made available to the field so far based on the current model resulting in 2 or max. 3 psychologists per 100,000 people in the country (see opinion report of the Turkish Psychologists Association) and that graduates of undergraduate programs are considered as insufficient by academic circles providing the education, it would be wise to say that it is time for this kind of a change in psychology education in our country that has been spending enormous efforts for EU membership.

Since there are about 2000 psychologists working in our country with diplomas of 4-year education and they have raised themselves in service for many years, it would be inevitable to make use of this existing capacity within the framework of the NMHP. Psychology graduates of 4-year programs in Turkey have the capacity of meeting various requirements in mental health services. It should be a priority to ensure adaptation of psychologists to the model change within a legally supported environment but without victimizing them in any way whatsoever in bringing along the requirement of certifying them with proper planning. Undoubtedly, this can be achieved by collaboration of the professional organization with official authorities such as the Ministry of Health.

PSYCHOLOGICAL COUNSEL OR EDUCATION IN TURKEY

Psychological Counselling and Guidance has first been introduced as a profession to our lives in Turkey in 1950’s although it goes back to 1900’s in the United States. This field first evolved as a result of the need for service delivery in education institutions. Scientists educated in graduate and doctorate levels abroad, particularly in the US, on this field took initiatives in raising professionals based on the American model upon their return to Turkey. The first choice of practice was raising Psychological Counsellors by short-term courses, training and certificate programs.

Psychological Counsellors help individuals with their personal, familial, educational, psychological and professional decisions and solution of their problems. Graduates of psychological counselling and guidance are currently employed at schools of the Ministry of National Education, guidance and research centres, prisons and detention houses of the Ministry of Justice, juvenile correction
facilities, psychological counselling and guidance centres of the Turkish Armed Forces, and hospital and health centres of the Ministry of Health. Psychological Counselling is defined amongst the professions with a growing need in the Occupational Outlook Handbook that evaluates the structure and outlook of various professions.

The first psychological counselling education was started in 1965 at the Education Psychology and Counselling Department, Education Sciences Faculty, Ankara University in Turkey. The first graduate level program on psychological counselling was set up in 1967 under the body of the Post-Graduate Education Faculty of Hacettepe University. ‘Psychological Counselling and Guidance Department’ was established within the Social and Human Sciences Faculty of Hacettepe University in 1974. In the years to follow, graduate level education programs were introduced at Ankara University, Middle East Technical University and Bosphorus University.

The first four-year undergraduate level psychological counselling and guidance program in the modern sense was started in 1982 at Hacettepe University following enforcement of the Higher Education Board Law no 2547. Programs were started in other universities for educating psychological counsellors as per the Higher Education Board. There are 18 universities providing undergraduate and 14 graduate level of academic programs for psychological counselling according to figures of 2004. The model used for raising psychological counsellors in Turkey has been developed in line with the American model in many aspects. In individual and group counselling, client-centered and behaviouristic approaches were taken as the basis. Like in the United States, education programs for psychological counsellors are organized within the body of the Faculties of Education in Turkey.

Every year, 650 undergraduate level psychologists and approximately 30 master’s and doctorate level specialists and physician psychological counsellors are educated from relevant departments in Turkey. In Turkey, there are about 8000 professionals having graduated from undergraduate, graduate and doctorate level psychological counselling and guidance programs in 2004.

The undergraduate level Psychological Counselling and Guidance programs are comprised of almost 45-50 different courses with about 130 credits/hours and completed in four years; whereas graduate level programs are comprised of 8-10 courses with 28-30 credits/hours plus master’s thesis. The doctorate level, on the other hand, comprises 8-10 courses with 28-30 credits/hours and a doctorate thesis work. There is no internship in education of professionals.

During the course of undergraduate, graduate and doctorate education, the fields of competency targeted for students by courses, practical studies and research work are as follows:

- Growth and development of human as a biopsychosocial existence,
- Social and cultural differences,
- Group psychological counselling,
- Psychological measurement and evaluation,
- General principles and practices regarding extension, definition, referral and prevention of mental disorders including dependence and emotional disorders,
- Basic principles and practices in individual developmental and preventive mental health,
- Basic principles and models on human development and psychopathology,
- Knowledge and skills on initiating, maintaining and ending the psychological counselling process when working with normal and mentally disordered individuals by making use of short, medium and long term interventions including crisis intervention,
- Skills of making and running programs on mental health education, awareness raising, psychoeducation, institution-based preventive mental health care,
- Professional development and carrier counselling,
- Research and program development,
- Professional identity development and ethics.

