REPUBLIC OF LIBERIA

NATIONAL MENTAL HEALTH POLICY

MINISTRY OF HEALTH AND SOCIAL WELFARE

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FOREWARD

This National Mental Health Policy marks an important milestone in our country's health care delivery system, and is the first major attempt by the Ministry of Health and Social Welfare to address the diverse mental health needs of our population in an integrative and holistic manner. It is based on a decentralized approach, which is consistent with the National Health Policy, and it utilizes the Basic Package of Health Services as a guiding document for health care service provision.

The policy could not have come at a more important and expedient time – extensive social disruptions, societal disorganization and varied war related traumatic experiences have escalated the mental health needs of our people to an alarming extent.

The Government of Liberia recognizes that mental health is an important element of general well being. It also recognizes the strong interconnected link between mental illness and poverty; mental illness can lead to poverty by limiting an individual's resource potential for productive economic engagement, while poverty severely limits an individual's access to mental health and other health services, thereby increasing the risk of morbidity, disability and mortality.

The policy foundation is based on a five tiered pyramidal structure which utilizes all existing human potential, services and facilities in playing a role in mental health education, prevention and treatment and rehabilitation services based on relevant expertise and resources at each level. It relies heavily on the primary health care system to provide a consistent and sustainable quality of integrated health care to the various communities around the country.

The initial wide gap in the availability of trained mental health manpower, including high levels of professional mental health expertise, will necessitate the utilization of individuals with lower levels of expertise to provide essential management and treatment services in some areas. The aim of the policy is to progressively increase the core of mental health experts, thereby improving the standards of service provision. The success of the mental health program is consequently highly dependent on the provision of quality mental health training programs and opportunities, for individuals designated to provide quality services.

We are indeed grateful to all our partners and donors for their varied assistance in the development of the mental health policy. Special thanks go the McCall MacBain Foundation, our principle funder, the World Health Organization and the World Bank for providing much needed funds for the policy development.

Walter T Gwenigale, M.D.

Minister

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We hope that your efforts and commitments in the formulation of this National Mental Health Policy will usher in new transformations in the mental health sector.

Bernice T. Dahn, M.D., M.P.H.

Chief Medical Officer/ Deputy Minister for Health Services

EXECUTIVE SUMMARY

The creation of a National Mental Health policy is critical to the development of Liberia's health system. Mental health is an integral component to any efficient, well-functioning structure of care. It is not only for the chronically mentally ill – who often represent a small part of a population – but for the many people who suffer from common mental diseases.

The treatment and prevention of mental health problems is of paramount importance in the Liberian context. Decades of a vicious civil war wrought devastating consequences. Many witnessed terrible acts of violence, most experienced tremendous loss and almost all were displaced at least once. The psychological impact of this period is still unknown. Research from other post-conflict areas, however, has shown high rates of post-traumatic stress disorder and depression in similarly affected populations. In addition to the lingering effects of the war, Liberian communities are beset by increasing rates of substance abuse, and the difficulties associated with widespread and chronic poverty.

The current mental health system has so far been unable to cope with these varied psychological and psychosocial issues. Unless appropriately managed, these problems will continue to undermine the recovery and development of the country.

The goal of this policy is therefore to address the mental health needs of all Liberians through high quality, culturally appropriate, evidence-based, equitable and cost-effective care. These core components along with accessibility, human rights, efficiency and sustainability, and community involvement and participation, are the principles and values from which this policy was developed.

Foundations of the policy

This policy mandates that mental health be integrated into the primary health system, and that consistent with the Basic Health Package, services be confidential and free of cost. A decentralized approach in which mental health treatment is available at the local health clinics and health centers, county hospitals and tertiary facilities will improve the quality of life for all patients and families. It will ensure that people have access to treatment as close to their home as possible. It will enable health workers to more readily identify, and monitor and manage mental health disorders. It will allow those with both physical and mental health related needs to be treated in a seamless and comprehensive manner. It will increase educational opportunities about mental health, and help to reduce the stigma and discrimination associated with mental illness. It will also minimize the cost of seeking specialized care at distant mental health facilities and maximize resources by having local providers treat common mental diseases. The following are the features of this new system:

- Highly trained, multi-disciplinary County Mental Health Teams that will provide high quality mental health care.
- Mental health outpatient teams at the local health clinics and health centers that will offer a range of community-based outpatient mental health services.
- Inpatient care in county hospitals Wellness Units, which will be for short-term psychiatric admissions. These units will allow acute, close-to-home care without requiring institutionalization.
- Restoration of a mental health inpatient facility at the country's general hospital. This will compensate for the eventual closing of the existing mental health institution where patients requiring long-term care are currently treated.
- Efforts for the prevention of mental illness.

This policy also recognizes that additional services must be implemented for certain vulnerable groups that are at particular risk for developing mental health related problems. The policy has focused on three such populations: children and adolescents, victims of sexual and gender-based violence, and the seriously mentally ill.

- Services for children will include mental health promotion and education, school-based mental health, guidelines for community-based and inpatient care, and recommendations for specialized populations.
- Services for victims of rape as well as for perpetrators of sexual and gender based violence will consist of specialized medical care from health workers with relevant training, support through trauma and empowerment based initiatives, and prevention strategies, such as Codes of Conduct, school safety zones and a Zero Tolerance policy.
- Treatment for the severely mentally ill will be, when possible, community-based. It will seek to reduce or eliminate symptoms, maximize quality of life and adaptive functioning, promote and maintain recovery from the debilitating effects of the illness, and include education for patients and families.

The lack of skilled mental health professionals in Liberia cannot be overstated. The services outlined in this policy will be ineffective and futile unless providers can accurately diagnose, evaluate and treat mental disorders, and appropriately respond to the psychological and psychosocial needs of the population. Human resource development is thus imperative to the success of this integrated system. The short-term goal will be to train the existing health work force in basic competencies and in the skills necessary for mental health care. The long-term goal will be to increase the number of highly qualified mental health workers. The following points, among others, will help accomplish these objectives:

- The MOHSW will create educational and training opportunities for psychiatrists, psychologists, psychiatric physician assistants, master-level psychiatric nurses and clinical social workers. These specialized professionals will ultimately assume the care for the mentally ill from non-specialized health providers.
- The MOHSW will produce mental health procedural guidelines and standardized curriculums for each profession.
- The MOHSW will explicitly define competencies, and the responsibility and authority of each profession as they relate to mental health care.
- The MOHSW will create relevant credentialing and licensing systems, and an accreditation process for organizations and institutions involved in mental health training programs.
- The MOHSW will extensively train both general health and mental health workers. It will educate professionals about the nature and treatment of mental health related issues. This will help reduce stigma and discrimination towards mental health patients.

A Liberian Center of Excellence – a partnership of the Ministry of Health and Social Welfare, academic institutions, professional boards, and relevant national and international groups – will buttress and help sustain the mental health workforce. The Center of Excellence will serve as the major repository for cultural- and evidence-based knowledge and practices in mental health treatment. It will offer expert advice, assist in the implementation and development of the policy, and help with training and education.

To ensure quality and achieve intended outcomes, the Ministry will fulfill the points listed below:

- The MOHSW will allocate specific funding for the implementation of policy initiatives.
- The MOHSW will have a National Mental Health Coordinator guide, direct and supervise the overall development of mental health programs through a Mental Health Unit within the Ministry.
- The MOHSW will create a monitoring and evaluation system to regulate care.
- The MOHSW will define mental health indicators to be collected and analyzed, and use the

results to inform future programming decisions.

- The MOHSW will encourage mental health research, and adopt international research standards to guarantee ethical conduct.
- The MOHSW will revise and update the essential list of psychiatric drugs, and routinely review which health workers can prescribe these medications.
- The MOHSW will launch and support campaigns to educate Liberians about the causes and treatments of mental diseases.
- The MOHSW will utilize existing resources and coordinate these efforts so not to establish parallel structures of care.
- The MOHSW will collaborate with other Ministry programs.
- The MOHSW will work with Professional Boards to develop competencies and ensure the quality of providers and training programs.
- The MOHSW will partner with Non-Governmental Organizations and traditional healers.

The measures outlined in this policy will have substantial benefits for Liberia. They reflect the needs and priorities of the population, and will significantly improve the well being of all citizens. They are also critical to building the social capital of the country – mental health is not an isolated discipline, but deeply intertwined with Liberia's socio-economic standing.

The development of this policy represents a momentous first step. The Ministry of Health and Social Welfare has shown strong leadership and commitment to mental health – an area that more than 40% of countries in the world fail to address in formal policies and plans. Furthermore, extensive consultation and input from national and international stakeholders has led to supportive and careful planning for a viable system that can successfully operate within the confines of Liberia's resources. This unified effort is laudable. It will help create a mental health system that cannot only reduce the burden of mental disease, but enable the country realize its overall goals as a post-conflict nation.

List of Abbreviations:

BPHS	Basic Package of Health Services
CHW	Community Health Worker
CMHT	Community Mental Health Team
CHO	County Health Officer
CMO	County Medical Officer
CVT	Center for Victims of Torture
GDP	Gross Domestic Product
IDP	Internally Displaced Person
JFK	John Fitzgerald Kennedy Hospital
MDs	Medical Doctors
MDD	Major Depressive Disorder
MDM	Médecins du Monde
MoU	Memorandum of Understanding
NGO	Non-Governmental Organization
NHP	National Health Policy
PA	Physician's Assistant
PCP	Primary Care Provider
PHC	Primary Health Care
PTSD	Post-Traumatic Stress Disorder
RN	Registered Nurse
SGBV	Sexual and Gender Based Violence
SMI	Severe Mental Illness
STI	Sexually Transmitted Infection

SW Social Worker
WHO World Health Organization

Glossary of Terms

Community-based mental health care is any type of care, supervision and rehabilitation of patients with mental illness outside the hospital by health and social workers based in the community. It is intended to provide public mental health services directly to people in need of assistance in a community setting.

Cultural competence is recognition of and response to cultural concerns of ethnic and racial groups, such as histories, traditions, beliefs and value systems. Cultural competence helps professionals create better services and ensures adequate utilization by diverse populations. Cultural competence entails a set of behaviors, attitudes and policies that come together in a system or agency or among professionals that enables that system, or agency or those professionals to work effectively in cross-cultural situations.

Evidence-based practices refer to a decision-making process for which there is consistent scientific evidence showing that a particular approach will improve outcomes.

A*n inpatient facility* is a medical facility where patients stay for a period of time to receive treatment. There are both acute (shot-term) and long-term inpatient facilities.

Integrated services refer to a system in which an array of services, such as mental health and primary care, are provided through a single agency or entity.

Mental disorders are health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof), and are associated with distress and/or impaired functioning.

Mental health is a state of well-being in which an individual can realize his or her own abilities, interact positively with others, cope with the stressors of life and study, work productively and fruitfully, and contribute to his or her family and community.

Mental health in primary care refers to the provision of basic preventive and curative mental health at the first level of the health system. Care is usually provided by a non-specialist who can refer complex cases to a more specialized mental health professional.

Mental health problems are when a person's emotional suffering leads to problems in thinking and behavior, and a decline in daily functioning. An individual will express his or her distress through physical, emotional and behavioral symptoms; some may feel spiritually disturbed, while many will show signs of abnormal thinking or functioning at work as well as in school, in the home and in the community. The more severe the emotional suffering becomes, the more problems develop. As the person recovers from suffering, his or her functioning usually returns to normal.

Mental illness is a term that refers to all diagnosable mental disorders.

Outcomes measure is a tool that systematically evaluates the impact services can have on the health and mental health of patients. The measure typically focuses on functioning issues.

Psychosocial rehabilitation refers to professional mental health services that bring together approaches from the rehabilitation and mental health fields. These services combine pharmacological treatment, skills training, and psychological and social support to clients and families in order to improve their lives and functional capacities.

Severe mental illness (SMI) is a term that applies to more seriously affected individuals. The category includes schizophrenia, bipolar disorder, severe forms of depression, panic disorder and obsessive-compulsive disorder.

Support services are rehabilitative services that are not strictly medical but are nonetheless considered to be necessary in the recovery process. Such services are designed to develop and/or restore a patient's functional capacities and may include support to help clients maintain independent housing, education, employment, or other activities associated with community integration.

1.0 INTRODUCTION

The National Mental Health Policy represents the Government of Liberia's first major attempt to address the country's diverse range of mental health problems in a comprehensive and integrative way. This policy reflects the commitment of the government to develop a system that incorporates all areas of health and health delivery. It is consistent with the National Health Policy and Basic Package of Health Services, which provide guidance and direction to all health related areas in the country.

Having emerged from a brutal period of conflict, it is essential that health related issues are dealt with in a holistic manner. This is a critical time in our history: as we recover from the past, and build our health system, we must make decisive and evidence-based decisions that enable us to manage all the needs of our citizens.

The Government of Liberia fully recognizes that mental health is the foundation for well being, and integral to the effective functioning of an individual and community. It is with these fundamental precepts in mind that this policy has been developed.

1.1 Methodology of Policy Development

This mental health policy is the result of a comprehensive series of consultative meetings and workshops with local and international key stakeholders.

The Ministry of Health and Social Welfare (MOHSW) first formed a Mental Health Policy Committee to plan, guide and direct the formulation of the policy. The Policy Committee created the terms of reference for the local and international consultants, and selected the relevant organizations that could aid in the production of the document.

In addition, the Policy Committee held a two-day national consultative workshop, which involved all major stakeholders, on October 2 and 3, 2008. A draft of the policy was subsequently written using stakeholder assistance, and literature and desk reviews.

This policy was also developed through extensive consultation and input from a team at the Massachusetts General Hospital Division of International Psychiatry, Harvard Medical School and the Harvard Program in Refugee Trauma. This group provided expertise in mental health care in post-conflict countries and the rebuilding of mental health systems in these areas. The group identified culturally appropriate, evidence-based models of health care and health delivery, and suggested Ministry partnerships for policy implementation.

To help inform their recommendations, team members participated in site visits in February and May, 2009. They also produced, in collaboration with the MOHSW, a needs assessment with 171 key informants of Liberian children, adolescents and young adults. This survey was conducted by social work students from Mother Patern College of Health Sciences.

Dr. Mardia Harris Stone and Dr. Benjamin Harris, two other lead consultants, communicated with the group weekly, and assisted and advised them throughout the process.

Once the draft was finalized, the MOHSW held a validation meeting, again with key stakeholders, on May 18 and 19, 2009 to affirm the contents of the policy document and to appreciate its national ownership.

1.2 Conceptual Overview of Mental Health

1.2.1 Definitions

Mental health is a state of well-being in which an individual can realize his or her own abilities, interact positively with others, cope with the stressors of life and study, work productively and fruitfully, and contribute to his or her family and community. It does not refer exclusively to the absence of mental disorders.

A person is considered to have a mental health problem when his or her emotional suffering leads to problems in thinking and behavior, and a decline in daily functioning. An individual will express his or her distress through physical, emotional and behavioral symptoms; some may feel spiritually disturbed, while many will show signs of abnormal thinking or functioning at work or school, and in the home and community. The more severe the emotional suffering becomes, the more problems develop. As the person recovers from suffering, his or her functioning usually returns to normal.

1.2.2 Mental health in Africa

Mental health has been a low priority in resource-poor settings. About half the countries in Africa and a third in the world do not have mental health policies, and of those that do, many have not been revised in years (Patel, et al 2007). Furthermore, 28% of low-income countries in the world do not have budgets for mental health, and in 37%, mental health makes up less than 1% of the overall health expenditure (WHO Mental health Context).

Mental health resources are extremely limited in Africa. Facilities are inadequate, drug supplies are unpredictable, and there are few psychiatric beds – most of which are in mental hospitals. The Institute of Medicine estimates that while 50% of affected persons are reached by mental health services in developed countries, this rate drops to about 15% in low-income areas (Gureje, et al 2007).

The lack of trained mental health professionals is a major problem. According to Prof Ndetei, Professor of Psychiatry, University of Nairobi and Director, Africa Mental Health Foundation (AMHF), the number of specialist psychiatrists per population on the continent is dismal: “While the United States and Canada have ratios of 14 and 12 psychiatrists respectively, per 100,000 population, Africa has a ratio of about 0.05/100,000. The situation in Africa today is even worse and more alarming than a few years ago when the ratio was about 1 per million population or .1/100,000.” In West Africa, the numbers of trained psychiatric doctors, nurses or other workers are alarmingly low.

Moreover, mental health resources are not appropriately allocated. Mental health professionals will often be relegated to other areas of the clinic or hospital to deal with acute cases or to compensate for staff shortages. Access to mental health care is not only constrained by supply, but also demand (Patel, et al (2007). Stigma towards mental illness is widespread, and many are reluctant to seek treatment for fear of being ridiculed, harassed or forced to leave their communities.

Table 1. Mental health resources in West Africa

	Population (millions)	Total Psychiatric beds per 10,000 people	Number of psychiatrists per 100,000 people	Number of psychiatric nurses per 100,000 people	Number of psychologists per 100,000 people	Number of social workers per 100,000 people
Benin	6.92	0.08	1.2	0	0.05	0.02
Burkina Faso	13.39	0.18	0.05	0.4	0.03	0.02
Ghana	21.37	1.03	0.08	2	0.04	0.03
Guinea	8.62	0.05	0.04	0	0	0
Liberia	3.49	0.08	0.03	0.03	0	0
Mali	13.41	0.2	0.06	0.15	0.02	0.01
Senegal	10.34	0.3	0.16	0.06	0.04	0.035
Sierra Leone	5.16	0.47	0.02	0.04	0	0.06
Togo	5.02	0.4	0.04	0	0.2	0

(WHO Mental Health Atlas, 2005)

1.2.3 Mental Health as a Leading Disability

Developing countries must create sustainable and effective mental health systems in order to cope with the growing global burden of mental diseases. Mental illness comprised of 12% of the global burden of disease in 2000 – a figure that is expected to rise to 15% by the year 2020. While communicable diseases continue to represent the leading cause of disease burden in resource-poor areas, non-communicable diseases are becoming increasingly more significant as causes of disability and premature death. In particular, unipolar depression is the third leading cause of disease burden worldwide – representing 4.3% of total disability adjusted life years. It is predicted to become the second leading cause of disease burden by the year 2020 (Ustun, et al., 2004; Michaud, et al, 2001).

