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# A Qualitative Study on Mental Health Services in Primary Care in Türkiye

## ABSTRACT

**Objective:** Mental health services are a neglected problem within primary care. Quality mental health service delivery at the primary level hinges on identifying and addressing related questions. The aim of this study was to evaluate the issues and solution proposals regarding service delivery based on the experiences of primary care workers in managing mental illnesses.

**Methods:** This research was conducted using the focus group interview method, which is one of many qualitative research techniques. The study sample consisted of 8 physicians and 9 healthcare workers providing primary healthcare (PHC) services in a city. The data collection process was carried out using a semi-structured interview form and a personal information form. The interviews were recorded and later transcribed. Subsequently, main themes and subthemes were identified through content analysis and a detailed content analysis was conducted based on these themes.

**Results:** Themes from interviews with PHC workers included education/training needs, service delivery barriers, and recommendations. The study revealed that PHC workers lack current knowledge on mental illnesses. There was fear of stigma regarding mental illness within the community. Workers experienced systemic issues such as heavy workloads, inadequate physical space, and inability to access data.

**Conclusion:** To reduce the treatment gap in primary mental health services and enhance access to high-quality mental health care, it would be beneficial to regularly update healthcare personnel training in mental health and increase public mental health literacy to prevent stigma and promote help-seeking behavior.

**Keywords:** Primary care, public health, community mental health services

## Introduction

In recent years, the prevalence of mental disorders in society has been increasing. According to data from the World Health Organization (WHO), the incidence of mental illnesses and substance use has increased by approximately 13% in the past decade. When considering the prevalence of mental illnesses, approximately 1 in 10 people worldwide (10.7%) are affected by any mental disorder, which corresponds to about 792 million individuals.[1]

Among the top 20 health issues causing years of life lost across all age groups and both sexes, 5 are mental health problems, with depression alone being the third leading cause of years of life lost and expected to rise to the top spot by 2030.[2]

In low- and middle-income countries, efforts to address the treatment gap caused by mental disorders involve encouraging the involvement of non-specialists in mental health services. The WHO has emphasized the importance of providing services through primary health workers (PHWs). Primary health workers play a significant role in diagnosing, treating, and referring all types of illnesses, whether physical, mental, or both, to specialist physicians when necessary. In recent years, there has been an observed increase in the importance of this role in primary healthcare (PHC) settings regarding the treatment of mental disorders.[3]



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There is a long-term, stable relationship between patients seeking care at PHC and PHWs.[4]

Therefore, PHWs have the opportunity to observe individuals' sensitivity to illnesses, illness behavior, periods of exacerbation, and remission of disorders more closely and to detect and treat accompanying illnesses at an early stage. They can also monitor the social, psychological, and environmental context of individuals' distress and illnesses more closely. From the patients' perspective, visits to PHC reduce barriers to seeking help for mental health problems and accepting treatment, thus reducing the stigma associated with seeking psychiatric help.[3]

However, the provision of mental health services in PHC is not sustained as expected. The competency, approach, stigmatizing attitudes, and confidence of PHWs in addressing problems influence the public's preference for services. Unfortunately, the level of preference for PHC for mental health issues is low for many reasons.[5-9] Furthermore, the recognition, diagnosis, and management of mental health problems in PHC are still inadequately researched and understood.

In Türkiye, psychiatric disorders rank second among national disease burden causes, accounting for 19% following cardiovascular diseases.[10] However, according to a study conducted in Türkiye, the rate of preference for primary care among patients with psychiatric problems is low.[11]

Türkiye has hosted and provided healthcare to a significant number of migrants in the past decade due to wars, climate crises, and other humanitarian emergencies. Additionally, following 2 major earthquakes in the past year, there is a lack of sufficient healthcare personnel to address the mental health issues of the population. Therefore, it is essential for mental health services in Türkiye to be much more effective.

