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Does the Messenger Make a Difference? Religious and Traditional Leaders' Role in Improving Access to Mental Health Services in Liberia

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Abstract

There are many mental health challenges, and opportunities, that are being addressed in Liberia in the wake of two civil wars, the last of which ended in 2003, and the 2014 Ebola crises. The civil wars are in the living memory of most of the population, and participants in the conflict live alongside survivors. This has caused trauma and political challenges, and slow rebuilding of trust among the parties to the conflict. The Ebola crisis also contributed to mental health challenges in another form, as the illness decimated the health workforce. This has caused further strain on an already resource strapped national healthcare system and workforce. While these conditions are more than unfavorable, they create opportunities to strengthen health systems, and they identify a "call to action" for mental health practices in the Ministry of Health's broader strategy. This follows action in 2011, where academic experts called on international organizations and national governments to place a stronger emphasis on global mental health.

The current research evaluates a strategy for promoting mental health services in Liberia via a scaling up approach using existing religious and traditional leaders. The aims of this research are to explore the efficacy of the use of religious and traditional leaders using Key Informant Interviews (KIIs). Results showed that training and incorporating religious and community leaders into collaborative mental health care is feasible and advantageous. Next steps include adopting recommendations for continuing mental health education for religious and traditional leaders, bolstering the collegiality and collaboration between religious and traditional leaders and county mental health teams, working to address access to medications and medication supply chains, and working to address transportation issues around seeking mental health support and treatment.

Acknowledgments

I want to express my sincerest gratitude all those who have supported me and this work, including Dr. Janice Cooper the country representative and lead for the Carter Center's Mental Health Program in Liberia and my thesis advisor Dr. Rachel Waford. I would also like to thank the Liberia team including Wilfred Gwaikolo, Dyonah Thomas, Josiah Monmia, Worpoe Woahloe, Tina Gbelia, Riches Jippy, Mark Kamara, Momo Konneh, Tete Seplah and many others who contributed to the success of the work. Thank you to all the religious and traditional leaders who were willing to speak with us, their contribution was invaluable, and they offered great insights.

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I also want to thank others at Emory who made the work possible: Dr. Deb Mcfarland and Lara Martin of the Global Field Experience. Practicum advisor and Institute of Developing Nations Interim Director, Dr. Dabney Evans. Others with the Institute of Developing Nations: Obse Ababiya and Stephanie Sorquira, and Rebeca Quintana of the Master's in Development Practice. Tim Daniel and Julian Wyatt deserve special acknowledgement also.

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Introduction and Literature Review

Liberia Context

Mental health and psychosocial issues affect a large portion of the population in Liberia, but these issues have received only limited attention to date due to the government's prioritization of other urgent needs and limited resources. Such issues largely stem from two civil wars (1989 to 1997 and 1999 to 2003), during which a significant portion of the population experienced traumatic events. A 2008 study from the Journal of the American Medical Association (JAMA) found that 40 percent of the Liberian population self-reported symptoms characteristic of major depression, and 44 percent noted indications associated with post-traumatic stress disorder (PTSD) (Johnson et al., 2008). In addition to the individual-level impact, available research points to the impact of such trauma on community and family ties (Eaton et al., 2011). The challenges of recovering from the wars were exacerbated by the death of large swaths of healthcare professionals and the broader public due to the 2014 Ebola epidemic. This further impaired a health system that was strained before the epidemic, the largest in history.

Liberia has a population of approximately 4.6 million people, a per capita GDP of $806 as of 2016 ("Liberia Country Profile", 2018), and a 10% expenditure of GDP on health as of 2014 ("Liberia Country Page", 2018). Responsibilities for health services fall under the Ministry of Health and Social Welfare in Liberia. The operational units within the Ministry of Health and Social Welfare consist of 15 county health and social welfare teams, one for each county (administrative units roughly equivalent to states). These teams address issues related to non-communicable diseases (NCDs). NCDs are diseases not caused by infections and include diabetes, heart disease, and mental health issues. In addition to work with NCDs, there are also

issue specific, national programing taskforces to combat communicable diseases like tuberculosis, malaria, and others. The county health teams continue to be the focal points in concentrating efforts to bolster the country's implementation of mental health strategies (Liberia Ministry of Health, 2018). Related to the mental health support for the structures and priorities of the Ministry of Health, there are only .02 psychiatrists per 100,000 in Liberia according to the WHO (Mental health Atlas Country Profile, 2014). The stark lack of credentialed mental health personnel inspired The Carter Center to take on the largest leadership role alongside Liberia's legislative and executive institutions in mental health advocacy, program implementation, and policy in Liberia in order to address mental healthcare. The Carter Center is a not-for-profit organization founded by former United States President Jimmy Carter and based in Atlanta, GA, USA, with the goal of advancing human rights and alleviating human suffering. The theme of mental health continues to be prioritized by former First Lady Rosalyn Carter both in Liberia and in Georgia, USA. Mental health issues are championed through the Carter Center's training of cohorts of healthcare professionals in "best practice" for supporting the mental health and psychosocial wellbeing of service users in Liberia. Scores of healthcare professionals have been trained to date.

In response to mental health challenges in Liberia, the Carter Center's mental health program was selected to support the implementation of the Mental Health Beyond Facilities (mhBeF) project in collaboration with the Liberia Center on Outcomes Research in Mental Health (LiCORMH) in 2012 by Grand Challenges Canada. The project is led out of the Makerere University School of Public Health in Uganda and is being implemented in Liberia, Uganda, and Nepal to bolster the capacity of formal health systems, community members, and leaders to respond to mental health needs.

When Ebola emerged, additional programmatic reinforcement was necessary to address the fact that the Ebola crisis was crippling Liberia's already strained healthcare system and healthcare workforce. The Carter Center's mental health program in Liberia adapted to the unanticipated change, implementing additional programming through the Supporting Psychosocial Health and Resilience Project dedicated to bolstering mental health in Liberia. This additional programing component, which began in 2015, has trained scores of local healthcare professionals in mental health, supported the Ministry of Health's policy and planning related to mental health (including the achievement of passing mental health legislation), and implemented programing designed to promote anti-stigma. The project is supported through the Japanese Social Development Fund administered through the World Bank.

The problems and challenges outlined above are many. There exist profound and endemic mental health issues in Liberia, not limited to acute stress and PTSD, following decades of crises and trauma. Careful consideration must be given to how mental health can best be incorporated within existing healthcare system units. Unlike Ebola or other infectious diseases, mental health interventions require iterative implementation sustained over years and years and careful fortification of existing health systems.