Turkish Psychological Counselling and Guidance Association (TURK PDR-DER) was founded in 1989 to facilitate professional
organization. The number of members to this association is almost 850 according to figures of 2004. The Association publishes the ‘Psychological Counselling and Guidance Journal’. Since 1997, the ‘Turkish Psychological Counselling and Guidance Bulletin’ has been published for the aim of facilitating communication between professionals. The Association has been holding the ‘National Psychological Counselling and Guidance Congress’ every two years.

Turkish Psychological Counselling and Guidance Association has been carrying out activities on bulding ethical standards relating to professional practices, education and research work. One of the commissions of the Association, the Ethics Commission, works to protect and develop professional standards.

There is very limited number of professionals and fields of specialization for those delivering mental health services. Services needed in the society on mental health issues should be produced by various professional groups and delivered by these groups to all individuals in need of their services. As in some other professions such as psychology, social services, physical therapy an rehabilitation, speech therapy or hobby therapy that may contribute to mental health other than medicine, psychological counselling is also a branch that lacks regulatory work on professional education, accreditation and practices. Similarly, preparatory works are still underway on regulations relating to education, accreditation, internship, professional practices, introduction to profession, stay in practice and expulsion with the contribution of the professional association. There has not yet been enacted a professional law in this field.

Problem fields relating to education of psychological counsellors may be listed as follows:

- There are major differences amongst academic programs for education of professionals,
- There is a gap of faculty members to provide education on psychological counselling and guidance particularly in newly established universities,
- Legal regulations are missing for education of professionals,
- Accreditation bodies are lacking,
- Professional education is not strong enough,
- There is no defined graduate or doctorate level program for specialization in fields of mental health counselling, rehabilitation counselling, school psychological counselling, marriage and family counselling,
- Since there is no professional law in this field, psychological counselling posts are generally occupied by people who are not educated in psychological counselling leading to a swift decline in quality of services in this profession.

Within all health services, mental health care, in particular, requires production of services by various disciplines under guidance of strict laws and with proper conditions. These services are being provided in cooperation with professionals from various disciplines in developed western countries and countries of the EU that we are willing so much to become a part of. Professional service delivery criteria are laid down in the Evidence Based Clinical Practice Guideline of the British Department of Health, which may be taken as a good example for professional standards from Europe. In these guidelines, psychological counselling is accepted as a profession in the class of health services.

Professionals of psychological counselling and guidance are educated in a limited fashion in the countries of the EU. Turkey is a country with a relatively developed education model in psychological counselling and guidance when compared to the countries of Europe. Turkey is actually in the position of being a model for Europe in this respect. Council of Europe has started a project, namely “Restructring in Counselling and Guidance” to be completed by 2010. There are attempts to extend psychological counselling and guidance practices to other countries of the European Union.

Recommendations for psychological counselling education in Turkey are given below.

- There is the need for a professional law regulating education programs intended for psychological counsellors.
• Psychological counselling education programs should be standardized. An acceptable baseline program should be created and taken as the basis by all universities providing education in this area.

• Education standards should be laid down for psychological counselling education programs including institutional and professional accreditation. This process should be controlled by an independent accreditation body.

• Skills acquired by psychological counsellors should be updated according to social needs.

• Programs at universities failing to employ sufficient academic staff should be strengthened; otherwise student recruitment should be suspended until this can be achieved.

• Practice standards subject to supervision should be identified within the education process before professional practice.

• Student quotas should be increased in undergraduate and graduate levels of education in universities with sufficient capacity.

• Standards should be set for institutions where students may complete their internship.

• In student admittance to undergraduate programs, student selection methods should be employed for evaluating personality traits of students in addition to central student selection system.