In Türkiye, mental health services follow a community-based model where patients access treatment and care services in their own living environment instead of traditional hospitals. Community Mental Health Centers (CMHCs) are responsible for providing patients with opportunities for rehabilitation and engagement in activities without hospitalization, as well as for conducting treatment follow-ups. Public health workers play a crucial role in ensuring healthy communication for close monitoring of these patients and coordination with these centers.[12,13]

Since 2005, PHC in Türkiye has been provided by family physicians and non-physician healthcare personnel (midwives and nurses) working in family medicine units. Additionally, in Türkiye, activities for the protection and promotion of PHC are also conducted through Healthy Life Centers (HLCs). While both family medicine units and HLCs engage in similar activities related to early diagnosis and health education, family medicine units are also responsible for the treatment and monitoring process of patients.[14]

Psychologists working at HLCs can conduct psychological assessments of applicants and, if necessary, refer them to psychiatric specialists. Family physicians, on the other hand, can initiate treatment for mental health issues such as depression and anxiety. However, they can prescribe anxiolytic medications with a type of prescription known as a "green prescription." A green prescription is a type of prescription issued for medications classified under the 1971 "Convention on Psychotropic Substances" as having potential for addiction and abuse.[15]

However, there is a gap in the literature regarding whether HLCs and family medicine units adequately meet preventive mental health services. Additionally, there are no available study results on how family physicians and non-physician healthcare personnel approach different types of mental health issues.

To provide effective mental health services in PHC, there is a need for further improvement in mental health policies, physical conditions, motivation for mental health service provision among physicians and non-physician healthcare workers, and their levels of education.[16,17]

When considering the literature, it is evident that mental health services in PHC are an overlooked area that requires further investigation. This study aims to identify barriers to service delivery, challenges encountered when dealing with mental health patients, and proposed solutions through the personal experiences of PHWs regarding mental health services, using a qualitative research design. This study represents an original research effort evaluating the experiences of physicians and non-physician healthcare workers in PHC regarding mental health services.

### MAIN POINTS

- *Mental health knowledge in PHC workers is outdated.*
- *The population density to be managed at the primary care level, insufficient physical space, and lack of inter-tier communication in the healthcare system pose barriers to the provision of mental health services.*
- *According to PHC workers, societal stigma toward mental health issues constitutes the primary obstacle to accessing mental health services.*

## Methods

This study was conducted through focus group interviews, which are one of the many qualitative research techniques. A focus group is a method involving 4-12 participants sharing common characteristics and a moderator, designed to gather data in an open environment where participants feel free to genuinely express their thoughts without reservation. The reasons why focus group studies are frequently used are the low cost, rapid acquisition of data, reliable information if a suitable environment is provided, and especially the fact that it is the most appropriate technique for community research.[18]

Focus group interviews were preferred so that PHC employees could clearly express their experiences in providing healthcare services, the problems encountered, and the practices related to the healthcare system.

### Identification of Participants

According to previous studies, the sample group in focus group interviews should consist of a minimum of 6 and a maximum of 12 individuals. When the number of participants in a focus group interview exceeds 12, each participant may not be able to share their own views and observations, and it may become challenging for the

researcher to guide the discussion. Conversely, when there are fewer than 6 participants, it might be difficult to sustain the discussion.[19,20]

The study sample consisted of healthcare workers providing PHC in the province of Kayseri. The study was carried out with 8 physicians and 9 non-physician healthcare professionals employed in primary care in different parts of the city between October 1-15, 2023. Participants were selected from people with primary care work experience in accordance with the purposive sampling method. The criteria for inclusion in the study were to have more than 1 year of work experience in primary care and to be a physician or non-physician healthcare employee (midwife, nurse).

### Data Collection

Research data were collected through a personal data form and a semi-structured questionnaire. The personal data form consists of 5 questions that include the personal and professional characteristics of the participants (age, place of employment, occupation, sex, professional period of employment, etc.).

The semi-structured interview form consists of 9 general questions prepared by the researchers in accordance with the purpose of the study (Table 1).

