



**MINISTRY OF HEALTH
REPUBLIC OF LIBERIA**

**MENTAL HEALTH POLICY
AND STRATEGIC PLAN FOR**

LIBERIA 2016 - 2021



Office of the Minister

REPUBLIC OF LIBERIA
MINISTRY OF HEALTH

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WEST AFRICA

Forward

Our long lasting Civil War had a severe impact on the mental health of the Liberian people and now, the impact of Ebola is being felt. Following the outbreak, there has been a large increase in the number of people reporting mental health, substance use disorders and psychosocial distress symptoms. The need for services to address the neuropsychiatric disorders (mental health, epilepsy and substance use disorders) in this country is now a top priority and continued support for survivors and families affected is vital.

With an estimated 3% of the population suffering from serious mental illnesses, 10% of the population suffering from common mental health problems and the Ebola virus outbreak, I have recognized that the need for an effective policy has never been greater. I am delighted to introduce this new Mental Health Policy and Strategic Plan for Liberia (2016 – 2021).

The mission is to improve Liberia's mental health services and make them locally available and accessible. All people with neuropsychiatric conditions (mental health disorders, epilepsy and substance use disorders), those at risk of these conditions and their families are entitled to a full array of services. The Ministry of Health supports the provision of mental health services as close to homes and communities as possible, to minimize stigma and discrimination. These services will facilitate fullest levels of functioning, inclusion and participation in the society. As the minister of Health, this document has my fullest support and consideration.

pp 
Dr. Bernice Dahn MD, MPM
Minister of Health, Liberia





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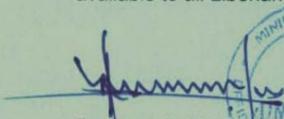
Message from the Chief Medical Officer

By 2020 mental illness and substance use disorders will be the number one cause of morbidity and dependency in Liberia and the rest of the world. It has been estimated that for every \$1 spent on mental health services the economy benefits by \$4.

Like most of the resource poor world, in Liberia mental health services are extremely limited. However recent advances offer a unique opportunity to alter this situation. The new United Nations Sustainable Development Goals now recognizes the need for investment in mental health services and major donors, including the World Bank recognise through innovative development, effective mental health services is affordable even in the most resource poor countries.¹ Many donors are prepared to invest in Mental Health.

Given a severe shortage of doctors, Liberia does have a history of innovation, for example, through training Nurses and Physician Assistants to become Mental Health Clinicians to identify and treat people with the most common mental illnesses including substance use disorders. This will be the springboard for increasing capacity for mental health and substance use disorder related services delivery among all health care workers commiserate with their education and experiences.

The new Mental Health Policy and Strategic Plan for Liberia (2016 – 2021) developed after extensive consultation and now validated builds on this innovation and will create an efficient, affordable and community based mental health service available to all Liberians.



Dr. Francis N. Kateh
Deputy Minister for Health Services & Chief Medical Officer

ACKNOWLEDGEMENTS

With profound gratitude, we acknowledge the immense efforts and support from all partners. We acknowledge the valuable inputs and guidance provided during the entire process of developing the Mental Health Policy and Strategic Plan 2016-2021.

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We thank and appreciate Dr. Alex Gasasira and Dr. Nuha Mahmoud, from the World Health Organisation (WHO) who provided their expertise, enabled research and funded the process for developing this new Policy and Strategy for Liberia.

We appreciate all Mental Health Partners including other Government Ministries (particularly the Ministry of Health and Ministry of Gender, Children and Social Protection, and Ministry of Education), other UN Agencies (particularly UNICEF), INGO's, local NGO's and training institutions (especially Mother Pattern), accreditation bodies (Liberia Board of Nursing & Midwifery and the Liberia National Association of Physician Assistants) who provided technical support and advised us in producing this important document. We also wish to thank the International Medical Corps (IMC) who in part funded a facility survey.

Finally, in a special way we wish to thank Assistant Minister Benedict Harris (Planning, Research and Development) for his expert advice and commitment, Dr. Janice Cooper of the Carter Center (who co-wrote the document), The Mental Health Unit of Ministry of Health and WHO's MHPSS Team including John Mahoney the Consultant (who is affiliated with the Centre for International Mental Health, School of Population Health at the University of Melbourne) who led the consultations and co-wrote the document. We are thankful for the research which was carried by Dr Ratnasabapathipillai Kesavan and Amanda Gbarmo Ndorbor (as the principal investigators) which informed this Policy and Strategic Plan.

LIST OF ABBREVIATIONS

BPHS	Basic Package of Health Services
CHD	Community Healing Dialogues
CHW	Community Health Worker
CMHT	Community Mental Health Team
CHO	County Health Officer
CHW	Community Health Worker
CMO	County Medical Officer
EPHS	Essential Package of Health Services
GCHV's	General Community Health Volunteers
GDP	Gross Domestic Product
IMC	International Medical Corps
JFK	John Fitzgerald Kennedy Hospital
MDs	Medical Doctors
MDD	Major Depressive Disorder
MGC&SP	Ministry of Gender, Children and Social Protection
mhGAP-ig	Mental Health Global Action Plan-intervention Guide
	Mental Health training for Primary Care staff
MOH	Ministry of Health
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
SO	Strategic Objectives
SMI	Severe Mental Illness
STI	Sexually Transmitted Infection
SW	Social Worker
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

This new Mental Health Strategy and Policy will expand the availability of Mental Health Clinicians (including those trained in child and adolescent mental health), open new Wellness Units in every county and develop much needed Rehabilitation/step down and addiction treatment services in all Regions. It will also develop systems to ensure a regular and effective supply of psychotropic drugs.

Most mental health conditions can effectively be treated in Primary Care and a comprehensive plan to provide mental health training to primary care workers will be undertaken. In line with the Essential Package of Health Services (EPHS) the role of primary care and hospital health workers in mental health activities will therefore be enhanced. It is proposed over the next few years that 1,312 Registered Nurses, Physician Assistants and medical staff (two for every health facility in Liberia) will be trained in mhGAP-ig, a training programme specifically designed by WHO for primary care clinicians.

It is also proposed within five years all general community health volunteers (gCHV's) in urban areas and the new Community Health Workers for rural and remote areas will be trained in basic identification, referral and psychosocial interventions.

Teachers, village leaders, traditional healers and religious healers will be trained in basic identification, referral and mental health and psychosocial skills so that they can help identify and support people with common mental health problems in the community.

Just as importantly, extensive mental health promotion and prevention and anti stigma and anti-discrimination activities will be undertaken. There is a widespread fear and misunderstanding amongst people in Liberia of people with mental illness.

This Strategy for Mental Health has been aligned with the National Health Policy and Plan and Investment Plan, as follows:

The National Health and Social Welfare Policy and Plan 2011–2021 (Basic Package of Health Services) and **The Republic of Liberia Investment Plan for Building a Resilient Health System 2015 to 2021** reinforces the provision of mental health and addiction services and states that the MOH will have the following Strategic Objectives (SO's) for the Mental Health Policy

- Increase the clinical capacity of mental health professionals
- Increase in-patient mental health capacity through the establishment of wellness unit's at all county hospitals.
- Train selected professionals in identification, management and referral of patients with mental health and substance used disorders at the Primary level.
- Provide the necessary psychotropic drugs at all facilities in order to expand the availability and access of mental health services in primary care.
- Train community-based workers to recognize signs of mental illness and make referrals to the appropriate health facilities.
- Sensitize communities about mental health and illness and modify negative perceptions about the mentally ill, thereby minimizing stigma and negative behaviours toward persons with neuropsychiatric disorders including epilepsy, mental health and substance use disorders.
- Encourage families of persons with neuropsychiatric disorders (epilepsy, mental health and substance use disorders) to be involved in the care and management of their loved ones.
- Build the new Catherine Mills Mental Health Center

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1. INTRODUCTION

1.1 Policy Context

The previous National Mental Health Policy (2009) consisted of six (6) Policy Objectives and ten (10) areas of Action. The Strategic Plan (2010 – 2015) consisted of six (6) major objectives, thirteen (13) strategic areas, and fifty eight (58) activities.¹

Due to the devastation and extremely poor economic conditions continuing long after the Liberian Civil war and the urgent need for reconstruction of the Country most of the aims of both the Policy and Strategy have not been achieved. Some important progress has been made however (see pp.10).

There is now a much-improved national and international environment which recognises the strong case to radically improve mental health services. The United Nations (UN's) new Sustainable Development Goals now recognizes the need for investment in mental health services and major donors, including the World Bank recognise through innovative development, effective mental health services is affordable even in the most resource poor countries. Many donors are prepared to invest in mental health.

Also The new 'Republic of Liberia Investment Plan for Building a Resilient Health System 2015 to 2021' and the 'National Health and Social Welfare Policy and Plan 2011–2021' do give a high priority to mental health services (see below).

It was agreed, consistent with this international and national momentum and the expiration of the 2009 Policy and the 2010 Strategy, to produce this streamlined document – the Mental Health Policy and Strategic Plan for Liberia (2016 – 2021)

Wherever possible the aims (not achieved) of the previous Mental Health Policy have been incorporated into this new document. This new document was written after extensive consultation at both County and Country level, Government Ministries, UN Agencies and with all the leading agencies, involved in mental health at primary, secondary and tertiary care levels.

A basic but comprehensive community based mental health system consistent with global mental health principles and accepted standards will be realised by 2021 if the areas of action outlined in this document are achieved.

1.2 Policy purpose and Scope

The National Health and Social Welfare Policy and Plan 2011– 2021ⁱⁱ mentions the high prevalence in the general population of mental health disorders, including major depression, post-traumatic stress disorder and substance use disorders.

Two distinct packages of services will be cornerstones of the national strategy to improve the health and social welfare of all people in Liberia: the Essential Package of Health Services (EPHS) and the Essential Package of Social Services (EPSS). The two packages lists the services the MOH assures will be available throughout the public system.

The Basic Package of Health Services (BPHS) in the National Health and Social Welfare Policy and Plan (2011 – 2021) includes the provision of mental health and prison health. The detailed plans stated in the BPHS for mental health is shown in the Policy Section (Section 3).

The EPSS prioritizes those services that are necessary for the social wellbeing of the population, especially those considered most vulnerable. It is a detailed package of services that will be prioritized and made available incrementally, including services for people with physical and mental health disability, prevention of disabilities, child and family services, child protection, as well as aged, juvenile, youth development, substance abuse and prison services. As such it is vitally important for the MOH to work in close collaboration with other Ministries but particularly the Ministry of Gender, Children and Social Protection (MOGC&SP) and the Ministry of Education (MOE).

The Republic of Liberia Investment Plan for Building a Resilient Health System 2015 to 2021 reinforces the provision of the following original package components to improve utilization, efficiency and quality of services, including neuropsychiatric (mental health, epilepsy and addiction) services. It supports plans to improve the accessibility and availability of quality mental health treatment at all levels of health care provision and to sensitize communities about mental health and illness and addiction and modify negative perceptions about the mentally ill and those with substance use disorders, thereby minimizing stigmatization and negative behaviours toward the mentally ill, individuals with epilepsy and those with substance use disorders.

It also supports renovations at JFK to solidify it as Liberia’s primary referral and training hospital (renovations to occur at JFK’s Medical Center, Maternity Hospital, Catherine Mills Mental Health Center and the TNIMA campus). The Liberia Investment Plan 2015 to 2021 commits the Ministry of Health to introduce strengthened and expanded mental health and addiction services.

The Basic Package of Mental Health Servicesⁱⁱⁱ mandated a decentralized approach to integrating mental health and neuropsychiatric care (epilepsy, mental health and addiction services) into the health care system. It provides for increasing the clinical capacity of mental health professionals and the health care workforce to meet the mental health needs of the population. In doing this, it will very important to work closely with and collaborate with other Ministries, UN Agencies, accreditation bodies, training institutions, International Non Governmental Organisations (INGO’s), local NGO’s and other organisations involved in mental health care.

It will also be important to advocate for funding from major donors for the next five years.

