

# WHO-AIMS

**WHO-AIMS REPORT ON  
MENTAL HEALTH SYSTEM  
IN TUNISIA**



**World Health  
Organization**



**MINISTRY OF HEALTH  
TUNISIA**

**WHO-AIMS REPORT ON**  
**MENTAL HEALTH SYSTEM**  
**IN TUNISIA**

*A report of the assessment of the mental health system in Tunisia using the  
World Health Organization - Assessment Instrument for  
Mental Health Systems (WHO-AIMS).*

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*WHO, Country Office in Tunisia  
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Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website:

[http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/index.html](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

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The WHO-AIMS project is coordinated by Shekhar Saxena.

## **Executive Summary**

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Tunisia. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Tunisia to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Tunisia is a small northern African country with an approximate geographical area of 163000 square kilometres and a population of 10 million people mostly Arabic and Muslim. The country belongs to the lower middle income group according to the World Bank 2004 criteria.

The mental health system benefits from an appropriate policy and legislative framework. A mental health policy began to be implemented in 1990 through a National Mental Health Program. Its main thrust is the integration of mental health care into primary care and the development of community mental health services. An essential list of drugs is also present and regularly updated since 1979, which includes antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs. The large majority of the population has free access to essential psychotropic medicines.

A mental health legislation was enacted in 1992 and reviewed in 2004, focusing on the “conditions of hospitalisation of individuals with mental disorders” and the mechanisms to oversee the involuntary treatment practices. Tunisia is indeed very concerned by the human rights protection, especially in vulnerable populations and many laws, official bodies and NGO’s look after this issue.

There is not a specific budget for mental health, except the small budget for the Mental Health National Programme and the allocations devoted to the mental hospital, but expenditures on mental health are still far below the needs.

Mental health services are organized in terms of catchment/service areas. Every academic service is responsible for the provision of care to the population and the training of primary care providers in its region.

There are 16 public outpatient mental health facilities available in the country, 7 community-based facilities and a single mental hospital. Few services are afforded to children and adolescents. The main users belong to the groups of schizophrenia and mood disorders. Women are underrepresented in inpatient units. Psychotropic medicines are available everywhere. In terms of affordability of mental health facilities, the system still suffers from an imbalance with a crucial lack of community-based services such as residential facilities or day treatment facilities.

Mental health services are mainly provided in the capital and along the coastline. This distribution makes their access more difficult for people living in the inner country.

Training of the primary care physicians is an ongoing process which aims to involve, step by step, the majority of them. In Tunisia, all primary health care clinics are physician based and almost all of them have assessment and treatment protocols for key mental health conditions available. Only doctors are allowed to prescribe psychotropic medications, whatever the circumstance and without restrictions. There is no interaction with traditional practitioners who are not legally recognised.

The country also suffers from a crucial shortage of mental health professionals, especially the psychosocial workers (e.g., psychologists, social workers). There is a total of human resource of 8 per 100,000 population.

Few NGOs are involved with mental health in the country, mainly in child psychiatry and rehabilitation.

In terms of public education, it took many years to break the silence about this taboo, but, nowadays, people are more and more sensitive to the issue of mental health and mental disorders and very willing to know more about them.

The country does have disability benefits for persons with mental disorders. Mental health patients can be afforded financial, treatment and transportation benefits. About a third of people who receive social welfare benefits do so for a mental disability.

In addition to legislative and financial support, there are formal collaborations between the Ministry of Public Health and many other departments/agencies (education, employment, welfare, criminal justice, women and family) which are members of the National Technical Committee for Mental Health, in charge of providing advice to the government on mental health policy, legislation and service planning.

The country has a data collection system concerning health indicators and diagnostics, but only in the Primary Health Care Centers. There is no mental health reporting system in the country, except the annual reports of the mental hospital and the annual report on the Primary Health Care centers and psychiatric consultations in general hospital annual reports.

Much research is carried out, despite the shortage of manpower and their involvement in the daily practice, but it is not sufficiently known, because it is not published (gray research).

# WHO-AIMS COUNTRY REPORT FOR TUNISIA

## Introduction

Tunisia is a small country located in Northern Africa, bordering the Mediterranean Sea, between Algeria and Libya. It has an approximate area of 163000 square kilometres and a population of 10 million people (10102000, 2005 figures). The official language is Arabic and the first foreign language is French but English is spoken among a growing number of Tunisians. Arabs form the ethnic majority and 98% of the population are Muslims. In addition, there are small Christian (1%) and Jewish (1%) communities. The country belongs to the lower middle income group according to the World Bank 2004 criteria.

The population is young with 26.7% under the age of 15 and 9.6% are over the age of 60. Thirty-five (35.1%) percent of the population is rural. The life expectancy at birth for males is 73 for males and 75 for females (2005). The healthy life expectancy at birth is 61 for males and 64 for females (2005). The overall literacy rate for adults is 74.3% (2004), 83.4.5% for men and 65.3% for women over 14 years.

The proportion of the health budget to GDP is 6.4%. The total per capita expenditure in health equals \$463 and the per capita government expenditure is \$350. Government expenditures on mental health are not known because there is not a separate budget for it within the total health budget. The public health system is structured in three levels of care. The primary care level is made up by more than 2200 primary health centres and 108 district hospitals. The second level is based on 32 regional hospitals. At the tertiary level are 29 academic hospitals. In addition, a dynamic private sector provides all types of care for outpatients and inpatients. There are 200 hospital beds per 100,000 population and 134 physicians per 100,000 population. Ten percent of all hospital beds are in the private sector. In terms of primary care, there are about 3600 physician-based primary health care clinics in the country (2200 public and 1600 private).

Data was collected in 2005 and is based on the year 2004.

## Domain 1: Policy and Legislative Framework

### Policy, plans, and legislation

Tunisia mental health policy was established in 1990 and is mainly based on the integration of a mental health component in primary health care to guarantee equity of access to mental health services to the majority. It includes as well developing human resources, protection of users' human rights, advocacy and promotion, quality improvement and monitoring system. However, it neither involved users and families nor refers to financing. It no longer addressed the issue of downsizing the mental hospital because it was already done. The last revision of the mental health plans was in 2001 and 2006 and contains the following components: mention of a budget to finance the training

of 10% of primary care physicians within the two following years, the celebration of the World Mental Health Day and other activities of public education and information. However, there is no emergency/disaster preparedness plan for mental health.

In addition, a list of essential medicines has been present since 1979 and was lastly updated in 2004. These medicines include antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs. A mental health legislation was enacted in 1992, and reviewed in 2004, which focused on access to mental health care (from the most to the least restrictive care), voluntary and involuntary hospitalization, accreditation of facilities, mechanisms to oversee the involuntary treatment practices, judicial system issues for people with mental disorders, rights of consumers and caregivers, sanctions in case of infraction and mechanisms to implement the provisions of mental health legislation. Issues regarding competency, capacity and guardianship for mentally ill are included in other common laws. Patients can be involuntarily admitted only in public structures and in so-called watched services (“services surveillés”).

