“Everybody’s responsibility”: Conceptualisation of youth mental health in Kenya

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Abstract

There is increasing interest in providing resilience-building interventions in low- and middle-income countries (LMIC), but limited evidence on how young people and their carers process mental health and related supports. The aim of this study was to establish stakeholders' conceptualisation of youth mental health in a disadvantaged area of Kenya through focus groups with seven young people aged 14-17 years and their parents, nine teachers and 11 practitioners or community leads. The four identified themes related to definitions of both mental wellbeing and mental health problems; a range of contributing factors related to identity resolution, parenting, poverty and social media; attribution of responsibility at different socioecological levels; and required awareness, supports and interventions at these levels. Stakeholders, notably young people, are thus essential in the development and planning of user-led and culturally-appropriate interventions in LMIC.

Key words

Young people, mental health, awareness, developing countries, stakeholders

Introduction

Children and adolescents represent one third of the world's population, with the majority living in low- and middle-income countries [LMIC] (UNICEF, 2016). The prevalence of mental health problems in the general population is approximately 10-12% globally, based on epidemiological studies (Bor et al., 2014). Prevalence rises with socioeconomic disadvantage, with further increase among vulnerable groups such as those exposed to war conflict or refugees or accommodated, with ratios of 4:1 or even higher (Eruyar et al., 2017).

Young people in LMIC, especially those living in contexts of conflict and deprivation, are exposed to multiple and inter-linked risk factors, are thus especially vulnerable (Kieling et al., 2011). These high levels of need remain largely unmet, because of barriers in recognition, stigma of mental illness, and limited resources (Patel and Rahman, 2015). Culture is thus often an important factor involved in the help-seeking process (De Anstiss and Ziaian, 2010). Youth mental health and help-seeking are also influenced by culture, in a dynamic process including values, norms and beliefs (Lasebikan, 2016) connected with the development, onset and continuation of mental health problems (Heim et al., 2017). Significantly for youth mental health in LMIC, the cultural context has also been shown to be inter-related with parenting functions, hence its conceptualisation by parents and other adults can have both a risk and protective impact (Atilola, 2015).

Young people are the least capable of defending themselves and voicing their views, and thus especially likely to be affected by stigma (World Health Organisation, 2017). In many LMIC, stigma still constitutes a taboo that is responsible for hiding mental

health problems and disabilities from the community (Amuyunzu-Nyamongo, 2013). Since young people depend on adults who can potentially detect and address their concerns, perceptions of mental health from those around them play a key role in recognising mental health problems (Abera et al., 2015). However, few studies have investigated the conceptualisation of mental health by young people and their caregivers in LMIC (Patel et al., 2008).

Limited evidence indicates there is still a low level of mental health awareness in many LMIC. For example, Abera et al. (2015) found that mental illness in Ethiopia was commonly attributed to supernatural causes, which influenced help-seeking from religious or spiritual leaders. Such views are not necessarily mutually exclusive from accepting mental health supports and services. In the Gaza Strip parents reported similar beliefs, but were also amenable to receiving psychoeducation and attending mental health services (Thabet et al., 2006). In Nepal, parents and teachers associated youth mental health problems with disadvantage; identified primary supports within their families, schools and communities; and wished for greater mental health awareness (Adhikari et al., 2015). The sampling of these studies could partially explain views towards mental health services, depending on whether participants largely lived in urban areas where most of the limited mental health services are usually concentrated, or in more remote rural communities.

Despite such sparse and inconclusive findings, establishing stakeholder-led evidence is crucial in developing culturally-sensitive interventions and service planning in LMIC (Rickwood et al., 2007), particularly for young people (Becker and Kleinman, 2013). Kenya, for example, is amongst the poorest countries in the world (World Bank,

2017), with high inequalities among the 45 million population (United Nations Population Fund, 2012). The health service system, broadly structured into six levels, is hampered by inadequate personnel, poor co-ordination, high poverty levels in the communities it serves, and lack of adequate drugs and equipment (International Institute for Legislative Affairs [ILA], 2011). The Government spends only around 10 USD per capita per year on health (Jenkins et al., 2010), with as little as 0.01% spent on mental health (ILA, 2011). As in other LMIC, mental health problems in young people are exacerbated by disadvantage, unemployment, internal conflict, displacement, HIV and chronic diseases (Marangu et al., 2014). Mental health care for children has attracted little attention, with services being largely hospital-based and designed for adults (Kiima and Jenkins, 2010).