In Turkey, there is a sophisticated and well-rooted experience and tradition of educating psychological counsellors. Professional staff should be educated with four year education process as in other fields. The contribution of well-educated professionals is an inevitable fact in prevention of mental health problems in this country. The most valuable asset of this country is its human power. This important asset should first be preserved and developed as a priority. The contribution of professionals delivering services in this area should be well-appreciated and properly guided in planning of human power and bringing individual prospect.

TRAINING OF SOCIAL WORKERS IN TURKEY

In Turkey, education in social work was for the first time provided by the Social Services Academy that became operational in 1961 under the Ministry of Health as per Articles 1/f and 9 of the Law Establishing Social Services Institute no 7355 of 12 June 1959. In 1967, the two-year Social Work School was founded in Hacettepe University, which was in two years affiliated to the Faculty of Social and Administrative Sciences of the same university to be named thereafter as the Department of Social Works and Social Services. This department was the first institution of higher education having started graduate and doctorate level education programs in Turkey. Within the framework of the Law on Higher Education Board, the Social Services Academy was transformed into the Social Work School under Hacettepe University in 1982 covering the Department of Social Services. The Social Work School, which has been the only school that prvided undergraduate, graduate and doctorate levels of education on social services until 2002 is a member of the International Association of Schools of Social Work. During the 2002-2003 education semester, Başkent University has launched the Department of Social Work under the Faculty of Health Sciences. With this second department, there are now two schools that provide education for social workers in Turkey. Both schools provide 5 year undergraduate education including the prep class and their graduates are entitled the title of “Social Worker” as per the relevant legislation.

Within the body of the Social Work School of Hacettepe University there are a total 6 scientific branches incuding two major branches, namely ‘Individual and Community Problem’ and ‘Social Development and Social Policies’.

In both schools, education programs are planned from a generalist approach. In generalist approaches, it is essential to approach the integrity of theory and practice from a general framework. The generalist approach has a systematic and integrated perspective towards human and community problems focusing on problem fields in practice, which gives it an inter-disciplinary character. The faculty members of the Social Work School agreed on reviewing the education program under the light of rapid changes and started a project for ‘Academic Restructuring’ in 1999 enforcing the new program in 2001-2002 education semester after three years of intensive work. Works are still underway for modifying the graduate level education programs.

It is aimed to develop the cognitive, emotional and behavioural skills of social work students during their first year following the
prep class. Accordingly, they take introduction to philosophy and logic; mathematics; ecology; youth, society and social work; introduction to information technology; basics of pedagogy; communication skills; psychology; sociology; economics; law; statistics; political sciences; in addition to acting and music from fine arts; communication with plays; psychodrama; creative drama and animation from communication skills during the first year of their education. Starting with fall of the second year, their professional and scientific formation starts. This year, basics of social work, methodology in social sciences, human behaviour and social environment, social structure and problems, social change and family, socioeconomic history of Turkey and psychosocial reviews in literature are the courses to be taken during the first semester leaving social economic system, social development and social justice, democracy and human rights, family and juvenile law and social research techniques to the second semester. Furthermore, the social research practices is another course that starts this semester. The third year is the most important year in scientific and professional formation. The courses of the year are arranged with an integrated approach in theory and practice of social work. The first semester includes courses on social work theory, social policies and planning, organizational institutions and management, communication theories, social work classes and seminar courses. The social research project is completed in this semester. Courses such as social work theory, social organization and group dynamics, political social service, social security and social assistance law, human community and media and seminar II are taken during the second semester of this year. Seminar I and II bring up social work interventions on various problem fields. The ‘prep to project seminar’ given in spring semester is the fundamental course of the fourth year. The other courses of the year are psychiatric social work, medical social work, crisis management, judicial social work, gerontologic social work, community health, guilt and social work, poverty and social work, disability and social work.

The fourth year is the stage of education when students complete their scientific and professional formations during the course of undergraduate education. This final stage of their education process is the level where students can reflect what they have acquired since the first year. The program enables the students to live through the integrity of theory. For this purpose, project seminar, practical project seminar and theoretical project seminar evaluations are included in the program.