Furthermore, depression is the currently leading cause of non-fatal burden, accounting for approximately 10% of all total years lived with disability (YLD) in low- and middle-income countries (WHO GBD 2004 Update; Ustun, et al. 2004). Neuropsychiatric conditions, in general, account for about 33% of YLD among adults aged 15 years and older (WHO GBD 2004 Update). These startling statistics show that depression has been overlooked as a major health priority, and underscore the need for public health programs targeting depressive disorders.

Table 2. Leading global causes of YLD, high-income and low- and midd-income countries,2004

Low- and middle-income countries				High-income countries			
	Cause	YLD (millions)	Percent of total YLD		Cause	YLD (millions)	Percent of total YLD
1	Unipolar depressive disorders	55.3	10.4	1	Unipolar depressive disorders	10.0	14.6
2	Refractive errors	25.0	4.7	2	Hearing loss, adult onset	4.2	6.2
3	Hearing loss, adult onset	23.2	4.4	3	Alcohol use disorders	3.9	5.7
4	Alcohol use disorders	18.4	3.5	4	Alzheimer and other dementias	3.7	5.4
5	Cataracts	17.4	3.3	5	Osteoarthritis	2.8	4.1
6	Schizophrenia	14.8	2.8	6	Refractive errors	2.7	4.0
7	Birth asphyxia and birth trauma	12.9	2.4	7	COPD*	2.4	3.5
8	Bipolar Disorder	12.9	2.4	8	Diabetes mellitus	2.3	3.4
9	Osteoarthritis	12.8	2.4	9	Asthma	1.8	2.6
10	Iron-deficiency anemia	12.6	2.4	10	Drug use disorders	1.7	2.4

*COPD, chronic obstructive pulmonary disease
(From: WHO Global Burden of Disease 2004 Update)

1.2.4 Mental Illness and Poverty

It is important to note the close interaction between poverty and mental illness. While it is well known that mental illness impedes the ability of individuals to learn and engage in productive endeavors, it is not generally understood that poverty itself is a risk factor for mental illness. Poverty, however, reduces the ability of individuals to access promotive, preventive, curative and rehabilitative services thereby increasing their risk of morbidity, disability and mortality. The stressors associated with widespread poverty can also exacerbate existing psychological and psychosocial problems, and increase the risk of developing mental disorders and substance abuse issues.

2.0 DEMOGRAPHIC AND SOCIOECONOMIC PROFILE

Liberia is located on the Atlantic coast of West Africa, bordering Sierra Leone, Guinea and Cote D'Ivoire. The population is an estimated 3.49 million with an annual growth rate of approximately 3.7%. More than half the people are less than 20 years old, and only 3% are more than 65 years of age. Average life expectancy is about 41 years. There are 16 indigenous tribes, of which 95% of Liberians are apart of, as well as Americo-Liberians (descendants of African-American settlers) and Congo people (descendants of Congo and Afro-Caribbean slaves). Approximately 40% of the population holds indigenous beliefs, 40% are Christian and 20% are Muslim (CCA 2006).

The economy of Liberia reflects the toll of two decades of civil war. While the country is rich in natural resources – diamonds, gold, iron-ore and timber – it is one of the poorest in the world. A middle-income country in the 1970s, Liberians are much worse off than they were 25 years ago (Social Welfare Policy). The per capita GDP is US$ 163 – an 87% drop from the 1980 GDP of US$ 1,269. An estimated 2.2 million people, or 63.8% of the population, live below the poverty line. Of this group, 76.2%, or 1.7 million people, live on less than a US$ 1 a day and almost half live on less than US$ 0.5 a day. The unemployment rate is an abysmal 85%. Most work in agriculture, or in informal trading or small-scale production. In addition, an estimated 91% of the population is considered vulnerable to food insecurity (40% highly vulnerable and 41% moderately vulnerable). Sixty-eight percent does not have access to safe drinking water. These issues are complicated by uneven population distribution. The displacement of more than 800,000 people during the war and the rapid urbanization that occurred in the aftermath of the conflict, has led to 75% people living in five of Liberia's fifteen counties (Montserrado, Nimba, Bong, Lofa, Grand Bassa and Margibi). More than half of the population resides in urban areas – with over a million people, or a quarter of the population, in Monrovia (National Health Policy). Poor waste and water management in these cities have increased pollution levels and the rate at which communicable diseases spread (National Health Policy).

Illiteracy is another major cause for concern. About 73% of women and 50% of men cannot read or write, and only 25% of those in rural areas are literate. Many Liberians have never had formal education. As of 2007, of people between the ages of 15 and 49, 56% of females and 39% of males had never attended school. Only 25% of females and 26% of males have had some primary education. More than a quarter of children between the ages of 5 and 14 do not currently go to school, and of those who do, many are absent at least once a week or for extended periods (LISGIS).

Table 2. Demographic indicators

Indicators	2008	1995	2005	2015	2025
Population					
Midyear population (in thousands)	3,335	1,975	2,902	3,923	4,753
Growth rate (percent)	3.7	4.7	4.6	2.0	1.9
Fertility					
Total fertility rate (births per woman)	5.9	5.9	6.1	5.3	4.5
Crude birth rate (per 1,000 population)	43	43	46	39	35
Births (in thousands)	143	86	132	153	167
Mortality					
Life expectancy at birth (years)	41	39	39	43	46
Infant mortality rate (per 1,000 births)	144	172	162	126	105
Under 5 mortality rate (per 1,000 births)	219	257	244	190	155
Crude death rate (per 1,000 births)	21	23	24	19	17
Deaths (in thousands)	72	45	69	75	79
Migration					
Net migration rate (per 1,000 population)	15	27	25	-	-
Net number of migrants (in thousands)	50	53	71	-	-

3.0 SITUATIONAL ANALYSIS

3.1 History of Mental Health in Liberia

3.1.1 Mental Health Treatment: 1847-1960s

Mental health initiatives in Liberia have in the past focused almost exclusively on severe mental illnesses and psychotic disorders. Traditional healers and religious leaders historically cared for these patients as most believed that mental related problems were caused by demonic possession or witchcraft. This understanding about the nature and root of mental illness resulted in some treatments being harsh and inhumane. There were instances, for example, when patients were subjected to beatings, and food and sleep deprivation, as a way to remove the responsible spirit. Patients were also restrained by having their legs locked into logs; the poor circulation to the limbs sometimes led to gangrene or death.

Patients who could not receive treatment roamed free. Many were mocked, ridiculed, stoned or beaten by local residents. Those who were violent were shackled and thrown into prisons with limited or no care.

3.1.2 Mental Health Treatment Post-1960: Development of a Formal Mental Health Service

The government first implemented a formal mental health delivery service in the 1960s after a group of concerned Liberian women fervently advocated on behalf of the mentally ill. The women mobilized support from both national and international sources, and within a short time, garnered enough funds and resources to construct a modern psychiatric facility outside Monrovia. They built the center on a 90-acre parcel of land donated by a Liberian legislator, Ellen Mills Scarborough, who was a member of the group. They named it the Catherine Mills Rehabilitation Center in honor of Mrs. Scarborough's mother, Catherine Mills.

The Catherine Mills Rehabilitation Center had both inpatient and outpatient services that catered to mentally ill patients from across the country. It had a capacity of approximately 75 beds for admission as well as a walk-in and referral community mental health facility in Monrovia.

The hospital hired international psychiatrists from Canada, Haiti and the United States to manage the facility given the dearth of trained local mental health specialists. It gave scholarships to Liberian nationals, however, to study mental health nursing and related disciplines as a means to increase the number of in-country professionals. These mental health workers assisted in supporting and caring for patients. The first indigenous psychiatrist joined the staff in 1984.

The Friends of the Mentally Ill, a Non-Governmental Organization, operated and managed the facility as a charitable institution until the early 1970s when it was turned over to the Government of Liberia. John F. Kennedy Hospital (JFK) later ran and utilized it as a teaching hospital for the A.M. Dogliotti Medical School.

The Catherine Mills Rehabilitation Hospital, like the majority of country's infrastructure, was completely destroyed during the war.

3.1.3 Limitations of Centralized Care

While treatment at the Catherine Mills Rehabilitation Center was considered modern, there were severe shortcomings to a highly centralized mental health system. It meant that mental health treatment was for most people far away and inaccessible. Many could not afford the direct and indirect costs of seeking specialized care at a distant location. There were also no standardized protocols or guidelines for referrals. As a result, patients were transported to the facility in various forms of restraints. Once discharged, there was no follow-up system that linked patients and providers with local health facilities. There was therefore no monitoring or evaluation of medications or adherence to treatment, or assistance with community reintegration. Patients from the interior would often be left in the city without help to return home; it was not uncommon for these individuals to relapse and become vagrant psychotics who wandered the streets of the capital.

3.1.4 Mental Health Services in the War Years

Few services were developed or administered during the years of civil war. Most were offered between 1994 and 1996, when there was a break in fighting. At this time, the United Nations, in collaboration with the warring factions and relevant stakeholders, planned and initiated a comprehensive demobilization process, which included mental health and substance abuse services as well as psychosocial support and counseling. It was never implemented.

Also during this period, the World Health Organization fielded an international mental health consultant, Dr. S. Jensen, to assist in the development of a two-year emergency mental health plan. This plan played a major role in the creation of the Grant Memorial Mental Hospital, the country's only functioning mental health facility, and in organizing mental health activities, such as the provision of psychiatric drugs.

All services and plans ended abruptly when fighting resumed in 1996.

3.1.5 Demobilization

Mental health services were for the most part absent from the demobilization process, which began in 2004 after the war ended. Almost every facility in the country – including those of United Nation agencies, supporting institutions, private donors and NGOs – had been looted, vandalized or destroyed in the course of the conflict. This resulted in the withdrawal of all post-conflict relief support, and the implementation of an urgent, fast-paced demobilization plan. According to the National Commission on Disarmament, Demobilization, Reintegration and Reinsertion, approximately 101,000 people were subsequently demobilized. Most were young men and women. About 13% were children.

The demobilization process was rife with problems. For medical workers in particular, it was hampered by poor coordination; logistical and political issues; continuous operational changes, such as the duration of the demobilization phase and the number of ex-combatants to be screened and examined; bad weather, which limited access to necessary equipment and resources; and inadequate working conditions, such as no toilets, furniture, partitions or locks in medical areas.

Arguably the greatest obstacle for mental health care was the lack of competent psychiatric specialists. Only a small number of ex-combatants with mental diseases could be identified, and only a few indicators of drug abuse were reported. The lack of competent mental health workers made it impossible to determine any conclusions about treatment (Larrauri, 2004).

No system that addressed the diverse psychological, psychosocial or neurological needs of ex-combatants was thus ever established. Few psychological interventions and counseling services have been made available to this population since the end of fighting. The Ministry considers this a missed opportunity – especially because many former soldiers have become violent criminals or gang leaders.

3.2 Current State of Mental Health

3.2.1 Guiding Documents Relevant to Mental Health

There has never been a national policy for mental health and there is currently no mental health legislation. The Ministry of Health and Social Welfare, with funding from the World Health Organization and in collaboration with stakeholders, has drafted the country's first national policy on substance abuse prevention and control. This document needs to be finalized.

3.2.3 Mental Health Expenditure

The current proportion of total mental health expenditure compared to the overall health expenditure is much less than one percent.

3.2.4 Mental Health Facilities and Services

Mental health care is virtually non-existent in the country. There are no outpatient or inpatient treatment options available at health clinics or health centers, and no psychiatric wards at county hospitals. In addition, there are no specialized services for the developmental and mental health needs of children and adolescents, and no services for other vulnerable groups, such as geriatric patients. There are also no rehabilitation services for alcohol and other substance use disorders or for individuals with deficits and handicaps that result from their mental illness.

The only functioning mental health facility is the Grant Memorial Mental Hospital. It is a private hospital that was built in the aftermath of the destruction of the Catherine Mills Rehabilitation center. It was turned over to the Ministry of Health and Social Welfare in a Memorandum of Understanding (MoU). This MoU expires in a few years; at this time, the hospital will close, and the property will revert back to its owner.

Grant Hospital is currently managed by a German-based NGO, Cap Anamur. It caters to about 50 patients, but with the addition of a new building, will have an inpatient capacity to treat 80. Patients pay a one-time fee for services (450 Liberian dollars for inpatient and 300 Liberian dollars for outpatient). Care is provided by an interdisciplinary team. The team is comprised of a social worker, nurse, therapist, psychologist, psychiatric advisor (who prescribes medications and supervises the staff) and physician assistant (PA), who serves as the Medical Director of the hospital. There are no doctors or psychiatrists at the facility.

A range of psychiatric disorders is treated at Grant Hospital. Unpublished data from 2008 showed that of all the patients that received care, 54% were female and 46% were male. Five percent were 10 years old or younger, 33% were between 11 and 25 years of age, 25% were between 26 and 40 years of age, 27% were between 41 and 60 years of age, and 9% were between 61 and 80 years of age. The majority of patients came from Montserrado County (N=659; 88%). Twenty-nine (4%) were from Bong County, 25 (3%) were from Margibi County and 13 (2%) were from Grand Bassa County. The most common reason

for admission was psychosis (n=228 (47%) (schizophrenia, organic psychosis [i.e. from malaria], post partum psychosis and drug-induced psychosis). Other admissions included 112 (23%) for epilepsy, 87 (18%) for "anxiety neurosis," 31 (6%) for dementia, 31 (6%) for PTSD, 20 (4%) for depression, and only 4 (1%) for mania. Outpatient follow-up treatment was most common for psychosis (n=127(44%)) (schizophrenia, organic psychosis, post partum psychosis and drug induced psychosis). Other outpatient follow-up treatment included 89 (31%) for epilepsy and 51 (18%) for "anxiety neurosis." Only 11 (4%) received outpatient follow-up care for depression and 11 (4%) for dementia. In 2000 and 2001, the average length of stay at the hospital was 14 days.

In addition to providing mental health care, Grant Hospital serves as a training site for nursing and social work students from the A.M. Deglioti College of Medicine, University of Liberia, United Methodist University, Cuttington University, Tubman National Institute of Medical Arts and Mother Patern College. There is currently no standardized training manual or procedure guidelines or regulations that are available.

3.2.5 Psychiatric Drugs

There are few psychotropic medicines on the Ministry's Essential List of Drugs. Moreover, these medications are often unavailable and too costly for the majority of Liberians. The anticonvulsants on this list – including Phenobarbital – are similarly expensive and in limited supply. It is also worth noting that some of the antidepressants and antipsychotics recommended by the Ministry have the most side effects and lowest safety margin.

Grant Hospital utilizes a range of psychotropic medications that are provided by Cap Anamur. Common drugs prescribed at the facility include chlorpromazine, haloperidol, trifluoperazine, fluophenazine (Hcl and decanoate), risperidone and thiothixene. Antidepressants that are used include amitriptyline, imipramine, nortriptyline, clomipramine, sertraline, paroixetine, citalopram and fluoexetine. Anti anxiety medications include diazepam and lorazepam, and anticonvulsants and mood stabilizers include phenobarbitone, phenytoin, valproate, and carbamezepine.

The most common psychotropic drugs prescribed by Medecins Du Monde, an NGO that treats mentally ill patients, are amitriptyline (29%), haloperidol (27%), paracetamol (18%) and phenobarbitol (8%). A small amount of other drugs are also used, such as paroxetine (4%), fluoxetine (3%) and carbamezepine (3%). Open mole (with second diagnosis) is treated with haloperidol (14%), amitriptyline (22%), and paracetamol (15%) of the cases.

Neither the Basic Package of Health Services nor the National Health Policy explicitly defines who can prescribe medications. There is no limitation based on degree or training. Doctors, nurses, physician assistants, midwives and other health workers currently prescribe psychotropic medications and anticonvulsants without any government oversight, supervision, support or continuing education. Training manuals used for prescribing complex medications or interventions have also not been adapted to the Liberian context.

3.2.6 Trained Manpower

The dearth of skilled mental health professionals cannot be overstated. The number of trained mental health professionals is severely inadequate for the population's mental health needs. There is currently one practicing psychiatrist in the country, and no fully qualified psychiatric nurses, psychiatric or clinical social workers, psychiatric physician assistants, occupational therapists or clinical psychologists. Clinicians, while legally allowed, do not generally have the knowledge or education to prescribe complex psychotropic drugs. Furthermore, the nurses at the one existing mental health facility, Grant Hospital, have a general education, and have received only a crash course in psychiatric diagnosis and

management. This facility has no psychiatrist to supervise or manage the staff, or to provide guidance for complex cases.

In general, the primary health workforce is made up of those with sub-standard qualifications (National Health Policy). They have received no training in the screening or identifying of mentally ill patients, and in treatment options within the primary care or emergency setting.

3.2.7 Education and Training Opportunities

Mental health education and training opportunities are scarce. Liberia's one medical school has no clinical rotation in psychiatry; instead, the one psychiatrist in the country intermittently lectures the students. There is also no psychiatric residency program.

There are also few options for psychiatric nursing, social work or physician assistant education and training. There is a psychiatric nursing course at the Tubman National Institute of Medical Arts (TNIMA), a school for non-physician students. The course lasts two semesters for nurses and one semester for midwives. It focuses only on the identification of and the referral process for mental health patients, and offers no training or education about vulnerable groups. Mother Patern College of Health Sciences has recently expanded a two-year social work degree to a 4-year program.