Interviews were conducted on the date and time approved by the PHC employees who agreed to participate in the study. Written consent and permission for audio recording were obtained from the participants. The interviews were conducted face-to-face in the meeting room of the Directorate for Health due to the ease of transportation. Two different focus group interviews were conducted for physicians and non-physician healthcare professionals. Physicians were coded DK (1-8), and non-physician healthcare workers were coded EK (1-9). The moderator and the participants were seated at the same level in a circular seating arrangement. A moderator and 2 reporters from the research team took part in each of the focus group discussions. Semi-structured open-ended questions were directed to the participants in the interviews, which lasted an average of 90 minutes. During the data collection phase, the first codes were created. The interview was terminated at the point where it was determined that the data obtained from the interview reached a saturation point (repetition of similar data, no emergence of new opinions, all questions asked).

**Table 1.** Questions Prepared for the Focus Group Interviews

| |
|---|
| 1. How do you provide preventive mental health services in primary care? |
| 2. What mental problems do persons apply with to the healthcare center where you are employed? |
| 3. Which mental disorders do you encounter the most? |
| 4. Which groups do you think are at risk for mental illnesses? |
| 5. Which patient group are you having trouble working with? |
| 6. What do you think may be the causes of mental health problems? |
| 7. What are the most common problems you encounter while providing mental health services? |
| 8. How do you evaluate your professional knowledge of mental health? |
| 9. What are your suggestions for providing more effective mental health services in primary care? |

### Data Analysis

After the audio interviews were recorded, transcriptions were made, and participants' verbal expressions were converted into written form. The content analysis method was used to analyze the data. The stages of content analysis were as follows: (1) coding the data; (2) identifying categories and themes; (3) organizing codes, categories, and themes; and (4) defining and interpreting the findings.[21]

MAXQDA, Software for qualitative data analysis, 1989 – 2024, VERBI Software. Consult. Sozialforschung GmbH, Berlin, Germany. Researchers carefully analyzed the data to better understand it and gain a comprehensive understanding. They read through the data multiple times to identify important concepts, themes, or patterns. As a result of these readings, related codes were grouped under themes and named accordingly. The obtained themes and subthemes were integrated into the scope of the study. Finally, they interpreted the findings to give meaning to the results.

### Validity and Reliability of the Research

The Guba and Lincoln (1982) criteria were taken into account to increase the quality of the study.[22] Guba and Lincoln have grouped the criteria under 4 main headings: credibility, reliability, confirmability, and transferability. In order to ensure the reliability of the study, the research method and analysis stages have been explained in detail. In the study, the statements of the participants were provided directly by which the aim was to increase the validity. Triangulation was realized throughout the study to increase the internal validity and reliability of the study and to compare the biases of the researchers. In order to ensure the transferability of the study, the participants were selected through the purposive sampling method.

### Research Ethics

The research was conducted in accordance with the World Medical Association Declaration of Helsinki. Written approval was obtained from the Clinical Research Ethics Committee of Artvin Çoruh University (135126) and from the participants.

## Results

We found that 47.1% of the participants were physicians and 52.9% were non-physician healthcare workers. All non-physician healthcare employees were female (Table 2).

When the data of the focus group interviews were examined, it was observed that 3 main themes emerged. These were "education level and the need for training," "obstacles to providing services," and "recommendations." The categories, subcategories, codes, and prominent statements determined during the interviews with PHC providers are shown in Table 3.

### Education Level and the Need for Training

We determined that physicians and non-physician healthcare professionals working in primary care focus on (1) inadequacy and quality of education and (2) education needs on mental illnesses.

Physicians stated that they did not receive postgraduate mental health education and those who did receive postgraduate education stated that the quality of education was inadequate. Non-physician healthcare professionals also stated that they did not feel competent on mental illnesses. The only common educational need of physicians and non-physician employees was suicide. Physicians need

**Table 2.** Characteristics of Primary Care Workers (N = 17)

| | | Physician (n = 8) | | Non-Physician Healthcare Worker (n = 9) | |
|---|---|---|---|---|---|
| | | Number | % | Number | % |
| Sex | Male | 4 | 50.0 | 0 | 0 |
| | Female | 4 | 50.0 | 9 | 100 |
| Age (years) | 20-29 | 1 | 12.5 | 2 | 22.2 |
| | 30-39 | 2 | 25.0 | 3 | 33.3 |
| | 40-49 | 2 | 25.0 | 3 | 33.3 |
| | 50 and older | 3 | 37.5 | 1 | 11.2 |
| Term of employment | 10 years or less | 2 | 25.0 | 2 | 22.2 |
| | 11-20 years | 3 | 37.5 | 3 | 33.3 |
| | 21 years or more | 3 | 37.5 | 4 | 44.5 |
| Place of employment | Community health center | 4 | 50.0 | 4 | 44.5 |
| | Primary care clinic | 4 | 50.0 | 5 | 55.5 |
| Total | | 8 | 100 | 9 | 100 |