Previous Calls and Responses to Address Global Mental Health

In 2011, as a follow up to a 2007 Lancet series calling for more comprehensive attention and implementation of global mental health with the rallying cry of "No Health without Mental Health" (Prince et al., 2007), Tol et al. (2011) conducted a meta-analysis to determine common mental health services provided in humanitarian settings. A humanitarian setting is identified as the aftermath of a natural or politically made disaster (typically armed conflict) where resource demands placed on the existing infrastructure exceed existing systems' ability to adequately

address them. Tol et al. (2011) demonstrated high prevalence of depression for those in humanitarian settings compared to general populations. As an example, one study looking at prevalence rates of PTSD in Nimba County alone in 2010 (before Ebola) determined them to be high at 48.3% (Galea et al. 2010). Tol et al. (2011) identified the five most cited areas of service provision in humanitarian settings. These areas consisted of basic counseling for individuals, facilitation of community support of vulnerable individuals, provision of child-friendly spaces, provision of community-initiated social support, and basic counseling for groups and families. This meta-analysis showed evidence that adults with symptoms of PTSD in humanitarian settings benefited from psychotherapy and psychosocial supports compared to those receiving usual care (identified to include being on a waiting list or including not receiving care). In children, benefits of psychotherapy and psychosocial supports were shown for internalizing symptoms. Overall, interventions showed promising effect for strengthening community and family supports, and for adults with symptoms of post-traumatic stress. Taken together, psychotherapy and psychosocial interventions (including community and community led interventions) are beneficial to and can be provided to those living in humanitarian contexts such as those in Liberia.

The prevalence of psychological challenges in humanitarian settings related to the effects of conflict-related traumas is wide reaching, and research has focused specifically on PTSD and efforts to address it. Unfortunately, the settings in which interventions such as those implemented by the Carter Center team in Liberia are unstable, and work continues despite an unknowable future. Interventions may struggle substantially to be implemented with regularity or with strong oversight. In turn, health systems and other physical and social infrastructure, which are already under great strain and spread thin, face additional protracted shocks and prioritization

of resources is made to feel more urgent. Thus, the system is forced to do more with less more urgently.

Because of these challenges, the basic interventions implemented in these contexts are often implemented by general healthcare providers. Two-thirds of the studies assessed by the Tol et al. (2011) meta-analysis looked at programing implemented by non-specialized personnel such as community workers, teachers, and school counselors. Their analysis offered many considerations including 1) ways to move forward in our understanding of mental health in humanitarian settings, 2) strengthening of evidence for mental health psychosocial support in humanitarian settings, and 3) systematic integration of rigorous monitoring and assessment, research, and funding to go with it.

Despite the robust outcomes from the meta-analysis, that included 192 humanitarian crises spread over 81 territories, Tol et al. (2011) highlighted that few findings exist from Latin America and western and central Africa. This is problematic, as program implementation must be culturally specific and acceptable. Programing which works in one country or region may not work in another. Moreover, religious leaders were not included in those playing a support role in addressing mental health needs in the meta-analysis (Tol et al., 2011). This is a notable problem in West African countries, because of the specific culture and history in West Africa, culturally significant mental health conditions, and because different religious dynamics and engagement with religious leaders impact their contributions differently.

In response to these limitations, Eaton et al. (2011), sought to gain an understanding of the extent to which mental health services in low and middle-income countries can be scaled up. Scaling up refers to the process though which “the overall volume of services provided to treat people with mental disorders” (The Lancet, 2007, pg. 1241) is bolstered so that more people

have access to and receive services. They assessed progress in scaling up mental health services internationally by conducting a literature review and survey of key stakeholders in mental health. They found that as few as two percent of those with mental health conditions receive treatment in low and middle-income countries compared with a third of people treated living in high-income countries (Eaton et al., 2011). They reported a high quantity of existing programs, and, some have useful strategies and the potential to scale up. However, the authors noted that mental health still lacks the prioritization and resources necessary to be implemented more broadly in most countries. Finally, they cite the need for political leaders and decision makers to understand, recognize the importance of, and prioritize action related to mental health needs (Eaton et al., 2011).

Efforts to improve both access to, and administration of, mental health services in humanitarian settings have centered on the idea of task sharing, as the number of formally educated and credentialed psychologists and psychiatrists and the services provided are paltry. Task sharing is defined as "delegating tasks to existing or new cadres with either less training or narrowly defined training" (Folton et al., 2011, pg. 01). The use of task sharing to facilitate access to and treatment of mental health symptoms has gained momentum and consensus. Because there are so few credentialed and formally trained professionals in humanitarian settings, this approach broadens the definition and identification of service providers. There is also a significant, related push to ensure that national and international investment is more heavily oriented towards the lower end of the Optimal Mix of Different Mental Health Services (Figure 1.), focusing on strategies in community engagement in self-care, informal community care, and referral pathways available mental health services (*Mental Health Policy*, 2018). This strategy of shoring up and growing broad basic services works to address mental health

interventions in a cost-effective manner through early interventions before mental health conditions compound and become costlier to treat.

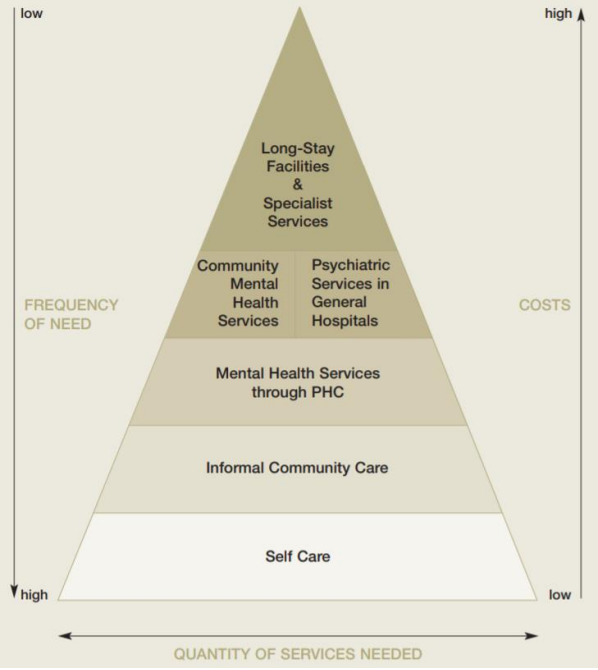

Figure 1. Optimal mix of different mental health services (WHO, 2007).