The Ministry currently does not have a system to evaluate or process of accreditation of psychiatric education and training programs. There is no standard curriculum or competencies required for practice. There is no system to evaluate teachers or trainers, or guidelines that demand and ensure they have appropriate degrees (from both local and international institutions). There is also no certification process for non-physician mental health workers trained by NGOs.

In addition, there are no scholarship opportunities in the country to attract students with a natural interest in mental health to the profession, and there are no financial incentives offered for health workers to complete additional training in mental health (since mental health and general health workers are paid the same).

There are also no self-care education programs for health professionals about mental health. Stigma and misconceptions about mental illness as well as other health issues, such as HIV/AIDS, are still widespread among health workers. Moreover, counseling opportunities or self-care initiatives for providers who see and treat very difficult patients are non-existent. Stress and burnout rates are high among mental health workers.

3.2.8 Monitoring and Evaluation

There is no organized system for data collection, storage or retrieval of mental health related activities. There is no defined list of mental health statistics to be collected or indicators to be evaluated. There is no reporting system to gather and forward relevant information, such as number of patients examined and treated or diagnosis, from those providing mental health services to the Ministry of Health. As a result, there is no Liberia specific data about rates of prevalence or patient demographics for those afflicted with or being treated for mental illnesses.

3.2.9 Mental Health Research

There is currently no system to monitor mental health research. There is no Internal Review Board to review studies, and to ensure the safety of subjects and the ethical conduct of research.

3.2.10 Forensic Services

There is no accurate count of mentally ill people who are incarcerated. There is no forensic service to manage individuals with mental conditions who have committed serious offences. The courts relegate mentally ill offenders to prisons where they receive no treatment, and where there are no secure or semi-secure areas.

3.2.11 Human Rights

Liberia does not have any provisions to protect patients against involuntary admission or treatment. Nor does it have a provision requiring consent for admission or treatment.

4.0 EPIDEMIOLOGY

As there is no monitoring or data collection system, there is little information about the mental health of the population. Studies in developed countries have shown that up to one-fifth or one-quarter of the general population suffer from some form of mental disorder at any given time. In 1996, Parry reviewed epidemiological studies in Africa and found similar or even higher levels of morbidity.

Rates from other post-conflict societies have shown a high incidence of trauma-related psychiatric illness such as posttraumatic stress disorder (PTSD) and depression in affected populations. This is consistent with a recent household survey by Johnson et al (2008), which involved 1600 Liberian adults aged 18 or older (of whom a number were ex-combatants). The study indicated that 40% of participants met symptom criteria for major depressive disorder (MDD) and 43% met symptom criteria for PTSD. Extrapolating to the general population, this study suggests that more than 1.5 million persons have symptoms suggestive of MDD and PTSD.

This study further showed that a third of the population had been involved in combat and that up to 55% of former combatants experienced symptoms of psychological distress. Moreover, the rate of substance abuse among this population group was reported to be significantly higher than that of the general population.

Another study, funded by the WHO in 1994 and that involved high school students, indicated that more than 60% of the students surveyed had witnessed someone being killed or tortured (Harris 1994). Eighty percent claimed to have lost a close relative or friend by death during the course of the conflict while 70% claimed that they had lost confidence in the humanity of others. Almost 70% of these students experienced some symptoms of psychological distress. These rates likely increased as the war progressed given that the last year of the conflict is often considered the most brutal and violent.

While there is no doubt that the war has impacted heavily on the mental well-being of individuals, it should be noted that symptoms of psychological distress may represent normal reactions to excessive stress and therefore the framing of these symptoms as severe mental illnesses may therefore be inappropriate.

Even without the impact of the war, the number of Liberians with mental health problems is alarming. Studies have shown that about 10% of the populations of the world suffer from a mild mental disorder while about 3% suffer from serious mental disorders. With a population of about 3.5 million people, one would expect about 350,000 individuals in Liberia to be suffering from a mild mental illness and an addition 105,000 from a severe mental disorder. Given the situation of the war, and in light of the study by Johnson et al, the total mental illness count would be approximately 1,640,000.

4.1 Special Vulnerable Populations

As previously described, this policy has identified certain vulnerable populations who are at particular risk for developing mental health related issues. These populations are susceptible to this risk for reasons outside of their control. The numbers below are one indication of the size and depth of the problem, and the urgent situation of some of these groups.

4.1.1 Children and Adolescents

Children and adolescents account for 55.6% of the population. According to data from the Ministry of Planning and Economic Affairs, more than 50% of the population is below age 18, and 43% are between 0 and 14 years old. Physical violence against children ages 2-14 is 15.2%. Orphan-hood between ages of 0-17 is 7.2%, and child Labor between ages 5-14 is 9%. Liberia and Sierra Leone are said to be the only countries in which young people are less literate than their parents (CCA 2006). Primary school enrollment is 74% for males and 58% for females, while secondary school enrollment is 37% for males and 27% for females (2000 – 2006 average).

Unfortunately, there is insufficient evidence-based research data available to fully comprehend the nature and extent of the wide range of problems that this group faces. Most of the present population was born during the period of conflict. This resulted in early developmental years characterized by civil disruptions and punctuated by protracted periods of widespread terror, torture and violence.

Many of the young people today have never experienced the normal interactional social processes necessary for normal growth and development, and have become maladaptive and dysfunctional in their social interactions. Increased violence, low anger threshold, increased irritability, and increased arousal, along with anxiety and depressive symptomatology are all pervasive, and may represent maladaptive adjustmental responses to prolonged stress and trauma.

4.1.2 Victims of Sexual and Gender Based Violence

Studies on rape in Liberia show alarming numbers. A WHO study showed that over 90% of those interviewed, regardless of rape, age, marital status and religion said they were subjected to at least act of sexual abuse during the war or after. Many reported being raped or violently abused by gangs of men. One study in 1995, funded by WHO and conducted during the initial demobilization period, showed that 33% of women had been raped by that point of the conflict. The study involved 450 women living in shelters in and around Monrovia. The age range of the victims was 10 to 70 years with 58% being between the ages 20 to 39.Three percent were over the age of 60. In 49% of cases, the victim knew the offender. In many cases, the act of rape was aggressive and brutal with 50% of the women reporting that they sustained some form of injury during the assault with vaginal laceration or bleeding occurring in 37% of cases. Eighty four percent of the victims reported that the rape attack occurred during periods of active fighting with similar risks during the day and night. In 59% of cases, the age of the offender was estimated to be 25 or less with the largest concentration being between ages 19 to 25. Six percent of perpetrators were thought to be less than 15. In 54% of cases more than one attacker was involved.

The prevalence rate of rape increased as the war progressed. Recent data from UN agencies in Liberia suggests that by the end of the conflict, 77% of women in the country were victims of some form of sexual assault and abuse. One study in 2004 in Montserrado and Bong counties found that 77.4% of victims had been raped in the conflict. A similar study in 2005 in Lofa, Nimba, Grand Gedeh and Grand Bassa estimated that 72.1% had been raped during the war. Of the women in the 2004 study, 69.9% claimed to have been raped in 2003 alone, which is widely considered the most brutal period of the conflict. The helps to explain the large differential between the rates reported in the 1995 and 2004 and 2005 studies.

Rape continues to be widespread despite the end of hostilities. Girls aged 10-14 are the most frequent victims. A recent UNMIL study showed that about 41% of perpetrators were between 20 and 30 years old, and that most were known to the victims.

4.2 Substance Abuse

Substance abuse is a burgeoning problem that is becoming increasingly prevalent among young people. A WHO sponsored mapping exercise in 2008 showed that Monrovia is rife with areas where drugs, such as heroin and cocaine, are inexpensive, and can be easily purchased and used (Harris 2008).

In addition, a high school survey of 800 students from 16 junior and senior high schools, also conducted in 2008, indicated that one in ten students were using drugs and more than 50% had used alcohol at least once (Harris 2008). More than 80% of those surveyed had engaged in sexual intercourse at least once. Most of the students rated their risk of contracting HIV as low. This study is consistent with other studies that suggest that certain groups tend to harbor an "optimistic bias" relative to their particular vulnerabilities (Weinstein, Hensen, 1986; Lee 1989, McCoy 1991).

4.3 Epilepsy

Epilepsy is regarded in Liberia, as in many other developing societies, as a curse. It is thought to result from demonic possession and believed to be contagious. The stigma associated with epilepsy is overpowering; it sometimes leads to further suffering and ostracism in the community. It is not uncommon, for instance, to hear about persons falling in open fires or drowning, and not being rescued because of the fears of this illness.

Research conducted by the Liberia Institute for Biomedical Research (LIBR) in collaboration with scientists from the Netherlands in March 1979 showed that an area of Nimba and Grand Bassa County on the southern coast of Liberia had an extremely high prevalence of epilepsy. While figures in other countries show prevalence of between 5 and 10 per 1000, this area showed prevalence rates of up to 50 per 1000 persons. The etiology of epilepsy in some areas with high rates is unclear, though it is possible that some cases may be related to violence (head injury) or substance abuse. Other reasons for the high prevalence may include intracranial infections of bacterial or viral origin, parasitic infections – particularly neurocysticercosis –
perinatal brain damage, head injuries, toxic agents and hereditary factors. Studies are needed to understand the reasons for such high rates. Many of these factors are, however, preventable or modifiable, and the introduction of appropriate measures to achieve this could lead to a substantial decrease in the incidence of epilepsy in Liberia.

In addition, in 1994, during one of World Health Organization's monitoring visits to shelters in the above areas, 187 persons with epilepsy were identified, clinically diagnosed and placed on treatment. It is important to note that none of the NGOs working in the shelters had previously focused any attention on these individuals. Unpublished data from MDM showed that in 2008, the most common diagnosis for children and adolescents was epilepsy.

4.4 Open Mole

The open mole syndrome is a relatively common disorder. It is found predominantly in women, and is a culture bound anxiety depressive disorder characterized by a myriad of somatic and vegetative disturbances. These include a severe headache localized around the frontal region of the scalp, a burning sensation in and round various parts of the body, and a belief that the frontal area of the scalp is open. Other symptoms are a rapid heartbeat, palpitations, sleep and appetite disturbances, increased arousal and startle reactions, and sometimes episodes of panic. The syndrome is named for what is locally referred in childhood as "open mole" in dehydrated young babies with sunken anterior fontanelle.

5.0 MENTAL HEALTH POLICY FOUNDATIONS

5.1 Mission

The mission of this National Mental Health Policy is to ensure a mental health system that addresses the mental wellbeing of all people through quality, affordable, accessible and available services. This policy emphasizes the development of activities that promote, prevent, educate, diagnose, treat and support people with mental disorders. It mandates that professional health workers with adequate and appropriate levels of training provide effective mental health services, and underscores the importance of collaboration with diverse and relevant sectors and ministries.

5.2 Vision

The vision of this policy is an improvement in the mental and physical state, and social status of all Liberians thereby making the country a model for post-conflict recovery.

5.3 Overall Policy Objectives

Goal: To provide quality mental health services to the people of Liberia in an efficient, equitable and cost-effective manner.

Strategy: Mental health services will be delivered through the primary care system in an integrated and decentralized fashion.

Policy Objectives:

1. Prevention of mental illness.
2. Improved accessibility and availability of mental health services.
3. Provision of special services to vulnerable groups with specific needs.
4. Provision of rehabilitative services to prevent and/or minimize secondary or tertiary handicaps.
5. Provision of social services to improve levels of social functioning.
6. Improved accessibility and availability of mental health services.

Areas of Action and Priorities:

1. Coordination of the mental health system within the MOHSW
2. Financing
3. Legislation and human rights
4. Organization of services
5. Human resources and training
6. Procurement and distribution of essential medicines
7. Quality improvement
8. Information services
9. Advocacy
10. Research and evaluation of policies and services

5.4 Values and Principles

The following values and principles form the pillars of this National Mental Health Policy. They have played a cardinal role in the creation of this document:

a. Quality services
    i. The highest quality services will be provided in accordance with best practices and evidence-based medicine.
    ii. Services will be provided by appropriately trained persons and consistent with established protocols.

b. Mental health within the primary care system
    i. Mental health will be integrated into the primary health system.
    ii. Integration will occur at all levels. All health care professionals will receive training to provide mental health care appropriate to their role within the health care system.
    iii. Prevention will be a priority.
    iv. There will be special services for identifiable vulnerable groups with specific needs.
    v. There will be rehabilitative services to help prevent and or minimize disabilities resulting from mental illness.
    vi. Social services to improve levels of functioning will be made available.
    vii. Mental health care will be linked to other sectors. This includes the judicial, social welfare, housing and education systems.

c. Accessibility and equity
    i. Mental health services will be free of charge and accessible to all. This is consistent with the BPHS.
    ii. There will be parity of mental and general health services.
    iii. Mental health care will be available for all levels of severity and need.
    iv. Efforts to reduce the discrimination of and stigma towards people with mental illness and developmental disorders will be pursued. These initiatives will target both the general population and specific groups, such as health care workers, teachers, professionals, and patients and families.

d. Efficiency and sustainability
    i. All aspects of the mental health program will be based on approaches that are culturally and contextually relevant, have proved successful in similar environments and are cost-effective. This will ensure value for money.
    ii. Strengthening collaboration with various sectors – including non-governmental organizations – will be a particular focus. This will help minimize the development of vertical programs.

e. Human rights
    i. The human rights of people with mental disorders will be upheld and protected. This will include the right to essential and appropriate mental health care, and freedom from stigma.
    ii. The seriously mentally ill will have all rights of citizens. This includes the rights to health care, shelter, education, and employment.
    iii. Treatment will promote autonomy and not be custodial.
    iv. The seriously mentally ill will be treated in a safe and the least restrictive environment.
    v. The use of physical restraints will be discouraged.
    vi. Specific legislation for the protection of the seriously mentally ill will be encouraged. This legislation should address access to care, the rights of family and caregivers, and the protection of the rights of people with SMI.

vii. Confidentiality will always be upheld and adhered to in the course of any mental health related treatment.
viii. There will be protection of vulnerable populations.
ix. Treatment will be consistent with international conventions on human rights.

f. Decentralization
   i. The mental health program will decentralize its activities at all the structural levels of management and control.
   ii. Care will be provided as close to home as possible.
   iii. Community level treatment will be integral to the mental health system.
   iv. Community level treatment will be utilized and exhausted before inpatient care is sought at county hospitals or tertiary facilities.

g. Community involvement and participation
   i. Care will be provided in the community when possible.
   ii. The mentally ill and their families will be engaged and consulted when designing programs that address their needs.
   iii. There will be education for families and mentally ill patients about the nature, care and treatment options for mental diseases.
   iv. There will be public awareness programs (through media outlets, such as the radio) to sensitize the community and reduce stigma.

h. Rehabilitation
   i. Programs that address skill-development, and that lead to improved functioning and employment opportunities for the mentally ill will be encouraged.
   ii. There will be a focus on improving the quality of life for those with mental health issues.

i. Culturally appropriate
   i. Services will be culturally appropriate and will reflect the values of the community.
   ii. Traditional healers and religious and community leaders will be involved in prevention and detection, and will collaborate with the formal mental health system.

j. Evidence-based care
   i. Scientific evidence will inform decisions for services and interventions.
   ii. Next "best practices" will be utilized when scientific evidence is lacking.

5.5 Basic Ethical Principles

Basic ethical principles refer to those general judgments that serve as a basic justification for the many ethical prescriptions and evaluations of human actions.

Three basic principles, among those generally accepted in the Liberian cultural tradition, are particularly relevant to the ethics of research involving human subjects: the principles of respect of persons, beneficence and justice.

5.6 Mental Health in Primary Health Care

5.6.1 Current Primary Health System

The mission of the Ministry of Health and Social Welfare is to reform the health sector so that all Liberians can eventually receive high quality, culturally valid health care. The MOHSW has given priority to a community-based system of care in which local health clinics and health centers are tied into county hospitals and tertiary facilities.

The small health clinics, which have no inpatient beds, are the front lines of health activity in local areas. The health centers, which are simple health facilities with a maximum of five beds, provide basic preventive and curative care. County hospitals, which have up to forty beds, provide preventive and curative services; this includes common surgical procedures and basic intensive care. The John Fitzgerald Kennedy Medical Center (JFK) provides tertiary care. There are currently 286 clinics, 50 health centers and 18 hospitals in Liberia. According to the MOHSW, 472 clinics, 54 health centers, and 29 hospitals are needed, at minimum, to make medical care available and accessible throughout the country.

5.6.2 Integrated Mental Health and Primary Care

The foundation of Liberia's health policy is a primary health care system that promotes good physical and mental health, and that provides preventive and curative care. Mental health treatment will therefore be integrated into the primary health system. It will extend from the local level health clinics and health centers to the county hospitals and tertiary facilities.

This approach is consistent with the MOHSW policy of decentralized health services in close proximity to citizens. A community-based model of care is also considered to be the most appropriate and efficient way to serve individuals with mental health problems. Community care has proven to be more effective than institutional treatment. It is in-line with recommendations from the WHO and international health experts, and evidence-based research from low- and middle-income countries that has shown this model of service delivery to both improve health outcomes and decrease costs.

5.6.3 Outpatient and Inpatient Services

Local health clinics and health centers will offer a range of outpatient mental health services. Providers with appropriate training will identify, screen, diagnose, treat, monitor and prescribe psychotropic medications, and make necessary referrals.

Inpatient care will be provided at the county hospitals. Each county hospital will establish a Wellness Unit, which will have four to six beds (based on county needs) available for psychiatric admissions. This unit will also serve as a decentralized training facility for community-level providers. The unit will be staffed by a Wellness Unit team. The length of stay will be no more than 14 days. As it is clear that the majority of admissions to the country's current Mental Health Hospital were in the Montserrado area, the re-establishment of the Catherine Mills Rehabilitation Center at the JFK Hospital will compensate for the eventual closing of this mental health facility. Of the 14 counties outside of Montserrado, the addition of a 4 to 6 bed Wellness Unit within each county hospital would provide approximately 70 beds. This would be adequate to meet the mental health demands of each county, and eliminate the need to refer patients to a Mental Health Hospital.

