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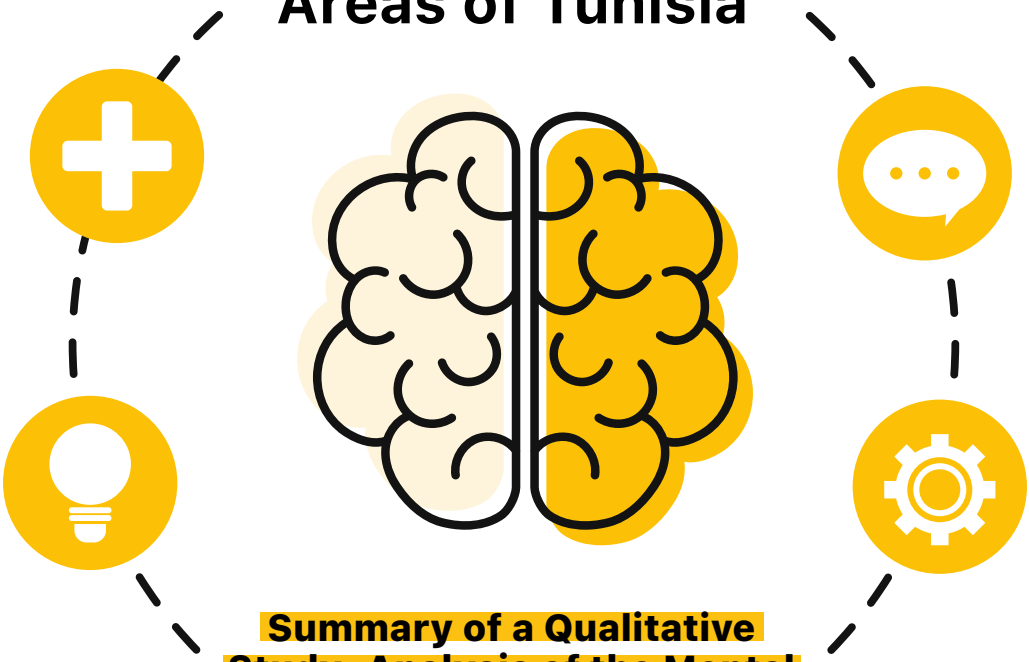
Developing an Agenda for Mental Health in Marginalised Areas of Tunisia



Summary of a Qualitative Study: Analysis of the Mental Health Needs of Young People and Psychosocial Support

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INTERNATIONAL ALERT

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We focus on solving the root causes of conflict, bringing together people from across divides. From the grassroots to policy level, we come together to build everyday peace.

Peace is just as much about communities living together, side by side, and resolving their differences without resorting to violence, as it is about people signing a treaty or laying down their arms.

That is why we believe that we all have a role to play in building a more peaceful future.

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CONTENT

1. INTRODUCTION TO THE STUDY

International Alert's project of developing a mental health agenda for marginalised areas of Tunisia aims to empower residents of border regions and working-class neighbourhoods, particularly young residents, to exercise their right to mental health and to mental health services. As part of this project, we conducted an in-depth analysis of young people's enjoyment of this right in these areas. In the first stage, we worked with a team of researchers from a range of fields to conduct a mixed-methods study on young people aged 18-29 in North Kasserine, North Tataouine and El Kabaria (Tunis).[1] This study focused on young people's impressions of their mental and physical health, their knowledge of psychological disorders and their treatment, their experiences of mental health problems - including how they deal with these problems and their attitudes to the services available - the effects of all these issues on their lives, and issues of violence and addiction as they see and experience them.