The aim of this paper was thus to gain insight into perspectives of youth mental health from key stakeholders, drawing upon insider viewpoints from Kenya. This was part of a larger study on developing culturally appropriate interventions (anonymised). In particular, this study addressed the question: How do key stakeholders conceptualise mental illness, contributing factors, and required supports for disadvantaged young people in Kenya?

Methods

A qualitative design was utilised for an exploratory, participant-driven approach (Silverman, 2017). Qualitative approaches have great utility in areas where there is a sparse evidence-base to inform the field of health (Morse, 2012). A social constructionist framework guided the project, as this ensured that the analytic focus was on the language used by the participants, recognising that youth and mental

health are social constructs (O'Reilly and Lester, 2017) and one that encourages reflexivity to promote quality in the approach (Finlay, 2003.

Participants

The study was carried out in Nakuru County. The County, with almost two million people, is exposed to extreme socioeconomic deprivation alongside having a high proportion of internally-displaced populations following ethnic violence. Participants were purposively recruited into four focus groups from one of the slum areas in Nakuru city, and comprised key community stakeholders. Young people, their teachers and parents who took part in the study, were selected from one school with high poverty and internal displacement levels. Young people aged 14-17 years and their parents were selected from each class register of Forms 1 to 3. Their teachers were invited, following which they helped to identify professionals who provided services locally to young people. Following informed consent, the focus groups thus consisted of seven adolescents, seven parents, nine teachers and 11 professionals (one counsellor, two local administrators, one police officer, two social workers, two church leaders and three health professionals).

Research and ethics procedure

Focus groups were conducted either in English or Swahili. The principal researcher provided required translations. A guide explored general understanding, definitions and explanations of young people's mental health needs and important factors involved. Focus groups were audio-recorded alongside field notes.

The study was approved by the (anonymised) research ethics committee; the National Commission for Science, Technology and Innovation in Kenya; and the Nakuru County Ministry of Education. The school principal subsequently agreed to the researchers approaching potential participants. In practice, the known vulnerability of the participants was accounted for through several mechanisms, as governed by the ethical practices of the UK deontological approach (see Beauchamp and Childress, 2012). It was recognised that qualitative research invokes certain requirements due to the depth of the data, the richness of data collection, and the encouragement of participants to speak at length about sensitive areas of their lives (O'Reilly and Kiyimba, 2015). To protect this, consultation with parents and teachers took place prior to data collection to ensure that focus groups were conducted in an informed way; safeguarding procedures were implemented, with possible confidentiality breach procedures outlined to young people, and age-appropriate information sheets were developed, and read to the young people prior to participation to clarify understanding. The local and cultural knowledge of the principal investigator facilitated relationship rapport and promoted appropriate questioning.

Data analysis

Thematic analysis was utilised for its meaning-making focus (Braun and Clarke, 2006). NVivo facilitated coding, with extracts coded inclusively, while contextual meaning was retained by the lead researcher (Bryman, 2008) and verified through a team-based approach. Throughout the analysis, meetings were held to collate coding frameworks, discuss discrepancies and make refinements. These enhanced the rigour of the research (Barbour, 2001). To ensure sampling adequacy, data analysis continued to

verify data saturation, i.e. when no new themes emerged (Fusch and Ness, 2015) to ensure no further data were required.

Results

Discussions with key stakeholders resulted in issues faced in relation to youth mental health that were both broad and general, as well as local and specific. Broadly, participants recognised that young people's understanding of positive mental health and mental illness was limited, and that the aetiology of mental illness was predominantly related to economic and parenting factors. Specifically, they reported that the local economic climate was a contributing factor, and argued it required a joined-up effort with everyone taking a role in promotion, prevention and treatment. From these discussions, four themes were identified. First, definitions and scope; as participants defined mental health and conceptualised core symptoms associated with mental health problems. Second, aetiology and impact; they considered the range of factors contributing to mental health problems, and the impact these had on the young person, family and society. Third, was responsibility regarding youth mental health. Fourth, was support; they considered the extent of need, offering suggestions on how those needs could be addressed.