The Mental Health Hospital, while it exists for the next few years, will be used as a referral source for when a patient requires longer hospitalization. Inpatient care at this facility will only be sought once treatment at the county hospitals has been exhausted or in exigent circumstances, such acute psychiatric emergencies, homicidal or suicidal ideation, or when a patient's safety or safety towards others is a risk. Admission will be no more than 28 days if possible.

In addition, primary health care needs will be incorporated into the Mental Health Hospital as well as the Wellness Units. All mental health patients will have a medical history, review of symptoms, and a

physical examination, and be administered all available diagnostic tests to rule out other medical disorders.

Discharge planning at all inpatient facilities will include help for housing, shelter, food, security and work (volunteer). Patients will not be discharged to the street, and the discharge plan for aftercare will be linked back to primary health care. There will be confidential communication between inpatient and outpatient caregivers (bi-directional).

5.6.4 Mental Health Staffing

A County Mental Health Team will provide mental health care in both the health clinics and health centers, and in the Wellness Units within each county. Each county team will be formed by a mental health outpatient team, which as previously noted, would work in the health clinics and health centers, and the staff from the Wellness Unit, which would work in the county hospitals and in some instances, the health clinics and health centers. The team will be lead by a County Mental Health Coordinator, a position that will be occupied by either a physician assistant (PA) or psychiatric nurse. This job will entail, among other things, assessing patients referred from primary care, stabilizing patients when required, assisting in psychosocial rehabilitation, offering counseling, making home visits, checking the availability of medications in the clinics, keeping mental health statistics and writing county reports. County Mental Health Coordinators will also regularly review with their supervisor, the County Health Officers, initiation of and changes made to patient medications. This will help ensure the delivery of quality services.

A County Health Officer (CHO) will be the overall supervisor for the County Mental Health Team. The CHO will play three roles: (1) operational manager of the County Health Team – which offers general health care – as well the County Mental Health Team, (2) hospital director and (3) chief medical officer of the county. The CHO will receive training in mental health as s/he is directly responsible for the quality of care rendered by the staff.

Each mental health outpatient and Wellness Unit team will be led by both the hospital director (who will be the overall supervisor) and by a PA (who in some instances would be the County Mental Health Coordinator) or psychiatric nurse. Each team will include nurses with some training in mental health, social workers and community health workers. This model of service delivery has been successful in other post-conflict countries. A number of studies have also shown that the use of such a multi-disciplinary team in a resource-limited setting can help increase service engagement and patient satisfaction, and improve adherence to treatment.

In specific, the mental health outpatient team will rotate to different health clinics and centers. Each health worker will be delegated specific tasks, responsibilities and authorities. Non-health workers will also be given explicit duties and priorities. As part of the team, social workers, for instance, will help manage problems associated with poverty, sexual abuse and other major social issues. It is well known that in the health clinics, many of the mentally impaired people are members of vulnerable groups and have serious associated problems. It is thus critical that MOHSW train and place social workers in these settings. This is consistent with the Ministry's Social Welfare Policy, which reveals the extent to which poverty affects the population and which underscores the significance of training social workers to help citizens deal with poverty-related issues. In addition, community health workers and community health volunteers will assist with identifying mental illness, monitoring of side effects, patient compliance with medication, early signs of relapse and mental health education. They can support vulnerable groups, and will be the first point of contact for violent and aggressive mentally ill people.

It is important to note that the outpatient health clinics and health centers will receive additional support from members of the Wellness Unit. These individuals will assist with evaluation, treatment and follow-

up in facilities that are in close proximity to county hospitals. This will allow for continuity of care as well as treatment as close to the patient's home as possible.

The Wellness Unit teams, as previously described, will be overseen by the hospital medical director as well as a physician assistant or psychiatric nurse who has extensive training in psychiatry. The PA or psychiatric nurse will directly supervise general health nurses with some psychiatric training, social workers, and community mental health workers and volunteers. The general health nurses with some mental health training will conduct structured diagnostic interviews, prescribe psychotropic medication when needed and review all diagnostic evaluations. These duties – in particular, the ability to prescribe medications – will be routinely reexamined and modified as the number of highly trained mental health specialists in the country increases. The nurses will also monitor for side effects and adherence to treatment, and gather all pertinent information at each visit. This will allow the PA or psychiatric nurse to determine whether changes to medications are warranted. The nurse will consult with the PA, psychiatric nurse or the County Health Officer for complicated cases, children requiring psychotropic medications, and for co-morbid medical disorders. The social worker(s) will deliver psychosocial interventions through individual, group and family treatment. A nurse and social worker will also provide education around the illness and the medication.

All staff will use a standardized structured diagnostic evaluation in all clinics and health centers, and in all county hospitals and tertiary facilities. This evaluation tool, once adapted for Liberia, will help to reduce the rate of misdiagnosis and to ensure appropriate treatment is administered. Each evaluation will collect similar information for patient demographics, history, family history and problems. There will also be a formally defined list of additional information to be collected by all Wellness Units in the county hospitals and tertiary facilities. This data may include diagnosis, use of restraints (and amount of time), length of stay, medication and recidivism. All clinics, health centers and hospitals will report and transmit the data to the government health department. The MOHSW will publish the statistics in an annual performance report on mental health; this be used for future planning, to monitor progress, to determine if targets and desired outcomes are achieved, and to assess service utilization.

The importance of appropriate and adequate training for primary care and mental health team workers cannot be overemphasized. Integrating mental health into the primary care system is futile if providers are unable to recognize, correctly diagnose or treat mental disorders. Ongoing supervision, training, and self-care support is essential to guarantee the sustainability and effectiveness of this system, as is the use of evidence-based and culturally valid screening instruments, and prevention and treatment programs. Please refer to section 7 for a more detailed discussion of human resource development and quality assurance measures.

Table 3. Health service structure, general tasks and mental health tasks

Health System	General Tasks	Mental Health Tasks
Ministry of Health	Overall supervision	• Overall supervision • Management • Training • Human resource development • Data collection

Health centers and health clinics	Outpatient care	• Integrated mental health and primary care • Prescribe and monitor psychotropic medications • Referral of difficult cases to Wellness Unit at country hospitals • Use standardized structured diagnostic evaluation • Collect mental health indicators and patient demographics • Collect simple case registers for people with severe mental illness to facilitate follow-up, prevention of relapse, outreach and planning medication regimens • Consult with experts and county hospitals about difficult cases • Liaise with community health workers and volunteers, social workers, and traditional health practitioners • Community mental health education
Wellness Units at county hospitals	Inpatient and outpatient care	• Integrated mental health and primary care • Use standardized structured diagnostic evaluation • Social support services • Collect mental health indicators and patient demographics • Support and supervision of health centers and clinics • Mental health education • Prescribe and monitor psychotropic medications • Training of mental health professionals • Support and supervision of health centers and clinics • Monitoring and evaluation of services and care • Consult with Country Health Officer and team leaders about medications and referrals • Follow-up care at local health clinics and centers
Mental health hospital/future inpatient unit at the general hospital	Tertiary care	• Inpatient mental health care • Referral source of last resort • Acute emergencies, and patients at risk of hurting themselves or others • Severe cases only
Dispensaries	Pharmacy	• Ensure availability of essential drugs: antidepressants, anti-psychotics, and anti-epileptics at all health facilities • Limit and reduce the use of benzodiazepines for mental disorders

5.7 Substance Abuse Emergency

Substance abuse care will be consistent with the MOHSW Substance Abuse Policy. Wellness Units in the county hospitals will provide treatment for substance abuse emergencies including overdose and withdrawal events. Alcohol, benzodiazepine and opioid withdrawals are the most common and dangerous; protocols will therefore be established for the identification of their respective withdrawal symptoms and emergencies, the monitoring of physical signs of withdrawal and the administering of medication tapers to resolve the withdrawal (SAMSHA 2008a). Referrals will be made to appropriate organizations and programs that focus on substance abuse recovery and disease management.

5.8 Neurological Disorders

Seizure disorders, such as epilepsy, will be best treated within the community-based health clinics and health centers. County hospitals will provide medical and additional mental health evaluation and treatment services.

It is important to note that nonepileptic psychogenic seizures represent a large subgroup of patients with

seizures. Furthermore, patients with seizures may also have nonepileptic psychogenic seizures. These seizures may be in the form of conversion where patients produce the seizures without conscious effort and obvious secondary gain. These patients frequently have a history of sexual or other psychological trauma, and are more likely female, and will therefore be screened for trauma history.

Patients with epilepsy or seizure disorders will also be screened for common conditions that mimic seizures, such as migraine headaches, panic disorder, sleep disorders (cataplexy and hypnagogic hallucinations in narcolepsy, and parasomnias), and periodic limb movement disorders. Finally, patients will be screened for common mental disorders, such as depression (which is found in 30% of patients with epilepsy), anxiety (which is found in 10-50%) and psychosis (which is found in 7%).

Providers must recognize that focusing solely on seizure control is not the most effective means to reintegrate a patient with epilepsy back into society. A focus on quality of life is necessary in combination with strategies that help reduce the shame and stigma associated with the disorder.

6.0 MENTAL HEALTH FOR VULNERABLE POPULATIONS.

Every society is responsible for caring for its most vulnerable populations. Vulnerable groups are at high risk for medical and psychiatric morbidity and mortality, and require additional and more comprehensive services. This policy has chosen three such groups of peoples to focus on: children and adolescents, victims of sexual and gender-based violence (SGBV) and the seriously mentally (SMI).

6.1 Children and Adolescents

This National Mental Health Policy will provide the foundation and guidance for a children's mental health program in Liberia. The MOHSW will ensure alignment of this program with other national policies that have an impact on the overall wellness of children and their families. Future policies and legislation that seek to reduce mental illness and promote healthy children, families and communities will be developed based on the points proposed below. In addition, local and international NGOs associated with children must make their programs and activities consistent with the document.

6.1.1 Development of Children's Mental Health Policy Framework

The recommendations for children's mental health outlined in this policy were partly informed by the Mental Health Needs Assessment of Liberian Children, Adolescents and Young Adults, which was conducted with 171 key informants of young Liberians in April, 2009. This study was created by the Massachusetts General Hospital/Harvard Medical School Liberia Mental Health Policy Working Group in conjunction with the MOHSW. The mean age of respondents was 44 years ± 9 years and the mean length of time respondents reported having spent in Liberia was 37 years ± 14 years (range 1-62 years).

The results of the survey indicated areas of priority for the mental health care of young people in the country. Respondents felt that young Liberians experienced high rates of war stress, sexual violence, exposure to fear, witnessing of atrocities, inadequate education, separation or death of a parent, loss of home, domestic violence, torture and being forced to harm others over the past twenty years. Sexual violence, poverty, disease, domestic violence and inadequate education were felt to be experienced in high rates over the past year. Children between 5 and 12 years old were felt to have high rates of poor concentration, delinquent behavior, lack of motivation, early sex, bullying of others, alcohol use and depression. Adolescents and young adults between 13 and 22 years old were felt to have high rates of unsafe sex, alcohol and drug use, a lack of respect for the law, delinquent behavior, gang participation, sexual violence, poor concentration, bullying of others and hopelessness. Respondents most commonly selected medical clinics as the best treatment setting child and adolescent mental health care. Schools and sports were also rated highly as appropriate treatment settings for these groups.

This policy was also developed using the recent report from the Committee on the Prevention of Mental Disorders and Substance abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions (Institute of Medicine; National Research Council). This report highlighted several significant points. One was that similar to family adversity, poverty is a powerful risk factor, and its reduction would have far-reaching effects for multiple negative mental, emotional and behavioral outcomes. Promoting healthy functioning of those living in poverty by interventions, such as early childhood education, programs to strengthen families and schools, and efforts to reduce neighborhood violence, should thus be a priority. The report also underscored that screening to identify those who have behavioral symptoms can take place at multiple levels. This includes the level of the population, the level of groups and the level of individuals. It noted, however, that screening without community acceptance of the nature and treatment of mental health issues, and sufficient service capacity to respond to identified mental health needs, is of limited value.

The report detailed several areas of progress that were considered during the formulation of this policy:

- Evidence that mental, emotional and behavioral disorders are common and begin early in life.
- Evidence that the greatest prevention opportunity is amongst young people.
- Evidence of multiyear effects of multiple preventive interventions for reducing substance abuse, conduct disorder, antisocial behavior, aggression and child maltreatment.
- Evidence that the incidence of depression among pregnant women and adolescents can be reduced.
- Evidence that school-based violence prevention can reduce the base rate of aggressive problems in an average school by one-quarter to one-third.
- Evidence that improving family functioning and positive parenting serves as a mediator of positive outcomes and can moderate poverty-related risk.
- Emerging evidence that school-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Evidence that interventions which target families dealing with adversities, such as parental depression and divorce, demonstrate efficacy in reducing the risk for depression in children and in increasing effective parenting.
- Evidence from some preventive interventions that benefits exceed costs, with the available evidence strongest for early childhood intervention
- Advances in the implementation science, including recognition of implementation complexity and the importance of relevance to the community.

Finally, the recommendations for children's mental health in this document were guided by the existing Liberian policies that pertain to children. These include, among others:

- The national policy on education, which mandates free and compulsory primary and secondary education, and embrace "back to school" and "stay in school" strategies.
- The National Health Policy, which seeks to improve the health status of citizens on an equal basis by focusing on child and maternal health, equitable access to quality health care, prevention, control and management of major diseases, nutrition status and access to quality social welfare services.
- The Social Welfare Policy, which strives to respond to the basic needs of the most vulnerable, provide social protection, and strengthen social capital and socio-economic enhancement.
- The documents from the Ministry of Gender and Development, which advocate for women and children's rights, and which integrates these rights into the overarching national development agenda.
- The National Policy on Youth and Sports, which promotes youth participation in the national decision making process. It also enables young people to provide input on community activities, national programs, and youth-centered activities and initiatives.

6.1.2 Goal of Children's Mental Health Program

The goal of the children's mental health program proposed in this policy is to develop a quality mental health, and alcohol and substance abuse prevention and intervention system for all young Liberians. In particular, it focuses on children's mental health promotion and de-stigmatization, school-based mental health, guidelines for the treatment of children in community- and hospital-based settings, and mental health services for specialized populations. This framework is consistent with the five-tiered pyramidal structure that represents the five pillars of service provision within this policy.

6.1.3 Scope of National Mental Health Policy for Young People

The term children in this policy will include infants, children and adolescents. It refers to those between ages the ages of 0 and 18, and is intended for both those who attend and who do not attend school. For those who are in school, this policy is directed for children attending public and private primary and secondary education, hybrid vocational and formal education programs, accelerated learning programs and vocational programs.

The scope of this policy is limited to children who are at risk or who suffer from serious emotional or behavior disturbances. The policy also stipulates broad guidelines for the prevention and treatment of alcohol and substance abuse, which – as previously noted – is widespread among adolescents.

6.1.4 Planning Population

It is important to recognize that youth in the context of Liberia is not clearly defined, and often denotes those between 0 and 35 years of age. The physical, psychological, cognitive, social and emotional development characteristics, however, differs significantly across this broad range. The Mental Health Needs Assessment of Liberian Children, Adolescents and Young Adults broke down this definition of youth, and characterized young Liberians as children between 5 and 12 years old, adolescents between 13 and 18 years old and young adults as between 19 and 22 years old. This policy was informed by the results of the survey, and consequently, describes youth using those categories.

6.1.5 Children's Mental Health Promotion, Early Intervention and De-stigmatization

The promotion of children's basic mental health awareness and de-stigmatization will emphasize the effectiveness of treatment. A total wellness approach for young people that integrates physical and mental health, social and emotional growth – in addition to educational and vocational development – will be the model for all public mental health promotion campaigns.

The Ministry of Health and Social Welfare will be responsible for developing public mental health campaigns, and alcohol and substance abuse prevention programs. The Ministry of Youth and Sports, Ministry of Information, Culture and Tourism, and other ministries will also carry out public mental health, alcohol and substance abuse prevention messages using their respective strategies. Faith-based and civil society organizations will also be encouraged to deliver these messages at churches and in community locations.

The MOHSW will develop an early intervention model for the poorest by ensuring that mothers have access to basic services for their children. The goal of such a program is to provide early physical and mental health, alcohol and substance abuse screening, and education and intervention for both the mother and the child. This type of program will also provide household resources and improve a woman's negotiating position within the family by offering mothers some form of incentive when they bring their children for medical check-ups.

It is critical to underscore that public awareness is unlikely to contribute significantly to mental health prevention if services remain unavailable. In addition, public awareness, without community acceptance, is likely to discourage significant utilization of services.

6.1.6 School-Based Mental Health

There is much evidence that most children who are in need of mental health care do not receive it. Since a growing number of children spend a greater part of their days in school, components of mental health will be incorporated into existing school-based health related activities. This will support children in their learning, attendance rate and social responsibility (both in the classroom and in the community). It is also consistent with the results from the Mental Health Needs Assessment of Liberian Children, Adolescents and Young Adults, which showed that respondents supported the need for screening and brief intervention within the system.

All school-based interventions will be culturally and developmentally appropriate for school-aged children. They will be based on the latest findings in child psychology and development, and will be adapted to the Liberian context. The MOHSW and the Ministry of Education will collaborate to develop these mental health interventions. They will consider primary, secondary and tertiary interventions, and prioritize them for implementation based on the availability of resources. These levels of intervention are defined as follows:

> (1) Primary prevention intends to build the capacity of a safe environment for all children in school. The violence prevention and intervention models that properly teach and reinforce how children can manage their behavior in school will thus be established. Life skills and social skills training will also be encouraged.
>
> (2) Secondary prevention intends to support children who are at risk for or are beginning to show signs of serious emotional and behavior problems. Small group interventions that help at-risk children with strategies to manage their own behavior will subsequently be implemented.
>
> (3) Tertiary prevention intends to individually intervene when problem behaviors are dangerous or highly disruptive. This is done before the behaviors result in school expulsion or referral to the outpatient mental health team for support and services. A screening, brief intervention and referral to treatment will therefore be made available.