As a broader part of the response to previous research and calls to action, the United Nations (UN) included in the 2015 Sustainable Development Goals (SDGs) the aim of reducing, by one-third, premature mortality from NCDs. They sought to do this through prevention and treatment of NCDs, and promoting mental health and wellbeing, by 2020. As part of the SDGs, the goal of promoting mental health and wellbeing is measured using estimates of national suicide mortality rates (*Goal 3. Sustainable*, 2018). This serves as an important step forward in measuring the burden of adverse mental health conditions globally, and can begin to address measuring mental health issues in Liberia as well. While global mental health professionals laud the inclusion of this indicator to measure mental health within the SDGs, there is consensus that suicide mortality rates alone are an insufficient representation of the global burden of mental health disease and must be considered comprehensively along with other indicators from other

goals. The use of suicide mortality rates as an effective way to measure global mental health burden is limited because these rates do not account for extenuating factors including access to means to take one's own life, number of previous attempts at suicide, formal diagnoses of PTSD and other different types of distress, and other mental health burden not resulting in suicide. As of 2016, Liberia's estimated age-standardized death rate due to self-harm stood at 16.5 per 100,000 (suicide mortality rate) ("Health-related SDGs", 2018).

Taken together, previous calls to action around global mental health advocate for significant steps. However, current implementations of mental health services are insufficient globally. Where there are services, improvements are needed for individuals who seek and receive services. There is robust evidence that it is useful, efficient, and cost effective for services to be implemented by the existing healthcare professionals and laypeople who have received some basic training in mental health. Moreover, research has shown that equipping these individuals is of particular value, as they are better positioned and have the necessary cultural and language stills to amplify their impact. Through their contributions, task sharing in providing mental health service has utility in in better serving individuals with mental health needs, globally. Understanding this, it is useful to consider the people in the community who are uniquely positioned to support progress on this front.

Incorporating Religious and Traditional Leaders for Improved Access to Mental Health Services

Religious and traditional leaders play an outsized role in the Liberian context. It is common practice in Liberia for people to engage religious and traditional leaders seeking solutions and guidance for a myriad of personal challenges related to religious, traditional, and medical issues. As part of the confidence community members place in religious and traditional

leaders, they often seek out leaders to provide services to address health and mental health. Approximately 85.5% of Liberians identify as Christian and 12.2% identify as Muslim (2010 Report on Religious Freedom, 2010). Traditional beliefs and practices are also deeply held, practiced, and incorporated within the religious practices of Christianity and Islam throughout Liberian society. The need to address mental health concerns stemming from the recent history of the wars and the impact of Ebola in Liberia is paramount. Leveraging the influence of religious and traditional leaders is a promising route to refer community members to appropriate mental health services.

Unfortunately, there is a history of abuse and maltreatment of people experiencing adverse mental health symptoms by religious and traditional leaders. That such mistreatment and abuse is often intended as help underscores the importance of working to understand and improve the knowledge and skills base of the religious and traditional leaders. Researchers have looked extensively at where and how religion and mental health intersect. Many have promoted and made progress on the strategy of collaborating with religious leaders to address the mental health needs of community members. Alem et al. (2008), worked with community health workers in sub-Saharan Africa to strategize what community engagement addressing mental health care might look like. Most importantly, they found that community workers agreed with the strategy of their being engaged in addressing mental health and emphasized the relationship with religious and traditional leaders as being paramount. Additionally, a systematic meta-analysis by Gonçalves et al. (2015) showed significant benefits to the reduction of clinically significant mental health symptoms including anxiety by using religious and spiritual interventions (Gonçalves, Lucchetti, Menezes, & Vallada, 2015).

A persistent concern related to the implementation of mental health strategies is the lack of credentialed and formally educated professionals and their uneven geographic distribution. In most countries, similar to clinicians practicing medicine, psychology and psychiatry professionals with high socioeconomic standing are incentivized to concentrate and practice in urban areas where urban amenities and strong compensation incentives are also concentrated. In a 2013 paper as part of a Lancet series on mental health integration with primary health care platforms, Patel et al. (2013) advocate for integrating mental health care into national primary healthcare systems to reverse the typically siloed nature of mental health and primary health care. They argue in the article and elsewhere in the Lancet series that by effectively addressing mental health issues, the burden of treating other diseases can be more effectively impacted. Specifically, they advocate for: assessing goals, functions, and resources of priority programing; identifying shared and achievable goals; and clarifying responsibilities and monitoring progress (Patel et al., 2013). These strategies could easily be applied with the collaboration and support of religious leaders as community stakeholders. The indication that these strategies are effective in low resource settings in both low income and high-income countries points the generalizability of the strategy (Hoeft, Fortney, Patel, & Unützer, 2018).

Study Aims

The principal aim of this study is to develop and implement an initial research tool intended to measure aspects of participation and collaboration between religious and traditional leaders and county mental health teams in Liberia. This tool could likely be implemented in other counties in West Africa with a similar goal. The tool is important as it is an initial step to gain an ongoing understanding of the knowledge and skills of religious and traditional leaders and their

ability to support the identification and referral of community members in need of mental health services.

Additionally, after review of the historical and current mental health problems in Liberia, and review of the relevant literature, the following conclusions can be drawn: 1) mental health issues are a priority in humanitarian settings, 2) there are rarely sufficient formally trained psychologists and psychiatrists in these settings for the size of the population, and 3) research has demonstrated success surrounding the implementation of strategies related to psychosocial support and task sharing with leaders in humanitarian contests. Thus, the current study also aimed to evaluate the role that religious and traditional leaders play in scaling up mental health services in Liberia.

The current study addresses the following questions:

1. To what extent do religious leaders support their engagement as part of the mental health referral mechanism?
2. Is it useful for religious and traditional leaders to engage in facilitating community members' access to mental health services?
3. Does the training of religious and traditional leaders improve their knowledge of mental health, improve their ability to support people experiencing adverse mental health symptoms humanly, and help to facilitate an appropriate route to referral?

The findings from this study will inform decisions for The Carter Center's mental health programing in Liberia. It will also inform future undertakings for researchers studying best strategies for collaboration between religious and traditional leaders and mental health professionals. Finally, it will also be used to bolster deeper integration of mental health into Liberia's broader health strategy and legislation.

Methods

Participants

Sample. The current sample was recruited from a pool of approximately 200 religious and traditional leaders. These individuals participated in mental health trainings through the Carter Center in 2016. Of the 200 individuals who participated in the training for religious and traditional leaders, twenty-seven agreed to participate in the current study. Individuals who participated in the training but did not participate in the current study did so because they were either unavailable or unreachable. Unfortunately, numbers for these groups are not available.

Informed consent and IRB. Informed consent was obtained from all participants and included understanding of the purpose of the study, voluntary participation, study procedures, potential risks, confidentiality, potential benefits, and consent for audio recording. Researchers compensated the transportation costs of the participants at $5.00 USD per day and provided participants with a branded wristband and a bar of soap as a gift of gratitude for their participation.