Theme one: Definitions and scope

Participants positioned the general population as having limited knowledge in this area. Interestingly, many participants, including young people, were able to describe what it meant to be mentally healthy. For example, some described mental health as a *'peaceful'* state of mind, which included a balanced state that would not exclude

illness, but would include being free from obstacles that can affect a person physically, emotionally, or cognitively:

"I think that mental health is when you are sober minded, you are not, you don't have stress." (Parent 2)

"Maybe it is the sound state of mind. When our mind is sound, it has no strings attached, we are mentally healthy." (Teacher 4)

Mental health was also described as the ability to make good judgments and being *'sober minded*' a positive state of mind was characterised as synonymous with an absence of stress. Moreover, they defined mentally healthy young people as having the ability to manage problems, and to adopt positive and resilient behaviours. To that effect, they recognised the importance of positive emotions:

"Maybe in decision-making; aah, you are well-balanced." (Parent 5)

"You are very happy, cheerful all the time." (Teacher 1)

Through a construction of a positive state of mind, participants were able to make the connection between a positive mental state, to good decision-making and a sense of wellbeing. Notably, some young people were also able to define positive mental health, which has often been conflated with mental ill health in both high-income and LMIC (Dogra et al., 2012):

“To feel comfortable. Nothing in your mind is disturbing you.” (Young person 5)

“Good mental health is, it is anything that does not disturb you physically, emotionally just like that.” (Young person 2)

Like their adult counterparts, young people conceptualised positive mental health in terms of positive emotions, positive state of embodiment, and strong state of mind. They recognised the broader overall sense of wellbeing, framed as feeling *‘comfortable,* showing that being mentally healthy means that an individual is free from a range of negative disturbances. . However, while those participating were able to define what it meant to be mentally healthy, they argued that, on the whole, people in Kenya did not have the same level of knowledge on these issues as they did. They reported that, overall, mental health was not well understood as a concept in their country:

“You know, mental health is a new concept in Africa. And many people are ignorant on the issue, on the issue of mental health.” (Psychologist)

“Mental health is actually a relatively new issue in, in Africa.” (Pastor)

The reason proposed by participants for such lack of understanding was that the notion of mental health is new in Africa, therefore relatively misunderstood. When discussing mental health problems, participants pointed out different aspects which were explained in terms of emotional, behavioural, social and physical characteristics.

Mental health problems were often defined as young people being confused and having too many thoughts in their mind, thus resulting in being overwhelmed:

"*You will be very confused*." (Young person 3)

"Lack of concentration." (Parent 3)

Both adults and young people constructed mental health problems as impacting on a person's ability to focus. In other words, they perceived them as having cognitive effects, which are known to impact on academic attainment and daily functioning. Participants also linked problems with a distorted sense of self during the developmental stage of adolescence:

"I have also found out that, um, there are many young people who are having an identity crisis." (Church elder)

Participants noted a general increase in negative emotions experienced by young people, which they argued reflected a wider problematic state of society. When asked to conceptualise mental health problems, participants recognised that certain emotional states tend to be inherent in problems such as anger and fear:

"I think one is having anger, you have, you have low self-esteem. If someone, let's say like your mother wrong you, you go and feel like to hang yourself because you are, you, you have nini (that) you have anger with him or her." (Young person 2)

"Sometimes you find that the mother is harsh or the father is harsh. When the child wants to tell the mother something she just stares harshly). The child will want to study the mother's mood first before saying anything. The child is scared." (Parent 7)

"We are seeing very angry children…they are angry and bitter with the society." (Social worker 1)

Evidently, the consequences of young people experiencing challenges in emotional regulation are positioned in relation to their relationships with the community and the broader society. The anger, fear and low self-esteem felt by these young people has potential to develop and create further challenges for them as they transition into adulthood.

Theme two: Causes and impact

In conceptualising mental health problems, participants focussed on aetiological explanations, while describing the impact on the young person and their family. The multidimensional aspects of ill mental health were considered in terms of the influence of peers, family, and society. In so doing, a range of different causal attributions were offered in relation to aspects of the family, community and society. These included a recognition that the economic climate of the country and a general lack of investment in young people influenced their mental health:

"It is about poverty." (Young person 3)

"No-one cares about them…they are forgotten." (Teacher 4)

Constructing these young people as '*forgotten'* by society, participants demonstrated that when they become mentally unwell, it is a consequence of a lack of societal caring. Indeed, young people themselves were able to demonstrate the link between a broader social detriment and their mental health, by constructing the link with poverty. Notably, broader social influences were also invoked, as participants argued that social media was at least partially responsible for mental wellbeing. Social media potentially has a negative impact on mental health in young people (Thomee et al., 2010), and participants argued that this is also the case in their community, with a risk of '*side-effects'*:

"I think what we have, em, technology is good, but it has side-effects." (Doctor)

"The social media has also a part to play in the mental health problems of these kids." (Teacher 2)

In addition to wider factors, they also recognised the impact of negative parenting styles in terms of care provision, or even abuse. Communication difficulties within the family and lack of recognition of emerging mental health problems were also cited:

"Let us say that their parents, their parents abuse them or call them names…" (Young person 2)

"We don't tell them [children] the right thing earlier enough." (Parent 3)

"You find that this kid, eeh, lost somewhere on the way because he has not been, the problem that he has, has not been discovered in advance to be assisted." (Teacher 2)

Parents' direct and indirect contributions were acknowledged, as all groups argued that they may contribute to the problem or its longevity. In different ways, participants felt that some parents did not sufficiently support their offspring and often did not identify the issues that the young person was experiencing. This was positioned not as parental-blaming, but as a lack of knowledge or awareness, as they are not provided with information *'earlier enough'.*

Theme three: Responsibility

Given the high prevalence of mental health problems and the argued lack of knowledge, participants critically assessed societal responsibility. It was reported to be *'of everybody'* in the community. Indeed, this was a premise agreed by all groups:

"It's, aah, a responsibility of everybody." (Parent 5)

"Whether you are a community, whether you are what, it's our responsibility." (Policeman)

Participants stated that all levels of society needed to take young people's mental health seriously and that *'everybody'* was responsible, but discussions also generated more specific responsibility discourses. For example, some participants reported that responsibility was more relevant to specific groups of parents, teachers, community or government. Particular stakeholders thus need to prioritise these issues in their roles

within society. Congruent with the discursive construction of the role parents play in terms of aetiology, they were consequently constructed as having a central responsibility for both support and mental health promotion. Moreover, family was mentioned as '*the basic unit of any society'*, from which responsibility should start:

"I also think the issue of family should be enhanced, because it is the basic unit of any society." (Social worker 2)

"Usually it's the parents' responsibility, because he or she stays with the children for long hours." (Parent 4)

"The most immediate providers for mental health should be, who? The mother and the father." (Psychologist)

"So, in a nutshell, um, mental health will start with the parents." (Doctor)

Professional and parent groups discussed what parental roles should involve and clarified that parents had a significant impact on their child's wellbeing. However, participants recognised that, while parents spend considerable time with their children, young people also spend significant periods of time in school. Consequently, concurrent responsibility through education was also ascribed to teachers:

"Uhmm, even teachers have a role to play." (Parent 3)

“Like when they have issues at home, the only place they can find, aah, refuge is with the teachers.” (Parent 3)

Although local and specific responsibilities were positioned with parents and educators, in arguing that mental health is everybody’s responsibility, participants believed that the community and government also had an important role to play. According to some participants, government should ‘*act for the citizens’*, and that should be a ‘*major role’* and a nation’s priority. Equally, the entire community should be involved in promoting mental health:

“According to me, I think it is the responsibility of the government…to take their part, because they, they are the ones act for the citizens.” (Young person 2)

“*The government has a role to play…and, in fact, a major role.”* (Teacher 7)

“I think even the community members, let us say the people in our country can contribute to help those people who have mental problems.” (Young person 2)

Cleary the stakeholders provided a systemic and holistic view of mental health in Kenya. They argued that youth mental health has an individual level of resilience and responsibility, but that this spans out across the family, educational sector and to the broader government and policy level. Such a holistic presentation of mental health was deemed essential to addressing the problems facing young people.