Department of Social Work under the Faculty of Health Sciences of Başkent University does not have graduates yet. Every year about 100 social workers graduate from the Social Work School of Hacettepe University. As of 2004, there are 3200 graduates of undergraduate, graduate and doctorate programs in Turkey. About 1500 of social workers are employed by public agencies such as the Directorate General for Social Services of the Primeministry, Ministry of Health and Credit and Hostels Institution, whereas the rest works at private institutions.

Social Works Club was founded and launched branches with the purpose of facilitating professional organization. This Club publishes regular bulletins to advocate communication between professionals. The Club holds International Social Work Conferences every two years in cooperation with the Social Work School. The Social Work Club has been spending efforts to become a member to the International Federation of Social Workers for the last ten years. The official application was filed in 2001 resulting in Turkey’s membership agreed on 12 July 2002 during the General Assembly of the Federation in Geneve.

There is a limited number of professionals directly delivering mental health care services in Turkey. There are around 30 social workers working in the field of mental health care. There are two education institutions educating social workers. There is the need for building up the necessary infrastructure in different universities with launching of new departments. The newly enforced undergraduate program should be subject to performance assessment. Furthermore, aftergraduate continuous education and supervision system is not efficient. The areas of development needed by field workers should be indentified to incorporate them into regular in-service training programs, which would improve quality of service and have a positive effect on work satifisfaction.

**NURSING EDUCATION IN TURKEY**

Previously, nursing education was based on vocational health schools, which later on evolved with opening up of two-year nursing
faculties in universities in 1955. These are the nursing schools that provide prep + 4 year undergraduate education. After 1997, two-year graduate programs were replaced by four year health schools providing education at the graduate level. There are graduate and doctorate level education programs in nursing since 1968.

In modern sense, nursing needs professionals, who have competency in self-management, appreciating and solving problems in their field of service, perceiving and presenting their roles in the proper manner. These characteristics and requirements make it compulsory to have a university-level education for nurses. The World Health Organization (1993) emphasizes the importance of nurses among other health professionals in delivering, managing and evaluating care services to individuals, families and groups both in preventive, therapeutic and rehabilitative, and supportive aspects. Besides, they should have the capacity of improving their knowledge and practices by making use of critical thinking and independent decision-making skills in reaching out to most effective outcomes in practice. This can only be possible by academic development (graduate and doctorate levels) in nursing.

Problems encountered in psychiatry nursing and education are similar to those experienced in current nursing education. Below is a summary of problems and recommendations relating to current situation in nursing schools and the level of education provided by them.

**CURRENT SITUATION**

- Currently, there are differences between the content, crediting, course hours and duration of nursing education programs (vocational health schools, two-year health schools and nursing schools).
- The graduates of vocational health schools, two-year health schools and nursing schools are entitled the same title undertaking the same roles and responsibilities in practice. Lack of job description for graduates of those institutions result in conflicts in this profession having a negative impact on the quality of service, loss of motivation and work satisfaction. Although vocational health schools were withdrawn from education for nurses, midwives or health officers in 1996, vocational health schools were reopened in some places starting with 1997. Although students of these schools graduate with the nurse title, they have the obligation of choosing nursing departments at the time of entering university, which have a negative impact on their professional development. Therefore, vocational health schools should be completely closed down and replaced by university-level education based on highschool experiences.
- The understanding of nursing and service are not considered together in nursing education, which leads to big gaps between the clinical environment and education.
- Lack of practice in nursing schools and insufficient number of field-nurses, who can constitute good role models are other problems that may be faced from time to time.
- Two-year health schools were opened in 1997 without proper infrastructure work and sufficient educators competent in nursing education. Some of these schools are managed by people from other disciplines.
- Faculty members in the universities of the periphery have limited graduate level availabilities relating to academic development.
- Faculty members taking role in nursing education fail to meet the precondition of clinical experience in the field they educate.
- Performance of educators or education programs in nursing schools cannot be properly assessed in understanding whether they meet baseline standards or not.
- There is no National Mental Health law that would pave the way for psychiatry nursing.
- There is no division at the Ministry of Health Department of Mental Health representing psychiatry nursing.
- There is no legal arrangement relating to national mental health in Turkey. As for compulsory hospitalization, compulsory treatment and reporting in various diseases, legal sanctions work according to the Turkish Penal Code and the Civil Code failing to meet expectations of health professionals working in the field of mental health and creating extra problems to them.
RECOMMENDATIONS