It was agreed that the following mental health services will, by 2021, be provided at Health Centers (HC), District Hospitals (DH), County Hospitals (CH) and Regional Hospitals (RH)

By 2021 - All facilities will provide services for the identification of the following mental health conditions (at every HC, DH, CH and RH) and treat or refer
Identification and treatment of the following mental health problems
Anxiety and stress-related disorders
Bi-polar disorder
Depression and other Mood disorders
Family psycho-education and support
Major mental health conditions
Psychosomatic symptoms
Schizophrenia
Other Psychotic disorders
Substance (Drug and alcohol) abuse and dependency
Suicidal ideation and acts
Trauma and post-traumatic stress syndrome
Identification and treatment of the following neurological disorders
Epilepsy
Identification of the following protection issues that impact greatly on mental health
Domestic and interpersonal violence including Referral to Social Worker
Survivors of rape including Referral to Social Worker

Progress has been made. The strategic plan for 2010-2015 was the platform for launching this and it accomplished the following:

- Established the National Technical Coordinating Committee
- Formed a Mental Health Unit at MOH
- Led to the agreement that all Counties should have a Wellness Unit available
- Led to drafting (but not passage) of a comprehensive mental health law
- Led to establishment of LiCORMH to coordinate all research
- Led to provision of mental health services in prisons
- Led to the creation of a cadre of specialists in mental health and 166 mental health clinicians were trained and some health care workers have been trained in mental health and social workers and some gCHV's trained in the non-clinical components. Many PSS workers have been trained in psychosocial responses especially Psychological First Aid
- Led to curriculum development for the clinical social worker
- Called for advocacy and education around mental health disorders that led to the establishment of a national consumer organization and a national anti-stigma organization.
- Led to the strengthening of mental health in primary care supported through mhgap-ig training

2. SITUATIONAL ANALYSIS

2.1 Demographic and Socioeconomic Profile

Liberia is situated on the west coast of Africa, bounded by Guinea in the North, Cote d'Ivoire (Ivory Coast) in the East, Sierra Leone in the West, and the Atlantic Ocean in the South. The country has a population of 3.9 million and covers an area of 111,379 square kilometres with a landmass of 96,370 square kilometres. The country's coastline is 579 kilometres in length and consists of lagoons, mangrove swamps and river-deposited sandbars.

Liberia is a low-income country (LIC) with a gross domestic product (GDP) per capita of US\$495.1 and an economy growing at the rate of 8.7 percent (IMF 2014). Liberia is divided into 15 political sub-divisions, called counties, and five regions. Monrovia is Liberia's largest city and serves as its administrative, commercial and financial capital.

Poverty is pervasive in Liberia and has limited the population's access to healthcare and increased its vulnerability. Based upon consumption income in 2012, statistics showed that 56 percent of Liberians lived below the poverty line at US\$1.25 per day. The absolute number of people living on less than US\$1 per day is 2.1 million and more than 1.9 million, or 48 percent of the population, live in extreme poverty. There is evidence of inequality in resource distribution, with the south-eastern region being the most deprived and poorest. There has been no dramatic decrease in this percentage as the gap between the rich and the poor continues to widen. Richly endowed with diverse mineral resources and a climate favourable to agriculture, Liberia had, until now, been a producer and exporter of basic products, primarily raw timber and rubber. About 45 percent of the land is covered by forest and 70 percent of the Liberian population depends on agriculture for their livelihood. In recent times, the global prices of Liberia's main agricultural commodities have plunged thus creating more hardship.

Liberia has endured nearly two decades of devastating civil conflict that shattered its health system. The effect of the Ebola crisis led to poor health outcomes and made difficult the attainment of the health-related Millennium Development Goals (MDGs). However, the country has made progress in attaining MDG's 4 and 5. The post-conflict recovery was promising, with progress made in major development indicators.

The National Health and Social Welfare Policy and Plan (2011-2021) and implementation produced some positive results in childhood mortality reduction and maternal health indicators. Health indicators were improving until the Ebola Virus Disease (EVD) hit the country, exposing the health system's weakness and vulnerability and causing unprecedented and devastating suffering and death.

2.2 Stigma

There is no better way to inform the situation in this Country than listening to Liberian people who suffer from mental illness. Their organisation '*Cultivation for Users Hope*' has described the issues they face as follows –

'In our communities and in our families, people call us 'names'; some say we are worthless; some say we don't have values; some say we should be bundled up from the streets and placed in care homes. We are stigmatized; we are rejected and abused by our own families; no-body trusts us, no-body values us; we are perceived as people who can't do any work; we don't have opportunities; the health care system is a no go area for us; health workers reject us and schools reject us... These are the issues we are founded to face. To bring into societies mainstream, all who are on the margins, to ensure that as society develops we too are developed and improved in our relationships with all'

In addition, the reason investment in mental health is needed, is detailed below.

2.3 Scale of mental health problems

Mental illness

By 2020 mental illness and substance use disorders will be the number one cause of morbidity in Liberia and the rest of the world. Liberia's population of about four million has a substantial young population.

This is important because mental health problems, mental illness and addiction disproportionately affect young people. Up to 75% of all mental health disorders start in youth. Even the most serious mental illness (schizophrenia) is a young person's illness with the average age of onset in the early 20's. Mental disorders are the highest cause of long-term disability and dependency. In addition, epilepsy, a neuropsychiatric disorder, is widespread in Liberia.

The general consensus based on an estimated global prevalence is that 10% of the general population will suffer from common mental health disorders (such as mild to moderate depression, anxiety disorders, and alcohol and substance misuse) and 3% will suffer from severe mental illness, such as chronic depression, schizophrenia and bi polar disorder.

It is estimated that at least 400,000 people in Liberia suffers from mental health, epilepsy or addiction problems and about 130,000 from a severe form.

Other factors such as conflict, exposure to sexual violence, poverty, overcrowded and poor housing, low levels of education, lack of employment and meaningful occupation all contribute to significantly higher rates of mental disorder. Moreover, maternal depression contributes to poor child health and developmental outcomes.

Substance use disorder is a significant 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.

While no recent studies have been done, many persons with epilepsy (see below) and mental illnesses are known to lose their lives and are left unattended because of stigma, mainly fear of contagion, lack of services, maltreatment and traditional beliefs.

Epilepsy

Epilepsy is one of the most common neurological disorders worldwide and part of WHO's classification of neuropsychiatric disorders. Approximately 80% of persons with epilepsy in low and middle-income countries live in sub-Saharan Africa. Epilepsy accounts for 12% of the disability adjusted life-years in Liberia, second only to depression for the toll it takes of the functionality, contribution and inclusion of persons in the society. While there have been no prevalence studies in Liberia on epilepsy, data collected in the 1980s showed a prevalence range from 28/1000 to 49/1000. Since those two studies, Liberia's recent history of war, poor access to health facilities and trained health personnel, poor birth outcomes and complicated births, infectious diseases and violence all contribute to high incidences of epilepsy.

Liberia's history and inadequate health services provide opportunities for both physical and psychological trauma. Treatment prevalence data put the number of persons with epilepsy as the highest among all those seen at facilities in Liberia for neuropsychiatric disorders and even higher in certain counties. Persons with epilepsy are also at a risk of developing a variety of other neuropsychiatric problems including depression, anxiety, psychosis and dementia.

In 2000 the African Declaration on Epilepsy was adopted.^x Successful epilepsy programs in developing countries include the following core ingredients: community-based approaches that address clinical management, social engagement and stigma reduction, strong skills in identification, diagnosis, treatment and frequent follow-up of persons with epilepsy; and, availability of free or low-cost choices of anti-epileptic drugs.

The impact of Ebola Virus Disease (EVD) on Mental Health

The total number of confirmed, probable and suspected cases of EVD are 10,666 and 4,806 deaths have been reported. Ebola has had a wide-ranging psychological impact as well as contributing to factors that exacerbate trauma and mental illness such as disruption and loss of livelihoods, pervasive fear, chronic illnesses and loss educational opportunities, loss of loved ones and colleagues. Many of the Ebola survivors and families who lost family members to the disease continue to face significant stigma, mental health problems, abject poverty, family breakdown and hostility.

Following the outbreak there has been an increase in the number of people reporting mental health and psychosocial distress symptoms. The Ebola crisis has had a devastating effect on the social fabric of the country, with significant cultural norms and coping strategies being denied, such as community gatherings and funeral rites. The need for mental health and psychosocial services remains a top priority. Continued support for survivors and affected families affected is vital.

The lasting impact of civil war

Liberia spent much of the 1990s and early 2000s engaging in ruinous civil war; 1989–1996 and again from 1999–2003. Around 250,000 people were killed during the war and one million people displaced having fled the fighting. The conflict left the country in economic ruin.

The capital remains without mains electricity and running water, corruption is rife and unemployment and illiteracy are endemic.

The Liberian conflict was characterised by the wide and indiscriminate use of sexual violence as a weapon of war. Women and girls were repeatedly subjected to rape (as high as 40%), including gang rape. Those who were not murdered experienced and/or witnessed acts of sexual brutality, mutilation, cannibalism and torture resulting in long-lasting physical and emotional trauma.

Liberia was notorious for recruiting child soldiers, with approximately 40% of these child soldiers being girls. Many of the children were forcibly recruited into the fighting forces during round-ups conducted by government forces or during raids on refugee and internally displaced persons (IDP) camps by armed groups. Many child soldiers suffered abuses including forced conscription into the armed groups; beatings and other forms of torture; and psychological damage resulting from being forced to kill others. Girl soldiers suffered the additional humiliation of rape and sexual servitude, sometimes over periods of several years in the role of 'wives' to militia commanders. Many former combatants are addicted to drugs and/or alcohol.

One study documented high rates of depression, suicidality and post-traumatic stress disorder amongst individuals with prior affiliation with the fighting forces who were conscripted as children or adolescents. This included reported high rates of depression (48%), PTSD (73%), and suicidality (20%). Rates of suicide behaviour were highest among girls (36%). Over two-fifths of youth in the exposure group had difficulty with social interactions and pro-social skills. In addition girls reported having greater issues with self-esteem and fewer pro-social skills. While both groups in the study had high rates of related mental health problems, those formerly affiliated with the fighting forces experienced greater problems: with 90% experiencing PTSD compared to 60% in the control group and 70% of former affiliates of fighting forces with symptoms of major depression compared to 30% of children and youth who did not associate with fighters.

Link between common mental health disorders and outcomes across all health programmes. HIV/AIDS, TB, Maternal and Child care and other Non-Communicable Diseases

Mental health problems often co-occur with medical problems that can substantially worsen health outcomes. When mental health problems are not effectively treated, they can impair self-care and adherence to treatments, and are associated with increased morbidity and mortality and increased health care costs. For example, it has been shown that achieving good adherence to HIV treatment was 55% lower among people with depression compared to those without. Post-natal depression affects up to 15% of mothers and it is thought to be even higher in resource poor countries like Liberia where maternal and child health indicators are some of the worst in the world. Treating post-natal depression improves health outcomes for mothers and children. Improving mental health care (and dealing with the whole person – body and mind) will improve population health and wellbeing across the full range of high priority health services in Liberia.

2.4 Major gaps in the present health system

- Psychotropic drugs are not available in most of the country (the supplies that do exist are mostly anti-epileptics);
- There are no Wellness Units in the counties;
- The only hospital, the E.S. Grant psychiatric hospital can only cater for about 80 in-patients and is in dire need of renovation and repair, psychotropic drugs and a full cadre of specialty care, clinical supervision and quality assurance;
- Most primary care staff are not trained to provide mental health services.
- Social workers are unable follow up patients in their homes and communities and some lack basic training in core social work skills.
- In-service training programmes are not in place for teachers or others who work with the population of persons with mental health conditions or those at risk.
- Few CHVs have been trained to conduct public awareness programs and to recognize signs of mental illness and make referrals to the appropriate health facilities.
- Lack of training among law enforcement to support persons with mental health conditions in crisis or emergencies.