As part of this second stage, we wanted to find out what young people believe their mental health needs are, both broadly and in terms of services. To do this, we adopted a participative quantitative approach, making use of focus groups. Each session was conducted on the basis of an interview guide focusing on:

- Views of mental health and mental health services
- The difficulties/obstacles/restrictions preventing people from accessing mental health services
- Young people's expectations of mental health services
- Future interventions in order to get the most out of mental health services

1.1 The groups

The study covered six equally distributed focus groups from six different towns in Kasserine and Tataouine, the two border governorates included in the project; both of these regions have an almost total lack of mental health facilities. Each governorate provided three groups:

- A women's group
- A men's group
- A mixed group (men and women)

Efforts were made to ensure that we had an even distribution of participants along the age scale from 18-29 in each group. We also took into account whether participants were socioeconomically active and their level of education in order to make the groups as qualitatively representative of the young people of each governorate as possible, so as to ensure the broadest possible range of views.

1 *Youth on the Margins: Mental health and risk-taking behaviours in El Kabaria, northern Kasserine and northern Tataouine*, International Alert, 2022. The study consisted of three parts. The first two, which followed a quantitative approach, looked respectively at risk-taking behaviours and anxiety as a mental health indicator. The third, which was qualitative, looked at young people's ability to access physical and mental health services while in prison.

1.2 Participants

55 young men and women took part in the study. The participants had an average age of 23.6 years, and were distributed equally between Kasserine (27) and Tatatouine (28) and between women (27) and men (28), with slight differences in the distribution within each region:

- The Kasserine sample comprised 12 young women with an average age of 22.9 years and 15 young men with an average age of 24.2 years, giving an overall average age of 23.5 years.
- The Tataouine sample comprised 15 young women with an average age of 24.4 years and 13 young men with an average age of 23 years, giving an overall average age of 23.7 years.

With respect to economic activity (self-defined), there was a degree of variation between the two regions:

- In Tataouine half the participants were unemployed (29%) or employed (21%), while the other half were either civil society activists (32%) or students (18%).
- In Kasserine only 15% of participants were unemployed and a mere 7% employed, while 33% were still in education (22% in school and 11% university students) and 45% were civil society activists.

2. HEADLINE RESULTS

The quantitative focus group approach allowed us to evaluate participants' conceptions, expectations and needs with respect to mental health and mental health services.

2.1 Participants' conceptions of mental health

The focus group participants did not have a single idea of what mental health was; in fact, there was a great deal of variation, ranging from the positive to the negative. When asked 'what do you think of when you hear the words "mental health"?', all focus groups came up with a rich and diverse range of responses. Some words came up in multiple focus groups. Respondents in five out of the six groups used the word *raha* ('comfort', 'relaxation', 'peace of mind'), but the next four most commonly cited words were all negative: four groups mentioned 'stress' or 'pressure', while 'depression', 'problems' and 'drugs'/'addiction' were all cited in three groups each. Some of the negative words were brought up repeatedly in the same group ('problems', 'stress' and also 'routine', even though this last word came up in only two groups), and the word *raha* occurred in a range of contexts and forms, including *rahit al-bal* ('peace of mind'), *mirtah* ('at ease', 'relaxed'), *mirtah fi dhato* ('comfortable in his own skin'), *ayy haja tkhalli linsan mirtah* ('anything that makes a person feel at ease'), and particularly *al-raha al-nafsiyya* ('being mentally at ease') as well as the French equivalent *à l'aise*. We noticed a greater tendency towards negative conceptions among young people in Kasserine, while those in Tataouine were more inclined towards positive phrasing, with the exception of the young men's group, who were noticeably more negative than the women's and mixed groups.

Although there were a range of clearly positive words used to describe mental health ('balance', 'happiness', 'being reconciled to yourself', 'leisure', 'optimism', 'ambition', 'enjoyment', 'calm',

'psychological stability', etc), some of the negative phrases were also positive in context ('he doesn't have any problems', 'he doesn't think about anything', 'solving psychological problems', 'the absence of psychological problems', etc). Explicitly negative phrases, however, were notably common among the young men from Tatatouine ('bad psychological state', 'traumas'/'shocks', 'painful social experiences', 'deviance', 'risky behaviours') and young people of both sexes from Kasserine ('migration', 'mental illness', 'hatred', 'traumas'/'shocks', 'failure', 'empty time', 'suicide attempts', 'isolation', 'violence', 'just like another ilnness', 'it controls your life and your destiny', 'it ruins people's interactions with one another', 'a poor understanding of mental health', 'conflation of mental and neurological illness', etc).