- Vocational Nursing Health Schools should be inactivated and education should be provided by graduate level (4 year) graduate programs following 11-year basic education.
- Curricula of schools providing nursing education should be standardized at the minimum level. The results of the ongoing ‘National Core Education Program in Nursing’ should be kept in consideration.
- Legal framework should be rearranged in a way that would meet legal responsibilities and job descriptions of nurses, as well as the requirements of the day and EU criteria.
- School-clinic cooperation should be emphasized in education, practice, research and management for full integration of theory with practice; this should be applicable for every school.
- Student quota should be increased in graduate programs of universities to meet the growing need for faculty members in nursing schools; graduate level of education should be made more available to support academic development of faculty members.
- Nurse educators should be involved in management and delivery of professional courses at nursing schools. Regulations relating to nurse faculty members become even more important at this point.
- At schools, people in charge of program-development should convene periodically reviewing the work.
- Faculty members working in developed nursing schools should visit other schools in need of their support upon request.
- Specialized nurses should be involved in the legislative works of the National Mental Health Law and in implementation of the law, making it possible for specialized psychiatry nurses to take part in these works.

It is recommendable to create posts to be occupied by psychiatry nurses for community mental health care services.

TRAINING OF CHILD DEVELOPMENT AND EDUCATION SPECIALISTS IN TURKEY

Child Development and Education Department was first founded in 1968 under the Home Economics School of Hacettepe University. The Special Education Major was founded on 23 December 1982 after start of preparatory work in 1976. Child Development and Education Department has been continuing its activities in two fields, namely ‘Child Development and Education’ and ‘Special Education’ providing undergraduate level diploma on child development and education to its graduates. Furthermore, there are graduate and doctorate programs on child development and education at the Child Development and Education Major of the Health Sciences Institute of Hacettepe University.

Since 1972, Child Development and Education Department has graduated almost 1700 students. The name of the department was altered as ‘Pediatric Health and Education’ upon decision of the Higher Education Board on 4 March 1987 but later on revised as ‘Child Development and Education’ upon a revision decision by the same Board on 23 March 1996. Following foundation of the Child Development and Education Department in Hacettepe University, similar departments were established at Gazi, Ankara ve Selçuk Universities.

UNDERGRADUATE PROGRAM

Duration of education is five years including one year of English prep class. Courses are taken in two semesters as fall and spring. It is obligatory to take minimum 15, maximum 22 credits every semester. The student to graduate should have taken minimum 128 and maximum 176 credits. The department can be completed in minimum 4 and maximum 7 years of time. Following 1 year of preparatory education, some of the undergraduate courses are given in English.

Students passing prep class exemption examination will be entitled to starting education from the 1st year. The students must take Turkish, Atatürk’s Principles and the history of Revolution and Foreign Language classes in addition to their routine undergraduate courses. Also, every year the students may take any one of the following elective courses: Gym (Volleyball, Basketball, etc.) or Fine
Arts (Theatre, Cinema, TV, Classical Western Music, Photography, Turkish Classical Music, Voice Education, Turkish folk Music, Turkish Folk Dances, Jazz, Plastic Arts). The students take the following courses during the first year of undergraduate education following the prep class: Introduction to Child Development and Education, Chemistry, Physics, Mathematics, Introduction to Sociology, Development and Education in Infancy, Dynamics of Family and Life, Terminology and Concepts in Professional Literature, Introduction to Psychology, Modern Biology, Education Programs in Infancy, Instroduction to Special Education, Introduction to Social Anthropology, Principles of Nutrition.

The courses of the second year are: Development and Education During Early Childhood and School Ages, Development of Adolescents and Problems, Developmental Psychology, Anatomy, Physiology, Preschool Education Programming, Plays and Play Materials, Plays and Communication, Psychodrama, Maternal and Pediatric Nutrition, Communication Skills, Children's Literature, Preschool Maths and Science Education, Introduction to Psychological Counselling and Guidance, Family Planning Education.