2.5 National Mental Health Survey

A National Mental Health Survey was performed in order to carry out the evaluation of the existing mental health & psychosocial support services in Liberia.

The MOH undertook the survey with the technical support from WHO and International Medical Corps (IMC). The survey covered most of the government and private health facilities across the country. The survey produced the following unexpected results.

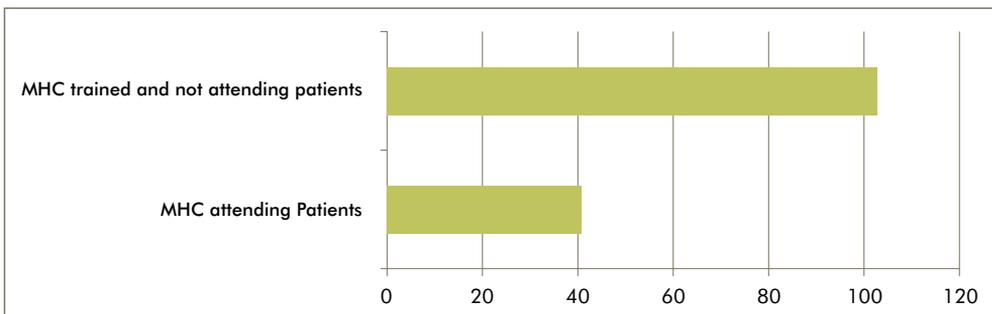
Out of the 166 mental health Clinicians (MHCs) who were trained 144 are still working in health services but only 41 identified themselves as Mental Health Clinicians, working full time with mental health patients.

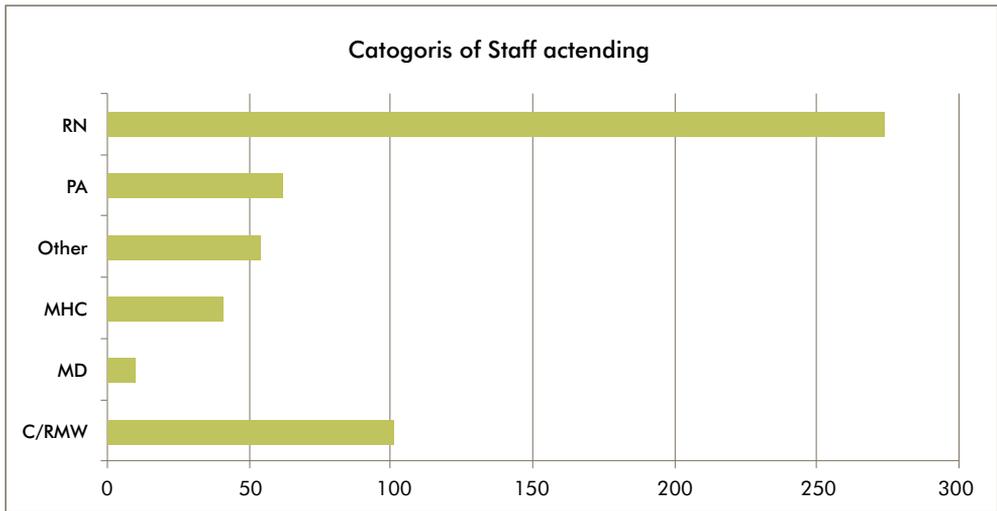
What is clear, however (from the second table below), is that many of the MHCs who were trained were working in different roles as Registered Nurses, Physician Assistants and other roles but they continued to see patients with mental illness.

It is also clear that some other staff (not MHCs) were seeing patients after being trained in mhGAP-ig.

As a result of Ebola, in addition to the WHO, a range of INGOs offered training to mid-level health care workers in the country. These included in Lofa, Bomi (9), Margibi (26), Montserrado (19), Nimba, Rivergee, Grand Kru (10), Sinoe (31), Rivercess, Grand Gedeh, Maryland, Bong, and Grand Bassa.

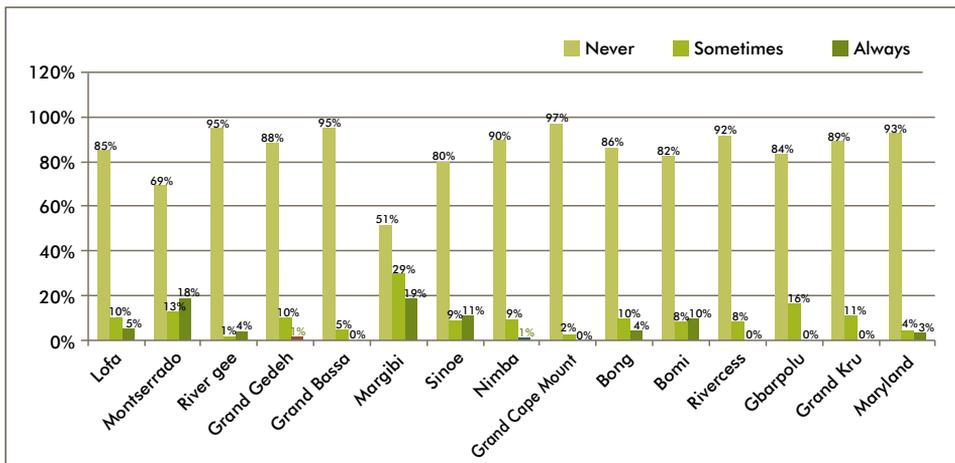
Number of staff, who identified themselves as mental health clinicians and work full time





It was also found that most of the facilities across the country have no psychotropic medications as the following table shows

Percent of facilities with at least one type of psychotropic medication available at any time of the year at county level



Only 7% of the facilities surveyed across the Country had staff trained in mental health and had psychotropic drugs available (see table below). These are possibly the facilities where Mental Health Clinicians work full time. Without medication it is almost impossible to treat people with serious mental illness.

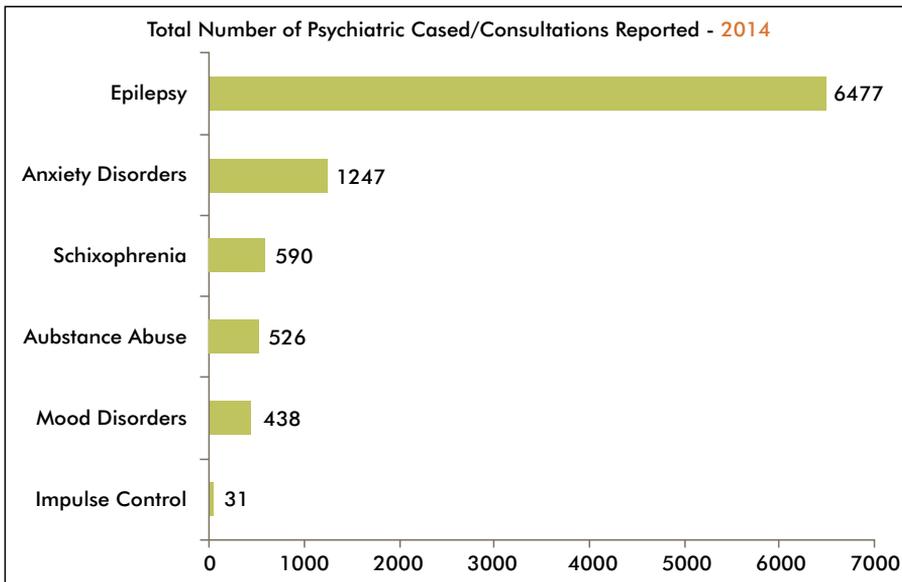
Facility report by MHC and drugs available	Count of MHC	
Percent and number of facilities with trained staff and available drugs	32	7%
Percent and number of facilities with trained staff with no available psychotropic drugs	9	2%
Percent and number of facilities without trained staff and without psychotropic drugs available	300	69%
Percent and number of facilities without trained staff but psychotropic drugs available	91	21%
Grand Total	432	100%

The survey confirms that the mental health system in the country is not formally established and nearly all patients have no access to mental health medication.

This again reflects the fact that the cadre for the mental health clinicians has not been approved (and no incentive given to them) and County Health Officers can move them back to their original roles. This has to be dealt with as an urgent priority

As the 2009 Mental Health Policy mentioned, 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.

There are clearly insufficient numbers of mental health clinicians to cope with the needs (70% of MHC's workload was involved in treating people with epilepsy). While providing services and managing patients with Epilepsy is an essential service, once diagnosed, medications prescribed and treatment managed, epilepsy can generally be handled by a less specialized cadre of worker such as a mhGAP-ig trained health care worker under the supervision of a Mental Health Clinician. The chart below highlights the mismatch between service provision and level of specialty knowledge required (see next page data on number of people treated for 2014).



As this situation is unlikely to change quickly alternative ways to address this chronic lack of service should be encouraged immediately.

Peer support (which is mentioned later in this document) is a low-intensity psychological intervention that can bolster 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. Peer support groups encourage mental health literacy, assistance dealing with stigma and addressing mental health related issues associated with activities of daily living. Peer support group (some condition specific and some mixed) are operating in some counties and communities in Liberia. Sinoe County has seen the development of patient support groups for persons with mental illness. Three patient support groups running in Diyankpo, Lexington, Greenville and Kabada have pursued economic/livelihood ventures in soap-making, tie and dye, peanut farming and rabbit rearing under the leadership of Cultivation for Users Hope.

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. Scholars have 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. This approach should be regarded as a top priority to support people with mental illness in the early years of this strategy.

3. POLICY

This Mental Health Policy and Strategic Plan for Liberia (2016 – 2021) has been formulated using latest evidence-based information about the huge burden of disease and the economic case for investing in mental health. Liberia is improving its Primary Care Services and Ministry of Health policies show a commitment to achieving equally high standards in mental health care services.

The key to its success will be to: a) develop systems to ensure a regular and effective supply of psychotropic drugs at primary, secondary and tertiary care; b) develop and enhance the skills of primary care workers to deliver quality mental health services; c) create and maintain a continuous quality improvement system for mental health services provision that measures progress and is integrated into the state's health management information systems; d) provide support for individuals and their families to live and thrive in communities; and e) support the inclusion of persons with neuropsychiatric disorders (mental health, epilepsy and substance use disorders) in the workforce and in schools by removing barriers to entry and providing appropriate accommodations.

Objectives at Primary Secondary and tertiary care

Primary and community care

- GCHV's in urban areas and the new Community Health workers for rural and remote areas will be trained in basic identification, referral and psychosocial interventions, including health promotion, prevention and anti stigma activities.
- Teachers, village leaders, traditional healers and religious healers will be trained in mental health literacy, identification, basic mental health and psychosocial skills and referrals.
- Extensive mental health promotion and prevention and anti stigma and discrimination activities will be undertaken.
- Most mental health services can be effectively delivered in primary care settings and a comprehensive plan to provide mental health training to primary care workers will be undertaken.
- Supervision of training primary health care workers by skilled mental health clinicians and MDs trained in mental health is critical to supporting this system.

Secondary Care

This new Mental Health Policy and Strategy will expand the availability of Mental Health Clinicians (including those trained in child and adolescent mental health)

Wellness units will provide crisis stabilization services, detoxification from substance misuse, basic primary and secondary mental health services (outpatient complex cases, dual-diagnosis/multiple diagnoses, referrals to Catherine Mills/Grant and returns to communities from Catherine Mills/Grant (a step-down level care facility for those who need more supportive re-integration), in-depth assessments, neuropsychiatric work, and case management of hospital level care. These clinicians will also supervise and support primary care staff in the provision of neuropsychiatric services.

Tertiary care

In 1962, the Government of Liberia received a donation of 90 acres of land in Paynesville from Ellen Mills-Scarborough to establish a state of the art mental health facility. The Catherine Mills Rehabilitation Center, in its heyday was a state of the art mental health hospital. The facility was a 75 bed facility with hospital staff quarters, research rooms and patient rooms. The present tertiary mental hospital E.S. Grant came into being when Catherine Mills was ransacked and looted during the Civil War. Dr Grant began practicing in his home.