Researchers submitted formal study documentation to the University of Liberia's Internal Review Board (IRB) including the Curricula Vitae of the co-researchers, the multi-part survey tool to be used, the participant consent form, IRB solicitation letter, and an initial review document template. The study received formal, documented approval.

Measures

Multi-part survey tool. A multi-part survey tool was designed to conduct KIIs with religious and traditional leaders in Liberia (see annex). The full survey consisted of thirty-nine questions. Four questions used for this study were designed to provide insight into the role of

religious and traditional leaders in connecting community members to mental health services provided by the Ministry of Health. These were presented in the form of Likert statements. The remaining questions were used as project-specific information and support.

In addition to the survey questions, three yes/no questions were asked to determine whether religious and traditional leaders felt they had skills determined important to researchers. Participants were then also asked open-ended questions to solicit skills they felt were important. Interviews lasted no longer than 1 hour and 30 minutes, and during that time participants were free to take a break or stop the interview if they wished.

Likert statements. The following four statements were presented to each participant to evaluate the degree to which religious and traditional leaders support their involvement in mental health care.: 1) “The county health team's mental health services are more integrated (it is inside) with the community”, 2) “Community members feel they benefit from the county health team's mental health services”, 3) “The way that the county health team carries out mental health services is correct”, and 4) “The county health team provides different mental health services to community members (for example: mental health crisis support, access to health care workers with training in mental health, counseling, trained social workers that can make sure people get community support services).” A 5-point Likert scale was used; with a range from strongly agree to strongly disagree.

Researcher-prioritized skills identification. Participants were presented with statements relating to skills determined a priori to be priorities in identifying and supporting those seeking mental health services. Participants were asked to respond “yes” or “no” to the following questions: 1) “I can identify individuals (people) experiencing acute mental stress,” 2) “I can

direct individuals (people) to community health service resources for help," 3) "I can tell between the different types of mental health issues."

Leader-provided effective skills. Participants were also asked to identify the professional skills that they felt were the first and second most effective in supporting community members' access to mental health services. This was open-ended and participants could report any skill they thought was effective for them. This was done to gauge which skills they felt they possess to support community mental health teams.

Procedure

Participant training. The initial trainings took place in Montserrado County, Liberia with attendees from Montserrado and Margibi counties over the course of two days during the rainy season in 2016. The trainings were held in these counties because half of the country's population of 4 million lives in these counties. Moreover, this is where the Carter Center interventions were being implemented and where the religious and traditional leaders are based. Participants were compensated for their lodging and travel. Trainings were held in an open forum, which allowed for engagement between facilitator trainers and participants. Training themes included introduction to mental health and illness, stigma and anti-stigma, collaborative care, the referral pathway, myths and facts about mental illness, stress and stress management, and community care.

Researcher training. Research assistants participated in a half-day training in July 2017, approximately one week before the start of the study. Researchers reviewed the KII tool, practiced questions amongst colleagues, and discussed the appropriate administration of the tool. Researchers were also provided information about the participant training in order to inform

modification and implementation of the interview tool. While the researchers were provided the training module names, they did not have access to the course content. All hired research assistants had previous experience in research, and data collection and enumeration previously.

Recruitment and data collection. Religious and traditional leaders who participated in the mental health trainings were recruited for participation. The recruitment was conducted by phone from the Carter Center's satellite compound in Congo Town in Monrovia, Liberia's capital city. Researchers recruited participants by calling attendees listed on attendance sheets from the conducted trainings.

Data was collected in Margibi county (N = 8) and Montserrado county (N = 19). Accessing and driving to individually interview participants over the course of several days was feasible in Montserrado County, as this is where the researchers were also based. In Montserrado County, researchers individually called all participants listed on attendance sheets from this county. Researchers identified interview sites, usually at or near their places of worship, and then developed routes and an itinerary according to where the participants were located. All of the interviews occurred over the course of two weeks.

Overnight travel and accommodations were required to conduct the interviews in Margibi County. Researchers contacted a county health team point of contact with the names of those participants who had attended the trainings in Margibi County. The point of contact coordinated eight participants to come to the main health center in a centralized location where the researchers conducted the interviews.

Data Analysis

Quantitative and qualitative data was analyzed to determine the extent of the engagement religious and traditional leaders have had with county health system teams, and their confidence,

due to the project interventions, in identifying and responding to individuals experiencing acute stress. The raw data from the interview recordings and survey were transcribed and organized in Microsoft Excel. The responses are summarized from the data to demonstrate an important, initial snapshot into the prospective and priorities of the religious leaders.

Results

Demographic Information

The average age of respondents (N =26, 1 missing) was 49.7 years. Eighty-five percent of the individually interviewed respondents were male (N =22), 11% were female (N =3), and 7% did not list their gender (N=1). Nineteen percent of the participants self-identified as Muslim (N=5), 63% of the participants self-identified as Christian (N=17), and 4% of respondents self-identified as a Community Leader (N=1). Four percent of participants did not identify themselves (N=1). Four percent of participants self-identified as both Muslim and a Traditional Leader (N=1), and 7% of participants self-identified as both Christian and a Traditional Leader (N=2).

Survey Results

Likert statements. The survey results are illustrated in Figures 2-5 below. The x-axis reflects the Likert scale range from “strongly agree” to “strongly disagree”. The y-axis reflects the number of participant responses in each category. The figures show counts of individual participant responses.

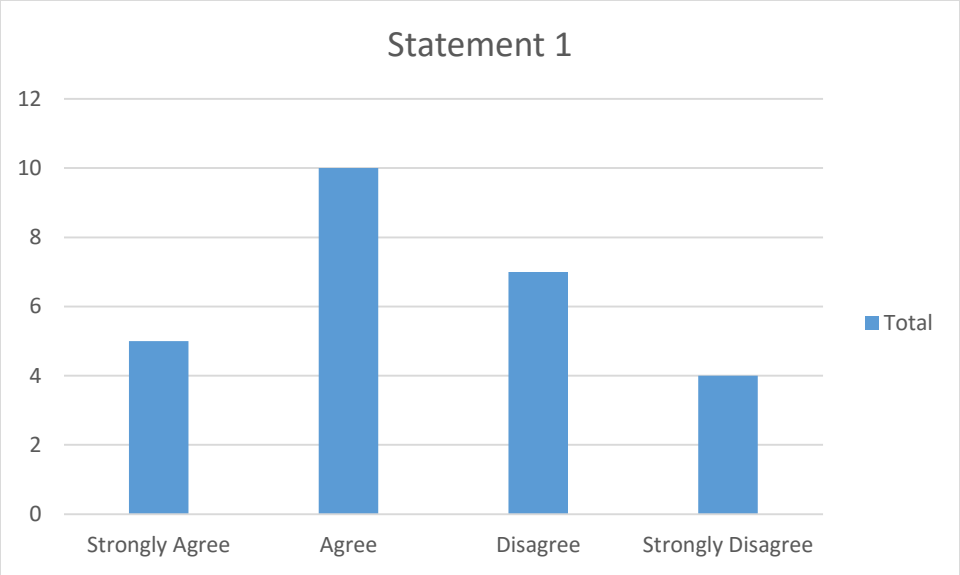

Figure 2. The county health team's mental health services are more integrated (it is inside) with the community.