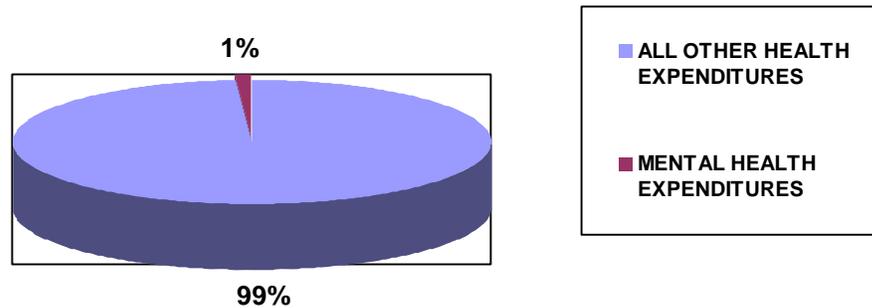
Many difficulties were faced in implementing the mental health legislation, given the absence of procedures and standardized documentation, which led to a reupdating of the law in 2004. Even though “watched facilities” are allowed under current legislation (see above), there are none of these facilities in existence. So, patients are hospitalized in the same way as they have been in the past, whatever their way of admission (voluntary or involuntary).

### **Financing of mental health services**

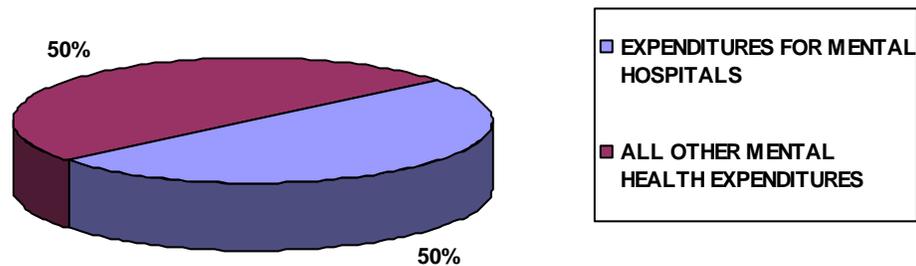
It is difficult if not impossible to provide figures concerning the financing of mental health services because there is not a separate budget for mental health except the \$30,000 allocated by the WHO every two years to help implementing the NMHP and the allocations provided to the mental hospital and \$50,000 from the National Budget for the Mental Health National Programme. Consequently, we can only estimate that an approximate 1% of health care expenditures are devoted to mental health. Of all the expenditures spent on mental health, 50% are probably devoted to the single mental hospital which comprises more than half the country psychiatric beds. In terms of affordability of mental health services, the large majority of the population has free access to essential psychotropic medicines. At least 80% are covered by the government (for needy or handicapped people) or the social security and other insurance schemes. For those that have to pay their medicines out of pocket, the cost of antipsychotic medication is \$0.16 per day and the cost of antidepressant medication is \$0.21 per day. All severe and some mild mental disorders are covered in social insurance schemes.

Expenditures spent on mental health are probably higher than 1% but, with the exception of the governmental allocation devoted to the mental hospital, they are impossible to be identified because they are included in various budgets (primary care, school medicine, general hospitals, prisons etc.).

**GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH**



**GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS**



### **Human rights policies**

A regional human rights review body exists which has the authority to oversee regular inspections in mental health facilities, review involuntary admission and discharge procedures and review complaints investigation processes. The review body sends its reports to the Ministries of Health and Justice which are the only ones to have the authority to impose the sanctions envisaged by law (including prison sentences). These reviews are mandatory. There is only one mental hospital in Tunisia and it has regular (between two to four times by year) inspections of human rights protection of patients. Similarly, 100% of community-based inpatient psychiatric units had such a review. Community residential facilities depend on the Ministry of Social Affairs which has its own review body. There was no specific training on human rights protection of patients but it is included in the current curriculum of all mental health professionals.

Tunisia is very concerned by the human rights protection, especially in vulnerable populations and has many laws, official bodies and NGO's look after this issue.

### **Domain 2: Mental Health Services**

## **Organization of mental health services**

A national technical Committee for mental health exists which provides advice to the government on mental health policies and legislation. The mental health authority also is involved in service planning. Mental health services are organized in terms of catchment/service areas. Every academic service is responsible, within a defined geographical area, for provision of care to all residents and training for all the primary care workers, especially, general practitioners.

## **Mental health outpatient facilities**

There are 16 public outpatient mental health facilities available in the country, of which 13% are for children and adolescents only. These facilities treat about 1000 (995) users per 100,000 general population (only in the public sector). Of all users treated in mental health outpatient facilities, 53% are estimated to be female and 8% are children or adolescents. The users treated in outpatient facilities are primarily diagnosed with schizophrenia (30%) and mood disorders (30%), followed by neurotic and somatoform disorders (25%). The average number of contacts per user is 3. All the outpatient facilities, except the outpatient clinic linked to the mental hospital, provide follow-up care in the community, while there are no mental health mobile clinic teams. In terms of available interventions, very few (less than 20%) users have received one or more psychosocial interventions in the past year, given the high number of patients and the short-time allocated to everyone. All the mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a nearby pharmacy all year round.

All the figures are very approximate and obviously underestimated. Actually, with the exception of the mental hospital, statistics of community mental health facilities are not distinguished from the overall statistics. We had to contact every facility one by one to get some of them when available. Secondly, we do not have any figure from the private sector that delivers a significant amount of mental health services. The situation is complicated by the frequent recourse by patients to both sectors.

## **Day treatment facilities**

There are two public day treatment facilities available in the country, which are for children and adolescents only. Some NGO's and family associations also provide this type of care (for children and adolescents) but they are not accessible to the majority. These facilities treat less than one user per 100,000 general population. Of all users treated in day treatment facilities, 42% are female and 100% are children or adolescents. On average, users spend around 20 days in day treatment facilities.

The lack of day treatment facilities and other ambulatory facilities in general is one of the main weaknesses of the mental health system in the country. It might be explained by the scarcity of human resources and the remoteness of mental health services.

### **Community-based psychiatric inpatient units**

There are 7 community-based inpatient units available in the country for a total of 3 beds per 100,000 population. 8% of these beds are reserved for children and adolescents only. 38% of admissions are female and 1% is children/adolescents. The diagnoses of inpatients were primarily from the two following diagnostic groups: schizophrenia (45%) and mood disorders (32%). The majority of patients received one or more psychosocial interventions in the last year. All the community-based psychiatric inpatient units had more than one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community-based psychiatric inpatient units were established during the last 20 years and are still going to develop to be available in all the regions of the country. It is only the lack of specialized human resources or their reluctance to settle far from the main cities which slows down their development.

### **Community residential facilities**

There are no community residential facilities available in the country. Only sheltered homes for mentally ill without family support exist, the capacity of which (two hundred beds) was exceeded for years.