The current facility is Dr. Grant's former home and is in need of complete renovation. The current facility does not belong to the Government of Liberia and is leased by the JFK. There is an agreed plan for building the new Catherine Mills Mental Health Center. The space will include a mixture of in-patient rooms and outpatient consultation space, education and training seminar rooms, common rooms for patient activities, a state-of-the art employee assistance program, staff quarters, classrooms and activity rooms for patients and for student health care providers, a conference center, research space and a home for LiCoRMH, There will be separate wings for different populations (by gender, age, specific conditions), by activities and include landscaped outdoor space.

This plan also proposes an interim development of much needed 20 bed rehabilitation/step down service in Monrovia that will serve as a lower level of care for persons who are leaving grant but need extra time before full community integration. Entry criteria for the step-down rehabilitation facility will be based on level of functioning criteria, individualized patient care plan and available programming. A complement of mental health clinicians/specialists, social workers and occupational therapists will staff the step-down rehabilitation facility. Both patients discharged from the step-down program and patients eligible for day rehabilitation services will be supported in the step-down program.

Staff at Catherine Mills/Grant Hospital and the step-down program will jointly conduct and manage discharge and program planning for the step-down program. Homeless mentally ill people will also be treated and supported in this way, which will include livelihood programmes.

3.1 Policy Orientation – Vision, Mission, Goal and Principles

Vision

We want to develop a system that promotes recovery/wellness and resiliency. The vision is to develop a comprehensive system of mental health care with robust community-based services. All citizens are entitled to services to promote and support their mental/psychological well-being and to prevent mental health conditions and mental illness, and to treat neuropsychiatric disorders (mental health and substance use disorders and epilepsy).

Mission

Individuals with mental health conditions and mental illness are entitled to access to services and supports to address their conditions, ameliorate their suffering and ensure their fullest functioning. These services and supports should be available as close to their homes and communities as possible and support their leading full and productive lives.

Goal

To modernize existing services, create new and additional services, recruit and train more skilled staff, and link to both other government and non-government sectors

Principles

- Provide mental health and addiction services at primary, secondary and tertiary levels.
- Develop the capacity and quality of health, education and social services to support effective health promotion and prevention activities
- Provide community level services with community, family and service user participation.
- Link mental health and addiction services to other health and non-health sectors.

- Ensure evidence based and culturally appropriate mental health and addiction services.
- Protect the human rights and dignity of people with mental illness.
- Recognise and cultivate the capacity of communities to prevent and reduce mental illness through social cohesion, collective resilience and shared problem solving

3.2 Objectives - Policy Strategic Objectives (SO)

To be an essential instrument to ensure clarity of vision and purpose in the improvement of the mental health and psychological wellbeing of the citizens of Liberia and to set out the roadmap for service development, implementation, evaluation and quality improvement as well as the principles underlying the mental health system of care. This Policy and Strategy for Mental Health has been aligned with the National Health Policy and Plan and Investment Plan, as follows

The National Health and Social Welfare Policy and Plan 2011–2021 (Basic Package of Health Services) and **The Republic of Liberia Investment Plan for Building a Resilient Health System 2015 to 2021** reinforces the provision of mental health services and states the following Policy Strategic objectives (SO's).

The MOH will -

- Increase the clinical capacity of mental health professionals. (SO1)
- Increase in-patient capacity through the establishment of wellness unit's at all county hospitals. (SO2)
- Train selected professionals to identify, manage and refer persons with neuropsychiatric conditions (mental health and substance use disorders and epilepsy) at the primary care level. (SO3)
- Provide the necessary psychotropic drugs in order to expand the availability and access of mental health services at all primary care facilities. (SO4)
- Train community-based workers to recognize signs of mental illness and make referrals to the appropriate health providers and facilities. (SO5)
- Sensitize communities about neuropsychiatric disorders (epilepsy, mental health and illness and addiction and modify negative perceptions about the mentally ill, thereby minimizing stigma and negative behaviours toward the mentally ill and others with neuropsychiatric disorders (epilepsy, substance use disorders). Encourage families to be involved in the care and management of their loved ones. Prepare mental health promotion and prevention policies (SO6)
- Build the new Catherine Mills Mental Health Center.(SO7)

Proposed actions for each of these Policy Strategic Objectives are shown in detail in the Strategic Plan (Section 4 below).

3.3 Enabling Environment

Mental Health Legislation

New mental health legislation (the Mental Health Act) for Liberia will be enacted. The main components of the new act will be to:

- Identify and confirm rights to treatment and care for the mentally ill.
- Safeguard human rights of mental health patients.
- Ensure that informed consent is given.
- Establish a set of minimum standards for patient care.
- Define protocols for detention and treatment in emergency situations.
- Appoint Mental Health Review Officers and authorized patient advocates
- Establish a Mental Health Act Advisory Board to advise the Minister of Health

4. STRATEGIC PLAN

Based on the assessed needs, current services and principles for mental health care, the following seven Strategic Objectives have been identified to achieve the vision and objectives of this policy. These areas for action will be included in a costed action plan for all counties that in consultation with stakeholders will be implemented based on a defined timetable and consistent with the implementation of other health services.

4.1 Organization of Services

Policy Strategic Objective 1 - Increasing the clinical capacity of mental health professionals (SO1)

Grades, performance expectations, specific roles with job descriptions and responsibilities, competencies and skill mix will be defined for the various proposed cadres below. Where necessary, appointments in rural areas will need to be in line with the rural retention strategy and incentive packages and career development pathways.

Mental Health Coordinators (one per County) will be the Clinical leaders of each county mental health care network.

Mental Health Clinicians (MHC) will be the focal point for services for each district within counties coordinating patient care both in hospital, health centres/facilities and in the community. There will be 380 MHC's by 2021 with at least two MHC's appointed in every district. The Phebe School of Nursing has been designated by the MOH to be the training center for MHCs. One hundred and sixty-six (166) MHCs have been trained but not all are currently working and a further 100 will be trained in Child and Adolescent Mental Health. The major locus of care for child and adolescent mental health clinicians will be in settings where children and adolescents frequent, schools, communities and child health facilities. A further 160 MHC's will need to be trained, which will include training in substance misuse disorders. To address the increasing specialized needs in geriatric mental health, there will be a cadre of mental health clinicians train (N=20) in geriatric mental health.

Grading for MHCs will be in line with Degree level nurses and it will be important for the MOH to negotiate with the Civil Service Agency to set appropriate grades and Job Descriptions and become an agreed new position.

There will be **Bachelor Social Workers** (BSW) who will be **Masters of Social Work** (MSWs) employed by Ministry of Gender, Children and Social Protection will need to be employed at all Wellness and Rehabilitation units. By 2016, there will be 15 MSWs trained every two years. By 2021, 45 MSWs will be required.

To address addiction to alcohol and drugs, specialized services will be developed. During the period of this plan at least one Mental Health Clinician (Addiction Specialist) will be appointed in every County. Primary care and hospital based staff will be trained. It is proposed that by 2021, **15 addiction specialists** will be appointed, one for each County. It has been agreed to develop addiction specialists at three levels, those who were trained as MHC with a focus on addiction and those at the secondary and community levels trained to provide outreach identification, referral and basic counselling.

In recognition of the role of **pharmacists** in improved outcomes in the management of mental health conditions and to support the need for quality mental health services that includes medications, all pharmacists must be trained to manage, dispense and provide collaborative care in mental health. It is proposed that the curriculum and training of new pharmacists meet internationally accepted standards and are competency-based. For pharmacists in practice, there must be a comprehensive training in mental health and mental health drugs. By 2021, all practicing pharmacists must receive yearly competency training in mental health medications.

Services for Children and Youth

Brief essential hospitalization for children and adolescents will be in a local paediatric or other specialist mental health children's wards or Substance Misuse Unit. Children will not be hospitalized in adult wards in Wellness units. Mental health services will be available for children and adolescents at all health care facilities.

School-based mental health services will be provided at schools and early care and learning facilities. Mental health and psychological services will be available to children and adolescents (and their families as appropriate) in child protective services, foster-care (including therapeutic foster care), kinship care, pre-adoption services and in support of an adoption order. Child and Adolescent Mental Health Clinicians (CAMHCs) are undergoing training to provide specialized mental health care to children, adolescents and their families, to support interventions in the home, schools, health care facilities and communities.

In conjunction with the Ministry of Education (Divisions of Inclusive Education) an individualized educational plan system is being developed to support the learning of children with severe emotional behavioural disorders and other learning difficulties and disabilities.

Mental health services must be provided at all SGBV units in the country. Mental health clinicians and nurses assigned to SGBV units will be specially trained in the psychological health of patients who have experienced SGBV. Each one-stop shop will have a full-time equivalent mental health clinician or SGBV clinician trained in mental health.

Human Resources for Health (HRH) longer term plans

It is proposed to begin the process now to develop the psychiatrists and other doctors trained in mental health. Training plans and bursaries (where necessary) will be available. A robust training of psychiatrists for Liberia must begin immediately. Liberia needs a minimum of 16 psychiatrists. Two strategies are proposed to fill this gap. Psychiatrists must be among the specialists that are part of the reinvestment plan who assist the Liberian government to train and provide services. Six cohorts of psychiatrists should be trained in the residency program at JFK, and at least 2 doctors per year during the strategic plan period must receive scholarships to enter into programs of psychiatry in Africa or in other similarly situated settings. At least 6 neurologists should be trained abroad and returned to Liberia. In addition, Liberian needs 30 clinical psychologists and 30 occupational psychologists who could be trained in other African countries through scholarships and return to support the mental health system.

Policy Strategic Objective 2 - Increase inpatient capacity through the establishment of wellness unit's at all county hospitals. (SO2)

Mental health services will be reorganized and decentralized and provide care for all age groups. Each County will have a network of services including wellness units, attached to the County Referral hospital which will include –

- Acute inpatient ward(s);
- A Community Support Centre (CSC), including a training facility;
- Out-patient consultation rooms and offices.

Wellness Units will be established in every county hospital to provide in-patient care for the acutely ill who cannot be managed at home. These units will have the following facilities/services:

- Separate Units in general hospitals with not more than 10 beds in a single ward with separate accommodation for male and female patients. Each unit will have at least six Mental Health Clinicians and ten nursing Aides with training in mental health.
- Patients will be admitted to the units only after assessment by a mental health clinician.
- Each Wellness unit will have space for assessment and therapy and equipped with facilities to manage people who are a significant risk to themselves and/or others.
- Adequate space to accommodate patients' family members and facilitate open visiting.

A system for referral and follow-up and continuity of care of patients near their homes will be established involving an appropriately trained community level workforce.

Outpatients services will be provided at a District level and include regular mental health clinics/outreach clinics (with primary health care workers), for supporting continuity of care, assessment, treatment and support.

Each County will have one mental health Community Support Center (CSC) as part of the Wellness Unit where all activities for mental well-being can be coordinated, including, if possible a training facility. In addition to in-patient treatment, services should also include outpatient consultations, health education and psychosocial support, occupational and other psychological services. The existence of Wellness Units does not negate the need for mental health care to be integrated in all primary care facilities. The relevant accreditation and standard-setting bodies will create policy and standards to assess adherence to this policy.

Mental health care in prisons and other state-run facilities will be improved and included as part of the strategic targets and monitoring activity of the Directorate of Mental Health. Each prison will have mental health clinician/s to oversee and provide mental health services and supports.

Policy Strategic Objective 3 - At the Primary level, selected professionals will be trained in identifying, managing and referring mental health cases. (SO3)

A comprehensive plan to provide mental health training to primary care workers will be undertaken. Most people with common mental health problems can be managed in primary care and need not be referred to specialist clinicians. Again in line with the EPHS the role of **primary care and hospital health workers** in mental health activities will therefore be enhanced. It is proposed over the next few years that 1,312 Registered Nurses, Physician Assistants and medical staff (two for every health facility in Liberia) will be trained in mhGAP-ig, a training Programme specifically designed by WHO for primary care clinicians. People with more serious conditions will be referred to Mental Health Clinicians. Eventually all registered nurses and physician assistants will at a minimum receive mhgap-ig training. At the pre-service level every graduating nurse, physician assistant, certified midwife, and registered midwife must receive mhGAP-ig training before graduation. mhGAP-ig should be the linchpin mental health in-service program with refreshers provided through the MOH training unit. All certified and registered midwives must undergo training in Thinking Healthy, a WHO guide for working with pregnant and parenting women with mental health needs. The national reproductive health strategy must include reference to this plan.