This proliferation of negative ideas may be explained, partially at least, by International Alert's finding[2] that large numbers of young people assessed their own mental health negatively (27.2%)[3], or said that they had felt the need to consult a psychologist or psychiatrist within the last year (26.8%)[4], that the COVID-19 pandemic had affected their mental health (45.8%)[5], or that they had previously experienced mental health problems (36%)[6]. Although high, it is likely that these figures understate the reality, because of an unwillingness to admit having suffered mental health problems.

2.2 Major obstacles to accessing mental health services

The near or total absence of service provision was the major obstacle that all groups of young people in both governorates agreed on. But even if services were available at the required levels, this would not necessarily mean that there were no other factors preventing young people from accessing them. All of the focus groups cited various other obstacles, both institutional and societal, with varying degrees of emphasis:

Institutional obstacles: The lack of quality control, or an uncertainty about whether it was present, was the most important factor preventing access to services and a major reason for young people not attempting to access those services that were available; it was mentioned in every group. From the perspective of the young people, these obstacles were diverse, with the most important being a lack of 'confidence' in specialists' 'capability', their familiarity with new developments in the field, their ongoing professional development, their respect for confidentiality and their communication skills (5 of 6 groups). In some cases, participants expressed concern about 'clinical error', cast doubt on 'professional ethics' and accused specialists of monetary exploitation. More than one group described the current organisation of hospitals as an important obstacle, particularly with regard to administration and administrators but also to the framework followed in appointments. Others used broader phrasings such as 'a mismatch between services and needs'.

Similarly, the absence of guidance or awareness-raising mechanisms and a lack of information on mental health services and how to access them was cited as an obstacle by the majority of groups, as were financial barriers, whether expressed as 'no free services' or 'high costs'. This corresponds with the findings of a previous study by International Alert, which showed

2 Young People on the Margins, ibid.
3 P. 83.
4 P. 85.
5 *P. 84.*
6 P. 92.

that 71.9% and 73.7% of young people respectively believed a lack of information (on mental healthcare organisations and how to access services) and high costs were reasons not to seek care.[7]

Societal obstacles: All groups placed a notable emphasis on societal factors, all of which revolved around a weak or nonexistent 'culture of mental health' or 'stigma, prejudices and stereotypes'. As one participant put it: 'you're seeing a psychiatrist – are you a nut?' This, too, chimes with the findings of our previous study, which showed that 83.2% of young people believed that fear of stigma was a reason for not seeking care.[8]

Figure 1 summarises these obstacles:

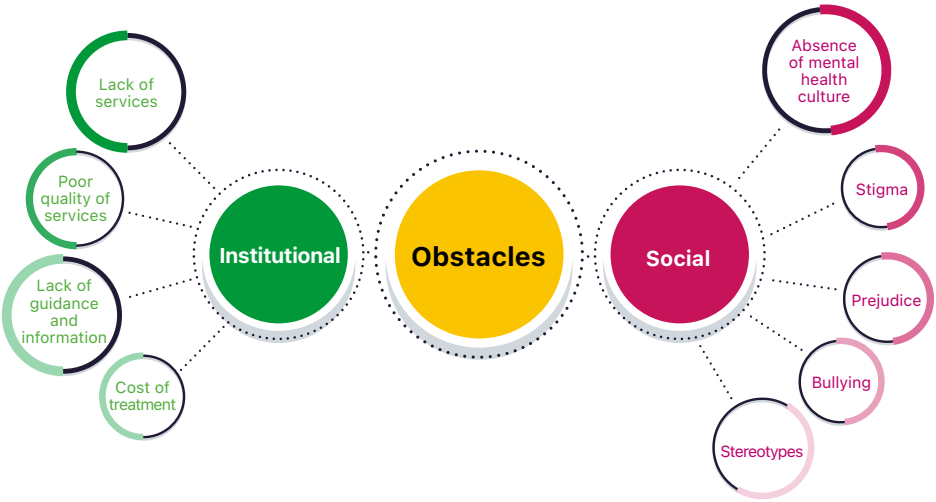

Figure 1: Mind map of obstacles to young people accessing mental health services

2.3 Solutions suggested by participants

The solutions and possible interventions that young people suggested might improve access to mental health services can be divided into two categories:

Organisations concerned with supporting and improving mental health

- **Health organisations** (in the broad sense, irrespective of the supervising body): hospitals, public clinics (basic health centres) and private clinics, health centres specialising in young people, addiction or psychological rehabilitation, and social integration centres.

- **Other organisations**, as set out in the following chart:

7 P. 90.
8 P90.

[* The relevant professional organisations are the Tunisian General Labour Union (UGTT) and the Tunisian Confederation of Industry, Trade and Handicrafts (UTICA)]

Figure 2: Other organisations involved in improving young people's mental health

Types of services required, standards and jurisdictions

Interventions: Three types: **Preventive, counselling and therapy, and treatment (figure 3).** Young people emphasise that these interventions must meet the **standards** of good practice: general quality, technical quality and efficacy, and access (Figure 4):

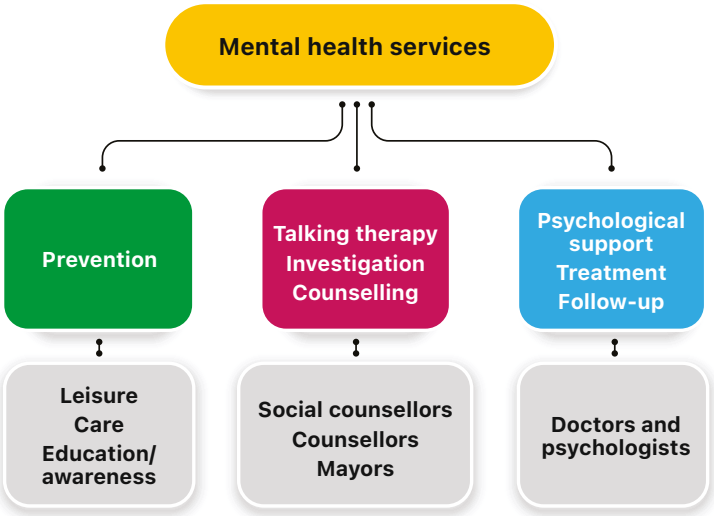

Figure 3: Services required according to young people in both governorates

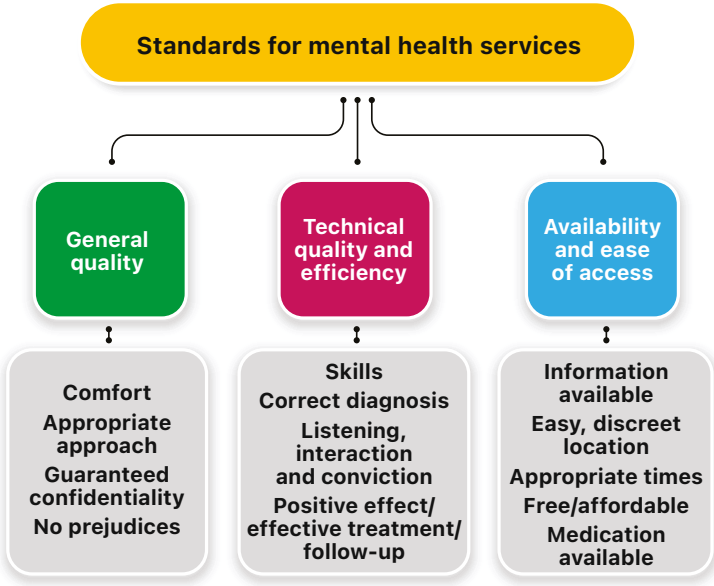

Figure 4: Standards of effective services according to young people in both governorates

With respect to expanding services, promoting their improvement and improving mental

health generally, young people suggested various processes that can be broadly divided into six main categories: an effective recruitment strategy for doctors and specialists, developing professionals' skills, digitising services, advocacy campaigns, awareness raising, developing young people's abilities.