The absence of residential facilities is a major problem which explains that a hundred patients without family are unable to leave the mental hospital, although they could live in the community.

### **Mental hospitals**

There is one mental hospital available in the country for a total of approximately six beds per 100,000 population. It is organizationally integrated with mental health outpatient facilities. Four per cent of these beds are reserved for children and adolescents only. The number of beds has not changed in the last five years, but the mental hospital was downsized by half in the past twenty years (from 1018 to 560 beds). The patients admitted to the mental hospital belong primarily to the groups of schizophrenia (46%) and affective disorders (31%). The number of patients treated in the institution is 46 per 100,000 population. The average number of days spent in the mental hospital is 27. This figure is unrepresentative because it is skewed due to a large number of long-stay patients; with the exclusion of the long-stay patients, the figure would be around three weeks. 75% of patients spend less than one year, 8% of patients spend 1-4 years, 7% of patients spend 5-10 years, and 11% of patients spend more than 10 years in the mental hospital. About half of the patients received one or more psychosocial interventions, during their stay in

the last year. The mental hospital had a broad range of all psychotropic medicines of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility. However, many of them are not available in the primary care settings.

The mental hospital experienced many advances: downsizing, it is no longer a locked facility, introduction of medical facilities, increase in the number of professionals, and academic accreditation. But its progress is hindered by the strong social stigma put on it and the reluctance of the population, especially young people and women or individuals with minor mental disorders, to seek care there. In addition, it takes in too many long-stay patients due to the lack of community residential facilities, which contributes to a frequent overcrowding.

### **Forensic and other residential facilities**

In addition to beds in mental health facilities, there are also 60 beds for people with mental disorders in one forensic inpatient unit located inside the mental hospital and 50 in a unit specifically reserved for people with substance abuse problems. In forensic inpatient units, 77% of patients spend less than one year, 17% of patients spend 1-4 years, 4% of patients spend 5-10 years, and 2% of patients spend more than 10 years. Finally, 196 beds exist in shelters where a majority of people have mental disorders (mental retardation, dementia, schizophrenia).

### **Human rights and equity**

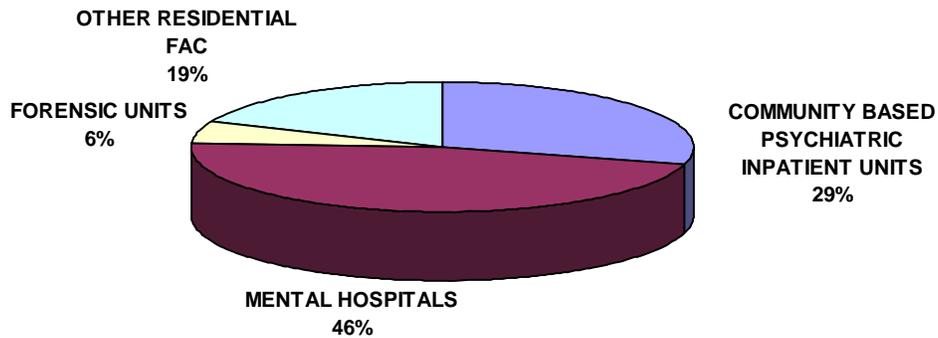
The rate of involuntary admissions is 14% of all admissions to community-based inpatient psychiatric units and 27% of all admissions to mental hospitals. Less than 10% (5-8%) of patients were restrained or secluded at least once within the last year both in community-based psychiatric inpatient units and in the mental hospital.

The density of psychiatric beds in or around the largest city is three times greater than the density of beds in the entire country. Such a distribution of beds makes access to care for rural users more difficult. This problem will be resolved with the gradual integration of mental health in primary care and the creation of specialized facilities at the regional level throughout the country.

Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is not an issue in the country because all of the population speaks Arabic.

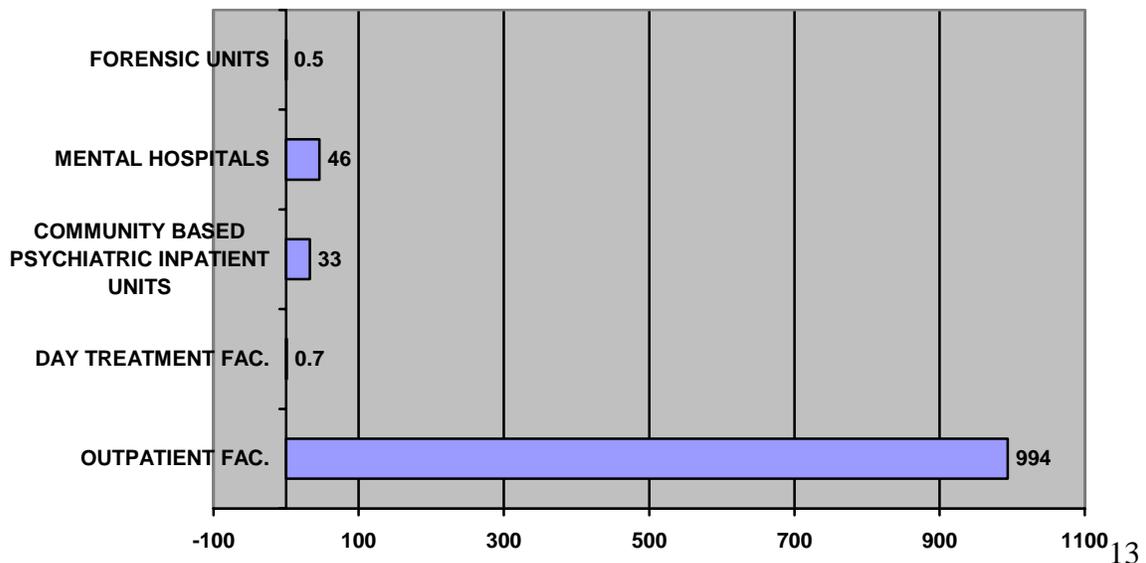
## Summary Charts

**GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES**



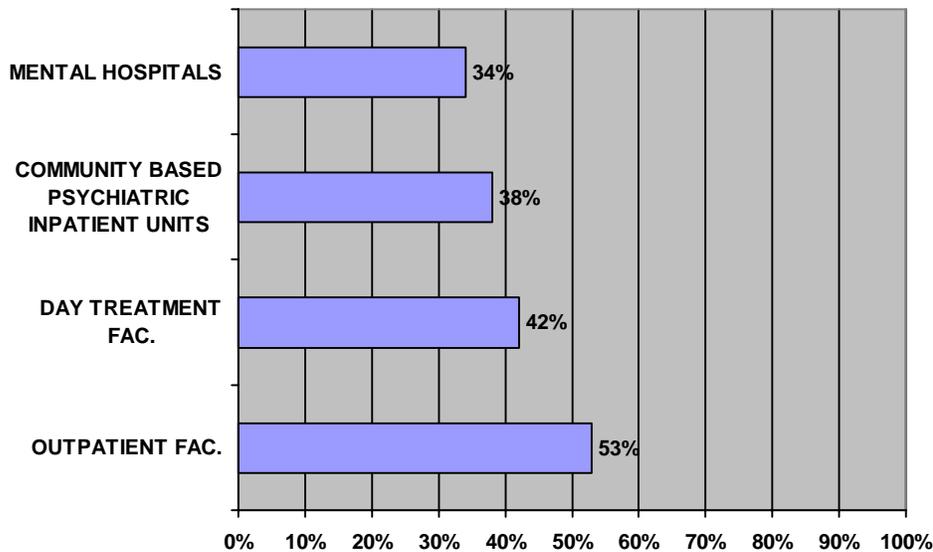
The majority of beds in the country are still provided by the mental hospital. The residential units available exist outside the general health system, belonging to the Social Affairs.

**GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES  
(rate per 100.000 population)**



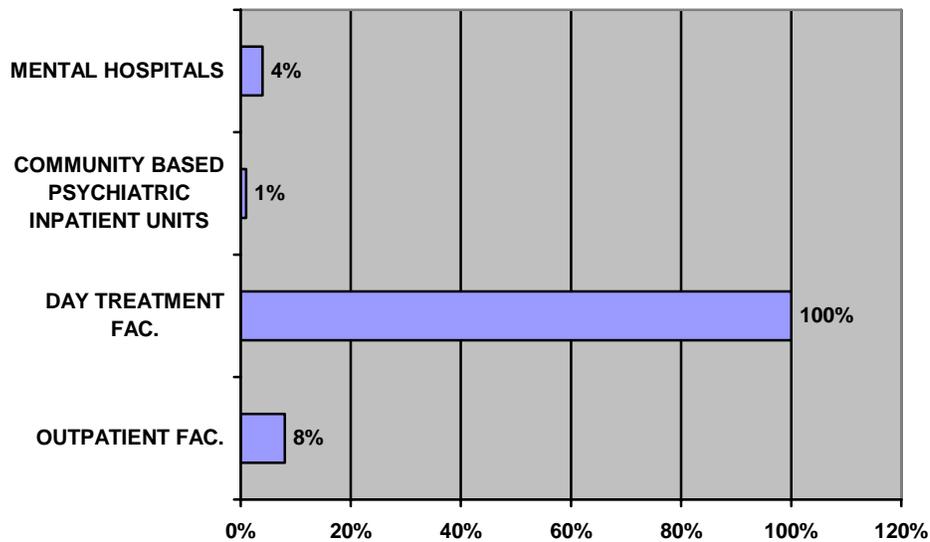
The majority of the users are treated in outpatient facilities and one of the objectives of the National Mental Health Program is to reduce the pressure on the inpatient units and provide mental care within the community. However, 50% are afforded care in the outpatient clinic of the mental hospital. Besides, the very low rate of patients treated in day treatment facilities reflects one of the major lacks of the mental health system.

**GRAPH 2.3 - PERCENTAGES OF FEMALE USERS  
TREATED IN MENTAL HEALTH FACILITIES**



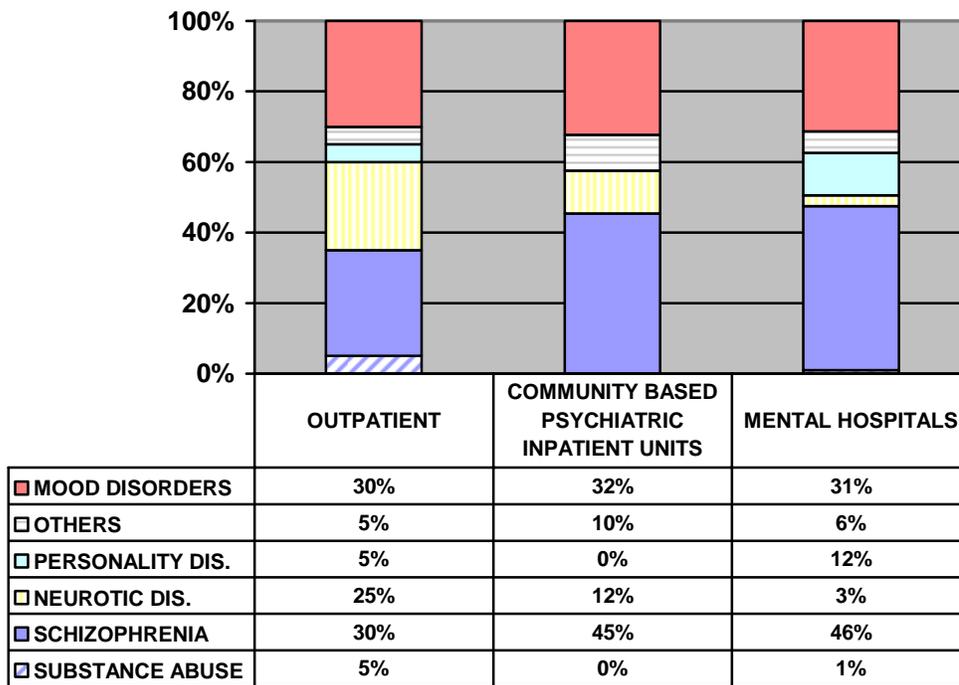
Female users make up over 50% of the population in outpatient facilities but are underrepresented in the inpatient population. This difference reflects both the crucial role of women as caregivers at home and the high stigma attached to their hospitalisation in psychiatric units, especially in the mental hospital.

**GRAPH 2.4 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS**



The percentage of users that are children and/or adolescents is extremely low, except in the day treatment facilities which are exclusively reserved for them. The scarcity of children and adolescent mental health services is another major problem faced in the country.

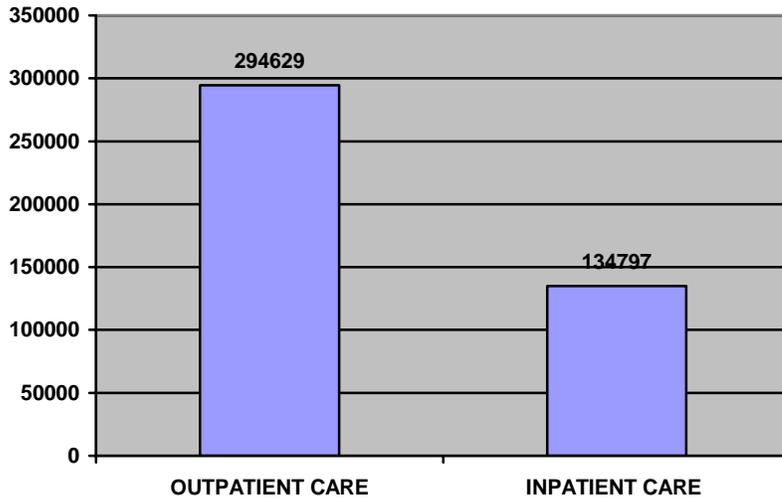
**GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**



The two major populations treated in all mental health facilities are patients with schizophrenia and mood disorders. The ICD is not used for diagnosis of patients that are treated in outpatient facilities and therefore the data for these facilities cannot be used as comparative overall but is useful in the context of Tunisia's mental health systems. Neurotic disorders, are less frequent in the inpatient units, which are overwhelmed by the severe mental illnesses. This under-representation of minor mental disorders also confirms the social stigma attached to psychiatric care.