The Ministry of Health and Social Welfare will establish a simple developmentally and culturally valid screening instrument to assist school personnel in identifying behavior and emotional issues of students. The MOHSW will also train school nurses, and or social workers and counselors to do mental health screening, brief intervention and referral. Primary prevention will be integrated into the current school-based health club model. Educational support for children with special needs will also be established.

6.1.7 Mental Health in Primary Care

The treatment of all child and adolescent mental health will be integrated into the primary health care system. Treatment will be offered to all children including pre-school age and non-students. Services will be delivered by the County Mental Health Team, who will be given opportunities to train with child mental health experts.

The County Mental Health Teams will provide – as a first level intervention – brief screening and short-term interventions based on a uniform standard of care developed by the MOHSW. The second level of intervention will be for children and adolescents with serious emotional and behavior disturbances, and

for children whose functional impairment limits or interferes with their ability to function in the family, school and or community.

The MOHSW will offer care and assistance through the primary health system to children and their families who need longer-term rehabilitation and recovery services. The care coordination will include a social worker from the local mental health outpatient team, who will provide support and coordination. In counties where little primary care exists, the primary care system will be able to scale up according to the availability of resources. The MOHSW will also establish a simple culturally valid screening instrument to assist the County Mental Health Teams in identifying behavior and emotional issues of children and adolescents; this should be used uniformly across the country. The Ministry will additionally train the teams to do mental health screening and treatment.

The mental health outpatient teams will develop liaison relationships with schools, police, prisons, social services and other institutions. The teams have will assist these institutions in early identification and intervention of at-risk children before more severe consequences occur. Simple screening instruments will be developed and validated. School nurses and counselors, police, traditional healers, traditional women and others working with children and adolescents, will also learn the instruments for early identification.

The continuum of mental health care for children, adolescents and families is based on the principle of least restrictive care, and hospitalization in the county hospital is the last resort. The system of care model will be used in lieu of hospitalization in an attempt to keep children and adolescents in their communities.

Parent education and behavior management skill training will also be made available. These policies are consistent with the results from the Mental Health Needs Assessment of Liberian Children, Adolescents and Young Adults in which respondents overwhelmingly supported mental health treatment within health clinics and health centers, and the establishment of programs that help young parents nurture their familial skills.

In addition to mental health treatment, coordination of all other services that cater to young people will be critical to meeting the multiple and changing needs of children and their families.

6.1.8 Inpatient Care

Inpatient care at the county hospital will only be used if the children and adolescents are a danger to themselves or others. The inpatient serves as a 14-day diagnostic work-up, medication evaluation and development of a comprehensive community treatment plan. The follow-up and access to resources for the children, adolescents, families or extended families will be available after discharge from the hospital. Children and adolescents will only be hospitalized at the county hospitals and other referral hospitals after all other treatment options have been exhausted.

6.1.9 Mental Health for Specialized Children and Adolescent Populations

The needs of vulnerable populations of children and adolescents, such as children with special needs, orphans, street youth, youth affected with sexually transmitted diseases, HIV and AIDS, and substance abuse, out of school and unemployed youth, violent and incarcerated youth, and ex-combatants will be catered to. An inter-ministerial policy will be established to provide outreach and integration with other ministries' programs that serve these populations.

Strengthening outreach capacity to the vulnerable and high-risk populations will be the first step for all ministries. Integrating mental health into programs that provide food, shelter and safety will be the second.

The Social Welfare system will also increase the number of social workers who can provide community-based counseling, case management and coordination for the vulnerable populations with complex needs. Screening and mental health care will take place at the health clinics, health centers and county hospitals. The MOHSW will be responsible for developing specialized psychosocial support, and work and educational programs that are evidence based for ex-combatants, and violent and incarcerated adolescents who need mental health services. Strong input from the Social Welfare department is envisaged.

6.1.10 Substance Abuse Treatment for Young People

One specialized population that this policy will specifically address is children and adolescents who are addicted to drugs and alcohol. Results from the Mental Health Needs Assessment of Liberian Children, Adolescents and Young Adults support the need for alcohol and substance abuse treatment for these groups. Early intervention and treatment services for older children and adolescents with alcohol/substance abuse or co-occurring with mental illness, and for those who are at risk of developing these disorders, will be delivered through a public health approach. Regular screening, education about alcohol and substance use, consequences and motivation to change behavior, and brief treatment by the outpatient mental health team will be made available while longer term treatment options continue to be developed. This early intervention system within the primary health structure, and which is adaptable to school and social service settings, will help reduce the incidence of substance abuse. Research has shown that large numbers of individuals at risk of developing serious alcohol or other drug problems may be identified through primary care screening. Interventions such as screening, brief intervention, brief treatment and treatment referral have been found to decrease the frequency and severity of drug and alcohol use, reduce the risk of trauma and increase the percentage of patients who enter specialized substance abuse treatment (SAMHSA, 2008).

6.1.11 Research Evaluation for Children's Mental Health, Substance Abuse and Violence Prevention

Liberia will have a systematic way to assess the extent to which the children's mental health services and individual programs achieve intended results. An outcome will indicate what changes have occurred for the people served. The research evaluation will prioritize expected short- and long-term results. The quality of care, evaluation of services and system performance will be data driven. The data will inform decisions in future funding and program development. The Liberia Institute of Statistics and Geo-Information Services should also provide the most updated census information to accurately plan for the target population. Baselines for outcome measures will be collected for comparison with future data.

6.1.12 Finance for Mental Health of Children and Adolescents

The Liberian government has financed very little for the overall mental health system. There is also no targeted funding for children's mental health, or alcohol and substance abuse, of which there are high rates among Liberian young people. The government instead relies on international NGOs to fill the funding gap, and subsequently, addresses children's mental health in a very fragmented way. The MOHSW will thus ensure targeted funding in future children's mental health, and alcohol and substance abuse prevention and treatment budgets; this will be one indictor of a developed mental health sector.

6.1.13 Roles of International agencies and Ministries in the Mental Health Treatment of Children

It is clear that no one single ministry can be responsible for the overall wellness of children, their families and communities. The term "wicked problems" is used to describe problems that seem intractable, that defy easy solutions, and that tend to be interwoven with other deep-seated social and economic conditions. They "present a special challenge to government because they defy precise definition, cut across policy and service areas, and resist solutions offered by the single-agency or 'silo' approach"

(Keast et al 2004). This term can be used to describe the needs of young people in Liberia, which as the Mental Health Needs Assessment of Liberian Children, Adolescents and Young Adults demonstrated, are complex and diverse.

Under the leadership of the Minister of Health and Social Welfare, a Children's Mental Health Task Force will consequently be established as a formal mechanism for inter-sector communication and collaboration across all ministries, teacher and parent associations, consumer and family groups, and local and international NGOs.

The MOHSW and the National Mental Health Coordinator will lead the development of new policies, action plans and regulations for service implementation related to child mental health. Future children's policies will be aligned with the policies of other ministries serving children and adolescents. The MOHSW will also be an advocate inside the national, county and local governments; it will campaign for the right to treatment, rehabilitation and funding for children's mental health.

The County Mental Health Teams will strengthen the decentralized response in overseeing the scaling-up of service structures, and ongoing consultation with other governmental agencies and communities on children's mental health. The team will coordinate with local and international NGO activities, and help community groups establish a basic awareness of children and families' mental health and substance abuse issues.

6.1.14 Workforce Development and Training for Children's Mental Health, Alcohol and Substance Abuse

The fields of child and adolescent development, and child and adolescent mental health and mental illness, are incredibly specialized. The skills required to work with young people in these areas are very different from those needed in the adult population. Human and material resources are currently absent or very inadequate for the mental health needs of children and their families. There is a need to increase the knowledge base for those working in the field by a standardized curricula that includes an understanding of the following: a simple standardized screening tool, gathering of developmental and psychosocial history, family assessment, social and emotional development, mental health and mental illness, and individualized service planning. Children's mental health, and alcohol and abuse assessment and treatment, will also be incorporated into the general education and training programs within social work, nursing, physician assistant and medical schools.

Broad knowledge training on children's mental health and detection of mental health problems in the context of Liberia will be needed for all practitioners including health care providers, teachers and educators, sports and recreation staff, traditional healers, traditional women and parents who can help other parents. Specialized training for the mental health specialists on children's mental health for the County Mental Health Teams is required. The Train-the-Trainer model should be used to increase training capacity.

The MOHSW will also train school nurses and counselors to do mental health, alcohol and substance abuse screening and brief treatment.

6.1.15 Human Rights for Children

The Ministry of Health and Social Welfare and the National Mental Health Task Force will work closely with all ministries and human rights groups to protect children from child labor abuses, domestic violence, sexual abuse and trafficking. They will ensure food, shelter, safety, education, and the right to treatment and rehabilitation.

If a children's rights policy does not exist, appropriate policies will be developed for all ministries. They will be implemented at all levels to achieve the mission and goal of children's rights. The United Nations Convention on the Rights of the Child sets out the rights that will be realized "for children to develop their full potential, free from hunger and want, neglect and abuse." It states that "children are neither the property of their parents nor are they helpless objects of charity. They are human beings and are the subject of their own rights. The child is an individual *and* a member of a family and community, with rights and responsibilities appropriate to his or her age and stage of development." If a child does not have a family or extended family responsible for his or her care and fundamental rights, the county will appoint a legal guardian for the best interest of the child and adolescent.

6.1.16 Economic and Skills Development for Children

The main development issue for children is their education. The MOHSW will work closely with the Ministry of Education to ensure that all children have access to school and that children with mental health problems have adequate support to meet their educational goals.

The Kakata Declaration declared young people as major partners and stakeholders in the development of Liberia and as leaders of the future. Research has also demonstrated the efficacy of a peer helping peer model in reducing mental illnesses (a similar model is also true for parents helping parents and traditional women helping parents). This could be a potential paid or volunteer workforce in Liberia if participants receive uniform training and supervision. The public awareness that would result from this peer model could be part of the solution to the lack of availability of services and early prevention. Additionally, the Ministry of Health and Social Welfare and the Ministry of Education will collaborate and further expand the pilot psychosocial skills training program currently in Monrovia and Bong County in which a group of trained teachers provide training to selected students to become "peer mentors" in their schools and communities. This could also provide a number of benefits.

6.2 Victims of Sexual and Gender-Based Violence (SGBV)

Research suggests that the majority of women and girls in Liberia are victims of sexual and gender based violence (SGBV). While rapists were ostracized in the community before the armed conflict, norms about sexual conduct and relationships with women and children have changed, and now it is the women and children who, as victims, are treated as pariahs. The stigmatization and limited services available to victims leave women and girls alone, isolated and traumatized. It is likely that the perpetrators are also traumatized as a result of the war, but in the absence of mental health treatment, traumatic conditions linger and its dynamics are often transmitted to their children.

SGBV and lingering trauma have tremendous implications for the present and future of Liberia. In particular, they raise questions about the country's capacity to have a viable workforce.

6.2.1 Development of SGBV Policy

Researchers have suggested three approaches to mitigating the harm caused by SGBV: (1) increasing access to justice for survivors, (2) providing support and therapeutic services to survivors and perpetrators and (3) preventing SGBV. These categories provide the framework for this policy's recommendations for the mental health of victims and perpetrators of SGBV.

This policy for mental health for victims and perpetrators was also developed in the context of the UN Joint Government Program on SGBV. This is an umbrella program comprised of members from the Ministry of Gender and Development in conjunction with the Ministry of Justice, the Ministry of Health and Social Welfare, the United Nations Development Program, and several NGOs and international charity organizations, is employing a number of strategies to confront the high levels of SGBV in Liberia. This is a comprehensive program with five pillars: 1) Psychosocial; 2) Health; 3) Legal; 4) Security and

Protection; and 5) Coordination of pillars. The policies described below compliment and will help facilitate a number of these goals.

6.2.2 Legal Definition of Rape

The legal definition of rape was redefined with a new Rape Bill enacted into law by the national legislature in January 2006. This law widened the definition of rape to penetration with any foreign object – not just the penis. It also changed the legal definition of a child to include all persons under the age of 18. This was in harmony with the United Nations Convention on the Rights of the Child, and made clear that children under 18 – because of their age – were legally unable to consent to sex. In addition, the law stipulated mandatory life imprisonment for anyone convicted of raping women, girls or boys. This penalty also applies to those involved in gang rape. There are, however, no laws prohibiting domestic violence.

6.2.3 Increase Access to Justice for SGBV

Liberia has two systems of justice – the community and the legal – of which there is currently more trust in the community. Efforts that increase the trust in the legal system in order to safeguard the human rights in the country are necessary.

The legal system is increasing its viability in a number of ways. Liberia has instituted a SGBV Court that is linked to a Crime Unit. These two institutions work together to improve the delivery of judicial services to the women and children who are victims of SGBV in Liberia. The role of the court is to hear and try all SGBV cases in a particular county. In an effort to improve the efficiency and professionalism of police reports and evidence gathering, employees of both the court and the Crime Unit receive specialized, thorough training in SGBV. The defense unit still needs SGBV training.

Because the majority of victims know the perpetrators, the families involved are psychologically impacted. Victims and their families are vulnerable to the constraints of community law, which allows for the negotiation of the grievance between the two families involved. As a result, many cases do not go through the court system because the women or children drop charges.

One consequence of this is that the majority of cases coming in front of the court at this time involve the sexual violence and exploitation of children by pedophiles. In these cases, families find children injured, have them seen medically, and in the process, evade the community system. Family and child treatment in these situations is necessary. In addition, victim support advocates must be provided to support the victim emotionally and to help increase the likelihood that the victim will press charges and not go through the community system.

To provide justice to the women and child victims and to have a serious cultural impact, SGBV courts, and corresponding Crime Units must be expanded to cover additional regions throughout the country.

Relevant coordination and collaboration between the Ministry of Health and Social Welfare and the Women and Children Protection Division of the Ministry of Justice must be adequately established in order to make it a viable institution that truly protects women and children.

6.2.4 Support and Treatment of SGBV

Mental health treatment will be provided according to the severity of symptoms following SGBV. Victims of SGBV who exhibit physical trauma symptoms need both medical treatment and mental health care. While the psychosocial and psycho-educational interventions called for in the Joint Program's Psychosocial Pillar might work well for victims who have low levels of severity in symptoms, those with higher levels of severity need specialized, trained clinicians who use trauma and empowerment based

interventions. Treatment can occur through individual, family or group modalities and may include psychotropic medications. Since the victim and family know the perpetrator in the majority of cases, the entire family is affected, and thus, family treatment might be required along with individual or group treatment for the victim. In collaboration with various ministries, NGOs and other organizations, women and children who are victims of SGBV will be provided safe houses where they can seek shelter. These safe houses require trained personnel who can treat the psychological pain that accompanies rape, and will be expanded to cover the entire country.

Empowerment based interventions have two components: the understanding of power and powerlessness, and the psychological transformation encompassing the development of a critical consciousness, self-efficacy and connection to social networks. The development of *critical consciousness* includes an understanding of how the power distribution in society affects the opportunities and constraints available to individuals, thus influencing their perceptions and experiences. In the case of SGBV, this entails realizing that, in patriarchal systems, women are seen as inferior to men and undeserving of equal treatment. In addition, in post-conflict societies like Liberia, critical consciousness involves understanding how armed conflict leads to militarization manifested in increased violent behavior. The objective of raising critical consciousness is to allow victims to locate the causes of individual guilt and shame in external forces and to facilitate the realization that women are subject to this violence by virtue of being women and not because of individual traits. Achieving a critical consciousness also allows women to know that others are in the same situation leading to a collective strength to mobilize. *Self-efficacy* results from the identification of strengths, skills, and interventions that build on these skills. Interventions that build self-efficacy will start by providing women and children with tasks that have attainable goals. Progressively, the difficulty of tasks increases as women and children gain confidence and mastery. When women and children gain a sense of self-efficacy, they are ready to take on and succeed in opportunities such as micro-enterprise. Lastly, *connection* involves the development of social networks that offer support and leverage, and which can open opportunities for the development of skills; this increases life chances (Gutierrez and Lewis, 1998; Dominguez and Watkins, 2003). Connection also requires finding others who are also victims in order to prevent isolation, decrease individualized guilt and shame, and gain mutual support. Empowerment based interventions have been found effective in addressing mental health problems including trauma, particularly in low-income communities.

Because men and the community ostracize women and children who are victims of rape, it is necessary to provide women with opportunities to support themselves and their children financially. Strategies, such as micro-financing enable women to earn a living. These strategies are empowering and must include access to credit to be sufficiently effective (Dessey and Ewoudou, 2006).

6.2.5 Mandated Services

Mandated services for SGBV perpetrators will be set up systematically throughout the country. These services will vary treatment according to severity of offenses (first time offenders, repeat offenders and multiple offenders). Perpetrators will be required to attend weekly group treatment that lasts several weeks. Only clinicians who are specially trained in SGBV and supervised by clinicians with SGBV expertise will be able to run these programs. Mandated clients need more than attitudinal changes – they need treatment that changes their cognitive processes that lead to violent behavior. SGBV treatment for perpetrators will therefore include psycho-education and cognitive behavioral components.