training on the diagnosis and referral of mental illnesses, whereas non-physician healthcare professionals need training in communicating with mental patients; counseling families, women, and young people; and counseling for sexual health problems and protective non-drug methods for mental health.

### Obstacles to Providing Services

Regarding the presentation of mental illnesses to physicians and non-physician healthcare professionals working in primary care, it has been determined that there are problems related to (1) healthcare workers, (2) patients, and (3) the healthcare system.

The most prominent issue among the problems related to healthcare workers is the lack of education. Physicians stated that they could not provide adequate preventive mental health services and they were reluctant to prescribe psychiatric drugs. Non-physician healthcare professionals, on the other hand, stated that their own mental health was not in good condition, that they were not happy with their work, and that this situation was reflected in their services.

The thoughts, behaviors, and attitudes of patients and their relatives toward mental illnesses can be an obstacle to the provision of healthcare services. The most prominent obstacle is the fear of stigma. It was stated that patients tend not to use psychiatric drugs regularly and ignore mental problems. Mental disorders were observed in a large part of society after the SARS-CoV-2 pandemic, and their prevalence has increased. Physicians mentioned problems related to stigma and drug use, while non-physician healthcare workers mentioned the existence of problems related to risk groups.

There are restrictions or procedures in the healthcare system that impede the provision of services. In this category, workload, insufficient health center facilities, the SARS-CoV-2 pandemic, a lack of communication between institutions, problems with accessing patient data, the lack of a solution for mental problems, and an inability to prescribe medication were mentioned. The common opinion of PHC employees in this subcategory was workload. Physicians pointed out the problems of access to patient data, the authorization to prescribe medication, and the lack of inter-institutional communication. Non-physician healthcare employees, on the other hand, drew attention to the inadequacy of physical parameters.

### Recommendations

Recommendations of physicians and non-physician healthcare professionals working in primary care regarding the presentation of mental illnesses were determined to be related to (1) the healthcare system and (2) society.

The common view of PHC workers regarding the healthcare system is to increase the education level of healthcare employees on mental health. Physicians recommended using ready-made scales, working with appointments, increasing the education of healthcare workers, ensuring access to patient data, reducing the pressure on family medicine, establishing a psychiatric support line, and providing effective communication between phases. Non-physician healthcare professionals drew attention to the importance of visiting families at home.

Regarding society, both physicians and non-physician healthcare professionals in primary care recommended raising the awareness of families on mental health. While physicians drew attention to protective practices for mental health, non-physician healthcare professionals recommended that family planning is important in this regard and that mothers should be prevented from having unwanted children.

## Discussion

This study investigated the problems, needs, and proposed solutions regarding the delivery of mental health services through the experiences of healthcare personnel working in primary care.

Participants in our study expressed that their knowledge level regarding mental health is low due to the passage of time since their graduation and the lack of exposure to up-to-date training. Similar research findings in the literature also indicate inadequate mental health knowledge levels among PHC workers.[23-25] A study conducted in Türkiye showed that doctors working in primary care feel insufficient in basic medical practices related to psychiatry.[5] These findings highlight that the lack of education on mental health issues and perceived competency gaps constitute significant barriers to primary mental health services.[6]

The Australian National Mental Health and Wellbeing Survey for 2020-2021 indicates that 38% of individuals with mental disorders consulted a general practitioner.[9] According to studies conducted in Türkiye in previous years, the rate of preference for PHC services among individuals diagnosed with mental illness is lower, and lack of trust in general practitioners and family physicians has been identified as one of the reasons for this.[26,27] These findings underscore the importance of strengthening mental health education for healthcare workers in primary care. The inadequacy of post-graduation continuous education programs further reinforces knowledge and skill gaps in this area, negatively impacting the overall effectiveness of healthcare services.[25]