To address integration of mental health into all platforms by 2021 every program that serves persons with HIV/AIDS, maternal and newborn health (Thinking Healthy, see above), and TB and leprosy must have all mid-level workers trained in mhgap-ig.

Policy Strategic Objective 4 - All facilities have the necessary psychotropic drugs in order to expand the availability and access of mental health services in primary care. (SO4)

The psychotropic medicines on the Ministry's Essential List of Drugs have been revised and will be made available to all health facilities. These medications are often unavailable and too costly to purchase for the majority of Liberians.

Training manuals used for prescribing complex medications or interventions will be adapted to the Liberian context.

Policy Strategic Objective 5 - Community-based workers will be trained to recognize signs of mental illness and make referrals to the appropriate health facilities. (SO5)

The community workforce will be trained. Liberia has a history of innovative approaches in meeting shortfalls such as training mental health clinicians who can also prescribe medications. However, they have no support. At present there are a total of 3,727 general Community Health Volunteers in post (which will be substantially increased) undertaking a range of duties, however only 90 are involved in mental health activities in three counties (10 in Sinoe, 40 in Margibi and 40 in Montserrado). Here using community identification and detection skills and tools they are supporting identification and referral, follow-up and even home visits.

A significant problem is most people with mental health conditions (particularly depression) rarely seek treatment from health facilities although many do attend hospital outpatient departments with non-specific medical symptoms, such as generalized pain, lethargy and tiredness. This is evidenced by the fact the Mental Health Clinicians treat very few people with depression. Over 70% of MHC caseloads are people with epilepsy (a neuropsychiatric disorder) and very few people with psychosis or depression (mood disorders).

The **National Community Health Services** Strategic Plan 2016 to 2021 which has just been validated states that specialized staff in community health interventions within 5 kms of health facilities such as those for HIV, TB, Leprosy and mental health adherence support may be remunerated in line with the community health services policy.

A different system is proposed for community level workers in remote areas. Approximately 29% of Liberians and 60% of rural populations live more than five kilometres from the nearest health facility. The new policy for community health services institutes a new cadre of certified Community Health Workers (CHWs) for rural and remote areas. Once trained they will deliver an integrated and standardized service delivery package which includes all curative, preventative, promotive, rehabilitative and palliative services (including mental health services) to households located more than one hour walk (more than five kilometres) from the nearest health facility.

There will be a large increase in this workforce. It is planned to appoint one CHW for every 40 to 60 households (up to 350 persons) who will receive a monthly incentive of \$70. They will be trained in the identification, referral and monitoring of patients in the community with signs and symptoms of mental health disorders.

The lack of identification and a referral system is a significant problem in Liberia. Community level workers are best placed to identify, refer and set up support systems for people with mental illness. All community level staff should be trained to

- Ensure identification of people with serious mental illness and referral procedures are developed
- Prioritize people with on-going problems and provide regular and practical support.
- Provide support with daily living.
- Provide information and health promotion.
- Help identify early signs of relapse.
- Support anti-stigma and advocacy campaigns at the community level

It is proposed within five years all gCHV's in urban areas and the new Community Health workers for rural and remote areas will be trained in basic identification, referral and psychosocial interventions and follow up of people with mental health problems. This is one of the recommendations in the EPHS.

The key staff to train early will be the proposed new cadre of Community Health Services Supervisors (CHSS) in rural and remote areas who will be a professionally trained health worker. They will supervise up to ten CHWs covering a population of approximately 3,500 people.

It is proposed that initially CHWs will be trained in post-natal depression and post-partum psychosis and the CHSS will receive mhGAP training to recognize and treat all people with common mental health problems who do not need to be referred to a specialist Mental Health Clinician but can be treated at the Primary care level.

Policy Strategic Objective 6 - Desensitize communities about mental health and illness and modify negative perceptions about the mentally ill, thereby minimizing stigmatization and negative behaviours toward the mentally ill. Families will be encouraged to be involved in the care and management of their loved ones. Mental Health Prevention and Promotion Policies will be developed (SO6)

Compounding the problem are the stigma and misconceptions around mental illnesses that perpetuate suffering. Some patients, families, and health workers without mental health training perceive mental illnesses as a punishment for bad behaviour and epilepsy as a contagious disease.

Because of misunderstandings about mental illnesses and lack of services, families and communities may isolate or restrain people with mental illness or resort to potentially harmful practices that worsen distress. Persons with epilepsy (and mental illness) are often shunned and discriminated against in education, employment and marriage because epilepsy and mental illness is seen as a highly contagious and shameful disease in the eyes of the public. Due to stigma, lack of mental health training and low supplies of essential medications, most individuals with mental illness and their families struggle throughout their lives.

To address stigma, a new strategy for mental health promotion and prevention will be developed. In some counties, in collaboration with Cultivation for Users Hope, facility-based anti-stigma campaigns have been conducted leading to greater awareness and acceptance of persons with epilepsy, mental health and substance use disorders. Promotion of good mental health requires multi-sectoral collaboration and action. The National Mental Health Technical Coordination Committee has, as one of its tasks to promote inter-departmental cooperation in this area to improving people's lives. The service users' organizations will have an important role to play.

Broad strategies for mental health promotion and the prevention of mental disorders across the life course will focus on: anti-discrimination and information campaigns that redress the stigmatization and human rights violations all too commonly associated with mental disorders; promotion of the rights, opportunities and care of individuals with mental disorders; the nurturing of core individual attributes in the formative stages of life (such as early childhood programmes, life skills and sexuality education, programmes to support the development of safe, stable and nurturing relationships between children, their parents and carers); early identification, prevention and treatment of emotional or behavioural problems, especially in childhood and adolescence; provision of healthy living and working conditions (including work organizational improvements and evidence-based stress management schemes in the public as well as the private sector); protection programmes or community protection networks that tackle child abuse as well as other violence at domestic and community levels and social protection for the poor.

Prevention of mental disorders and vigorous promotion of healthy behaviors are critical for decreasing stigma and the burden of mental illnesses and for helping people to realize their full potential. The National Mental Health Technical Coordination Committee will follow WHO's international reviews of scientific evidence for interventions; particularly in lower and middle income countries. The main recommendations which demonstrate the effectiveness of programmes and

- Early childhood interventions (e.g. home visiting for pregnant women, pre-school psychosocial interventions, combined nutritional and psychosocial interventions in disadvantaged populations); support to children (e.g. skills building programmes, child and youth development programmes);
- Family therapy training
- Economic and social empowerment of women (e.g. improving access to education and microcredit schemes);
- Social support to old age populations (e.g. befriending initiatives for the aged);
- Programmes targeted at vulnerable groups such as survivors of Ebola, family members affected and for people affected by war (including ex combatants)
- Mental health promotion activities in schools (e.g. child-friendly schools);
- Mental health interventions at work (e.g. stress prevention programmes); and supported employment and psychosocial rehabilitation for people recovering from mental health problems
- Housing policies (e.g. housing improvement);
- Violence prevention programmes (e.g. community policing initiatives);
- Community development programmes (e.g. Communities That Care, integrated rural development) and strengthening community networks
- Good access to physical health care, including home visiting and emphasis on reducing substance misuse
- Exercise
- Spiritual enhancement, including meditation, and
- Raising mental health literacy

To further this agenda the following initial interventions will be undertaken:

Provide support for a mental health service user/consumer movement/organization. By 2017, a nationally representative mental health service user organization and a family organization will be fully engaged in policy development, service planning and systems' outcomes evaluation.

Foster the creation of peer support groups with trained peer support specialists to facilitate recovery among persons with mental health and substance use disorders and epilepsy and their families. By 2017 pilot programs in facilities with mental health clinicians and mhgap-ig trained mid-level health workers and social workers will integrate trained peer specialists/family support specialists and the peer support/family model into their service delivery system.

By 2018, 40% of all health care facilities will include mental health services users and family members in health care planning, service delivery and evaluation for persons with mental health and substance use disorders, and epilepsy. By 2021, all facilities will have peer support groups, family support groups and peer specialists available for persons with mental health disorders, epilepsy and substance use disorders in their facilities.

Strengthen mental health in the national agenda for persons with disabilities through representation with the National Commission on Disabilities fully integrating services and supports for persons with mental health disorders, epilepsy and substance use disorders in the Agenda for Transformation and its successors.

Establish a national suicide prevention taskforce charged with developing and implementing a plan to address suicide including but not limited to creating mandated reporting and registry for all suicides. Create and adequately staff a crisis and suicide prevention hotline and publicize its existence widely.

Mental health prevention and promotion activities will build on lessons learnt from the Ebola response regarding community members' engagement in and ownership of health activities. Post-EVD interventions that promoted social cohesion, resilience and shared problem solving, such as Community Healing Dialogues (CHD) and Social Reconnection groups, had a strong impact on the wellbeing of affected individuals and communities. Facilitating the capacity of communities to care for one another using community-led approaches will be a vital component.

This will require regular coordination between the County Mental Health and Social Work staff, as issues will touch both fields. It will also require careful understanding of local terminologies and beliefs, coping strategies and help-seeking behaviors, and working alongside key stakeholders such as traditional and religious healers.

Every Community Resource Centre (part of the Wellness Units) will organize and arrange in-service training. The Centre will be amongst other things the focus for all health staff in-service training under the technical guidance of the County Coordinator will be supported by:

- Two **Psychosocial Trainers** (MHC's) will be attached to each Wellness Unit who will be able to train a range of staff and leaders in the community (gCHV's, teachers, village leaders, traditional healers, religious healers etc.) in basic mental health and psychosocial skills so that they can help identify people with common mental health problems in the community. By 2021, a national 3 tier level credentialing system for psychosocial workers will be established along with a board that will regulate and ensure continuous adherence to set standards.
- One **Community Mental Health Education Officer** (MHC) who will carry out mental health promotion/prevention activities, media and community programs to combat stigma and discrimination and to raise public awareness on mental health issues.
- **Authorized patient advocates**

Policy Strategic Objective 7 - Building the new Catherine Mills Mental Health Center (SO7)

The agreed plans for the new Catherine Mills Mental Health Center includes –

- 100 bedded inpatient adult facility for acute mental disorders and Rehabilitation beds and facilities
- 100 beds for substance abuse (or 5 Regional Centres of 20 beds each, one specialising for youth)
- 30 bed children and adolescents unit, and a
- 25–30 bedded maximum security unit for prison inmates with mental disorders.
- Discharge planning team with 25 clinical staff
- 2 psychiatrists
- 2 occupational therapists
- 1 recreational therapist
- 1 psychologists
- 2 social workers

However recognizing the significant problem of transitions between different levels of care, between hospitalizations and community care/family care and lack of access that result in homelessness amongst people with long- term serious mental illness, it is proposed by 2017, a rehabilitation/step down unit will be set-up in Montserrado.

In the longer term it is proposed each Regional hospital should have at least one rehab/step-down unit. The Rehabilitation/Step down units will have:

- Twenty beds with at least four Mental Health Clinicians and two social workers (BSW) and appropriate nursing aides trained to support mental health services
- All staff trained in Neuro-psychiatric clinical practice and psychosocial rehabilitation.
- Entry to care will be based on level of functioning with the goal to maximize people's ability to return to the community.
- Focus of care will be on psychosocial rehabilitation activities (with a maximum length of stay of six months) to ensure that patients maintain/develop essential skills for independent living, including livelihood skills to return to society.
- Family involvement will be required. Where patients cannot be integrated with families and communities, a suitable alternative should be found through inter sectoral mechanisms.