Psychotropic drugs are widely available in the mental hospital, inpatient units, and outpatient mental health facilities.

**GRAPH 2.6 INPATIENT CARE VERSUS  
OUTPATIENT CARE**



The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospital and general hospital units) which is slightly superior to 2 indicates the poor extent of community care in the country. It should be taken into consideration, however, that the amount of care provision in private practice is not taken into account.

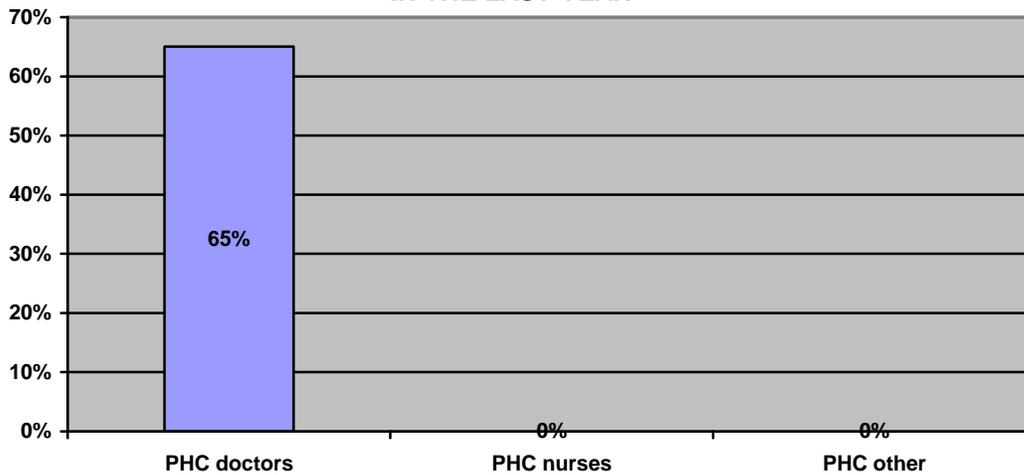
### **Domain 3: Mental Health in Primary Health Care**

#### **Training in mental health care for primary care staff**

Nine percent of the training for medical doctors is devoted to mental health, in comparison to 3% for nurses. The rate for non-doctor/non-nurse primary health care workers is unknown because it is included in other fields of training (social work, legislation etc.). In terms of refresher training, more than 50% of primary health care doctors have received at least two days of refresher training in mental health, while no other category of professionals benefited from such training as nurses and psychologists. We must however mention that 15% of doctors have received one to three months of training inside an academic unit.

Training of the primary care physicians is an ongoing process which aims to involve, step by step, the majority of them. This process, for the moment, included only those who applied for such training.

**GRAPH 3.1 - % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR**



### **Mental health in primary health care**

In Tunisia, all PHC clinics are physician based and almost all of them have assessment and treatment protocols for key mental health conditions available. Around 75% of physician-based primary health care doctors make at least one referral per month to a mental health professional. In terms of professional interaction between primary health care staff and other care providers, around 15% of primary care doctors have interacted with a mental health professional at least once in the last year. None of physician-based PHC facilities have had interaction with a complimentary/alternative/traditional practitioner. In primary care, only doctors are allowed to prescribe drugs.

In the country, traditional practice is not officially recognized (it is legally prohibited but tolerated) and thus there is no contact between the two systems. There is a lack of interaction between PHC and specialized facilities, despite the high level of referrals, because of the remoteness of the different structures, the poor availability of both physicians and specialists and the rarity of personal links. For this reason, some mental health services have chosen to involve a few PHC doctors in their work, once a week or once a month, to create closer relationships and discuss common topics regarding the catchment area.

### **Prescription in primary health care**

Only doctors are allowed to prescribe psychotropic medications, whatever the circumstance and without restrictions. As for availability of psychotropic medicines, most (between 81% and 100%) of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

## **Domain 4: Human Resources**

### **Number of human resources in mental health care**

The total number of human resources working in mental health facilities or private practice per 100,000 population is 8.2. The breakdown according to profession is as follows: 1.5 psychiatrist, 0.2 other medical doctors (not specialized in psychiatry), 3.7 nurses, 0.3 psychologists, 0.2 social workers, 0.1 occupational therapists, 2.2 health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors). As for medical doctors, we included only those who work full-time in mental health facilities, however, all of the primary care physicians also provide mental health care. See graph 4.1

Psychiatrists are equally distributed between the public and private sectors. None work only for NGOs and twelve or so work for the government and NGO's/ non-profit mental health facilities. Most (96%) psychologists, social workers, nurses and occupational therapists work only for government administered mental health facilities and 1% works only for NGOs/for profit mental health facilities/private practice. 3% work for public or private sectors and NGO's.

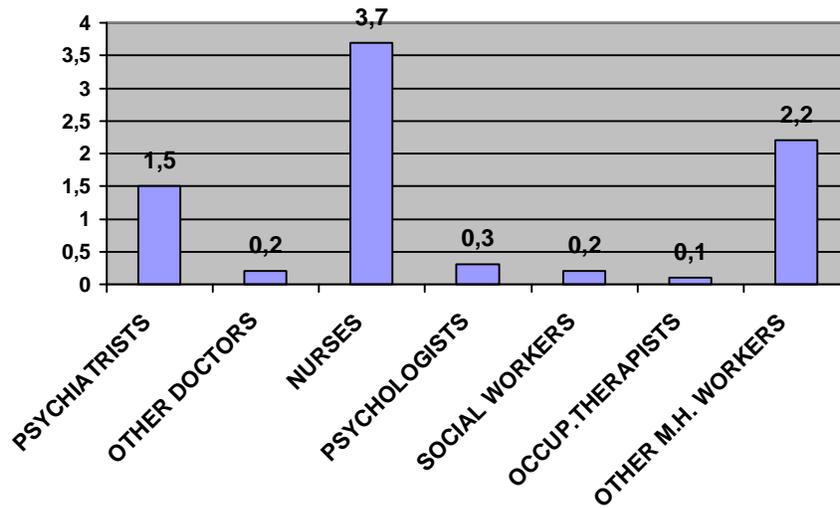
Regarding the number of mental health professionals working in the various mental health sectors, 10 psychiatrists work in outpatient facilities, 30 in community-based psychiatric inpatient units and 30 in the mental hospital. Two other medical doctors, not specialized in psychiatry, work in outpatient facilities, two in community-based psychiatric inpatient units and 15 in the mental hospital. As for nurses, five work in outpatient facilities, 35 in community-based psychiatric inpatient units and 325 in the mental hospital. No psychosocial staff (psychologists, social workers and occupational therapists) works in outpatient facilities, 15 in community-based psychiatric inpatient units and 14 in the mental hospital. As regards to other health or mental health workers 21 work in outpatient facilities, 73 in community-based psychiatric inpatient units and 216 in the mental hospital.