Theme four: Support structures

In discussions on the available support structures, participants argued that the current situation was insufficient. It was clear there was a need for trained, professional counsellors and other means of support in the community:

"So, aah, if we would have a professional guidance and counselling." (Teacher 6)

They argued that it was important that more specialist services in the form of '*professional guidance and counselling'* should be provided. This had implications for resources, and participants reported a need for appropriate facilities:

"Give them enough funds or resources to fulfil their needs." (Young person 2)

"And governments also, government, many governments in Africa should also set a budget specifically for what? For mental health, because without that, then actually Africa is awaiting a very serious disaster." (Psychologist)

Most of the participants reported that to address the mental health of young people, a designated budget was required. Globally mental health is severely underfunded, and youth mental health specifically is inadequate, as typically young people fail to receive appropriate support until they are at crisis point (World Health Organisation, 2012). Consequently, it was argued that support was needed at government level. However, some argued that this commitment to provide resources was slowing becoming visible, as governments started to take steps to address this gap:

"I think the government has taken a step to help these people, because when you walk around the streets, you might see the guiding counselling centres." (Young person 4)

A new initiative in Kenya is the use of guidance counselling centres, which are designed to help young people with emotional problems, and some participants actively recognised the addition of this source of support *'around the streets'*. This was viewed positively by young people. However, supporting the mental health of Kenyan young people was not just in meeting the needs of those with ill mental health, but also in promoting wellbeing and increasing awareness. In that sense, there was a value afforded to a change of attitudes and lifestyle. Participants also recommended that society needs to adopt a more tolerant attitude towards those with mental health difficulties:

"I am to recommend for lifestyle change. If their lifestyle is changed first from our homes before we go outside, it can lead or it can make a child to be at a state of being changed easily." (Teacher 3)

"Mmm, I think there are, if they open up their mind, their hearts and, and, and talk about those problems there, there will be help given to them." (Young person 2)

To address mental health awareness and acceptance, a change of attitudes is needed while stigma remains prevalent (Amuyunzu-Nyamongo, 2013). This can be achieved by targeting parents and professionals, and in enhancing awareness of children's development and well-being:

“If this parent was sensitised and knew that these girls grow…these stages, expect these this time, there would be no rebellion between her and her daughter.” (Teacher 4)

Finally, the previously stated importance of school-based input was accompanied by the acknowledgment that teachers often lack skills, time and support in broadening their conventional duties. It was thus argued that teachers should guide children, but they find themselves with a burden of responsibility which goes beyond their academic role:

“So, teachers have a big task with children. Listening to them and not knowing what to tell them about a certain issue.” (Teacher 4)

“Many a times counselling is done by teachers, not professional guidance and counselling.” (Teacher 6)

Teachers specifically argued that they felt ill-equipped to support the mental health needs of young people in their care. As part of their responsibility to these young people, they noted that often ‘*counselling is done by a teacher’*. However, because of lack of specialist support, there are limited options, thus leaving it to teachers to deal with. This is a common challenge across societies in providing emotional literacy and interventions within schools (Hussein and Vostanis, 2013).

Discussion

The purpose of this study was to explore the conceptualisation of mental health problems, contributing factors and required supports for young people in Kenya. To fulfil this aim, it was meaningful to acquire views from young people and key stakeholders involved in their care. Understanding different perspectives is important in detecting mental health problems, initiating help-seeking and planning interventions. Four key themes were identified: definitions of positive mental wellbeing and mental health problems; causes and impact; responsibility; and support structures. These findings corroborate previous research, with issues of responsibility being the distinct theme in this study (Abera et al., 2015; Adhikari et al., 2015; Thabet et al., 2006).

The central issues identified through the themes reflected both the children and adult's views. However, the extent and scope of their perspectives varied, i.e. children appeared more comfortable with definitions of positive mental wellbeing and mental health problems, by providing concrete examples to illustrate their points than in identifying causes of these problems. Adults appeared to adopt a broader perspective in most themes. For example, children identified that child mental health improvements rested mainly with the government, while adults viewed this as a collective responsibility of parents, teachers, professionals and the community working collaboratively; but with the main focus being with parental duties.

Despite the acknowledgement that mental health remains a relatively new notion in Kenya and Africa generally, several holistic definitions of mental wellbeing were put forward, which were not a mere absence of problems. Perceived ingredients of mental wellbeing included thinking positively, thus coping effectively with adversities through resilient behaviours. Interestingly, despite the perceived lack of knowledge, young

people articulated core concepts about mental health. This discrepancy might mirror western imposed definitions without taking into consideration cultural and developmental variability in how mental health is construed in LMIC (World Health Organisation, 2013).