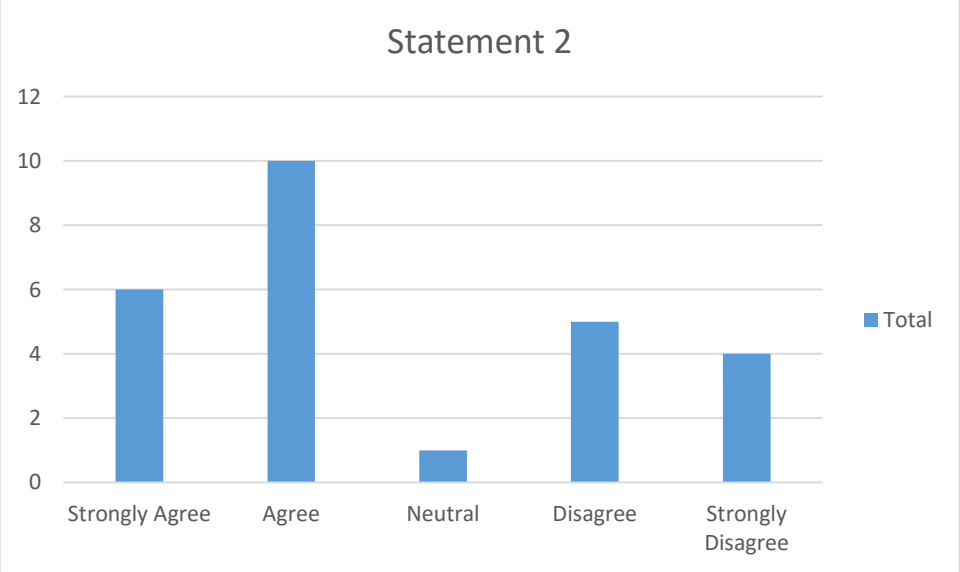

Figure 3. Community members feel they benefit from the county health team's mental health services.

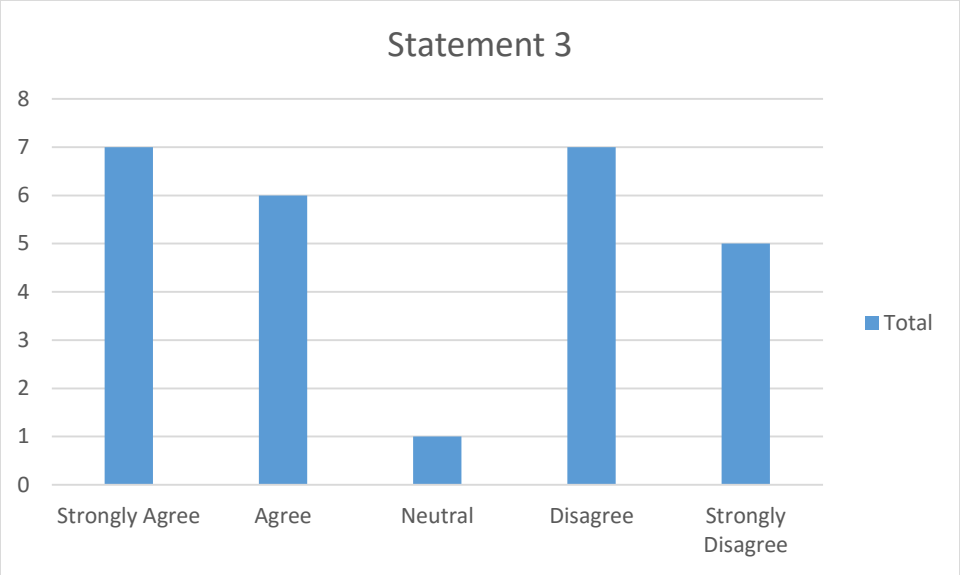

Figure 4. The way that the county health team carries out mental health services is correct.

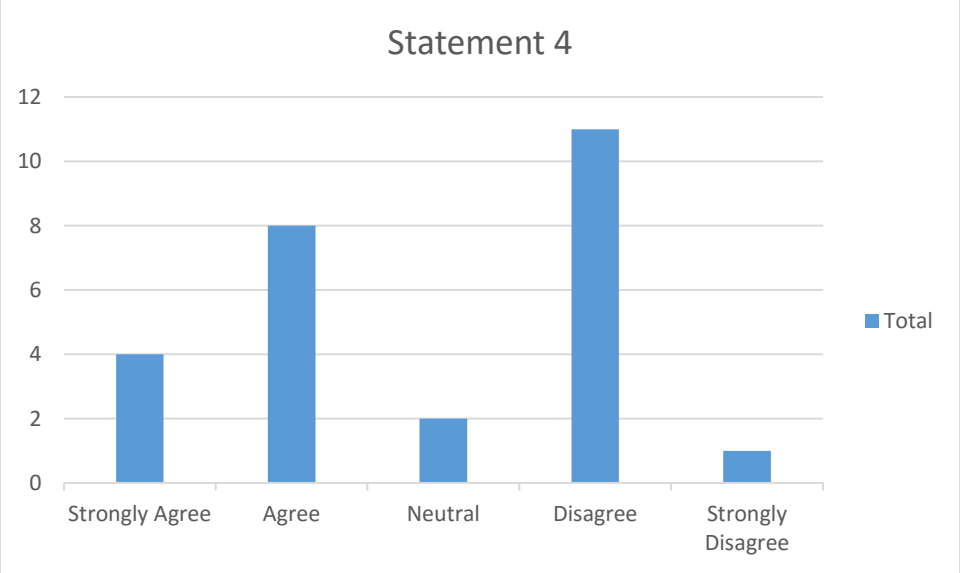

Figure 5. The county health team provides different mental health services to community members. (for example: mental health crisis support, access to health care workers with training in mental health, counseling, trained social workers that can make sure people get community support services).