Figure 5 shows the most important aspects of these:

Figure 5: Types of intervention proposed by participants

3. RECOMMENDATIONS

Recommendation 1: Providing mental health services as an integrated network with sufficient coverage for the whole country, including the three health lines and related organisations, ensuring quality and overcoming access difficulties

• Making mental health a key responsibility of frontline health care (preventive, diagnostic and treatment of straightforward cases, guaranteeing care from a body responsible for those cases that require guidance, with active and ongoing follow-up of these cases). This will require:

- Qualifying general practitioners, midwives and nurses in Basic Health Centres and local hospitals according to an effective recycling plan, providing active and effective ongoing training.
- Providing psychological specialists in public health bodies in all health offices, in numbers appropriate to the population for whom they will be responsible.
- Providing effective counselling, guidance and therapy in sufficient quantities in the various other relevant educational, cultural, social and municipal bodies, in particular those concerned with young people, women, children and vulnerable groups who are particularly at risk of mental health problems. Equipping them with what they need to be effective.

• Setting up psychiatry departments and child/teen/youth psychiatry departments in all regional hospitals in governorate centres. Creating highly specialised departmental units in the Health Regions in the west and south of the country, ensuring that they have the funding and the conditions necessary to carry out their work effectively.

• Creating effective mechanisms for coordination between the three lines and the various interventions, ensuring the continuity of individual treatment and the efficiency of shared services.

Recommendation 2: Developing and implementing a strategy for communication, capacity-building and awareness in mental health, focusing in particular on:

• Targeted activities and plans for the benefit of the broadest possible section of society (and for all age groups), via:

- Media and social media.
- Local partners in organisations and institutions and individuals.
- Mental health professionals (scientific symbols giving credibility and increasing the likelihood of behavioural change).

• Making mental health education a key part of all public and private educational institutions within the framework of educational programs, using a new approach that integrates the concepts and key ideas of mental health in the units taught at all levels of education.

• Providing special mental health programs for high-risk groups (drug users, school dropouts, those without family support, delinquents).

Recommendation 3: Training and capacity-building

• Providing training and capacity-building in mental health for young people. Developing and leading awareness campaigns using communications technology capable of changing mindsets and behaviours.

• It should be noted that training, as well as its core aim (developing skills), also provides an opportunity to get young people involved in social life, giving them the chance to play a key role in running awareness campaigns and develop their enthusiasm for taking responsibility as active members of society. This, in turn, will reduce their risk of mental health problems.

• Providing mental health training and capacity-building for employees, aiming to improve their grasp of the human dimension of their work and to continually maintain and develop their skills. This should facilitate adaptation to the demographic, psychological and social context in which they practise their profession, ensuring that they meet young people's care and support needs.

• Building institutional capacities, by:

- Identifying institutional shortcomings that affect professionals' working conditions and their wellbeing and, as a result, their performance.
- Providing the necessary facilities for mental health professionals' work.
- Digitisation of some mental health services, such as counselling or information.

• Building organisational, individual and group capacities among those new to mental health, including newly established companies operating in the field.

Recommendation 4: A targeted, comprehensive and multilateral advocacy strategy, including:

• An advocacy campaign aiming to develop the legal framework regulating mental health services.

• An advocacy campaign seeking to build infrastructure that would allow better access to bodies providing health services to citizens and professionals.

• Advocacy campaigns to encourage the creation of comprehensive and effective mental health services in every part of the country.

Recommendation 5: Guaranteeing ongoing and institutionalised coordination, cooperation and integration and regular evaluation in order to improve mental health services and facilitate more effective and efficient interventions:

• Between the various administrative bodies responsible for interventions or otherwise concerned with mental health.

• Between the various service providers on the ground, irrespective of level of intervention, field or sector.

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