Stakeholders' views on a broad range of potential causes or contributing factors to the development of mental health problems in young life appeared to endorse the socio-ecological systems framework of an interaction of vulnerabilities between the individual, family, school, community and wider society (Broffenbrenner, 1979). This theory is increasingly influential in informing interventions and services for vulnerable children and young people across the world (Vostanis, 2017). This is not consistent with some findings that not-western populations are less likely to assume biopsychosocial beliefs (Yeh et al., 2004). In the current study, social and parenting factors were prominent. Disadvantage appeared to relate to both a socioeconomic explanation of lack of resources in Kenya, but also to an attitudinal explanation of young people in slum areas being 'forgotten' by society. It is noteworthy to highlight that young people themselves linked poverty with mental health problems. This awareness reflects the strong evidence (Boardman, et al., 2015), especially among young people in LMIC (Yatham et al., 2017), where a disproportionate part of the population lives in extreme poverty (World Bank Group, 2017). Interestingly, societal influences were not confined to economic disadvantage, but were extended to the negative impact of technology, mainly social media. The role of this factor has only recently been explored, even in high-income countries (Thomee et al., 2010).

Views on the role of parenting incorporated negative parenting styles, inadequate care and family communication; as well as lack of parental recognition and understanding of risk factors for mental health problems in young life. These diverse issues are all important, but require different approaches. Despite the increasing global recognition of child abuse and neglect, and the development of child protection and children's rights driven policies (Fegert and Stötzel, 2016; World Health Organisation, 2017), these are still patchy or even absent in many LMIC (Veenema et al., 2015). Furthermore, adolescents may not fall under safeguarding criteria in LMIC because of their positioning within society, as they are often expected to contribute under hardship to their family income. Although the association between child labour, maltreatment and mental health problems is well established (Thabet et al., 2010), solutions require multiple strategies that incorporate legal reinforcement, education and alternative economic supports to families. These approaches should not be confined to safeguarding but rather extend to parental engagement in different aspects of young people's life, to enhance their resilience.

The theme with the highest conceptual and practical significance related to assuming responsibility for promoting youth mental health and alleviating mental health problems. Crucially, this was shared among all stakeholders. Such shared views of responsibility can possibly be traced to the participants' attributions of mental health contributors along the layers of the socioecological framework. Developing shared responsibility for young people's mental health took many years and is still being debated in high-income countries with extensive mental health policies and resources (Hindley and Whitaker, 2017). The finding that stakeholders in an extremely deprived part of the world with limited access to services adopted the same principles

highlights opportunities for developing both awareness programmes and interventions that maximise communities' strengths in LMIC, without necessarily being at odds with traditional values and beliefs. Again, one can look towards the socioecological systems framework for integrated strategies at all these levels (Eruyar et al., 2017).

Naturally, changes in attitudes cannot be viewed in isolation from policy and funding. Enhancing young people's mental literacy at school, even in deprived areas, is supported by promising evidence but also places additional burden on teachers for competing time pressures and skill acquisition (Fazel et al., 2014). This need extends to a range of frontline practitioners and the relatively small number of mental health professionals in LMIC (World Health Organisation, 2015). Taking into consideration the overwhelming needs across all sectors of life, most LMIC countries allocate less than 1% of their budget to mental health (Saxena et al., 2011), and this almost exclusively relates to adult provision (World Health Organisation, 2013).

Some young people described a new initiative of counselling centres, which was viewed as a 'first step' taken by the government to provide help in the community. Participants attributed importance not only to mental health problems, but also to increase of awareness and promotion of mental health, which is consistent with international policy guidance (World Health Organisation, 2015). A related perspective was expressed in such programmes needing to help change attitudes to embrace people with mental health problems. This indicates the importance of co-ordinated action between policy, awareness programmes, anti-stigma campaigns and establishing mental health care pathways (Collins et al., 2011). As Hoven et al. (2008)

demonstrated in a youth mental awareness intervention across nine countries, lessons of good practice cross geographical borders and avoid costly duplication.

The findings need to be interpreted within the methodological limitations of this study. The sample may have presented with self-selection characteristics, with more motivated participants expressing positive views towards mental health. Furthermore, it is not known from this cohort whether young people and their families were more or less influenced by previous experience of mental illness. Nonetheless, the salient issues identified through this study contribute to the platform for recruitment from different target groups according to sociodemographic and mental health criteria, which can promote the synthesis and generalisability of the findings. The integration of different stakeholders' viewpoints demonstrates the importance of community and user involvement in the development of interventions and services. It will thus be interesting for future research to link similar stakeholders' perspectives to mental health awareness, resilience-building and culturally adapted psychological interventions.

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