Researcher-prioritized skills. Researchers also asked participants to identify the skills that felt they possessed and could best use to support community members seeking support for

mental health issues. Three yes/no statements were presented. When responding to the statement: "I can identify individuals (people) experiencing acute mental stress," 96% self-reported that they possess this skill, 4% did not respond. When responding to the statement: "I can direct individuals (people) to community health service resources for help," 93% self-reported that they possess this skill, 4% reported that they could not, and 4% did not respond. When responding to the statement: "I can tell between the different types of mental health issues," 78% self-reported that they possess this skill, 11% reported that they could not, and 11% did not respond.

Leader provided effective skills. Participants were then asked to identify the skills that they felt were first and second most effective in supporting community members' access to mental health services. These were open-ended questions and participants could report any skill they thought was effective for them.

Responses were wide ranging, but the skill most identified by religious and traditional leaders as effective or best in supporting community members' access to mental health services was counseling or variants of counseling, a skill highlighted by 15 participants. Participants also mentioned community mobilization, education, and anti-stigma programing.

Discussion

Key Informant Interviews (KII)

The results indicate that religious and traditional leaders support their participation in the facilitation of mental health services. Results also demonstrate that religious and traditional leaders feel that the county mental health team's services are integrated into the community and believe that community members feel that they benefit from community mental health services. However, participants were equivocal that mental health services are carried out appropriately, and largely did not feel that the county health team collaborates well with community members.

Overall, the findings demonstrate that while the mental health services and interventions are supported by participants, there is some ambiguity around whether the services are carried out appropriately. There is also disagreement that the county health teams collaborate well with community members. It is important to consider the feedback of religious and traditional leaders in order to identify areas of agreement and disagreement with the approaches undertaken to facilitate community member access to mental health services. As the religious and traditional leaders disagree that the county health teams are collaborating well with community members, it indicates an area of opportunity to improve how well the community mental health teams relate to, positively impact, and work within the humanitarian context with community members and leaders. It is a tangible way to show the county health teams how they can improve their work through the feedback of religious and traditional leaders.

An important thread that religious and traditional leaders expressed was that religious, traditional, and medical understandings and interventions for mental health issues can work together in identifying, referring, and treating mental health issues. This is a clear indicator that there is a willingness and desire to work together on the part of the religious and traditional leaders. They want to support the efforts of the county health teams and the efforts towards improved mental health services and are willing to serve as a bridge to get congregants and community members appropriate care. The county health teams should welcome this support as it will relieve some of their overwhelming burden. Additionally, these groups working together have the potential to foster cross-discipline professional support and learning. The religious traditional leaders can gain a deeper understanding of mental health issues and treatment, and the county health teams can learn about skills derived from religious traditions to encourage people in seeking support and engaging with mental health services.

Limitations

The current findings are specific to the context of Liberia and the humanitarian settings in which the religious and traditional leaders live and work. The results aren't generalizable because religious practices and understandings around how to address mental health challenges vary dramatically due to country and cultural context.

All the interviews were conducted in Liberian English and/or American English, and opportunities were not available for interviewees to participate in other languages of their choosing, be it an indigenous language, Arabic, or any other language. In addition to challenges related to language, many efforts were made to clarify questions for participants with varying degrees of success as the participants had varying degrees of formal education attainment and literacy rates. The impact of this on the current study results is that there may have existed confusion around cross-language terms and definitions even though researchers took every step to avoid this. However, choosing to conduct the interviews in English was most appropriate, as it is the official language of Liberia and the most widely understood.

Logistical challenges such as conducting the research in the rainy season also made for minor adaptations to the settings and contexts in which interviews were conducted. Examples include concentrating participants in Margibi County versus visiting participants individually in Montserrado County. This impacted the study in terms of the number of people researchers were able to reasonably reach in the time allotted, and also may have impacted the willingness of religious and traditional leaders to participate if they were unable or unwilling to navigate transportation in the monsoons and mud. The limited timeframe also affected the number of interviews that the team could reasonably conduct. Travel was labor and time intensive, and was

possibly more involved than conducting the actual surveys. While the 27 people we were able to reach was an impressive achievement, it would have been even more beneficial to reach more.

Another glaring limitation is the dearth of women in the current study, and women represented in formal religious leadership. Therefore, the prospective of women parishioners should be considered to further flesh out the dynamics of seeking and accessing mental health services. The lack of women in formal religious leadership roles may serve as a significant barrier to women seeking mental health services though the facilitation of religious and traditional leaders. The lack of women interviewed reflects the gender disparities in the ranks of religious leaders in both Christianity and Islam in Liberia. Women participate strongly in religious activities as lay leaders and in other roles. Women religious leaders who were interviewed were exclusively Christian. Men and women participate in separate traditional secret societies (Poro and Sande, respectively) and take on different leadership role in these societies. This limitation is problematic because not only do women play an outsized role in congregational laity, they are understood to be disproportionally impacted by the traumas of humanitarian settings, and tend to be over represented in mental health diagnoses. A future study of parishioners and the role they see for themselves and their religious and traditional leaders would be valuable for further understanding opportunities for task sharing and collaboration between religious communities and the county health teams related to accessing appropriate mental health care. Steps could be taken, with the potential to be led by women leaders of Christian congregations, to advocate for women to serve unencumbered in every role in religious institutions. One goal of such activism should be that gender parity is achieved in religious institution leadership. If the leadership becomes more gender balanced, future researchers will be able to better incorporate the perspective of religious and traditional leaders who are women.

Implications and Recommendations

Religious and traditional leaders were largely of the perspective that the county health teams are integrated within the community, that community members feel they benefit from the county health team's mental health services, that they consider the way that the county mental health team carries out mental health services to be appropriate, and that the county mental health team provides many different services related to mental health. The religious and traditional leaders were not, however, in unanimous agreement on these points, which is something which could be explored in additional trainings and workshops. Additional responses from the religious and traditional leaders indicated that collaboration was experienced on a case-by-case basis, particularly if they felt there existed individual personal good will between the leader and the county health team staff. Future training should involve interpersonal skills, and further understanding of mental health issues from the perspective of the health care professionals. Training could also include a sharing of experiences from individual cases where the working relationship is positive.

Task sharing. Ideas for further training should buttress the skills that religious and traditional leaders professed confidence in such as counseling, community mobilization, and education. Respondents also expressed being receptive to task sharing and addressing community mental health needs as a division of labor between the spiritual and the physical, and between religious, traditional, and medical professional leaders. This is useful for training purposes if trainers can look to find a way to continue to define and clearly demonstrate how the three spheres (religious, traditional, and medical) interrelate and how they work as legs of a stool to support individuals getting access to mental health.