Perpetrators will be mandated to services upon arrest. Those who violate or receive complaints from the mandated reporting or Codes of Conduct systems must also complete mandated perpetrator services. In addition, any person charged with SGBV and those who are awaiting trial for a SGBV crime at the Monrovia Central prison will receive mandated services. Moreover, since many women do not report SGBV in the family because they do not want to criminalize their partner and lose the partner's breadwinning capacity, mandated services will be available as an alternative to judicial involvement. Failure to comply will result in judicial proceedings or other sanctions.

It should be noted that while some rapists can be treated through psycho-education and cognitive behavioral techniques, others such as pedophiles and those who sexually abuse and exploit children, require distinct forms of mental health treatment.

6.2.6 Forensic Social Workers

Forensic social workers are trained to work with issues intersecting law and mental health. SGBV requires training social workers with the specialized skills required to adequately meet the metal health needs of both victims and perpetrators. Social workers must acquire the clinical skills necessary to work with both mandated and voluntary clients, as well as with women and girls who have been victims of SGBV. These skills include an ability to treat diverse ethnic populations. Social workers trained in forensic mental health will be prepared to work with different types of mandated clients, violent offenders, and their victims, as well as provide services to court-related populations and those in prison.

6.2.7 Forensic Clinic -Training, Research, and Treatment

A long-term goal will be the development of a Forensic Clinic attached to a major teaching hospital. This clinic will act as a forensic unit responsible for teaching, treating, evaluating, and researching the intersection of mental health and law. Initially, this will be a unit attached to the SGBV Courts that will provide expert services for victims and perpetrators. With time, the Forensic Clinic will become part of a state-of-the-art medical training system for social workers, psychologists and psychiatrists.

6.2.8 Preventing SGBV

6.2.9 National Program of Mandated Reporting

The adoption of Codes of Conduct will pave the way for a national and systematic program of mandated reporting affecting all teachers, health professionals and civil service employees. As mandated reporters, individuals will have to report SGBV when they see or became aware of it happening. The status as mandated reporter will be a condition of employment and spelled out in the documents of rules and responsibilities of each profession. Such mandated reporting will carry penalties if not followed.

6.2.10 Codes of Conduct

Codes of Conduct prohibiting SGBV are presently working their way through ministries. These documents lay out the rules of correct behavior across gender in a manner that guarantees the rights of women, children, and men. The codes will be implemented as part of an effort to educate employees about the prohibition against SGBV. Codes of Conduct are an important step in changing norms that devalue women and minors, and make real the possibility of penalties for SGBV violations. Codes of Conduct have so far been developed for teachers, health personnel, and civil service employees. It is imperative that each ministry involved works towards the adoption of the codes, and that the codes become a system of rules and regulations, relevant in all sectors of daily life, with stiff penalties if ignored.

6.2.11 Male Leadership Development and Toll Free Numbers

The Association of Female Lawyers in Liberia, the group that spearheaded the introduction of the SGBV court and crime unit, is also currently identifying and training men to reach out and train other men in their communities on SGBV. The emphasis on men is a necessary component to create a cultural change in normative behaviors that moves away from violence against women and children. This association has also introduced a Toll Free Number for sexually abused women and children. Accessing this number

provides contact with services, such as free legal representation. Both interventions are vital to the prevention and treatment of SGBV and will be expanded beyond Monrovia to the rest of Liberia.

6.2.12 School Safety Zones and Zero Tolerance

In line with the Joint Program's pillar on Security and Protection, this mental health policy calls for the development of safety zones in schools. These safety zones are essential, given the fact that teachers are among the top three sexual abusers, and that girls require safety in order to remain in school. Failure to attend to this issue will result in the failure of all other educational policy.

Furthermore, Gender Clubs, Children Clubs, Theater Clubs, Art Clubs, and other similar groups, which NGOs have established for children in certain areas, will continue and expand, as they can lead to the development of skills in the school setting. The Children Clubs, for instance, offer activities, such as work plans for safety, which are devised individually for each child. This is an example of an intervention that increases self-efficacy. Moreover, the School Clubs link to Community Clubs, whose members are trained to be advocates for the safety and health of children in the community. In turn, these community groups are linked to Child Protection Committees, which are made up of adults trained in child-appropriate conduct; they provide a safety net and protection, and act as a reporting mechanism for the children in that community. All participants engaged with this model receive training on how to behave with children in respectful ways that observe safety and integrity. This is paramount since groups of adults with access to children can attract pedophiles. Therefore, adult groups need to be carefully trained and monitored in an effort to eliminate potential for child abuse.

The Global Fund, through the Ministry of Education, provides an additional initiative in the schools. This initiative entails the provision of Health Clubs focused on social studies and science with a life skills curriculum. Unfortunately, these are only in selected communities, offer no mechanism for reporting and are not linked beyond the school. These components, if integrated, will make this initiative more effective.

Liberia will work towards the establishment of Zero Tolerance policy on the violations of human rights, including rape and sexual exploitation in schools. Teachers who perpetrate against children will be arrested and punished accordingly. Research suggests that when perpetrating teachers are sanctioned for breaking the law, the climate in the schools improve and creates safety. Interventions will create safety zones in schools and surrounding communities, provide the development of skills, and offer a reporting mechanism. These types of interventions are vital to the prevention and treatment of SGBV, and to the preparation and education of Liberia's future. It is imperative that government ministries, through national policy, implement them.

6.2.13 Victim Assistance Mechanisms

The Victim Assistance Mechanism protocols were established in other countries in response to the high level of SGBV committed against women and children by NGO and UN-related personnel. The protocols are developed according to specific locality and services available, and ensure psychological care, education and housing for victims. While these have yet to be developed in Liberia, once in place, they can serve as a model way to deal with victims of SGBV. This model should become a standard for all SGBV victims in Liberia, and not only those whose perpetrators are NGO or UN personnel.

6.2.14 Standardizing Forms that Identify SGBV

The Ministry of Health and Social Welfare developed a standardized medical form that is part of medical intake and that identifies victims of SGBV. These forms are being piloted at the present time, but should be adapted by all health care settings nationally. It is imperative that the capacity of mental health personnel is expanded so that a referral can be made when sexual and gender based abuse is identified.

Collection of sensitive information related to a traumatic event like SGBV will never be done in the absence of psychological referral sources.

6.2.15 Self Care for those Caring for SGBV Victims

When individuals meet with victims of trauma and hear their stories, they may eventually suffer from "vicarious traumatization" or secondary trauma. Systems of support and supervision will be instituted for those who hear traumatic stories as part of their job. Through self-care, such professionals can work for extended amounts of time without burnout and be more productive in their role.

6.3 The Severely Mentally Ill

6.3.1 Care for the Severely Mentally Ill

Proper treatment will be provided for the care of the severely mentally ill based on best practices. Consistent with a decentralized approach to mental health care and in consonance with the Basic Package of Health Services, the treatment of severe mental illness (SMI) will take place, when possible, at the health clinics and health centers. This will allow care to be delivered as close to a patient's home and community as possible. It is also in harmony with evidence-based research that demonstrates the cost-effectiveness and positive health outcomes of managing chronic mental illness in a community setting.

Treatment at health clinics and health centers must be utilized, when appropriate, before inpatient care is sought in county hospital Wellness Units or tertiary facilities. Referral of SMI to the Mental Health Hospital or the future inpatient unit at the general hospital should only occur once all other resources have been deemed ineffective or unsuitable. Concern for the safety of the patient or concern for the safety of others should be considered when making this decision. Referral to the Mental Health Hospital should be made when community settings cannot guarantee safety. Referral should also be made during acute emergencies, such as uncontrollable psychosis and agitation, or suicidal or homicidal ideation, which warrant urgent inpatient hospitalization.

In addition, the MOHSW will collaborate with the JFK Hospital for the reestablishment of the Catherine Mills Rehabilitation Center to serve as a national tertiary teaching and referral facility.

In regard to the staff required to treat the SMI, estimates place human resource requirements to treat schizophrenia, bipolar affective disorder, depressive episode and substance abuse at .5 psychiatrists and 1.0 psychologist per 100,000 population, 2.0 psychiatric nurses per 100,000 population, and 2.5 community health workers for severe mental disorders for middle-income countries (Chisolm et al, 2007). These targets are not attainable in Liberia at the present time. However, a minimal attainable level shall be set within the period of this document.

6.3.2 Goals of Treatment of SMI

Treatment for the SMI should have three goals: (1) reduce or eliminate symptoms, (2) maximize quality of life and adaptive functioning, and (3) promote and maintain recovery from the debilitating effects of illness to the maximum extent possible. An accurate diagnosis is critical for short- and long-term treatment planning. It is also important to note that diagnosis is a process rather than a one-time event. Once a diagnosis has been established, it is critical to identify the targets of each treatment, to have outcome measures that gauge the effect of treatment, and to have realistic expectations about the degrees of improvement that constitutes successful treatment. For example, targets of treatment may include psychotic symptoms, depression, suicidal ideation and behaviors, substance use disorders, medical co morbidities, PTSD, and a range of community adjustment problems, such as homelessness, social isolation, unemployment, victimization, and involvement in the criminal justice system.

The goals of treatment during an acute emergency may be to prevent harm, control disturbed behavior, reduce the severity of psychosis and associated symptoms (e.g. agitation, aggression, negative symptoms, and affective symptoms), return to the best level of functioning at rapid speed, develop an alliance with the patient and family, formulate short- and long-term treatment plans, and connect the patient with appropriate aftercare in the community. Efforts to engage and collaborate with family members and other natural caregivers are often successful during the acute crisis.

It is recommended that every patient's initial evaluation be as thorough as his or her clinical status allows. This includes obtaining complete psychiatric and general medical histories, and physical and mental status examinations. It is important to pay special attention to the presence of suicidal potential and command hallucinations, and to take precautions whenever there is any question about a patient's suicidal intent; prior suicide attempts, current depressed mood, and suicidal ideation can be predictive of a subsequent suicide attempt in schizophrenia. Similar evaluations are recommended in considering the likelihood of dangerous or aggressive behavior and whether the person will harm someone else or engage in other forms of violence.

6.3.3 Providing Patient and Family Education and Therapies

Working with patients to recognize early symptoms of relapse will help result in preventing full-blown illness exacerbations. Family education about the nature of the illness and coping strategies can markedly diminish relapses and improve quality of life for patients. The interventions that have been shown to be effective involve face-to-face interactions in individual or group sessions.

6.3.4 Attending to the Patient's Social Circumstances and Functioning

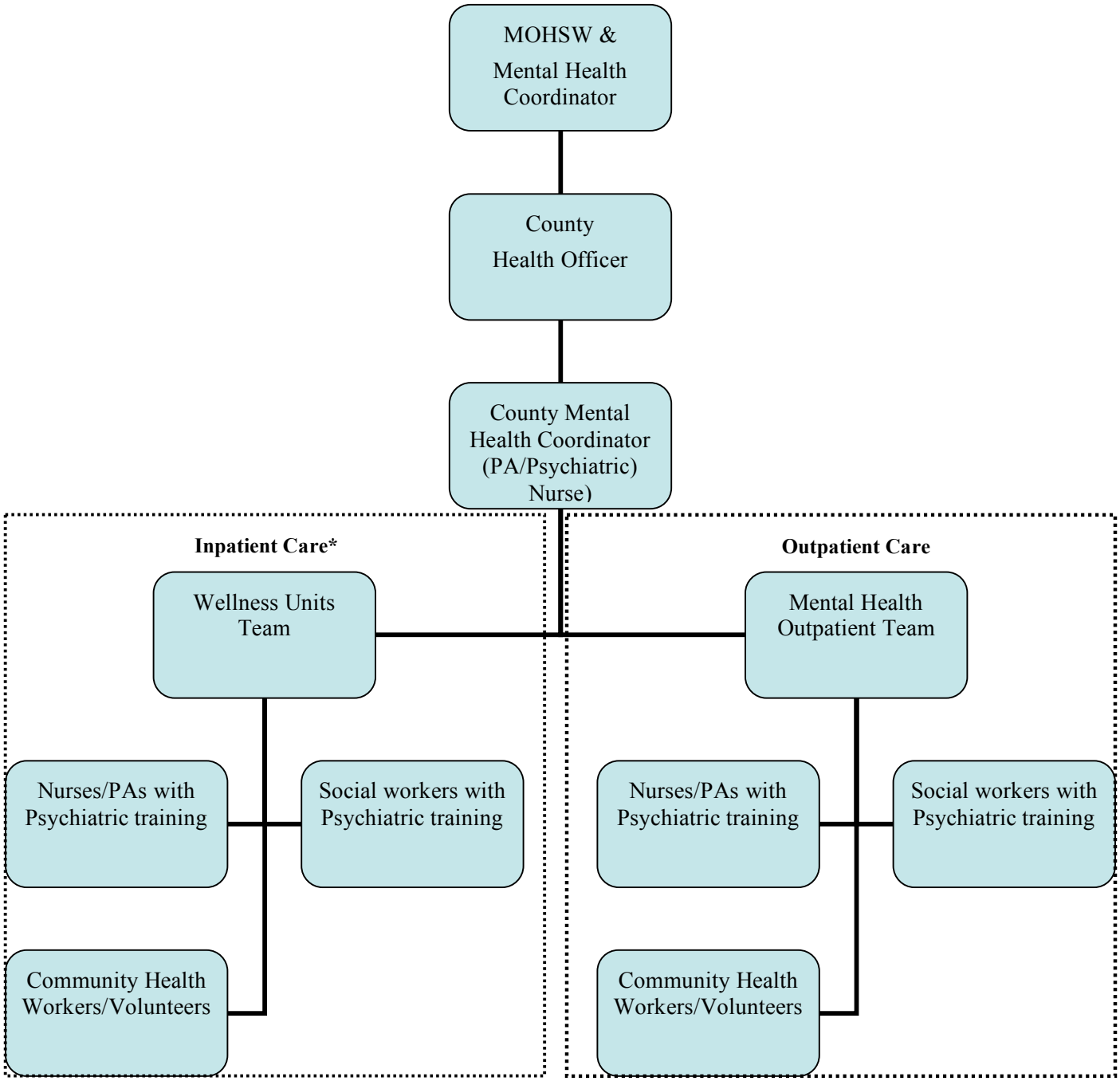
The social circumstances and functioning of the patient can have profound effects on adherence and response to treatment. The patient's living situation, family involvement, sources and amount of income, legal status, and relationships with significant others (including children) can produce both stress and be protective; thus, all are areas where periodic exploration by mental health care clinicians is warranted. A frequently neglected aspect of social assessment is the parenting role of patients with children.

6.3.5 Patient and Self-help Treatment Organizations

Peer support is social-emotional and sometimes instrumental support that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition. It is used to bring about a desired social or personal change. The oldest and most widely available type of peer support is self-help groups. Based largely on uncontrolled studies of self-help groups for persons with severe mental illness, Davidson et al. (1976) concluded that self-help groups seem to improve symptoms and increase participants' social networks and quality of life. Additional studies of self-help groups have demonstrated other positive outcomes, including reduced hospitalization rates, improved coping, greater acceptance of the illness, improved medication and illness management, improved daily functioning, lower levels of worry, and higher satisfaction with health.

7.0 ORGANIZATIONAL FRAMEWORK

Figure 1: Organizational



***Wellness Unit Team members will also provide some outpatient care in both the county hospitals and nearby health clinics and health centers.**

7.1 Coordination of the Mental Health System

After many years of conflict, the mental health system in Liberia is not formally organized or managed. The system's current state must be examined so that a network of well-organized structures and services can be implemented. This network will enhance communication between various units in the system and will improve mental health services. Below is a proposed basic organizational framework that has been contextualized to the present situation in the country.

In addition to the Ministry levels, the MOHSW has also formed a National Mental Health Task Force to support and advise the Minister. This task force consists of governmental and non-governmental individuals and organizations, and will be expanded to include relevant ministries and agencies. The MOHSW will routinely review its mandate and terms of reference so it is appropriate to the mental health situation.

7.1.1 National Level

Staff Required:

A National Mental Health Coordinator to guide, direct and supervise the overall development of the mental health program. The Assistant Minister of Health for Preventive Services will oversee this position. The coordinator will collaborate with other experts to formulate principles as a base for quality indicators.

Tasks:

- Develop evidence-based quality indicators
- Promote the use of indicators
- Remain informed about the quality indicator efforts of other organizations (NGOs)
- Maintain liaisons with appropriate components and staff
- Maintain on-going liaisons with representatives of allied organizations
- Review and comment on proposed quality indicators of other groups
- Highlight trends and policy areas requiring further attention

Functions:

The MOHSW will develop norms and standards for the mental health component of the BPHS, including treatment protocols for psychosis, depression, PTSD, and epilepsy. There exists a significant variation in the quality and content of standards of care among many organizations. *The office of the Mental Health Coordinator will oversee these standards by providing visits to facilities and programs on a quarterly basis. Each organization must meet the minimal standards as outlined by the MOHSW.*

7.1.2 Central Level (MOHSW)

Staff required

A multidisciplinary team of part-time and full-time professionals and para-professionals will oversee central coordination in the interim period. Consideration will be given to public health physicians, psychiatric nurses, social workers and other professionals trained in basic psychiatric or mental health care.

Tasks

- Revise and update mental health policies, plans, and legislation as necessary to meet the evolving

needs of the population.

- Prepare and review mental health related medications on the Ministry's Essential List of Drugs.
- Ensure that essential psychotropic drugs are available in all counties.
- Prepare a budget for the mental health system and mental health services.
- Develop guidelines and tools for mental health data collection.
- Develop monthly reporting forms and prepare annual report on mental health.

Functions

- Ensure that there are adequate numbers of mental health professionals to meet the mental health needs of the country.
- Ensure capacity building and regular continuing mental health education.
- Implement and supervise community-based mental health programs.
- Ensure that mental health is integrated into primary health care.
- Liaise with other ministries and sectors to coordinate mental health activities in the country.
- Monitor and evaluate mental health facilities, services, and other relevant activities in the country.
- Monitor implementation of this policy and subsequent strategic plan.