In addition to the seven Strategic Objectives mentioned at the beginning (part of National Health Policies and Strategies) we have agreed an eighth Strategic Objective recognising the importance of research and ethics

Strategic Objective 8: Support a Center for Mental Health Research and Ethics

The 2009 Mental Health Policy called for the creation of a Center of Excellence in Mental Health and the Liberia Center for Outcomes was formed under the auspices of the Technical Coordinating Committee for Mental Health and through a Memorandum of Understanding with the Ministry of Health, the John F. Kennedy Medical Center and The Carter Center until September 2018. It is designed to ensure that Liberia advances mental health through the availability of quality services and supports for its people. LiCORMH will support effective health services through the identification and dissemination of quality, research-informed practices; the development of appropriate models of service delivery based on local research; and, the infusion of evidence-based mental health practice into education and training. Its core goals are to:

- Foster research-informed practice to improve the mental health of all Liberians
- Develop different practical models for quality assurance in health care delivery systems

- Contribute to national health care assessments and studies
- Support the implementation of guidelines for standard of practice through audits, reviews and operational research
- Conduct and support mental health research with a focus on interventions for the Liberian population, especially those that build on the natural supports and resources of Liberians (for example research that establishes empirical support for local practices that work in the treatment of behavioral health conditions)
- Serve as a hub for the coordination of mental health services research and clinical research in mental health
- Develop and sustain a cadre of locally-based clinical and services-related mental health researchers
- Provide a repository of mental health services data to support the annual accreditation or audit of the health system
- Advance human resource development-related decision-making
- Create training opportunities for mental health research with a strong focus on methodology
- Collaborate with, and benefit from research opportunities within Africa and other low and middle income countries

The paucity of mental health research governance to support practice is pervasive in low and middle-income countries.^{xv} Liberia is no exception. The LiCORMH provides the opportunity to address the “service and information gap together” to more effectively use existing and limited resources.¹ It fills a significant research capacity gap, supports decision-making about mental health research priorities (which heretofore has been externally driven), fosters evidence-informed planning and bolsters the further development of the mental health component within the overall health care plan.

Most importantly, it provides the necessary stewardship of mental health research that is the obligation of the Government of Liberia to ensure.

This policy and strategy provides support to the LiCORMH to oversee mental health and substance use disorders related research. This multidisciplinary research entity will promote, undertake and examine research to support best practice, link with Liberian universities to identify and build capacity of Liberia researchers and identify priority areas for research and development. Priority research questions in mental health, international and local funding support for mental health research, ethics and supporting links between academia, government and service provision will be the among the core focus of LiCORMH’s work.

¹ Op. cit.

4.2 Implementation Arrangements – Leadership and Governance

The Role of the Ministry of Health

Provide strong leadership for the implementation of this National Mental Health Policy and advocate for donor assistance and funding.

- 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. Advocate for the passage of the Mental Health Act into law
- Standardize salaries and create new cadres of staff that offer incentives based on training, experience, responsibility and job location.
- Provide a budget for mental health services. This budget should strive to reflect the worldwide disease burden of mental health disorders.
- Collaborate with other ministries and sectors to coordinate mental health activities.
- Establish a quarterly meeting of the MOH and other ministries.

The **National Mental Health Technical Coordination Committee** will oversee and assist with the implementation of the mental health policy and Strategy for Liberia. The membership will comprise of Leaders from the Ministry of Health and the Ministry of Gender, Children and Social Protection and representatives from other ministries including Education, Justice, Finance, Planning and Development, Information, Internal Affairs, Labour, Youth and Sports and Presidential Affairs. Professional representation will include the Liberia Board of Nursing & Midwifery, the Liberia National Physician Assistants Association, the Liberia Medical and Dental Council, Liberia Association of Mental Health Practitioners, Liberia Board of Social Work and other representatives of mental health clinicians, nursing and social work, teaching and learning, occupational health specialists. Other representation should include service users (Cultivation for Users Hope), carers and representatives of relevant donor, service provision or teaching institutions as well as Representation from the National Commission on Disability and other registered NGOs.

The **Mental Health Department, Ministry of Health** will be managerially and administratively strengthened to support implementation of the policy. The department will be adequately financed and staffed with a Director who will be supported by the Deputy Director and four Technical Officers for Clinical Services, Community Services, Mental Health Promotion, Prevention, Education and Research and Monitoring and Evaluation.

The Department will:

- Develop mental health promotion and prevention strategies and initiate activities in collaboration with the National Health Promotion Division
- Carry through decisions of the Technical Coordination Committee.
- Specify strategic targets and outcomes to be achieved at County level.
- Develop a routine management information system (linked to HMIS and other data management and surveillance systems) to identify resource needs and monitor outcomes of mental health services.
- Develop a mechanism (in consultation with the Pharmacy Board) to regularly review and implement national guidelines for the management of psychotropic and other medication. This will include integrating psychotropic medicines into a single supply chain system run by the Liberian National Drug Service and addressing transportation and surveillance systems
- Support the Liberian Board of Nursing and Midwifery and the Liberia National Physician Assistants Association to provide supervision. Including the development and validation of clinical standards, strengthening the testing and credentialing of MHCs and providing conducting regular M&E.

The Mental Health Department will assist each county to develop integrated local plans that are consistent with the Liberian Mental Health Policy and Strategy. All counties will appoint MHPSS Coordinating committees. The Ministry of Health and CHTs will initiate and maintain links at all levels between mental health and other relevant sectors such as education, women empowerment and social welfare, local administration, poverty alleviation, child protection and developmental NGOs.

It will be very important to liaise with the following Ministries. Their important roles in advancing this Policy (also mentioned in the last Mental Health Policy in 2009) are mentioned below

Role of the Ministry of Education

- Train all school-level teachers in the basic knowledge of mental health problems, and identifying and reporting child abuse.
- Incorporate life-skills in school curriculums to ensure child friendly learning environment.
- Implement mental health promotion programs in all schools that are age appropriate and that reflect the different developmental needs of various age groups.
- Develop, implement and oversee an individualized education plan for each student with a disability, including children with neuro-developmental and neuropsychiatric (epilepsy, mental health and substance use) disorders.
- Ensure counselors are available within the schools to provide assessments and basic counseling, and to refer complicated cases to the primary care system.
- Support the implementation of school-based and school-linked health and mental health services through support for classroom-based and whole school interventions, identification of mental health and neuropsychiatric disorders.
- Provide supports for learning for children with disabilities, including neuropsychiatric disabilities.
- Train teachers to implement and support social emotional learning skills, pro-social skills, behavioral management and support and classroom management and support

Role of the Ministry of Youth and Sport

- Incorporate volunteerism and link with the mental health service users
- Provide opportunities for youth with social-emotional and behavioral disorders to fully participate in social and work opportunities
- Foster inclusion by providing opportunities for sports participation for children and youth with mental health conditions

Role of the Ministry of Gender, Children and Social Protection

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 Social Welfare (and Social Workers) in order to address the needs of disadvantaged individuals with mental illness.

It will be important to advocate for the protection of mentally ill individuals from gender based violence. There is a strong collaboration between the MOGC&SP and the MOH's Mental Health Unit. Mental health providers must be available to support preventive and intervention programs for survivors of SGBV. A program that trains mental health clinicians on SGBV and how MHCs can present in the courtroom should be strengthened and include a continuum of cadre of health and social service providers.

Role of the Ministry of Information

Collaborate with the MOHSW to orchestrate mental health awareness and prevention initiatives, such as media or radio programs to promote the rights and needs of those with mental illnesses as well as to reduce the associated stigma using research-informed strategies.

STRATEGIC PLAN ANNEXES

1. Monitoring and Evaluation Framework with indicators by objectives
2. Operational plans for each year (2016 to 2021)
3. Cost estimate (financing the next five years)
4. Risks and assumptions (national county and local level)

References

Annex 1 Monitoring & Evaluation (M&E) Framework with indicators by objectives - Mental Health Program

Major Strategic Objectives	KEY ACTIVITIES	INDICATOR	DEFINITION	BASE	TARGET 2021	DATA	PERIOD	RESP. UNIT	REPORT
Strategic Objective #1: Increasing the clinical capacity of mental health staff	Selection and training of professional health workers (RNs, PAs & Doctors) to provide quality mental health services	Number of MHCs trained Number of Doctors trained	All categories and level of professional staff identified, trained and deployed at different service delivery points. Approval by Civil Service Agency	166 MHCs	Total staff by 2021 380 MHCs 160 CMHCs 15MDs	MHU	Annually	Mental Health Unit	Training reports to MOH
	All pharmacists will be trained to manage, dispense and provide collaborative care	Number and percentage of Pharmacists trained	Total numbers of pharmacists who receive training to better manage and dispense psychotropic drugs	1	114	SCMU	Annually	SCMU	Training report to Mental Health Unit
	Mentally ill patients provided quality care at health facilities	Number of Mentally ill patients provided quality care at health facilities	Total number of patients with different mental conditions who receive care and treatment	9,309 2014	45,000 OPD	HMIS	Monthly	Health facility	HMIS monthly report
SO #2: Increase inpatient capacity through establishing of wellness unit's at all county hospitals.	Establish Wellness Units within every county hospital to provide inpatient care for the acutely ill who cannot be managed at home.	Number of wellness unit established at county hospitals.	All mental health units set up and equipped at county referral hospitals to manage acutely ill mental health patients.	0	15	MH data base	Annually	MH unit	Annual report

SO # 3: Primary health care level, selected staff trained in identifying, managing and referral	<p>Primary health care workers will be Provided mental health training to identify mental health conditions and manage or refer to specialized MHCs.</p>	<p>Number and percentage of professional PHC staff trained to manage/ refer mental health patients</p>	<p>Total number of professional non mental health clinicians at the primary health care level who receive mhGAP training in mental health</p>	<p>400</p>	<p>1,312 (at least 2 at every health facility)</p>	<p>MH data base</p>	<p>Annually</p>	<p>MH Unit</p>	<p>Training report</p>
		<p>Number and % of mentally ill identified and managed at PHC</p>	<p>All mental health conditions identified and managed at PHC facilities by professional PHC staff</p>	<p>2,832</p>	<p>20,000</p>	<p>HMIS</p>	<p>Health facility</p>	<p>Monthly</p>	<p>Health facility</p>
SO # 4: All facilities have the necessary psychotropic drugs in order to expand the availability and access of mental health services in primary care.	<p>Training manuals used for prescribing complex medications or interventions will be adapted to the Liberian context.</p>	<p>Number of people referred from PHC facilities and MHCs to wellness units.</p>	<p>Total number of people treated at wellness units who were referred</p>	<p>None</p>	<p>7,000</p>	<p>HMIS</p>	<p>Monthly</p>	<p>Health facility</p>	<p>HMIS report</p>
		<p>Number and percentage of wellness units/PHC facilities reporting no stock out of psychotropic drugs</p>	<p>Total number of mental health facilities constantly having stock of psychotropic drugs.</p>	<p>7%</p>	<p>100%</p>	<p>LMIS</p>	<p>Monthly</p>	<p>SCMU</p>	<p>LMIS report</p>