Reinforcing these skills will improve the ability of religious and traditional leaders to participant more fully in the task sharing that is being prioritized and engaged in to support mental health workers. Skills like task sharing could be reinforced and peer led such as peer support related to identifying mental health conditions, which would be beneficial for religious and traditional leaders with less exposure to the medical perspective. Continued training can focus its efforts on helping religious and traditional leaders differentiate between various types of mental health issues. Differentiating symptoms from conditions would also be helpful ways to prioritize task sharing, as well as identifying and referring community members to mental health services. Additional examples of task sharing could also include religious and traditional leader support in meeting transportation needs, collaboration and community support of accountability strategies for ensuring medicine supplies, and advocacy by religious and traditional leaders for further incorporating mental health into legislation and local systems. A common critique is that planning for task sharing does not take a systemic approach (Javadi, Feldhaus, Mancuso, & Ghaffer, 2017). The work here responds to the limited systemic approach by looking at how different groups work together for the goal of strengthening mental health systems. There has also been work on the feasibility of introducing task sharing in broad contexts. Examples include conditions such as "increased numbers of human resources and improved access to medications; adequate training, support, and compensation for health workers who take on new mental health tasks; and ongoing structured supportive supervision at community and primary health care levels," (Mendenhall et al., 2014). Surely, such a broad undertaking cannot be accomplished by certified mental health workers alone, and will need the support of other community members and professionals willing to give it.

Future trainings should also focus more on destigmatizing terminology. Religious and traditional leaders were able to name a variety of mental health conditions included in the Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM, American Psychological Association, 2013), and additional culturally relevant conditions. Often the religious leaders point to a variety of changes in behavior as symptoms for a wide range of mental health conditions, but in identifying symptoms and different aspects of mental health needs, they occasionally used colloquial, unproductive, and ill-defined terms for mental illness like, “crazy”. Use of these terms can be counterproductive to the parallel efforts of anti-stigma.

Engagement and communication. A strong emphasis was placed by the religious and traditional leaders on being in the community and going to and seeking out those who required mental health support services. Different leaders gave distinctly different accounts as to how well the county health teams worked within the humanitarian settings with other community leaders. These differences seemed to vary based on the individual relationships developed between the community and county health teams. If members of the county health team were viewed in a negative light, or as not contributing or being engaged with the community on the community’s terms, then the care they provided was deemed ineffective or not worth the effort. If members of the community health team were viewed as effective and engaged with the community, then the care was viewed as effective and worth the effort and the relationship and the referral pathway was maintained. This provides credence to the understanding that much of the collaboration between the religious and traditional leaders and the county health teams is heavily dependent on their interpersonal relationship as to whether the collaboration is strong. These types of collaborations and positive working relationships are as important as the rapport built between practicing psychologists and the people they work with. These types of positive relationships and

rapport are vital and can be created and strengthened at the community level by working to build and rebuild strong relationships and friendships within the community. A positive example of using the strengthening of friendships to promote and improve mental health can be seen in the success of the "Friendship Benches" program in Zimbabwe. Here, "Lay health workers deliver a talk therapy at (the) primary care level to help people suffering from anxiety and depression," (Friendship Benches, 2018). This type of communal space used for conflict resolution already exists in Liberian society in the form of palaver huts where community disputes are hashed out and resolved, often through restitution and restorative justice. Perhaps more importantly, the idea of a wide spectrum of both strained and positive relationships suggests that education and training can be inconsistent in how it is provided and/or received. These ideas would help to address the finding that religious and traditional leaders see room for improvement related to relationship between the community and the county mental health teams. Relationship and interpersonal skills can be taught and grown through capacity building, which would be useful to improve relationships vital to individual and collective mental health. The idea that additional capacity development is needed agrees with the assessment of others engaged in global mental health work, who have also called for training for researchers, clinicians, and policy makers to overcome the substantial barriers that exist (Wainberg, 2017). It is important to note that the work of capacity building is a long term endeavor, and collaboration between the various stakeholders will go a long way in improving the systems and understandings through which people seek and receive care.

Overall, religious and traditional leaders were convinced about aspects of the county mental health teams' role in mental health service provision. Next steps focused on task sharing and communication are expected to further define and emphasize the role of religious and

traditional leaders. Programing should also prioritize religious and traditional leaders taking ownership of their role as it develops. As their knowledge and proficiency in supporting assess to mental health and provision of services deepens they will be better able to inform and advocate for how the county health teams, ministry of health, and legislative bodies prioritize the integration of mental health. Further, formalizing the role of religious leaders would also allow them to take a leadership role in addressing deficiencies they identified in health service provision such as lack of transportation and disruption in medicine supply chains. More fully realized potential on the part of religious and traditional leaders could hypothetically result in a more fortified and integrated health system, improved provision of health services including mental health, and improved county health team reputation.

Conclusion

Religious and traditional leaders support collaboration with the county health team around mental health. While this is present in some form, there is also room to expand and deepen the collaboration between the religious and traditional leaders. Religious and traditional leaders report having a base of skills that they can build upon and develop. While the Liberian context makes for some unique challenges, there is clear interest and willingness to engage on the theme of mental health, and to broaden participation in task sharing in order to better support those in Liberian society who want to seek out and engage mental health services.

This work is important because of the limited successful efforts to date to understand the practical and potential contributions of religious and traditional leaders to the efforts of professional mental health service providers in humanitarian and post conflict settings. Our work developed what may be the first survey to engage with these issues, filling the need for a better understanding of how religious leaders could participate in supporting access to and provision of

mental health services. The trainings for the religious leaders, which inspired this research, were able to provide a baseline understanding of mental health for approximately two hundred religious leaders in Liberia. There is an abundance of religious and traditional leaders who also have the advantage of living in the communities they serve and have shared experience and background with community members. In contrast, there are only .02 psychiatrists per 100,000 in Liberia according to the WHO (Mental health Atlas Country Profile, 2014). Meaningful headway cannot be made with rates of practicing psychiatrists as low as these, which is why efforts to scale up Liberia's mental health workforce are extremely important. They are making strong inroads, and are gaining traction. A way to complement these important efforts and scale understanding of mental health issues and ways to address them is to leverage the numbers and access to community that religious and traditional leaders represent. Through the ongoing process to bolster the skills and knowledge of the religious and traditional leaders so that the religious and traditional leaders in turn can support the county mental health teams and alleviate the mental health burden in Liberia.