In terms of staffing in mental health facilities, there are 0.09 psychiatrists and 0.1 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.05 psychiatrists and 0.6 nurses per bed in the mental hospital. For other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.05 per bed for community-based psychiatric inpatient units, and 0.03 per bed in mental hospitals. See graph 4.3

The distribution of human resources between urban and rural areas is largely disproportionate. The density of psychiatrists in or around the largest city is 3.6 times greater than the density of psychiatrists in the entire country. The density of nurses is 4.3 times greater in the largest city than the entire country.

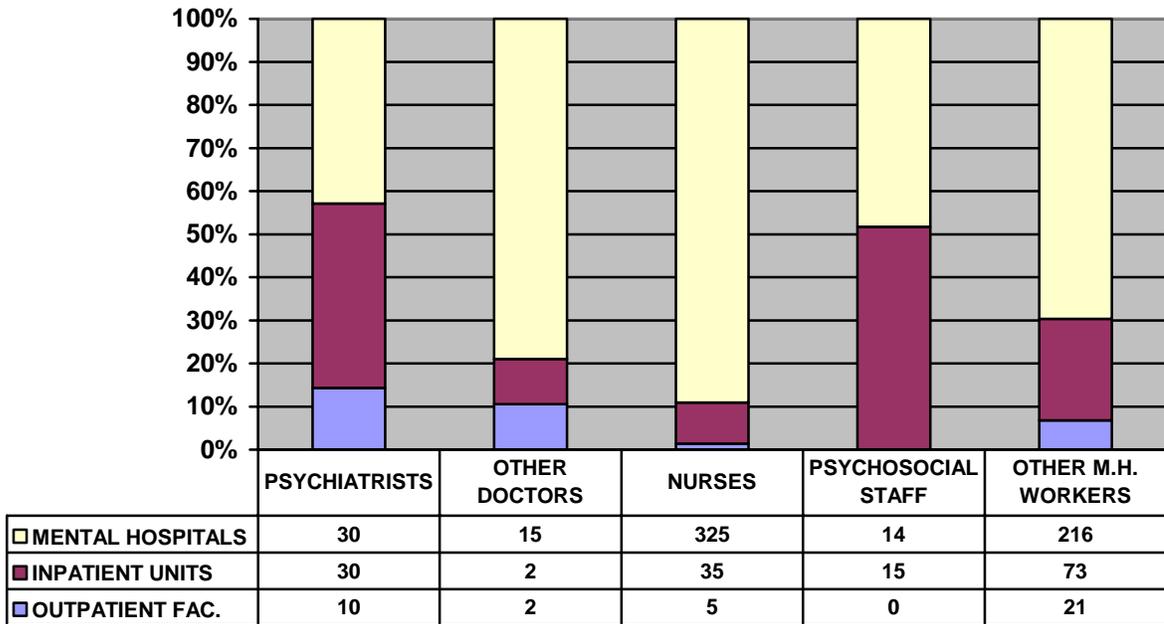
Again, the only precise figures concern the mental hospital. For the outpatient mental health facilities outside the mental hospital, it is impossible to get data about the personnel that is shared by several outpatient clinics. As for the psychiatric services in the general hospitals, figures provided by some colleagues helped us only give estimates for the whole.

**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH**  
(rate per 100.000 population)

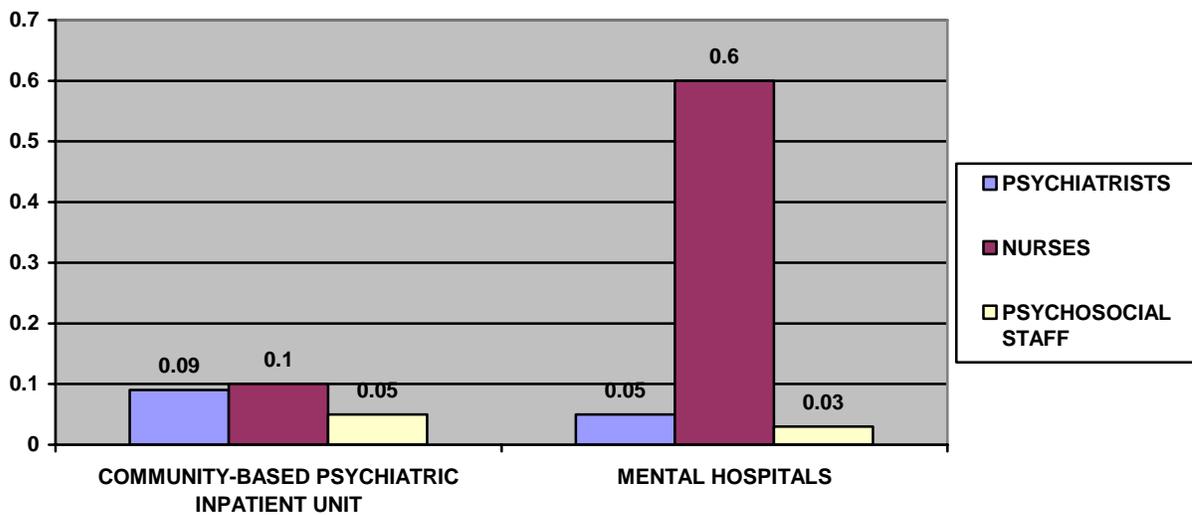


This graph illustrates the crucial shortage of mental health professionals, especially the psychosocial workers.

**GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES**  
(percentage in the graph, number in the table)



**GRAPH 4.3 - AVERAGE NUMBER OF STAFF PER BED**



## **Training professionals in mental health**

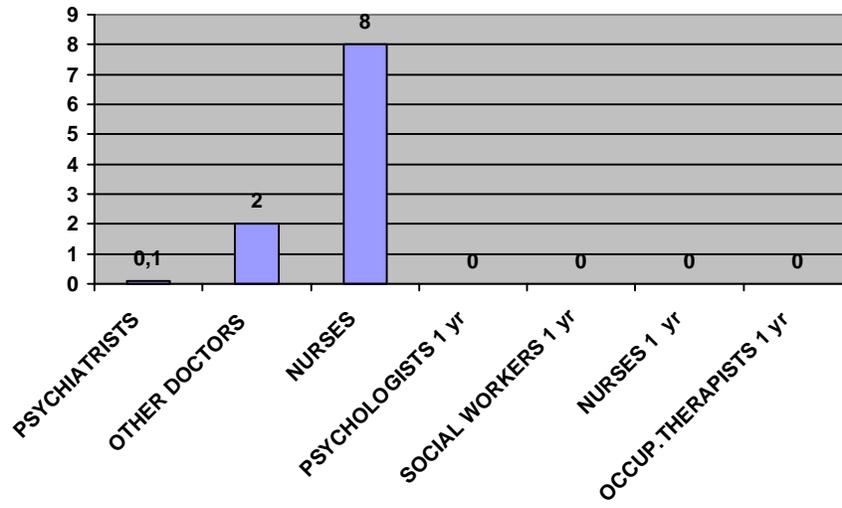
The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 2 medical doctors (not specialized in psychiatry), 0.1 psychiatrists and, 3 nurses. The number of nurses graduated refers to public schools only. It is unknown how many nurses graduated from private institutions. No psychologists, nurses, social workers or occupational therapists with at least 1 year training in mental health care, graduated last year in academic and educational institutions.. 15% of psychiatrists emigrate to other countries (mainly France) within five years of the completion of their training.

The majority of psychiatrists (90%) and doctors (100%) benefit regularly from refresher training in the rational use of psychotropic drugs; this is not the case for the other mental health care staff who also do not receive any refresher training in psychosocial interventions or child/adolescent mental health. A minority of psychiatrists and doctors do receive refresher training in psychosocial interventions but not in child/adolescent mental health, see graph 4.5. Child psychiatrists do have their own specific training, however.

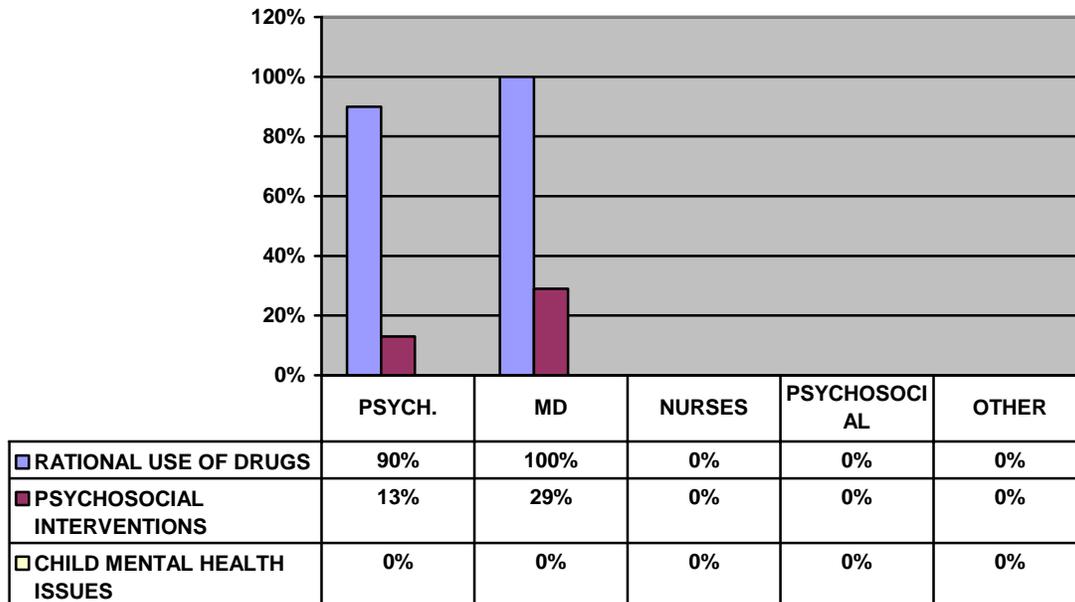
The country is still confronted by a crucial shortage in human resources for mental health. Psychiatry is not yet a priority despite many incentives as an attractive specialty for doctors or nurses. In addition, a new problem emerged these last years with the emigration of trained mental health professionals (psychiatrists and nurses) to more privileged countries.

The lack of staff combined with the huge need for care allows little availability for refresher training in most settings.

**GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)**



**GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR**



### **Consumer and family associations**

There are only family associations in the country and data regarding the number of their members are not available. Many associations involved in the social care field help promote child mental health. All the associations receive some economic support from the government. The family associations have not been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. Only professional associations were implied.

A few facilities (about 15%) interact with family associations, especially child psychiatric services.

Once more, it is the stigmatization of mental illness and psychiatric care which prevents the development of associations in the field, except for children, while there are thousands of NGO's in the country.

## **Domain 5: Public Education and Links with Other Sectors**

### **Public education and awareness campaigns on mental health**

There is a coordinating body to oversee public education and awareness campaigns on health and illnesses in general, which also include mental health and mental disorders since the implementation of the NMHP. The Ministry of Health (Division of Health Education), NGOs and professional associations have carried out several public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: general population, students and women. In addition, there have been public education and awareness campaigns targeting professional groups including conventional health providers, teachers and social service staff.

It took many years to break the silence about this taboo, but nowadays people are increasingly more sensitive to the issue of mental health and mental disorders and are very willing to know more about them. This growing awareness was greatly facilitated by the visit paid by the Head of State and the First Lady to the mental hospital in 1997 at which time they declared their support to the mentally ill.

### **Legislative and financial provisions for persons with mental disorders**

The following legislative provisions exist to provide support for users: (1) provisions concerning a legal obligation for employers to hire a certain percentage of employees who are disabled, but they are not fully enforced; on the contrary (2) provisions concerning protection from discrimination (dismissal, lower wages) solely on the account of a mental disorder are quite completely enforced, at least in the public sector. No legal provision exists concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders. At the present time, there are no legislative or financial provisions for discrimination in housing.

Despite the support to the NMHP at the highest level of the State, as mentioned above, mentally ill people are still subject to discrimination and are not considered by the authorities as high priority compared to other underprivileged citizens. In addition, the very important role played by the family at large masks the difficulties met by individuals with mental disorders. Actually, at present in the whole country, patients without family support and in need for housing are “only” a few hundred.

### **Links with other sectors**

In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and the departments/agencies responsible in the primary health care department, for reproductive health, child and adolescent health, substance abuse, child protection, education, employment, welfare, criminal justice, the elderly, women and family but not for HIV/AIDS or housing.

Representatives of these departments are members of the National Technical Committee for Mental Health.

In terms of support for child and adolescent health, seven percent of primary and secondary schools have either a part-time or full-time mental health professional, and between 20-50% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

The percentage of prisoners with psychosis is around 3%, while the corresponding percentage for mental retardation is less than 2%. Regarding mental health activities in the criminal justice system, the majority of prisons have at least one prisoner per month in treatment contact with a mental health professional. Eighty (80%) of prisons employ a part-time psychiatrist.

As for training, few police officers, judges and lawyers (less than 20%) have participated in educational activities on mental health in the last five years.

In terms of financial support for users, no mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, about the third of people (27%) who receive social welfare benefits do so for a mental disability.