7.1.3 County Level

Staff Required

At least one County Mental Health Promotion Officer, preferably a psychiatric nurse or a registered nurse, who has completed basic psychiatric training courses.

Tasks

- Collect mental health related data for monthly reporting.
- Ensure that a sufficient supply of drugs is available for distribution to health facilities.
- Promote mental health through education and public awareness activities, life skills training, etc.

Functions

- Liaise with health facilities within other counties to ensure parity in resources and services.
- Ensure that there is continuous mental health education among health providers.

7.1.4 Health Facility Level

Staff Required

General practitioners and nurses who are trained in the diagnosis and treatment of basic psychiatric and mental health disorders

Tasks:

- Provide screening for mental health disorders in patients
- Provide mental health assessments
- Diagnose and treat common mental health disorders

Functions:

- Functions as the frontline treatment team within the health facilities for diagnosing and treating common mental illness
- Provides mental health education to patients, families and communities

7.1.5 Community Level

Staff Required

Community health workers or volunteers to work within the community and coordinate with the health facilities.

Tasks:

- Provide screening for mental health disorders in the community
- Provide home visits
- Provide mental health education for patients, families and communities
- Monitor compliance with medication regimens
- Monitor side effects
- Monitor for early signs of relapse and make quick referrals when necessary
- First aid management of violence and aggression

Functions:

- Provides outreach to patients and families to ensure effective treatment
- Provides mental health education to patients and families and helps to reduce stigma within the community

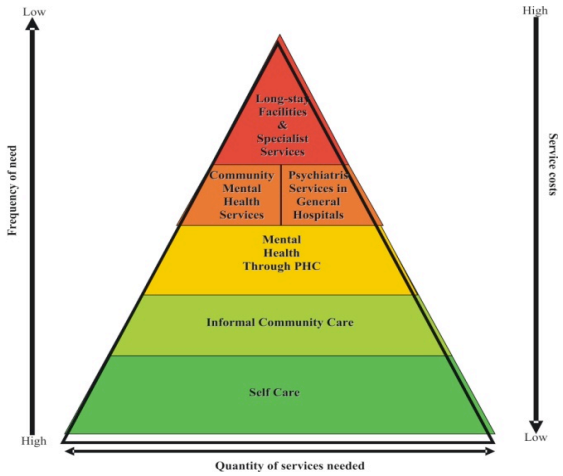
7.2 Pillars of Mental Health Services: the WHO Optimal Mix of Services

The Government of Liberia is committed to providing cost-effective and efficient mental health services to the general population through a system of care proposed by the World Health Organization entitled "Optimal Mix of Services." This is a broad based, integrative system of services based on best practices and principles, and that caters to the diverse mental health needs of the society.

This multi-tiered system of services is consistent with the three-tiered system of care outlined earlier in this policy (primary, secondary and tertiary). It also focuses on the roles that individuals can play in the prevention of mental illness; that if provided with relevant information, they can make informed decisions about their lives and ultimately minimize risks. In addition, it incorporates how traditional healers, teachers and other non-health professionals can participate and assist in the mental health program.

The five-tiered pyramidal structure below is a representation of the "Optimal Mix of Services."

Figure 2: WHO Optimal Mix of Services



7.2.1 Pillar I: Self Care

Services will be geared toward the provision of education to individuals about mental illness and the risks involved in mental illness. All informal community structures will be utilized.

It will seek to assist individuals in making informed decisions relative to the various risks. This will help to minimize contact with situations likely to negatively impact their mental health and well being.

Services will be geared toward helping individuals identify and manage stressors in their lives and to make appropriate decisions about when to seek further help.

7.2.2 Pillar II: Informal Community Mental Health Services

Services offered by the informal health sectors will be encouraged and supported.

Teachers will be educated, so they can provide social skills training and rudimentary counseling in their schools.

Traditional healers, who account for a significant extent of mental health care, will be trained to improve their skills and services.

Local and international NGOs will be encouraged to provide mental health and psychosocial interventions in an improved, organized and standardized manner.

Involvement of Churches and other social organizations will be encouraged.

7.2.3 Pillar III: Mental Health Services through Primary Health Care

Primary health care will be an important avenue thorough which mental health services will be accessed. This will represent the first formal portal of entry for mental health care.

Mental health will be provided in the short-term by psychiatric nurses, physician assistants, nurses, doctors and other health workers working in the primary health care system. As described in the later part of this section, care will ultimately be provided by psychiatrists and other highly trained mental health professionals.

Early identification, provision of initial treatment and management based on appropriate levels of expertise, and referrals when required to other levels of care, will form the basis of this service.

The above multi-tiered approach is consistent with the National Health Policy 2007-2010 and with the Basic Package of Health Services described therein. It recognizes the potential for impact by appreciating individual action oriented decisions and the role of the informal sector.

7.2.4 Pillar IV: Community Mental Health Services and Provision of Psychiatric Services in County Hospitals and General Hospital.

Health clinics and health centers will provide psychiatric treatment and psychosocial counseling, and support those requiring such services.

These centers will liaise with county hospitals, which offer acute inpatient psychiatric services, crisis intervention and liaison psychiatric services, and the inpatient until at the country's tertiary facility.

7.2.5 Pillar V: Mental Hospital and Specialist Services

The development of large psychiatric hospitals will be discouraged. They are expensive to manage and encourage institutionalization, which leads to prolonged disability and dependency.

Small, specialized units within general hospitals will provide necessary backup for county hospitals and other community-based services. They are essential facilities for training in psychiatric assessment, management and treatment.

7.3 Mental Health Financing

As a result of competing priorities, mental health has received scant attention in the development of national programs, especially in developing countries. In most of these resource-poor areas, allocations for general health care are extremely inadequate, thereby relegating mental health to an even more dismal status.

With the development of more research driven data on the impact of mental health problems on physical health and the close association between mental health and well being on heart disease, diabetes, hypertension and other conditions, including the available data on the Global Burden of Disease and disability-adjusted life-years, it has become imperative to ensure that mental health financing is an integral part of general health financing. Adequate mental health financing is even more pressing given Liberia's post-conflict status.

It is increasingly evident that when adequate mental health services are available, not only are there reductions in the general costs of physical health care, but there is also increased productivity and decreased demand on the criminal justice system.

As stated in the National Health Policy, the Government of Liberia is committed to financing health care at the highest level compatible with its revenues, taking into consideration competing priorities. While the Government will strive to apportion a greater share of its revenue towards health in general, the Ministry of Health and Social Welfare, at the same time, is committed to progressively and significantly increasing the amount of its budget apportioned for mental health to not less than 10% of the health budget within the next four years, thereby reflecting present realities. Additionally, other sources of funding including the "pool fund" will be accessed and utilized for mental health purposes.

The Liberian Government, realizing the potentially beneficial returns of a significant investment in mental health services, will provide mandatory coverage for mental health through a variety of revenue generating systems.

7.4 Human Resources and Training

The need for training at all levels cannot be overemphasized. The short-term goals will be to train existing providers to deliver care for the mentally ill. The long-term goal, however, will be to develop well-trained psychiatrists, psychologists, master-level psychiatric nurses, and master-level and clinical social workers. They will assume the care for the mentally ill.

Reliance on non-specialized health workers to implement certain clinical services usually reserved for more qualified health workers should be looked upon as an ***interim measure*** *during which time emphasis will be placed on the* ***training*** *of more qualified health workers to implement certain highly skilled services requiring more advanced training. The use of nurses to prescribe certain psychotropic medication should be viewed in this light.*

7.5 Human Resource Development

In order to implement an effective mental health program, a system of training of all cadres of health workers in the diagnosis and management of mental disorders at their level of functioning and expertise is fundamental and vital. A number of evidence-based studies have shown that those in the primary health system, with the proper training, assistance and supervision, can identify, diagnose and treat those suffering from mental disorders. The Ministry of Health and Social Welfare will therefore provide the opportunities for strengthening the capacity of health workers in this regard. It will also ensure the training and recruitment of a core group of essential mental health experts who will be involved in training and capacity building, and who will serve as resources for referral and tertiary support.

The MOHSW will develop protocols and guidelines for all levels of care to ensure standardization and quality of services throughout the system.

The MOHSW will liaise with the various professional boards to develop standardized curricula for training of all levels and categories of persons involved in mental health activities. The boards will oversee the development of the training standards, while the MOSHW will monitor this process. The boards will build a network of psychiatrists, psychiatric nurses, psychologists, and other mental health workers, and invite foreign experts to qualify Liberian staff in the country.

The MOHSW will support the development of standardized nomenclature relevant to mental health workers in Liberia, which will guarantee consistency with international standards of practice. It will ensure the development of relevant credentialing and licensing systems that will be competency-based. It will also collaborate with the Ministry of Education and other training institutions in the development of procedures and systems related to the proper accreditation of organizations and institutions involved in mental health related training programs.

Psychiatric training programs, standardization of curricula and teaching methods, evaluation of training, licensing and defining the roles of institutions are all areas that need improvement. Many countries have either no training facilities or only a number of providers trained each year (Atlas: Psychiatric Education and training across the world, 2005). Liberia is no exception. The MOHSW will ensure the development of national guidelines and strong professional leadership to strengthen psychiatric training. The Liberian Medical Board and other professional health related boards and institutions will assist with curriculum development, help maintain the quality of programs and provide expert opinions on guidelines. They also will build a network of psychiatrists, other mental health practitioners and specialists, and support workshops, seminars, continued medical education. Saracoma et al (2007) underscored that general primary health care workers with basic mental health education can be only effective if they have good training and close supervision by mental health specialists.

The MOHSW will designate funds explicitly for training the existing and future mental health workforce.

7.5.1 Psychiatry Residency Training Program

A residency-training program will be established to increase the number of psychiatrists in the country. This is of paramount importance.

An effective model for the creation of a psychiatry residency has already been developed, and proved successful in a resource-poor setting. This model may serve as a framework for the program in Liberia. It involves gathering teams of two psychiatrists and one psychiatry resident from a country with a highly developed mental health system. This team would provide clinical supervision for local psychiatric

residents. Initially, there could be three trips per year in which the team visits Liberia. Each trip would focus on a topic determined by the local curriculum. The first graduates of the psychiatry residency could subsequently join the faculty of psychiatry at the medical school. The number of trips could be ultimately reduced to two per year. A one-year fellowship could also be offered in the exchange country for a local Liberian junior faculty member (Teshima 2008). This model will have to be adapted to conditions in Liberia as there were already several psychiatrists in the countries where this model has been previously applied.

7.6 Establishment of a Liberian Center of Excellence for Community Mental Health

The Ministry of Health and Social Welfare will establish a Center of Excellence for Community Mental Health. The aim of this center will be to serve as the major repository of cultural- and evidence-based knowledge and practices that can assist in the implementation and further development of this National Mental Health Policy. Its focus will be to work in partnership with the MOHSW to help plan and implement all policy recommendations in a culturally competent way. It will train future leaders from Liberia and surrounding countries. It will need, in the onset, two experts in psychiatry and primary care who have backgrounds in public health and a supporting administrative staff.

Initial projects of the Center of Excellence will be to (1) assist in the development and training of the new and expanded mental health workforce, (2) help in the establishment of licensing and credentialing standards for the new and current workforce, (3) aid in the development and implementation of a national mental health monitoring system, and (4) establish a national website and reference library readily available to all health care practitioners and consumers. The Center of Excellence will be obligated to provide national state-of-the-art knowledge on mental health care. The latter can be achieved by forming a liaison with other international Centers of Excellence.

A Center of Excellence will be critical for the development of a Psychiatry Residency Training Program. This is of utmost significance as it is psychiatrists who will improve the quality of care and the expertise in the treatment of mental illness. A Center of Excellence can be characterized by the following components:

- A highly trained professional staff with the requisite skills and knowledge to provide state-of-the-art services.
- A national center for training, supervision, research, technical assistance, and the dissemination of science- and culture-based knowledge and practices. It will collaborate with local NGOs, a policy-planning group, the Ministry of Health and Social Welfare, and hospital and training institutions.
- It will offer training in clinical care and research; local and international faculty will transfer skills for state-of-the-art clinical care, education, and research to key Liberian faculty across disciplines.
- Staff will receive training by experts so they can provide optimal clinical care, help establish excellent standards of clinical care and become the expert trainers of psychiatrists, PAs, nurses and other healthcare workers in Liberia.
- It will establish a website and electronic reference library that is readily available to all healthcare practitioners.
- The Mental Health Coordinator within the MOHSW will collaborate with academic institutions to develop the assessment for training needs, and training initiatives of all levels of health workers. This includes physicians, PAs, nurses, midwives, social workers, occupational therapist and community health workers. Models of mental health care and substance abuse prevention within the training curriculum of these professional schools should be integrated.

- A curriculum for the medical school and a psychiatry residency-training program involving collaboration with clinical training sites (inpatients and outpatients) should be developed.

7.6.1 Establishment of a Mental Health Research Unit at the Center of Excellence

- **Initial Research:** mental illness prevalence and the meaning of the best practices of mental healthcare within the regions of the country.
- **Qualitative Research**: Testing definitions, experiential findings, and case series for hypothesis generation.
- **Quantitative Research**: Prevalence studies, review of best practices and evidence-based services research, clinical outcome studies, educational studies, child development and resiliency enhancement studies, trauma recovery studies, case-control studies, and randomized clinical trials.
- **Guidelines and Protocol Development Consultation** (bi-directional process with Liberian stakeholders): Work with Mental Health Task Force to develop guidelines and protocols based on research available and make them living documents susceptible to new data from research collaboration above. Training on research methods, design of studies, and ethical conduct of research and protection of human subjects is necessary.

7.7 Certification and Licensing

International and local mental health programs will be officially evaluated and certified by the MOHSW in order to operate or practice mental health care in the country. Professional, paraprofessional, and volunteer standards need to be established by the MOHSW for all programs currently functioning and for all new programs prior to their start-up. The licensing and certificate team of the Liberian MOHSW can include members from in-country organizations and the new Center of Excellence. All programs will also agree to participate in the new national monitoring system. Licensing criteria will need to be established by the respective professional boards.

Since building mental health capacity is an essential element of the new Mental Health Policy, the standards of training of new practitioner groups, e.g., community mental health workers, will need to be established. Priority will be set on training general community health volunteers, social workers, nurses, PAs and physicians in the primary health care system in health clinics, centers, and the new hospital inpatient units. Liberian and international groups will collaborate to develop a standardized culture- and evidence-based training curriculum for Liberia based on a "train-the-trainers" model. The MOHSW has initiated a train-the-trainers initiative for rebuilding basic health services, including mental health. Ongoing supervision of the new trainees and trainers is a significant element of any capacity building component of mental health trainings so that transfer of skills and knowledge is sustainable. To date, many training approaches and models do not produce qualified professional and paraprofessional staff. The monitoring and ongoing evaluation of training results is essential.

As the new mental health capacity in Liberia grows, ongoing medical and mental health education courses can be added as needed by the Center of Excellence and the qualified mental health groups with a focus on training in local areas. All trainings of new mental health professionals and paraprofessionals will need a certificate from the MOHSW that guarantees the trainer has obtained an adequate level of knowledge and skills, and is ready to practice effectively and ethically in the new mental health system. This certification will ensure the trainees' official recognition by the MOHSW, legitimate access to pay, and professional/paraprofessional support as defined by the Ministry.

Collaboration with the Liberian Board of Nursing and Midwifery, Board of Medicine, and Boards for Social Work and occupational therapy will ensure national standards are adhered to. As recommended for nursing in the Assessment of Health Training Institutions in Liberia, the board authority should be enhanced and supported by the MOHSW so that as training improves, the licensing of professionals will

be uniform. Additionally, curriculum needs to be reviewed and aligned with the National Mental Health Policy at each level of service delivery.

7.8 Monitoring and Evaluation of Programs

Monitoring and evaluation are key elements of any functional program. Adequate and systematic monitoring and evaluation ensures data proven information gathering and, in addition, forms the basis for informed decision making thereby ensuring sustainable and quality services. A system of basic mental health data needs to be developed by the Liberian MOHSW. While treated prevalence does not reveal the prevalence of a specific disease or illness, the monitoring of mental health service consumers can indicate to a government health ministry (1) what type of patient is successfully receiving mental health care, (2) the relative degree of use of the integrated holistic system of mental health care in the community, and (3) manpower and resource needs. The new mental health data monitoring system will be tied to current government efforts to collect data on infectious diseases, infant mortality, and sexual abuse.

A basic mental health survey at minimum will need to collect information from all potential mental health environments, private and public, including health clinics, health centers, and provincial general hospitals, as well as peace and forensic units where completed/attempted suicides and rape and sexual abuse cases can be identified.

The Ministry will ensure the development of a standardized system of data collection and analysis, and train the relevant personnel thereby enabling proper utilization of forms and reporting information. It will specify a defined list of statistics to monitor.

The Ministry will support the integration of this system into the existing health information system. The central level will receive data on a monthly basis from the county hospital and clinics as well as quarterly reports on services rendered, and key standardized information. Mental health indicators will be added to the other health indicator used in the National Health Plan.

A simple monitoring survey will include at least:

1) Basic demography: age, gender, tribal status, town, county, etc.
2) Identification of type of health/mental health setting, e.g., health, police, or forensic
3) ICD-10 mental health diagnoses
4) Indicators of rape/sexual violence and/or suicide attempts/completed suicides
5) Use and type of psychotropic drugs
6) Employment and/or school status
7) Nutritional and housing status (e.g., malnutrition, homeless)

National suicide rates will be collected by requiring police and health authorities to report incidents. Depression and psychosis prevalence rates will be based upon unduplicated counts of patients in treatment for depression and psychosis in the primary health system. The monitoring of psychotropic drugs used yearly will be included in the "stuck-out" rates of essential drugs.

All these areas will need to be closely defined. The MOHSW should develop and implement a mental health client monitoring system that is similar to those being developed in other African nations.