<p>SO # 5: Community-based workers trained to recognize signs of mental illness and referral to health facilities.</p>	<p>Training of community health volunteers to identify and make referral and support people with mental health conditions.</p>	<p>Number and percentage of GCHVs trained to identify mental health conditions and make referrals, including Peer support workers</p>	<p>The total number of GCHVs receiving training in mental health among the total number of gCHVs in the country.</p>	<p>90</p>	<p>4500</p>	<p>CHD MOH</p>	<p>Annually</p>	<p>Mental health unit</p>	<p>Annual report</p>
<p>SO # 6: Communities Desensitized, modify negative perceptions, minimizing stigma</p>	<p>Develop new strategy for mental health promotion and prevention.</p>	<p>Copies of Mental Health strategy for promotion and prevention distributed to stakeholders.</p>	<p>A new strategy detailing Mental Health promotion and prevention for distribution to the public and institutions.</p>	<p>None</p>	<p>50% of Institutions will have materials, including posters</p>	<p>Mental Health Unit</p>	<p>Annually</p>	<p>Mental Health Unit</p>	<p>Annual report</p>
<p>Mental Health service delivery points will be supported to integrate trained peer specialists/ Family support specialists and the peer support family model into their service delivery system.</p>	<p>Number and percentage of mental health service delivery points with peer support family model integrated in service deliver system.</p>	<p>The number of mental health service delivery point gradually integrating peer support/family model in service delivery among total number service delivery points.</p>	<p>NA</p>	<p>By 2021 all facilities will have staff trained in peer support and all facilities will have peer support groups</p>	<p>Mental Health Unit</p>	<p>Annually</p>	<p>Mental Health Unit</p>	<p>Annual report</p>	
<p>Develop mechanism for mandatory reporting of all suicide cases.</p>	<p>Number of suicide cases reported & recorded in national registry</p>	<p>All suicide cases occurring in the country are investigated, reported and recorded.</p>	<p>NA but to be very high</p>	<p>All suicides reported and reported yearly</p>	<p>Task Force</p>	<p>Annually</p>	<p>Mental Health</p>	<p>Annual report</p>	

<p>SO #7 Building the new Cathari Mills Mental Health Center.</p>	<p>A specialized mental health referral hospital will be constructed to provide long term quality care for all mental health conditions</p>	<p>Number of specialized referral hospital built and equipped to provide mental health services.</p>	<p>The one specialized referral hospital for all mental health conditions.</p>	<p>1 but rented and in a very bad state of repair</p>	<p>1 new Tertiary hospital open or in process of being built</p>	<p>Mental Health Unit</p>	<p>5 yrs +</p>		<p>Report</p>
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Annex 2

Mental Health Strategy and Plan – Operational Plan - Activities 2016 to 2021

Seven Strategic Objectives have been identified to achieve the vision and objectives of this policy over the next five years. Listed below are indicators of priorities of areas of work for each year. This may change over time as certain areas are accelerated or slip. It shows the enormity of the work required.

2016 Priorities

- The Mental Health Department (MHD), Ministry of Health will be managerially and administratively strengthened to support implementation of the policy.
- The Mental Health Department will assist each county to develop integrated local plans that are consistent with the Liberian Mental Health Policy. All counties will appoint MHPSS Coordinating committees.
- The MHD will work closely with and support the Ministry of Education, Ministry of Gender, Children and Social Protection, Ministry of Education, Ministry of Youth and Sport and the Ministry of Information to discuss and prioritize their suggested roles outlined in the Mental Health Policy and Strategic Plan
- The National Mental Health Technical Coordination Committee will be reconstituted and will oversee and assist with the implementation of the mental health policy and Strategy for Liberia.
- The Ministry of Health (and CHTs) will initiate and maintain links at all levels between mental health and other relevant sectors such as education, women empowerment and social welfare, local administration, poverty alleviation, child protection and developmental NGOs.
- The MHD will assist Counties to prepare a costed action plan for all counties that in consultation with stakeholders will be implemented based on a defined timetable and consistent with the implementation of other health services
- Prepare training plans to Increase the clinical capacity of mental health professionals. MHC/Carter Center and approved by TCC
- Create a case for an approved cadre of MHCs with commiserate incentives approved by the Civil Service Agency (CSA). Grades, performance expectations, specific roles with job descriptions and responsibilities, competencies and skill mix will be defined. Where necessary, appointments in rural areas will need to be in line with the rural retention strategy and incentive packages and career development pathways.

- Mental Health Coordinators (one per County) will be the Clinical leaders of each county mental health care network.
- Prepare plans with CHOs for the establishment of wellness units at all county hospitals.
- By 2016 pilot programs in facilities with mental health clinicians and mhgap-ig trained mid-level health workers and social workers will integrate trained peer specialists/family support specialists and the peer support/family model into their service delivery system.
- Begin plans for training midwives and health care providers working with pregnant women in Thinking Healthy, a WHO intervention for reducing maternal depression.
- In collaboration with Health Promotion Department the Mental Health Unit develop extensive mental health promotion and prevention and anti stigma and anti-discrimination activities and policies as follows - The main recommendations which demonstrate the effectiveness of programmes and interventions include:
 - Early childhood interventions (e.g. home visiting for pregnant women and parents of young children (HIPPI program piloted in low-income communities in Caldwell), pre-school psychosocial interventions, combined nutritional and evidence-based psychosocial interventions for children under age 5 in disadvantaged populations); support to children (e.g. Life skills building programmes, child and youth development programmes; classroom-based and individual and group interventions for school-aged children);
 - Family therapy training
 - Economic and social empowerment of women (e.g. improving access to education and microcredit schemes);
 - Mental Health and social support to old age populations (e.g. befriending initiatives for the aged, MH interventions for those with dementia, depression and other cognitive problems);
 - Programmes (such as CHD) targeted at vulnerable groups such as survivors of Ebola, family members affected and for people affected by war (including ex combatants)
 - Mental health promotion activities in schools (e.g. child-friendly schools); First phase will be to introduce the training of life skills in schools

- Mental health interventions at work, including at health facilities for health care workers (e.g. employee assistance programs, stress prevention programmes, support groups); and supported employment and psychosocial rehabilitation for people recovering from mental health problems
- Housing policies (e.g. supportive housing for PWMHDE, housing improvement);
- Violence prevention programmes (e.g. community policing initiatives, mental health embedded in SGBV programming and with WACPS);
- Community development programmes (e.g. Communities That Care, integrated rural development) and strengthening community networks)
- Good access to physical health care, including home visiting and emphasis on reducing substance misuse
- Exercise
- Spiritual enhancement, including meditation, and
- Raising mental health literacy:
- Develop peer support services in all counties. These include: peer support groups, patient support groups and trained and credentialed peer specialists in all counties in collaboration with the national user organization, Cultivation for Users Hope. Peer supports services include a range of strategies that strengthen the capacity of the mental health system to respond to the needs of persons with mental health disorders and epilepsy and extend the limited reach of health service providers by: a) providing low-intensity psychological interventions using peers that provide instrumental support and enhances mental health literacy (peer support groups); b) enhancing economic supports for persons living with mental illnesses and epilepsy (patient support groups); and, c) ensuring that health facilities supports engagement and treatment and prevents relapse (peer specialist). At least 4 peer support groups will be established in at least 8 counties.
- Roll out community healing dialogues to communities highly affected by EVD. Mental health prevention and promotion activities will build on lessons learnt from the Ebola response which had a strong impact on the wellbeing of affected individuals and communities. Facilitating the capacity of communities to care for one another using community-led approaches will be a vital component.

- Teachers, village leaders, traditional healers and religious healers will be trained in basic identification, referral and mental health and psychosocial skills so that they can help identify and support people with common mental health problems in the community. At least 100 leaders in each category.
- This policy and strategy endorses the LiCORMH to oversee mental health and substance use disorders related research in collaboration with the Ministry of Health. This multidisciplinary research entity will promote, undertake and examine research to support best practice, link with Liberian universities to identify and build capacity of Liberia researchers and identify priority areas for research and development.

2017 Priorities

- Expand the availability of Mental Health Clinicians (including those trained in child and adolescent mental health). Begin MHC training at Phoebe School of Nursing - 40 MHCs and 40 CAMHCs to complete training in 2 cohorts by end of 2017.
- Provide support for a mental health service user/consumer movement/organization. By 2017, a nationally representative mental health service user organization and a family organization will be fully engaged in policy development, service planning and systems' outcomes evaluation.
- The first set of peer specialists will be trained, credentialed and place in collaboration with the national users and family organization.
- Complete community healing dialogues (CHD) to communities highly affected by EVD.
- A robust training of psychiatrists for Liberia must begin immediately. Liberia needs a minimum of 16 psychiatrists. Three strategies are proposed to fill this gap. Psychiatrists must be among the specialists that are part of the reinvestment plan who assist the Liberian government to train and provide services. Psychiatry must be among the medical specialities that are awarded scholarships to study abroad. At least 6 scholarships must be offered to Liberian nationals to study at medical schools with a program in psychiatry. Six cohorts of psychiatrists should be in the residency program at JFK. The first cohort will begin in 2017.
- Train selected professionals in identification, management and referral of patients with mental health and substance used disorders at the Primary level.
- Provide the necessary psychotropic drugs at all facilities in order to expand the availability and access of mental health services in primary care.

- A comprehensive plan to provide mental health training to primary care workers will be completed. Most people with common mental health problems can be managed in primary care and need not be referred to specialist clinicians. Again in line with the EPHS the role of primary care and hospital health workers in mental health activities will therefore be enhanced. It is proposed that by 2021, 1,312 Registered Nurses, Physician Assistants and medical staff (two for every health facility in Liberia) will be trained in mhGAP-ig, a training Programme specifically designed by WHO for primary care clinicians. The MOH will work with all schools that provide training for health professionals to develop competency-based mhGAP-ig training and make it a requirement for graduation and licensure.
- Pilot training of Thinking Healthy and supervision of health care workers working with pregnant women. By the end of 2017, 200 midwives will be trained in Thinking Healthy.
- All pharmacists must be trained to manage, dispense and provide collaborative care in mental health. It is proposed that the curriculum and training of new pharmacists meet internationally accepted standards and are competency-based. For pharmacists in practice, there must be a comprehensive training in mental health and mental health drugs. By 2017, all practicing pharmacists must receive yearly competency training in mental health medications. Training manuals used for prescribing complex medications or interventions will be adapted to the Liberian context.
- Rehabilitation/step down and addiction treatment service established in Montserrado
- Extensive mental health promotion and prevention and anti-stigma and discrimination activities will be agreed between Ministries.
- New mental health legislation (the Mental Health Act) for Liberia will be enacted. The main components of the new act will be to:
 - Identify and confirm rights to treatment and care for the mentally ill.
 - Safeguard human rights of mental health patients.
 - Ensure that informed consent is given.
 - Establish a set of minimum standards for patient care.
 - Define protocols for detention and treatment in emergency situations.
 - Appoint Mental Health Review Officers and authorized patient advocates
 - Establish a Mental Health Act Advisory Board to advise the Minister of Health

- Pilot in at least 45 facilities in 2 counties the inclusion of mental health services users and family members in health care planning, service delivery and evaluation for persons with mental health and substance use disorders, and epilepsy.
- The key staff to train early will be the proposed new cadre of Community Health Services Supervisors (CHSS) in rural and remote areas who will be a professionally trained health worker. All CHSS will be trained in mhGAP
- Train gCHVs/CHA in the community components of mhGAP (community identification, detection and referral, mental health/addiction emergencies and mental health/addiction services education) consistent with planned training modules.
- To address stigma, a new strategy for mental health promotion and prevention will be developed in collaboration with Cultivation for Users Hope using evidence-informed strategies such as the social engagement model already implement in 6 counties in Liberia, leading to greater awareness and acceptance of persons with epilepsy, mental health and substance use disorders. Promotion of good mental health will require multi-sectoral collaboration and action. Training in anti-stigma, grief and loss and mental health promotion for at least 50 religious and traditional leaders in at least 6 counties.
- Establish a national suicide prevention taskforce charged with developing and implementing a plan to address suicide including but not limited to creating mandated reporting and registry for all suicides. Create and adequately staff immediately a crisis and suicide prevention hotline and publicize its existence widely.
- Social Workers will be used in all community or school based mental health programs

2018 Priorities

- Expand the availability of Mental Health Clinicians (including those trained in child and adolescent mental health). An additional 40 MHCs and 60 CAMHCs will be certified to practice.
- Transition, in conjunction with the Liberia Board of Nursing and Midwifery, transition the training of CAMHC to a national nursing school.
- Increase in-patient mental health capacity through the establishment of wellness unit's at all county hospitals.