The courses of the third year are: Pediatric Health and Diseases, Mental Health and Adaptation Problems in Children and Adolescents, Drama in Education, Neurological development, Development and Education of Mentally Disabled Children, Program Development and Implementation for Mentally Disabled Children, Development and Education of Physically Disabled Children, Program Development and Implementation for Physically Disabled Children, Art and Creativity in Childhood, Music in Childhood, Gymnastics in Childhood, Biostatistics, Field Work – Practical Internship, Summer Internship (min. 30 days, 448 hrs).


GRADUATE AND DOCTORATE LEVEL PROGRAMS

The Child Development and Education Major of the Home Economics School under the Health Sciences Institute provides two options for graduate level education, namely Child Development and Education and Special Education, and one doctorate level program on Child Development and Education. Graduates of Child Development and Education, Home Economic School of Hacettepe University as well as graduates of medicine, health and education-related faculties and other 4-year faculties (subject to approval of the Department Board) are admitted to the graduate program. Candidates having passed the LES exam, foreign language exam and interview are expected to prepare their thesis on their own field in addition to courses with 24 credits. Those having passed the thesis exam will be given 'Scientific Specialization' diploma on Child Development and Education (we currently have 170 graduates of master's programs). Candidates having been awarded the 'Scientific Specialization' degree are entitled to apply to the doctorate program.

Graduates of Child Development and Education with master’s degree and those approved by the Graduate Level Department Board are admitted to the doctorate program. Doctorate students take minimum 36 credits, after which they are entitled to take the doctorate level proficiency exam. It is a must to have passed the language exam for public servants (60 scores). Students having completed the thesis work with success are awarded the ‘Scientific Doctorate’ diploma (we currently have 56 doctorate graduates).

DUTIES OF CHILD DEVELOPMENT AND EDUCATION SPECIALISTS

Child Development and Education Department carries out the following scientific activities to increase efficiency of families and strengthen the socio-economic and cultural functions of families relating to normal, disabled, vulnerable (risky), criminal, abused, working, hospitalized, socially-disadvantaged, refugee and street children in the age group of 0-18.
Graduates of Child Development and Education Department are assigned to education, health, social services and other fields. They mainly work to:

- Evaluate all aspects of development in children and adolescents,
- Identify education targets for individuals and/or small and/or large groups according to results of developmental evaluation,
- Prepare, control and evaluate the most suitable education programs for development,
- Prepare environmental setting that would best meet the needs of the child/children under observation,
- Apply education programs meeting the interests and needs of the child/children by using proper techniques and methods,
- Monitor development in defined intervals to assess the changing performance, interests and needs,
- Provide education, guidance and counselling to families on development, education and raising of their children,
- Educate child development and education specialists to work at various levels in the organized education system,
- Plan and provide in-service training activities intended for people, institutions and agencies working in relevant areas,
- Carry out scientific works (research, books, panels, conferences, symposia, etc.)
- Design and develop educative materials,
- Prepare children’s programs and provide counselling to media,
- Produce and run projects for institutions and agencies related to child and family, provide them counselling,
- Produce policies with related public institutions and agencies, voluntary organizations in line with the needs of our country,
- Provide management to relevant agencies and institutions,
- Work on child development and education in inter-disciplinary groups,
- Contribute to awareness-raising activities for the aim of raising modern, creative, independent individuals useful for the society,
- Plan research for educating professionals in line with the needs of the country and make necessary revisions in the curriculum accordingly.

Graduates of Child Development and Education may undertake the following duties in Health, Education, Social Services and in other sectors:

**Health**
- Child Development and Education Specialist at Mother and Child Health and Family Planning Centres of the Ministry of Health;
- Child Development and Education Specialist at polyclinics, pediatric wards and child development units of hospitals affiliated to the Ministry of Health and Universities.