Our research findings have provided valuable insights into the challenges faced by participants and how educational content should be shaped to address these challenges. Participants expressed a need for education on general and fundamental mental health topics, including principles of diagnosis and treatment of common psychiatric disorders, management of mental health emergencies (such as

**Table 3.** Categories, Subcategories, Codes, and Prominent Statements

| Category | Subcategory | Codes | Prominent Statements |
|---|---|---|---|
| Educational level and educational need of medical personnel concerning mental health | Inadequacy and quality of education | • Inadequate knowledge of mental health<br>• Self informing<br>• Lack of postgraduate education<br>• Education of instructors<br>• Raising awareness in instructors<br>• Expert instructor | • Mental health issues are increasing worldwide; however, we physicians have not furthered our knowledge of these mental health disorders beyond that which was learnt during 5 years in medical school. We do not educate ourselves after graduation. We are not adequately prepared to treat mental health issues. (DK 4)<br>• We do our best for mother-infant health, but we are not adequately prepared to treat mental health issues. (Attachment 1)<br>• I think we do not have adequate awareness. (DK1)<br>• We have been trained on mental disorders before, but not by experts. We have received specific in-service training; however, it is of no use. (DK6) |
| | Educational need | • Inadequate communication skills<br>• Risky groups<br>• Nonpharmacological treatment<br>• Suicide<br>• Common mental illnesses | • Communication concerns both the personnel and patients. There are inadequacies in this matter. (Attachment2)<br>• I am afraid of schizophrenic patients. They might attack us. (DK3)<br>• There are student hostels in the area where I work. Young people have a lot of mental issues. (Attachment3)<br>• Most family practitioners are unaware of Community Mental Health Centers (CMHCs). What are they? What is their purpose? (DK4)<br>• Women say that they have sexual problems but cannot tell anyone. We do not know what to do with those with sexual problems. (EK4)<br>• Families see us before the physician and tell us about their problems. We even talk to those who have attempted suicide. However, it is not in a professional manner. Maybe that is wrong. We approach them as a mother and human. We do not know what is right. (EK6)<br>• Some friends have difficulty identifying depression or treating it. (DK5)<br>• Primary healthcare physicians have inadequate knowledge of mental emergencies. (DK2)<br>• Physicians avoid talking about suicide. (DK8)<br>• All family healthcare professionals should be able to provide mental counseling. We need family counseling training. We are the ones who see families the most. (EK8)<br>• It may be better to know what to do before starting medication, at least for those who do not see a psychiatrist. (EK4) |
| Obstacles to providing mental health service in PHC | Problems related to medical personnel | • Superficial family practice<br>• Lack of knowledge<br>• Inability to provide preventive mental health service<br>• Reluctance in prescribing medication<br>• Fearing the illness<br>• Psychological issues<br>• Work environment | • Some physicians have difficulty following the medications of patients diagnosed with depression. They are immediately referred to secondary healthcare. (DK1)<br>• Family practitioners have a problem with the preventive physician approach. There is a scarce number of physicians that see it as a requirement of the profession. Referring a patient to mammography should actually be considered in the same category as referring them to psychiatry. (DK5)<br>• 80% of family practitioners do not write green prescriptions. However, they can. Some of them are defensive against green prescriptions. (DK6)<br>• We can help other people, but we cannot solve our own problems. (EK6)<br>• We are not happy with our work. (EK1) |
| | Problems related to patients and their families | • Fear of stigmatization<br>• Not taking the medicine regularly<br>• Not going to the doctor<br>• Ignoring mental issues<br>• Avoiding the treatment fee<br>• Avoiding taboo issues<br>• Risky groups<br>• The severe acute respiratory syndrome-related coronavirus (SARS-CoV-2) pandemic | • They do not want children to be diagnosed and treated for the sake of their future job. (EK7)<br>• People usually come here for being unable to cope with their family problems, partners, or adolescent children, rather than for mental disorders. Outside these issues, they do not want to share a lot.<br>• They do not want people to hear it. (DK7)<br>• Patients have a problem with going to a psychiatrist. Of the patients that we refer, 25% are persuaded and only 20% of them see a psychiatrist. Indeed, although the patients seem to have been referred to psychiatry, I can see that they do not actually go. I take notes, write down the reason and try to persuade them. (DK6)<br>• As long as chronic patients take their medicine regularly for disorders like bipolar and schizophrenia disorder that may lead to suicide rather than just for major depression, they will have a proper life. Unless they take their medicine, they may be destructive both for themselves and other people. (DK3)<br>• They start medication themselves. They buy drugs upon the advice of their neighbors or relatives. (EK2)<br>• There is a list of people who have attempted suicide. They are recorded in our system. We get the list and our psychologists call them and interview them for support. Most of them refuse to talk. (DK5)<br>• Since the SARS-CoV-2 pandemic, almost everyone has had difficulty understanding their medical condition. Everyone has a negative perspective of life. The SARS-CoV-2 pandemic seems to have ended hopes. (EK8)<br>• Young people apply too scarcely. (EK3)<br>• Unemployed patients with financial difficulties have a greater mental risk. We never see this group. (EK6)<br>• Housewives with no occupation and are not taken care of are mentally at risk. They apply very often. (DK5)<br>• They ask us to prescribe from home. I want them to come. I compliment on them for walking and tell them how happy I am to see them. I advise them to always move. (DK6) |