- By 2018, 40% of all health care facilities will include mental health services users and family members in health care planning, service delivery and evaluation for persons with mental health and substance use disorders, and epilepsy.
- Sensitize communities about mental health and illness and modify negative perceptions about the mentally ill, thereby minimizing stigma and negative behaviours toward persons with neuropsychiatric disorders including epilepsy, mental health and substance use disorders.
- Encourage families of persons with neuropsychiatric disorders (epilepsy, mental health and substance use disorders) to be involved in the care and management of their loved ones.
- Teachers, village leaders, traditional healers and religious healers will be trained in basic identification, referral and mental health and psychosocial skills so that they can help identify and support people with common mental health problems in the community.
- Strengthen mental health in the national agenda for persons with disabilities through representation with the National Commission on Disabilities fully integrating services and supports for persons with mental health disorders, epilepsy and substance use disorders in the Agenda for Transformation and its successors.
- 45 Basic Social Workers (BSW) who will be Masters of Social Work (MSWs) employed by Ministry of Gender, Children and Social Protection will need to be employed at all Wellness and Rehabilitation units. By 2016, there will be 15 CSWS trained every two years. By 2021, 45 MSWs will be required.
- All certified and registered midwives must undergo training in Thinking Healthy, a WHO guide for working with pregnant and parenting women with mental health needs. The national reproductive health strategy must include reference to this plan.
- The lack of identification and a referral system is a significant problem in Liberia. Community level workers are best placed to identify, refer and set up support systems for people with mental illness. In 2018 1,500 community
 - Ensure identification of people with serious mental illness and referral procedures are developed
 - Prioritize people with on-going problems and provide regular and practical support.

- Provide information and health promotion.
- Help identify early signs of relapse.
- Support anti-stigma and advocacy campaigns at the community

2019 Priorities

- Expand the availability of Mental Health Clinicians (including those trained in child and adolescent mental health). 40 MHCs begin training 40 CAMHCs.
- Increase in-patient mental health capacity through the establishment of wellness unit's at all county hospitals.
- Supervision of training primary health care workers by skilled mental health clinicians and MDs trained in mental health is critical to supporting this system.
- Build the new Catherine Mills Mental Health Center
- At least one Mental Health Clinician (Addiction Specialist) will be appointed in every County. Primary care and hospital based staff will be trained. 15 addiction specialists will be appointed, one for each County. It has been agreed to develop addiction specialists at three levels, those who were trained as MHC with a focus on addiction and those at the PSS level trained to provide outreach identification, referral and basic counselling.
- At the pre-service level every graduating nurse, physician assistant, certified midwife, and registered midwife must receive mhGAP-ig training before graduation. mhGAP-ig should be the linchpin mental health in-service program with refreshers provided through the MOH training unit.
- In 2018 1,500 community level staff should be trained in the areas mentioned above

2020 Priorities

- Expand the availability of Mental Health Clinicians (including those trained in child and adolescent mental health). 46 MHCs begin training
- Increase in-patient mental health capacity through the establishment of wellness unit's at all county hospitals.
- To address integration of mental health into all platforms by 2021 every program that serves persons with HIV/AIDS, maternal and newborn health (Thinking Healthy, see above), TB and leprosy must have all mid-level workers trained in mhgap-ig.
- In 2020 1,500 community level staff should be trained in the areas mentioned

2021 Priorities

- Increase in-patient mental health capacity through the establishment of wellness unit's at all county hospitals.
- By 2021, all facilities will have peer support groups, family support groups and peer specialists available for persons with mental health disorders, epilepsy and substance use disorders in their facilities.
- In 2021 another 1,500 community level staff should be trained in the psychosocial areas mentioned above
- Mental health services must be provided at all SGBV units in the country. Mental health clinicians and nurses assigned to SGBV units will be specially trained in the psychological health of patients who have experienced SGBV. Each one-stop shop will have a full-time equivalent mental health clinician or SGBV clinician trained in mental health.
- Psychiatrists and other doctors trained in mental health. Training plans and bursaries (where necessary) will be available. At least 6 neurologists should begin training abroad. In addition, 30 clinical psychologists and 30 occupational psychologists will begin training in other African countries through scholarships and return to support the mental health system.
- In line with Government Policy the following mental health services will, by the end of 2021, be provided at Health Centers (HC), District Hospitals (DH),

By 2021 - All facilities will provide services for the identification of mental health conditions (at every HC, DH, CH and RH) and treat or refer

Identification and treatment of the following mental health problems

Anxiety and stress-related disorders

Bi-polar disorder

Depression and other Mood disorders

Family psycho-education and support

Major mental health conditions

Psychosomatic symptoms

Schizophrenia

Other Psychotic disorders

Substance (Drug and alcohol) Abuse and dependency

Suicidal ideation and acts

Trauma and post-traumatic stress syndrome

Identification and treatment of the following neurological disorders

Epilepsy

Identification of the following protection issues that impact greatly on mental health

Domestic and interpersonal violence including Referral to Social Worker

Survivors of rape including Referral to Social Worker

Annex 3

New Mental Health Strategy 2016 to 2021 - Funding required

Funding required per year	2016	2017	2018	2019	2020	2021
Training (capacity building) costs						
160 Mental Health Clinicians and 160 Child and Adolescent MHCs		80,000	80,000	80,000	80,000	80,000
45 Clinical Social Workers (MSW) MOGCSP/MOH		75,000	150,000			
15 Addiction Specialists trained			75,000			
1,312 Primary Care staff trained in mhGAP and 4,000 gCHV's trained		300,000	300,000	300,000	300,000	300,000
Incentives for selected community level workers (see Annex 4)		50,000	100,000	100,000	100,000	100,000
15 Health Education Officers trained and 30 Psychosocial trainers		90,000				
Bursaries for medical staff to train overseas as Consultant Psychiatrists				100,000	100,000	100,000
Bursaries for 15 medical staff in a one year Diploma to become Assistant Psychiatrists	100,000	100,000	100,000			
Leadership course in Mental Health (see Annex 4)	50,000	50,000	50,000			
Recurrent revenue costs per year						
Health promotion, prevention activities and anti-stigma activities		100,000	100,000	100,000	100,000	100,000
Psychotropic Drug supply		250,000	300,000	500,000	500,000	750,000
Mental Health Department at MOH	60,000	60,000	60,000	60,000	60,000	60,000
Complete CHD for all people affected by Ebola, including survivors	500,000	500,000				
Infrastructure costs						
Wellness Units x 15 (3 per year)			450,000	450,000	450,000	450,000
Rehabilitation Unit x 5	100,000		150,000	150,000	150,000	150,000
Regional Substance misuse treatment Units. (one specialising for youth)		150,000	150,000	150,000	150,000	150,000
Essential Improvements to E.S. Grant hospital	150,000					
New Psychiatric referral and teaching hospital (200 beds) to replace E.S. Grant					3,000,000	9,000,000
Total (Million USD)	810,000	1,805	2,065	2,140	4,990	11,240

A total investment of approximately \$23.05 Million USD, most of which (\$15.4 Million) is infrastructure (building costs) would create a modern mental health system with appropriate infrastructure. It is hoped Donors interested in major construction projects will assist the Government of Liberia to achieve improvement in this long neglected area of health care.

A modest investment of \$7.65 Million (revenue costs) would develop the staffing, training, incentives, bursaries, psychotropic drug supply, and health promotion, prevention and anti stigma activities to meet the aims of this new Mental Health Policy and Strategy. It would also address the continuing needs of Ebola survivors and the families affected.

Annex 4

Risks and assumptions (national country and local level)

MAJOR RISKS	ASSUMPTIONS/MITIGATION
National level	
<p>Given all the other health priorities a low Priority might be given to mental health</p>	<ul style="list-style-type: none"> • Attract major Donor/s to invest over 5 years • Stress the links to good mental health and improved patient outcomes across all health programmes - HIV/AIDS, maternal and newborn health, TB and leprosy and all non communicable and non communicable diseases • Arrange Leadership courses in mental health for senior managers and CHO's, in conjunction, for example, with the Centre for International Mental Health, University of Melbourne • Work closely with other Ministries to advocate for, and invest in, improved mental health services
County level	
<p>New Mental Health Clinicians moved to other general posts. Low levels of staffing</p>	<ul style="list-style-type: none"> • Create a cadre of Mental Health Clinicians (MHCs) approved by the Civil Service Agency. This should also be applied for existing MHCs • Staff new wellness and Rehabilitation/step down units with MHCs who can also arrange outpatient clinics and engage with primary care and the community level workforce • Develop peer support services in all counties to provide support. • A comprehensive plan to provide mental health training to primary care workers will be completed.
Local level	
<p>Local Health volunteers and community staff not engaged and community stigma</p>	<ul style="list-style-type: none"> • Train all community level workers in mental health • Create (pay) incentives for a proportion of community level workers to engage in supporting people with serious mental illness and undertake Health Prevention, Promotion and anti stigma activities • Select Community level workers with the right attitudes and train them with skills. Recruit for attitudes and train for skills • Train the new Community Health Service Supervisors (CHSS) in mhGAP • To address stigma Health Promotion Division, develop a new strategy for mental health promotion and prevention in collaboration with Cultivation for Users Hope using evidence-informed strategies Develop the social engagement model (already implemented in 6 counties in Liberia) leading to greater awareness and acceptance of persons with epilepsy, mental health and substance use disorders in communities. • Teachers, village leaders, traditional healers and religious healers will be trained

REFERENCES

- ⁱ Ministry of Health and Social Welfare. (2009). National Mental Health Policy. Monrovia, Liberia.
- ⁱⁱ Ministry of Health and Social Welfare. (2011). National Health and Social Welfare Policy and Plan: Final Draft for Validation. Monrovia, Liberia.
- ⁱⁱⁱ Ministry of Health and Social Welfare. (2011). January 2011 BPHS Accreditation Final Results Report. Monrovia, Liberia.
- ^{iv} Africa.; E. C. f. (2015). MDG Report 2015: Assessing Progress in Africa toward the Millennium Development Goals. Addis Ababa, Ethiopia, United Nations Economic Commission for Africa.
- ^v Surkan, P. J., et al. (2011). "Maternal Depression and Early Childhood Growth in Developing Countries: Systematic Review and Meta-Analysis." Bulletin of the World Health Organization **287**: 607-615D.
- ^{vi} Ministry of Health & Social Welfare, et al. (Undated). Mental Health Needs Assessment of Liberian Children, Adolescents and Young Adults: Summary of Initial Findings. Monrovia, Liberia.
- ^{vii} Preux, P.-M. and M. Druet-Cabanac (2005). "Epidemiology and Aetiology of Epilepsy in Sub-Saharan Africa." Lancet Neurology **4**: 21-31.
- ^{viii} World Health Organization. (2008). Global Burden of Disease: 2004 Update. Geneva, Switzerland, WHO Press.
- ^{ix} Gerrits, C. (1983). "Letter to the Editor: A West African Epilepsy Focus." The Lancet: 358.
- ^x Goudsmit, J. and F. W. van der Waals (1983). "Letter to the Editor: Endemic Epilepsy in an Isolated Region of Liberia." The Lancet: 528-529.
- ^{xi} World Health Organization. (2004). Epilepsy in the WHO Africa Region: Bridging the Gap. Hoofddorp, The Netherlands, WHO.
- ^{xii} Behrendt, A. (2008). Mental Health of Children Formerly Associated with the Fighting Forces in Liberia: A Cross Section Study in Lofa. Dakar, Senegal, Plan International.
- ^{xiii} Patel, V., Belkin, G.S., Chockalingam, A., Cooper, J., Saxena, S., and Unutzer, J. (2013). "Grand Challenges: Integrating Mental Health Services into Priority Health Platforms." PLoS Medicine **10**(5): e1001.
- ^{xiv} Phyllis, S. (2004). "Peer Support/Peer Provided Services Underlying Processes, Benefits and Critical Ingredients." Psychiatric Rehabilitation Journal **27**(4): 392-401.
- ^{xv} Davidson, L., et al. (2006). "Peer Support among Adults with Serious Mental Illness: A Report from the Field." Schizophrenia Bulletin **32**(3): 443-450.
- ^{xvi} Yasamy, M. T., et al. (Plos Medicine). "Responsible Governance for Mental Health Research in Low Resource Countries." PLoS Medicine **8**(11).