**Education**
- Academic staff at undergraduate and graduate levels in universities,
- Child Development and Education Specialist of the following divisions of the Ministry of National Health: Directorate General for Preschool Education, Directorate General for Primary Education, Directorate General for Technical Education for Girls, Directorate General for Counselling and Guidance Services in Special Education, Head of the Department of Planning Research and Coordination, Guidance Reserach Centres, Public Education Centres,
- Kindergarten teacher and special classes teacher at the Ministry of National Education after having completed the necessary formation work,
- Child Development and Education teacher at Vocational High Schools for Girls of the Ministry of National Education after having completed the necessary formation work,
- Founder, manager, expert and Child Development and Education Specialist at private and public nursing homes and daycares affiliated to the Ministry of National Education,
- Founder, manager, expert and Child Development and Education Specialist at private and public education homes,
Social Work
- Manager, education coordinator, advisor and Child Development and Education Specialist at children's nursing schools, orphanages, community centres, family counselling centres and related units of the Institution for Social Services and Child Protection of the Primeministry.
- Manager, education coordinator, advisor and Child Development and Education Specialist at the Presidency for the Disabled of the Primeministry, State Statistics Institute, State Planning Organization and Directorate General for Social Research,
- Child Development and Education Specialist in projects carried out by the Institution for Social Services and Child Protection of the Primeministry and Voluntary Organizations for street children, working children, abused and neglected children, refugee children, socially disadvantaged children, risk group children such as children and their families affected by natural disasters,
- Manager and Child Development and Education Specialist at preschool institutions of the Turkish Parliament.

Turkish Armed Forces
- Manager, specialist and Child Development and Education Specialist at education institutions of the command posts,
- Child Development and Education Specialist at hospitals of the Turkish Armed Forces.

Other Fields
- Expert and advisor at juvenile courts of the Ministry of Justice, Child Development and Education Specialist and education expert at juvenile correction houses,
- Executive education coordinator, advisor and Child Development and Education Specialist at institutions and agencies affiliated to other Ministries (State Highways Authority, State Railways Authority, etc.),
- Manager and Child Development and Education Specialist at education institutions and community centres of local authorities,
- Project producer, executer and advisor at UNICEF, ILO and voluntary organizations,
- Program producer, advisor and expert for children's and youth radio and TV programs and educative shows,
- Producer, advisor, author and supervisor at children's theatres,
- Author, expert, advisor, editor and redactor in preparing children's books, magazines and journals,
- Designer, advisor and supervisor in production of educative toys.

PSYCHIATRY EDUCATION AND RECOMMENDATIONS FOR RESEARCH

RESEARCH:
A. Founding an institution which will identify the research priorities, ensure coordination between research units for researches and give financial support to appropriate projects; or tailoring TÜBİTAK (The Scientific and Technological Research Council of Turkey) for this aim.
B. Educating personnel who are able to carry out researches.
C. Founding institutes having the capacity for specializing on certain areas and are conformant with interdisciplinary studies supported by universities or foundations.
D. Scheduling the time and work burden of researchers in an appropriate manner and providing the required physical conditions.
E. Encouraging researches and identifying objective criteria for promotion of researchers and other arrangements.

F. Setting minimum standards for research and education institutions as well as trainers and training institutions, controlling to what extent those standards are met by a national authority, making new arrangements for institutions and individuals not meeting the standards.

G. In this context, the minimum standards to be met by trainers on psychiatry and child psychiatry are as follows:
   1. Having the knowledge of psychotherapy at a level sufficient for providing supervision (having a relevant certificate)
   2. Having the knowledge of neuropsychiatry and neuroanatomy at a level sufficient for providing supervision
   3. Being able to deliver research training (publications may be a criteria for determining)
   4. In order for a trainer to work in a training institution, s/he should meet at least one of the above-mentioned standards; as far as training institutions is concerned, it should meet them all. It should be checked through regular, periodical and occasional supervisions by a national authority whether the same level of training is sustained.