(*Continued*)

**Table 3.** Categories, Subcategories, Codes, and Prominent Statements (*Continued*)

| Category | Subcategory | Codes | Prominent Statements |
|---|---|---|---|
| | Problems related to healthcare system | • Workload<br>• Physical incapacity<br>• SARS-CoV-2 pandemic<br>• Lack of intercorporate communication<br>• Inability to access patient data<br>• Inability to generate solutions to mental issues<br>• Inability to prescribe psychiatric medication | • We watch them change the baby's diaper. We observe. We watch them hold the baby while nursing. However, we do not have adequate time and space to do these things. There is a lactation room in the common area of 6 physicians. A lot of work is done there and the next pregnant woman will have to wait. There is no space for their partners. (EK4)<br>• We want to be useful. However, we do not get the opportunity due to the polyclinic, vaccination, COVID follow-up, anxiety of injection issues, and arrangement of documents. (EK3)<br>• The population is 3500 people and we examine 70 to 80 patients. There is no time to take care of patients with psychological issues. (DK6)<br>• We cannot see psychiatric diagnoses. (DK5)<br>• In healthy life centers (HLCs), if psychologists see a pathological situation, they will refer them to psychiatry. However, we cannot follow them afterwards. We will know about it only if patients say that they saw a psychiatrist or if we call them. (DK7)<br>• Being unable to prescribe medication and greater number of patients decrease our motivation. (DK6)<br>• I think tertiary healthcare is unaware of the field in particular. (DK7)<br>• We train both pregnant women and children. We have their psychosocial studies in our field. However, we cannot spare enough time due to the SARS-CoV-2 pandemic and our workload moving to other areas. (EK3)<br>• These tests are also available for the psychosocial development of pregnant and puerperal women but, unfortunately, we cannot spare enough time due to the workload. (EK3) |
| Recommendations for mental health service in PHC | Recommendations for healthcare system | -Using ready scales or tests<br>-Multidisciplinary approach<br>-Enhancing mental treatment units<br>-Including family practitioners in the process<br>-Establishing a psychiatric emergency service<br>-Home patient follow-up<br>-Telemedicine | • Enhancing the training of PHC physicians. We need modules to raise awareness against mental health just as modules that are available for reproductive health and mother-child health. Primary healthcare physicians should be trained to detect or notice mental issues lying behind everything and refer people. (DK7)<br>• It will be good to raise awareness in physicians. (DK3)<br>• An appointment system will contribute to the primary management of psychiatric disorders to spare more time. (DK4)<br>• Family practitioners should be able to see psychiatric diagnoses. (DK5)<br>• A line such as a psychological support line can be useful. (DK7)<br>• If the population of family practice decreases and we are able to prescribe, we think that we can take care of these patients better. (DK6)<br>• The number of CMHCs should be increased. Families can breathe thanks to them. (DK4)<br>• There is a need for a psychiatric emergency line. Or it would be great if we had an emergency service in the psychiatric hospital. (DK4)<br>• I wish we had a list to evaluate everyone mentally so that we can tell them where to go based on the items that suit them, such as depression and anxiety. (DK8)<br>• They need to build a bridge between the stages. We need a multidisciplinary approach. Psychiatrists do not know the field. (DK4)<br>• In the community health center system, we used to visit homes and see the lives they had. Now we do not. We used to be closer and they would share their private life more easily. We would know all their problems. We need to go back to that system. Family practice is so superficial. You only get to see who comes to you. (EK4) |
| | Recommendations for society | • Enhancing the knowledge level<br>• Raising awareness in families<br>• Protecting the mental health<br>• Family planning<br>• Regular check-up | • A family's view of treatment is so important. They should be trained, too. (EK5)<br>• We see children for the last time when they come for vaccination at 4 years of age. More conscious mothers will give us the opportunity to follow their children in the course of time. We warn problematic mothers and talk to them. But that is all. We need to be trained more profoundly. (EK1)<br>• As family planning materials for women aged 15-49 years have not been sent properly by the Ministry of Health in 3 years, the number of unintended pregnancies has increased. (EK8)<br>• I advise elderly patients to move and visit me more often. (DK6) |