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Annex

Assessment of Training and Group Activities for Religious Leaders and Traditional Healers Related to Mental Health Services Access and Use

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Assessment of Training and Group Activities for Religious Leaders and Traditional Healers Related to Mental Health Services Access and Use

I. Support and Strength

This assessment assesses existing community and family practices that promote resilience and recovering and informs next steps in the Supporting Psychosocial Health and Resilience in Liberia project. Activities under Component 1, Support for Intermediate Psychosocial/ Mental Health Impact of the Ebola Crisis and Component 2, Support to Build Long-Term Psychosocial Health and Resilience at the Individual and Community Level are being evaluated through Key Informant Interviews. We use an interview tool designed to get information from religious leaders and traditional healers. The selection of the key informants will be drawn from the all of the individuals who participated in trainings and, or group meetings.

This assessment component serves as an important tool to understand the impact of working to support immediate psychosocial/mental health following the Ebola crisis. It will focus on the goals of community support activities that promote community healing and sticking togetherness. It also examines the impact of community-level "Anti-stigma activities." The assessment will also look at how religious leaders and traditional healers' practices have changed as a result of training initiatives in Margibi and Monserrado counties.

These trainings sought to teach religious leaders and traditional healers to identify individuals experiencing acute stress, and identify and make appropriate referrals. Data gathered from the interviews will be analyzed to determine the effectiveness of the training.

Interview Script:

(Greetings, Introductions)

"Thank you for taking the time to join this study on how religious and traditional leaders help people living with mental illness. This is to see what has happened since you were part of: 1. World Health Day/World Mental Health Day activities; 2. Mental Health anti-stigma training; and/or 3. Mental Health training in recognizing, identifying and supporting people facing acute stress and to refer them when they need help. The interview will take between 30 minutes to one hour. Taking part in this study is voluntary, nobody can force you, it is by your own free will. You do not have to answer any question that you don't want to answer, and you can stop the interview at any time you wish. We are asking you these questions in secret and your name will not be connected to your answer after we collect your answers. At all times, every effort will be made to protect your privacy. All the answers will be put in a separate, secured location." You may not benefit directly from this interview but the answers you give will help us make the work better next time.

"Are you willing to participate?" Y/N

"Do you have any questions before we begin asking you the questions?"

II. Training

Did you take part in any of in the following:

___ Training(s) on anti-stigma, identification, and referral in Montserrado and Margibi counties, and how many times did you participate?

_____

___ Monthly Group Meetings, and how many times did you participate?

_____

___Planning Meetings for Awareness Days, and how many times did you participate?

_____

The training was about reducing Stigma Y/N

The training was about knowing the signs and symptoms of mental illness Y/N

The training was about showing people how to get help with mental health challenges Y/N

III. Respondent Information

Interviewer Name:

Respondent Code:

Respondent Age:

Respondent M/F:

Which religious community does the respondent represent:

Which neighborhood does the respondent represent:

IV. Interview Questions

Likert Scale Questions

Please respond to the following statements based on a 1 – 5 scale with 1 meaning "I strongly disagree" and 5 meaning "I strongly agree" as a result of participating in World Health and World Mental Health Day, Mental Health Anti-stigma training, and/or Mental Health Training.

Key: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

The county health team's mental health services are more integrated (it is inside) with the community.

Strongly Disagree 1 2 3 4 5 Strongly Agree

Community members feel they benefit from the county health team's mental health services.

Strongly Disagree 1 2 3 4 5 Strongly Agree

The way that the county health team joins and carry out mental health services is correct.

Strongly Disagree 1 2 3 4 5 Strongly Agree

The county health team collaborates (work) well with community members

Strongly Disagree 1 2 3 4 5 Strongly Agree

The county health team provides different mental health services to community members. (for example: mental health crisis support, access to health care workers with training in mental health, counseling, trained social workers that can make sure people get community support services)

Strongly Disagree 1 2 3 4 5 Strongly Agree

As a religious or traditional leader, do you have any of the following skills related to mental health services access for community members? Please circle all that apply

Skills:

1. I can identify individuals (people) experiencing acute mental stress

2. I can direct individuals (people) to community health service resources for help

3. I can tell between the different types of mental health issues

4. I can provide counseling

5. I can mobilize the community to support mental health programs at the local and county level

6. I can educate and work to reduce stigma

7. Other _____

Of the skills you mentioned, which is the most effective/working good?

Of the skills you mentioned, which is the second most effective/working good or well?

Open Ended Questions:

What are some of the <u>teachings</u> from religious and/or traditional sources (Bible, Koran, Other) that you use to address the mental health needs of community members?

Follow-up? Can you please tell me exact references from the text and/or source?

What are some of the <u>skills</u> from religious and/or traditional sources (Bible, Koran, Other) that you use to address the mental health needs of community members?

Follow-up? Can you please tell me exact references from the text and/or source?

Are there differences between religious and/or traditional skills you use to address the mental health in individuals and the skills presented at the training? Y/ N

What are some differences between religious and/or traditional skills you use to address mental health and the skills presented at the trainings?

Can you please list at least three?

1.
2.
3.

How do you identify individuals experiencing acute stress?

How many individuals experiencing acute stress have you identified since the training?

How many persons with other mental health problems have you identified?

What types of mental health problems are these? List up to 5 please. (If you have seen less than 5 it is okay.)

1.
2.
3.
4.
5.

How do you identify the referral mechanisms?

How many persons have you referred through the county's referral mechanisms?

We regard a completed referral as one where you referred someone to the county mental health provider and that person went and the provider saw that person. With that understanding:

a) **how many persons would you say you have referred to the county mental health provider since the training?**

b) **How many persons with acute stress or other mental health problems have you identified?**

c) **How many persons with other mental health problems have you identified?**

Did you work with or relate to the mental health provider? Y/N

Did you talk to, text or see the mental health provider? Y/N

What other ways did you work with or relate to the mental health provider? (List up to 3 ways)

1. **1.**
2. **2.**
3. **3.**

What services did the persons you referred get?

How would you describe your role related to mental health services for people in your congregation, your church, your mosque before your taking part in the training event?

How would you describe your role related to the access to mental health services after taking part in the training event?

One of the challenges previously identified related to access to mental health services is stigma placed on those seeking services. What have you done/seen that is working in reducing stigma?

If you could change one thing about the way people get mental health services what would you change?

If you could change one thing about the way mental health services are provided, what would you change?

How did this training(s) effect/impact you personally?

What else would you like to share with us?

V. Thank You, Wrap Up

Thank you very much for your participation and contribution to a better understanding of access to mental health services in the communities and the role of religious and traditional leaders, we will try to share the results, any additional questions can be made of the Carter Center mental health program staff.