H. Research Priorities:
   1. International - scientific
   2. National – aiming at defining and evaluating the problems peculiar to Turkey
   3. Researches aiming at increasing the quality and provision of preventive and therapeutic services

I. Arrangement of research units
   1. Providing technical equipment and developing relevant projects.
   2. Defining terms of references for researchers and details of their engagements, providing conditions suitable for these references, supervising whether these standards are in conformant with minimum standards.
   3. Identifying success criteria in accordance with the terms of references of researchers, making arrangements for promotion, wage and other issues according to such criteria.
   4. Assigning researchers with administrative roles

J. Training of researchers:
   1. Training of researchers should be definitely at or above minimum standards that will be identified by a national authority.
   2. Determining the core curriculum and ensuring and supervising its implementation at institutions by a national authority (periodical examinations)
   3. Ensuring organized participation of researchers in training and other fields of production.
   4. Utilizing a considerable part of university revenues for research purposes.
   5. Making universities autonomous institutions bearing scientific concerns.
   6. Currently, researchers in most institutions can deal with researches only when they have time remained from their routine engagements. The time that will be allocated by researchers for making research should be set in laws and supervised.
   7. The number of physicians in training institutions should be adjusted in a way that the work burden of trainees is lessened.
   8. Minimum number of patients to be examined by researchers, supervision hours, basic research knowledge to be acquired (statistical, epidemiological, etc.), neurological, anatomical and physiological knowledge should be specified.

K. The structure of national authority that will supervise training institutions, trainer and training fields, and set the minimum standards:
   1. Professional organizations: Turkish Psychiatric Association, Child and Adolescent Mental Health Association of Turkey, Turkish Psychologists Association, Psychiatry Assistants and Specialists Association
   2. Scientific Organizations: TÜBİTAK
   3. Turkish Medical Association
   4. Representatives of Training Hospitals affiliated to Ministry of Health
5. Representative of Coordination Board of the Residency Associations
6. Representatives of education institutions affiliated to Higher Education Council

L. Supervising function of the national authority
   1. Periodical (biennial) or
   2. Occasional (upon the suggestion of one of the components).
   3. The supervision should be standard.
   4. The training institutions, trainers and training fields not meeting the minimum standards will be given a time period to
      be defined by the national authority which will not exceed one year with the aim of eliminating deficiencies. The training
      institutions, trainers and training fields still not competent at the end of this period will be provisionally suspended
      from work, and if it is still the case as a result of a second supervision after a while, these will be permanently discarded.

M. Making legal arrangements with regard to all issues mentioned above and resorting for the views of all parties during the process.

EDUCATION

A. Points related to the education of trainers are stated above.

B. Psychiatry Education in Faculties of Medicine:
   1. Psychiatry education in faculties of medicine should be based on practice and focus on the treatment of common cases
      and preventive medicine.
   2. Students of medicine should be educated on pharmacological treatment, proper time for referrals and other physical
      disorders included in differential diagnosis.
   3. Students of medicine should be able to apply to institutes for psychotherapy education anytime, this should be regarded
      as a part of the education and supported by the dean’s offices.
   4. Physicians to be should be equipped with the knowledge of the epidemiology of psychiatric disorders and scanning
      methods for such in the society.
   5. Psychiatry education in faculties of medicine should be eligible for supervision by the national authority.
   6. Psychiatry internship in the last year of medical education should largely focus on polyclinics and most common
      disorders and include practical information regarding pregnant, baby, child and adolescent mental health.

C. Ongoing training of general practitioners:
   1. Primary care services are largely provided by general practitioners in Turkey. These practitioners should be continuously
      trained on the treatment, follow-up, rehabilitation and prevention of psychiatric disorders through their professional
      lives.
   2. The existence of an institution to give supervision to those physicians for such training may prevent the accumulation
      of patients in big cities and hospitals.
   3. General practitioners may be encouraged to get psychotherapy – psychopharmacology in the course of their practice.

D. Education of psychologists:

E. Education of psychological consultants:

F. Psychotherapy institutes and psychotherapy certification:
   1. It is important in treatment services that psychotherapy is done more frequently but in a controlled and supervised
      manner at the same time. To ensure this, institutes affiliated to universities, foundations or private institutions should
      be established and render certification.
2. Minimum standards of this education and the certification process should be set by the national authority and supervised in line with above-mentioned principles.

3. It should be specified to whom the therapists with a certificate will provide their services and after passing which obligatory phases as well as according to which objective criteria they will be supervised.

The state should provide possibilities for the employment of therapists who successfully pass the certification process and are properly supervised considering especially the prevalence of disorders such as anxiety and depression responding relatively better to psychotherapy as observed in Turkish Mental Health Profile studies, and their negative effects on the public health.