The link with the other sectors unfortunately remains largely theoretical. This may be explained by the irregularity of the National Technical Committee meetings and the frequent change of the department's representatives.

## **Domain 6: Monitoring and Research**

A formally defined list of individual data items that ought to be collected by all mental health facilities did not exist during the year of data collection, but it started in 2005. The government health department collects data including number of beds, admissions, length of stay, and rate of occupancy, by hospital and not by specialty. That is why the division of mental health elaborated this year a specific list to be completed by mental health facilities and its implementation has started already. This list includes the number of beds, admissions, involuntary admissions, length of stay, and patient diagnoses.

As shown in the table 5.1, the extent of data collection is variable among mental health facilities. The government health department received actual data directly from the single mental hospital. But data from community based psychiatric inpatient units and mental health outpatient facilities are integrated to the overall data of the general hospital to which they belong. Only some general hospitals provide separate data for psychiatric activities. Some mental health data have been published in a report achieved by the Division of Primary Health Care, but without comments.

In terms of research, only 1% of all health publications in the country (listed on PubMed) were on mental health. The research focused on various topics, especially epidemiological studies in clinical samples, clinical assessments of mental disorders, policy, programmes and therapeutic interventions.

It should be noted that the number of publications on mental health is much higher but the majority is published in 'gray literature' so it is not possible to ascertain a precise figure. In particular, all psychiatrists have to present a research study before graduating. These doctoral theses are available in the libraries of the faculties of medicine and the majority of studies and surveys are communicated as oral papers.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%	100%	NA
N° inpatient admissions/users treated in outpatient facilities	100%	100%	0%
N° of days spent/user contacts in outpatient facilities.	100%	100%	100%
N° of involuntary admissions	100%	100%	NA
N° of users restrained	0%	0%	NA
Diagnoses	0%	0%	0%

## **Strengths and Weaknesses of the Mental Health System in Tunisia**

The assessment of the mental health provision in our country through the WHO-AIMS instrument was a great opportunity to make a fair diagnosis of the situation through objective indicators and according to the norms of a comprehensive mental health policy.

### **Strengths**

- A strong political will to develop a comprehensive mental health system affordable to all.
- The existence of a mental health policy, plan and legislation and their periodical updating.
- A dense primary care network accessible to 90% of the population.
- Strong family involvement and support
- The existence of mechanisms to protect the human rights of patients
- The availability of essential medicines in all facilities
- The ongoing process of training on mental health for primary care staff
- The policy of sectorization (catchment areas) which allow closer mental health services to the community
- The development of more outpatient care in place of inpatient care
- The equal distribution of psychiatrists between public and private sectors

### **Weaknesses**

- The lack of mental health services in the face of an increasing demand for care
- The imbalance between the mental hospital and the community mental health facilities: the mental hospital remains the main provider of inpatient and outpatient care, given the limited number of ambulatory facilities
- The poor extent of community care
- The absence of community residential facilities
- Limited child and adolescent mental health services
- The shortage of human resources, especially psychosocial workers
- The imbalance between drug treatment and psychosocial interventions (i.e., patients have limited access to psychosocial interventions)
- The imbalanced access to care between serious and minor mental illnesses
- The meager financing of mental health services
- The poor involvement of NGO's
- The poor involvement of other relevant sectors
- The lack of interaction between mental health providers and primary care staff
- The strong social stigma attached to mental disorders and psychiatric care
- The absence of an effective mental health information system at all levels
- The large volume of "gray research" that is not more widely published

The situation of the mental health system in Tunisia reflects the status of a low middle income country. When it is compared to regional and world information, it seems to rank midway between the most and least developed countries, benefiting from the essential services but still unable to address the growing burden of mental health needs in a comprehensive way.

In fact, mental health care began to develop only in the 1990s. Indeed, for a long time in Tunisia, as in other developing countries, confronted other critical public health problems (epidemic diseases, maternal and infant mortality etc.); mental disorders were not afforded high priority. Today, real progress has been achieved but the network of mental health facilities is far from being complete. The main facilitators for progression are the strong political will to develop the mental health system and the important involvement of the professionals in activities of education and advocacy. The most critical barriers are the pervasive social stigma which hampers the access to care, the lack of development of consumers associations, as well as the lack of access to work and housing for mentally ill people.

## **Next Steps in Strengthening the Mental Health System**

The assessment of the mental health provision in our country through WHO-AIMS was impressively instructive and very helpful to point out the real deficiencies/ areas for improvement in our mental health system and open the way towards the existing opportunities and the relevant solutions.

Some feasible and inexpensive actions could help to dramatically improve the current mental health system. Many of them are already planned and scheduled.

- This assessment pointed out a first major deficiency: the difficulty to collect reliable data. Consequently, it is of crucial importance to develop a mental health information system and to carry out a community-based epidemiological study at the national level. It is the only way to better adapt resources to the needs of the population. Preparation is underway for some relevant indicators in the annual health reporting system.
- Allocating a larger separate mental health budget within the total health budget
- As for care provision, the most urgent need is to strengthen the network of community-based facilities: mental health outpatient facilities and community-based psychiatric inpatient units at the secondary level of care, day treatment and residential facilities, sheltered homes etc. The development of community care is highly supported by the authorities but is hindered by the shortage of human resources and their reluctance to settle far from the main cities. Incentives have been afforded to motivate psychiatrists, namely the possibility to have also a private practice when they choose to work in the underserved regions.
- Incentives must likewise be offered to increase the numbers of health professionals and psychosocial staff, such as longer holidays as it is applied in radiology.
- Strengthening advocacy, public education and sensitivity to fight the stigma
- Creation of "watched units" to admit people who are involuntary hospitalized

- Continuing the training of primary care providers, including nurses and social workers
- Involving and supporting family associations to help them play a greater role in mental health prevention, care and rehabilitation
- Strengthening child and adolescent mental health care has already begun with the establishment of new community-based outpatient facilities and the increasing of the number of specialists.
- Strengthening the training in psychosocial interventions.

The mental health system in Tunisia started its development in the 1990s when mental health and mental disorders became considered a higher priority. A national mental health program began to be implemented, aiming mainly at integrating mental health care and primary care in order to provide services to the whole population inside the community. In fact, the country benefits from a dense network of 2000 physician-based primary care centers accessible to 90% of the population. Real advances have been achieved but the mental health network is far from being complete and fully adequate. Resources remain grossly insufficient and inadequate to address the growing need for care.

Despite the enacting of modern policies and legislations, the downsizing by half of the single mental hospital, the creation of psychiatric units in general hospitals, or the multiple incentives afforded to increase the numbers of professionals, the provision care system still suffers from a lack of community mental health services, a shortage of manpower and a scarcity of reliable and relevant data. Supported by a strong political will, the development of the mental health system is nevertheless hampered by the pervasive social stigma attached to mental illness which poses a critical barrier to the public awareness.