Note: Physicians were coded DK and non-physician healthcare workers were coded as EK. PHC, Primary Health Care.

assessment and intervention for suicide risk), and destigmatization. Similar training content has been provided to PHWs in various countries, and successful outcomes have been reported.[28-30]

Creating awareness about mental health and providing effective support, especially to specific at-risk groups, is increasingly important today. Non-physician healthcare workers emphasize the need for specific training in areas such as family counseling to effectively communicate with and provide appropriate counseling services to particularly vulnerable groups such as women, adolescents, and students. In Türkiye, in-service training programs are currently implemented for PHC workers on issues such as domestic violence and postpartum depression. However, individuals belonging to vulnerable groups, including women, adolescents, and others, are more susceptible to social, psychological, and/or financial mental health problems. These groups should be prioritized regarding efforts to combat health inequalities. Preserving and enhancing mental health is crucial for overall health. Therefore, academics, healthcare workers, governments, and policymakers are focusing on using available, accessible, effective, less stigmatizing, and culturally appropriate preventive techniques for these groups and society as a whole.[31]

Participants expressed a desire for more education on sexual health and sexual dysfunction. Non-physician healthcare workers mentioned that they are often asked for counseling on these topics because families and mothers find them more accessible, but they feel they lack sufficient knowledge on how to be professional and effective in this process. Primary healthcare workers also serve as a type of family counselor and are often the first point of contact for the most intimate issues. They are expected to approach issues, particularly mental health, without displaying stigmatizing attitudes and to provide appropriate identification.[32]

Similarly, it has been found that PHWs need education on communication and help-seeking behavior related to mental illnesses. The literature also indicates that healthcare professionals struggle to communicate effectively with individuals with mental health issues.[33] It has been stated that the most important factor causing communication problems may be the perception that individuals with mental health issues may be dangerous.[34]

When barriers to providing mental health services in primary care are categorized, it is observed that there are some reasons related to healthcare personnel, patients, their relatives, and the healthcare system that stand out. Reasons related to healthcare personnel include a lack of education and competence in providing mental health services. There are also expressions indicating that healthcare personnel may struggle to cope with their own mental health issues. This situation negatively affects the efficiency of healthcare personnel. Increasing mental health literacy is needed for healthcare personnel to cope with their own mental health issues. Mental health literacy involves recognizing mental health problems, being aware of treatment options, and moving away from stigmatizing attitudes.[35] Additionally, health managers need to develop preventive and supportive policies for mental health issues among healthcare personnel, alongside these increasing mental health problems.[36]