7.9 Research

The Ministry of Health and Social Welfare in collaboration with partners will seek to secure the necessary funding for the undertaking of research relevant to mental health in Liberia.

Relevant procedures for obtaining clearance for the conduct of research will conform to the guidelines

and procedures established by the MOHSW. These guidelines and procedures will be strengthened thereby making them consistent with international standards especially where human subjects are involved. Relevant review boards will be formulated and instituted as part of the clearance procedure. Notwithstanding the constraints in a developing country, in a population with low levels of literacy and education, the quality of informed consent is critical for establishing acceptable standards for public health research. Research will comply with the standards outlined in the Belmont report, adopted worldwide, for the ethical conduct of research.

Research in the first stage of primary health care development needs to focus on developing standardized, valid program evaluation tools and technologies, so each health clinic, health center and county hospital can monitor its efficiency and outcomes. Once this has been achieved, randomized trials can establish the relative cost and clinic effectiveness of various treatments including indigenous and community traditional healing.

In addition, early research from the general hospital unit will focus on recidivism. The first priority for scientific research will be on the cultural, social, and psychosocial risks factors that reduce recidivism and maximize the quality of life.

7.10 Infrastructure Needs

Because the mental health program will be an integrative program, the need for new infrastructure and massive infrastructural spending will be limited and curtailed. It is important, however, to realize that although the primary health care approach is the most effective means of delivering health services, including mental health care, this approach in isolation of other supporting structures is insufficient in meeting the mental health needs of the society.

As is indicated in Pillar IV of the WHO's Optimal Mix of Service, the MOHSW will support the development and establishment of community-based services in collaboration with stakeholders involved in mental health services. This type of service will complement the other existing services in providing support to those in need. The referral will be available at the community level up to all other levels of care. Walk in and referral services are not new to Liberia. The Catherine Mills Rehabilitation Hospital operated such a service in the past, which made a substantial contribution to the community. In addition, the Government of Liberia, through the MOHSW, will support the development of small regional tertiary facilities with capacity of not more than 15 to 20 beds thereby catering to those individuals with special needs that cannot be adequately met with existing facilities.

7.11 Basic Package of Health Services

The Government of Liberia has developed a Basic Package of Health Services (BPHS) thereby ensuring that a standard set of prevention, treatment and rehabilitative services are provided in a consistent and coordinated manner throughout the health service delivery system.

The Mental Health program outlined in this policy will be integrated into the BPHS thereby ensuring a comprehensive and holistic approach to health care delivery in Liberia. The BPHS will be expanded to be consistent with the newly adopted staff for this mental health program.

The table below is a modified version of the one found in the BPHS. It denotes where interventions and services will be provided

Table 5: Interventions and Services

INTERVENTIONS AND SERVICES PROVIDED	Clinic	Health Center	County Hospital
Danger signs of acute mental illness. Acute Management and Referral.	Yes	Yes	Yes
Injury from domestic or other interpersonal violence. Provide care and initial counseling. Document injuries. Counsel attacker.	Yes	Yes	Yes
Anxiety or depressive state. Counsel. Refer to family or community resources.	Yes	Yes	Yes
Psychosis, acute treatment	No	No	Yes
Psychosis, chronic treatment	Yes	Yes	Yes
Psychosomatic symptoms: recognize, counsel, and refer as appropriate.	Yes	Yes	Yes
Substance abuse: Counsel and refer to support person.	Yes	Yes	Yes
Substance Abuse Detoxification	No	No	Yes
Maintain register of people on long-term medication for mental health condition or epilepsy. Arrange supply of psychotropic drugs.	Yes	Yes	Yes
Supervise and supply medications for persons on long-term medication for mental health condition or epilepsy.	Yes	Yes	Yes
Psychosocial counseling	Yes	Yes	Yes
Psychotherapeutic medication	Yes	Yes	Yes
Medicines used in psychiatric disorders (maintenance)	Yes	Yes	Yes
Medicines used in depressive disorders (maintenance)	Yes	Yes	Yes

7.12 Information, Education, Communication and Advocacy

Provision of adequate information and education of the general population about various aspects of mental health will be encouraged and supported. Special focus will be on targeting young people in their various localities – schools, churches, and youth organizations. Psychosocial skills training will be provided thereby improving their social interactions in society.

Targeted messages for street children, war affected persons, ex-combatants and the population at large will be developed utilizing a variety of media and innovative ideas in the dissemination of these messages.

Advocacy is the most effective and efficient way to create change in any society. The Ministry of Health, through its advocacy program, will seek to promote the rights and needs of those with mental illnesses and to reduce the stigma associated with it. All levels of advocacy will be encouraged and supported utilizing all human resources, organizations and groupings.

Mental health awareness programs are essential for community psychiatric services in the developing

world (Jacob, et al 2001). The use of radio and TV can be helpful to reduce stigma and increase education about disorders and treatments among populations with high rates of illiteracy (Jacob, et at 2001).

Eaton et al (2008) found in Nigeria that a grass-roots level mental health awareness program was responsible for approximately half of the dramatic surge of new referrals of new mental health cases at community clinics. The four-year program was carried out by the Nigerian government and an NGO, Amaudo Itumbauzo. The program trained 2310 existing village based health workers (VHW), who had been active in other primary health care programs. These volunteers were respected community members, literate and knowledgeable about local beliefs and cultures. Clinic psychiatric nurses and primary health care coordinators conducted the VHW training. It included detailing clinic locations, opening days, referral systems and costs.

7.13 Psychiatric Drugs

Essential drugs are not readily available in the country. The Ministry of Health and Social Welfare will support the revision of the essential drugs list to include psychotropic substances required for utilization by the program. Treatment guidelines are needed for clinicians to safely and effectively prescribe these medications. The MOHSW will determine the drugs that may be prescribed at the various levels of care including the cadre of workers who may prescribe the various classes of drugs. This will be done in line with the standardized protocols that will be developed.

The supply chain will be integrated into the institutional and structural arrangements within the MOHSW as outlined in the National Drug Policy thereby ensuring not only the sustainability of drugs but also the availability of drugs when and where required. The availability of appropriate psychotropic and psychiatric medications is critical for the country. This will be an ongoing process that will be frequently evaluated as the research agenda unfolds and data becomes available. However, as there is some overlap with Liberians and African Americans, the MOHSW can for now rely on data from this population to inform best practices—an initial identification of salient drugs could occur as early as 2009. The development, update, and refinement of this drug list could last for the duration of the mental health program.

There will also be a revision of the list of available psychotropic medications. Many of the old drugs are dangerous – lethal in overdose – and will be used cautiously. Many newer psychotropic drugs (antidepressants and antipsychotic) are now available in generic form. These medications have been found to be safer, better tolerated, and easier to use. Studies suggest that they are also cost effective and may improve adherence. Additionally, because of their dosing, patients are more likely to receive therapeutic doses compared to older medications (such as amitriptyline). In one study, for example, fluoxetine, an affordable antidepressant, proved to be effective in treating depression in a district hospital used by people of low socioeconomic status because it generated quick recovery and lead to savings in cost (Patel, et al 2007).

The recommended dose is that which is both effective and not likely to cause side effects that are subjectively difficult to tolerate, since the experience of unpleasant side effects may impact long-term adherence. It is recommended that in Liberia, the starting doses be 50% of what is recommended in western countries. The dose may be titrated as tolerated to the targeted therapeutic dose.

The framework to manage and coordinate the pharmaceutical sector in Liberia is contained in the National Drug Policy. The pharmaceutical support to the delivery of local mental health services will be aided by the MOHSW's proposed posting of pharmacists to county health teams throughout the country. It is assumed that these pharmacists will inspect, monitor, and support the use of psychotropic drugs at the local level. The MOHSW will guarantee that all Liberian pharmacists have specialized training in the correct prescribing and dispensing practices of all essential psychiatric drugs. Pharmacists should report

to the MOHSW about drug utilization and make recommendations about whether specific psychiatric drugs can be eliminated and/or replaced by more effective and cost-effective medications. Prescription practices (overdosing and underdosing) will also be monitored regularly and reported to the MOHSW on a quarterly basis. The MOHSW will ensure that all essential psychiatric drugs used in Liberia are registered and approved for their intended use, and meet Good Manufacturing Practice (GMP) international standards.

7.14 Role of local and international Non Governmental Organizations

The role of NGOs in the primary health care system can be considerable. NGOs undertaking new primary care efforts must avoid establishing parallel primary health care facilities and systems in competition with the MOHSW system. Existing NGO mental health programs must enter into an agreement with the MOHSW in order to coordinate their mental health and/or psychosocial activities with the newly formed mental health teams.

Psychosocial and mental health programs run by international NGOs in Liberia shall be integrated into the emerging primary health care system. All NGO programs shall establish liaison links in order to coordinate their mental health activities with the new mental health teams.

7.15 Complementary Medicine

It is well known that traditional medicine plays an important role in Africa, not only in the area of mental health, but health in general. Studies have shown the high prevalence of mental disorders among patients of traditional healers. Ngoma, et al (2003) reported higher rates of common mental disorders in patients of traditional healers as compared to rates in a primary care setting; the prevalence of common mental disorders recorded among those attending a traditional healer center in Dar-Es Salaam was twice that recorded in a primary health care clinic (48% vs. 24%). Peterson, et al (2009) found that in a district in South Africa, two-thirds of primary health care service users had utilized both western and traditional systems for mental health.

As with other illnesses, people will consult a traditional healer before attending a general clinic. Traditional healers are often against the use of medication, which can worsen the problem. Traditional healers need to be integrated, not isolated (Okasha 2002).

There exist in African societies many belief systems, rituals and practices that aid the healing process in the traditional setting. A survey conducted at the Catherine Mills Rehabilitation Hospital in the past showed that 75% of patients admitted to the center for treatment had sought help from traditional sources prior to seeking established medical assistance. It was also discovered that a significant number of the inpatients were also seeking traditional treatment even while admitted in the hospital.

It is important, therefore to utilize all existing resources available, enhance their capacity to provide services, thereby assisting in plugging the resource gap for service delivery.

The Ministry of Health and Social Welfare will therefore collaborate closely with this segment of service providers. It will encourage research in this area and share experiences and research driven findings thereby maximizing the benefits of this area of medicine.

Along with Community health workers (CHW) and Community Health Volunteers (CHV), traditional healers will be encouraged to participate in seminars and workshops about the recognition of psychiatric disorders. In addition, sensitization seminars about the biopsychosocial and spiritual consequences of war will be presented.

The Ministry of Health and Social Welfare will also incorporate a member of the complementary medicine team in the Mental Health Task Force thereby aiding in this mutual collaborative effort. It will work along with the complementary medicine team to establish guidelines for ethical and acceptable practices thus minimizing the potential for harm.

7.16 Social Welfare

As a result of the inextricable link between mental illness and poverty, and the fact that poverty and mental illness ascribe a considerable degree of disadvantage and handicap to afflicted individuals, the mental health program will work closely with the Social Welfare Division of the Ministry of Health and Social Welfare in order to address the needs of disadvantaged individuals with mental illness. The MOHSW will seek to ensure the existence of a strong and viable linkage between the Social Welfare Department and the Mental Health Department.

8.0 SECTORAL ROLES AND RESPONSIBILITIES

It is important that all sectors in the area of health and social development, whether governmental or non-governmental, are involved in mental health service provision in a coordinated manner. The Ministry of Health and Social Welfare will interact with the various government ministries and sectors to support the needs of the mentally ill. There will be formal collaborations between the government departments responsible for mental health and the departments and agencies responsible for primary health care, and certain needs, such as for HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection and education. Ministry meetings will be held quarterly, and meetings with stakeholders and the MOHSW will be held monthly.

This section of the policy will outline some of the roles and responsibilities of each sector.

In regards to support for child and adolescent mental health, information on the proportion of primary and secondary schools that have either a part-time or full time mental health professionals is not available, but thought to be few if any. The number of primary and secondary schools with school-based activities that promote mental health and prevent mental disorders is unknown.

8.1 Government Ministries and Departments

8.1.1 Role of the Ministry of Health & Social Welfare

- Provide strong leadership for the implementation and further development of this National Mental Health Policy.
- Ensure that mental health services in Liberia encompass promotion, prevention, treatment and rehabilitation – the components necessary to improve the quality of mental health care in the country.
- Ensure the development of human resources for mental health services through active recruitment, capacity building and appropriate training that is in accordance with best practices.
- Standardize salaries and offer incentives based on training, experience, responsibility and job location.
- Recruit graduates to work in the mental health sector.
- Provide a budget for mental health services. This budget should strive to reflect the worldwide disease burden of mental health disorders.
- Provide public awareness and education on the causes, nature and treatment of mental health related issues and mental health disorders.
- Monitor and evaluate the delivery of mental health services.
- Collaborate with other ministries and sectors to coordinate mental health activities.

- Establish a monthly meeting of the MOHSW and other ministries.
- Establish a monthly meeting with key stakeholders, select ministry representatives and NGOs to exchange ideas and experiences.
- Change the status of community health volunteers to contract employees (community health workers).
- Establish a yearly regional and national meeting on mental health, which can serve as a continuing education program for providers.
- Establish a mechanism of ongoing supervision to maintain and improve the skills learned from training initiatives.

Department of Social Welfare within the MOHSW

- Social welfare services must consider mental illness a priority when distributing welfare benefits.
- Ensure that mental illness be a priority when distributing welfare benefits to family members if they are the principal providers of care.
- Train staff of social welfare services to appropriately and properly recognize and assist people with mental disorders.

8.1.2 Role of the Ministry of Education

- Train all school-level teachers in the basic knowledge of detecting mental health problems and identifying child abuse.
- Collaborate with the MHOSW to train teachers in screening students for psychosocial functioning problems using an approved, culturally valid standardized screening instrument.
- Incorporate life-skills in school curriculums to ensure a child friendly learning environment.
- Create and incorporate education programs for children with special behavioral and development needs.
- Implement mental health promotion programs in all schools that are age appropriate and that reflect the different developmental needs of various age groups.
- Ensure counselors are available within the schools to provide assessments and basic counseling, and to refer complicated cases to the primary care system.
- Adopt school safety zones to protect students from sexual or gender based violence, exploitation or abuse.
- Adopt a “Do No Harm” approach to education.
- Uphold a Zero Tolerance policy for teachers who perpetrate sexual violence, exploitation or abuse.

8.1.3 Role of the Ministry of Labor

- Develop and implement mental health promotion and prevention programs in the workplace.
- Create a working environment that is free of discrimination and that caters to employee well being.
- Ensure that there are policies that integrate people with mental disorders into the workforce.
- Assist those who are unable to work because of their mental illness or because of a deficits or handicaps resulting from their mental disease.

8.1.4 Role of Housing Authority

- Prioritize people with mental illness in government housing schemes.
- Provide subsidized housing for people with mental illness.
- Prevent geographical housing discrimination against people with mental disorders.

8.1.5 Role of the Ministry of Commerce and Industry

- Examine economic and restructuring policies that impact the employment rate, and as a result, exacerbate mental health related issues in the country.
- Create economic reform and restructuring policies that can reduce both absolute and relative poverty.

8.1.6 Role of the Ministry of Justice

- Advocate for the promotion of mental health services for prisoners.
- Collaborate to develop a screening instrument, protocols, guidelines and treatment options for prisoners with mental health problems.
- Collaborate with the MOHSW to provide mental health awareness and basic training in mental health related issues for relevant personnel. This includes for judges, lawyers, police, and prison officials and workers.
- Ensure that mental health legislation is current, and promotes and protects the human rights of prisoners with mental disorders.
- Establish and implement appropriate and humane legal mechanisms for managing mentally ill people who commit crimes, and develop a system to refer them for evaluation and treatment.
- Collaborate to develop programs that address perpetrators of SGBV. These programs must be mandated for anyone arrested for SGBV related crimes. They must be completed before those arrested are reintegrated back into the community.

8.1.7 Role of the Ministry of Youth and Sport

- Incorporate volunteerism into the healing process.
- Increase the capacity of the National Youth Volunteer Services to include older adolescents. This will enable them to become peer leaders in the community, and help support education provision.
- Continue to address skill-development for young Liberians.
- Explore collaborative opportunities for mental health screening of young people during MYS sponsored events.

8.1.8 Role of the Ministry of Gender and Development

- Advocate for the protection of mentally ill individuals from gender based violence.
- Collaborate to develop preventive and intervention programs for victims of SGBV and mandated services for alleged and convicted perpetrators.

8.1.9 Role of the Ministry of Information

- Collaborate with the MOHSW to orchestrate mental health awareness and prevention initiatives, such as media or radio programs.
- Collaborate with the MOHSW to develop and disseminate targeted messages for the general population, as well as for vulnerable groups, such as street children, war affected persons and ex-combatants.
- Develop an advocacy program to promote the rights and needs of those with mental illnesses as well as to reduce the associated stigma.

8.2 Role of Consumer and Family Groups

- Work to reduce the burden of stigma associated with mental illness.
- Lobby the relevant government agencies and sectors for relevant and appropriate mental health services.

- Advocate for the rights of people with mental disorders.

8.3 Role of Non-Governmental Organizations

- Coordinate with all sectors in planning and implementation of mental health services.
- Enter into an agreement with the MOHSW to coordinate mental health and/or psychosocial activities with the newly formed County Mental Health Teams, and in specific, the mental health outpatient teams at the local health clinics and centers.
- Provide programs consistent with the National Mental Health Policy.
- Ensure that programs are culturally appropriate and in accordance with best practices.
- Ensure that program – both training and treatment --
- NGOs undertaking new primary care efforts must avoid establishing parallel primary health care facilities and systems in competition with the MOHSW system.
- Assure appropriate level of skill and training based on proposed imitative.
- Function as integral partners in the discharge, planning, and necessary support of the chronically mentally ill, such as in the areas of housing.

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