At the forefront of reasons related to patients and their relatives is the fear of stigma. Due to negative perceptions and judgments about mental health issues in society, this fear significantly restricts people's seeking of treatment.[37] This situation can lead individuals to behaviors such as avoiding seeking medical help, not adhering to medication, ignoring mental health issues, avoiding treatment, and considering mental health-related topics as taboo. The process of stigma negatively impacts the course of psychiatric illnesses and often prevents the seeking of professional help.[38] Unresolved issues due to the fear of stigma among mentally vulnerable individuals such as adolescents and marginalized groups can manifest in severe situations, even leading to suicide.[34]

Negative attitudes and behaviors of healthcare workers toward patients also reinforce the self-stigmatization of the patient. In Türkiye, data from all healthcare institutions' patients are transferred to the e-Nabız software program. Individuals can allow their physicians to view as much information as they want through e-Nabız. However, the physicians participating in our research believe that they are prevented from intervening in mental illnesses due to patients who do not want their past information about mental health to be visible. Patients experiencing fear of stigma restrict healthcare workers' access to their health information. Unfortunately, there are study results in the literature indicating that healthcare workers also exhibit stigmatizing attitudes toward mental patients.[39-40] Reducing stigma and facilitating access to mental health services can be achieved through increasing societal awareness and implementing policies that support mental health.[41]

The most significant barrier to mental health services within the healthcare system is the high workload of PHC workers. While participants have indicated that the increased workload during the SARS-CoV-2 pandemic has impeded mental health services, the fundamental issue lies in the high population per family physician. The statements of the participants regarding their excessive workload and the inadequacy of their physical environments to handle this load are noteworthy. According to Organization for Economic Co-operation and Development (OECD) data, there are only 2.2 doctors per 1000 people in Türkiye, which is a relatively low ratio compared with other OECD countries. In order for healthcare personnel to deliver quality services within their scope of work, the population they are responsible for should be lower.[42]

Another issue related to the coordination of mental health service providers has emerged as another problem within the healthcare system. Participants indicate insufficient communication between different levels of healthcare services. In the Turkish healthcare system, there is no obligation to adhere to a referral chain. Therefore, individuals with mental health issues can directly seek services from any healthcare institution they prefer. Despite the existence of Community Mental Health Centers (CMHCs) and Healthy Life Centers (HLCs) as primary providers of mental health services, the lack of a standard collaboration infrastructure for patient referral, follow-up, and counseling is reflected in the statements of healthcare workers.

The recommendations provided by participants regarding the challenges encountered in the field are evaluated in 2 categories. First, there is a recommendation to enhance the mental health knowledge and competence of healthcare personnel. Physicians express the need for ready-to-use and standard mental health scales. Suggestions such as using a telephone hotline for psychiatric emergencies and

monitoring mental health patients at home have emerged as part of recent telepsychiatry or telemedicine practices. These applications aim to increase access to mental health services, provide early intervention for psychiatric emergencies, and facilitate continuous patient monitoring. Particularly, the use of a telephone hotline can offer anonymous support and counseling to individuals with mental health issues, thereby reducing stigma and increasing access to treatment. Home monitoring, on the other hand, provides a more effective care model by regularly tracking patients' mental health status through remote healthcare services and intervening when necessary. Such telepsychiatry applications can contribute to making mental health services more accessible, effective, and personalized.[43]

Participants' suggestions for the community focus on increasing mental health awareness and implementing an education program to combat stigma. Additionally, there is an emphasis on the importance of early detection of mental issues within families, ensuring access to appropriate treatment options and, most importantly, highlighting the significance of family counseling, family education, and family planning for the preservation of mental health. However, it is not realistic to expect healthcare workers alone to bear the responsibility for improving and preventing mental health issues. It should be recognized that social and political actors play a role as responsible stakeholders in enhancing and maintaining the mental health of the community. Healthcare workers, on the other hand, have a scientific, ethical, and moral responsibility to guide these stakeholders.[44]

## Conclusion

The present research examined the challenges faced by PHC workers regarding mental illnesses and provided recommendations for addressing these issues. To reduce the treatment gap in mental health and enhance access to high-quality mental health services at the primary care level, it would be beneficial to regularly update healthcare workers' education on mental health, reduce the population receiving care to manageable levels, and increase mental health literacy among both healthcare workers and the public to prevent stigma and promote help-seeking behavior.

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