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## Report on Comparative Study of Community Mental Health in Low and Middle Income Countries: Liberia Case Study.

by

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### Introduction

Mental health conditions affect a significant segment of the Liberian population. Estimates are that as many as 40% of adults may experience clinical depression, 45% PTSD, and 11% have experience substance used disorders (Johnson et al., 2008; Galea et al., 2010, 2008). Depression, epilepsy and schizophrenia, bipolar disorder, and substance use disorders are among the diseases that carry the highest burden of disease among neuropsychiatric disorders in Liberia (World Health Organization, 2008). Research suggests that despite the success of community-based rehabilitation to addressing the needs of individuals with disabilities, there has been less comparable success with mental disabilities. AIFO applied for and received funding from the European Union to conduct a study that examined the intersection between mental health and community-based rehabilitation.

AIFO and the Carter Center Mental Health Program in Liberia hypothesized that mental health services in community-based rehabilitation (CBR) programs would be weak or non-existent. Research from other low- and middle-income countries with mature CBR systems indicate that mental health services and supports were less developed than other aspects of CBR programming to support persons with disabilities (World Health Organization and Swedish Organization of Disabled Persons International Associations, 2002).

The study investigators proposed to:

- Further understand problems of access to mental health services and barriers persons with mental disabilities faced including difficulties in getting medications.
- Examine the level of inclusion of persons with mental disabilities in CBR programs.
- Identify areas where persons with disabilities, but particularly those with mental disabilities, could benefit from a conversion of community mental health programs and CBR based on a human rights approach with specific attention to human rights challenges at the community level.
- Inform efforts to strengthen: a) the quality of mental health services at the community level and b) collaboration between CBR programs and mental health services in Liberia.

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Therefore AIFO and the Carter Center initiated an ambitious research initiative that sought specifically to:

- 1) Assess attitudes, knowledge and skills of persons working in CBR programmes (mental health clinicians, community volunteers, CBR workers, supervisors and managers) towards different aspects of mental health conditions through qualitative methods (focus group discussions) guided by a semi-structured questionnaire.
- 2) Understand who are the persons classified under the CBR programmes as persons with mental illness, intellectual disability and epilepsy and what difficulties in functioning they faced, as well as their participation in various activities of CBR through a questionnaire.

A third component of the research was proposed to adapt and administer the WHO Quality Rights tool at the national referral mental health hospital, Grant Hospital. This part of the research was proposed for the second year of the project. This report is confined to the first two elements of the study outlined above and represent findings from activities in year 1.

The project engaged the services of a national advisory group (NAG) who met to review the study protocol prior to IRB submission. The group included key stakeholders in mental health including: users of mental health services, caregivers and professionals in the delivery of mental health services.

**NAG members meeting at Grant Hospital, Monrovia, July 4, 2012.**



The study employed two methods of data collection: a survey and focus group discussions using a semi-structured discussion guide. One hundred and fifty individuals participated (n=150 surveys, and N= 95 focus groups participants, these numbers are not mutually exclusive). Among groups represented in the survey and the focus groups were persons with disabilities, referred to throughout the document as



users, mental health clinicians, CBR facilitators, and community health and social workers. The research was conducted in 5 counties (Bong, Grand Gedeh, Margibi, Montserrado and Nimba). Montserrado and Grand Gedeh are areas where there are no current CBR activities and could provide good control data. Both these counties have mental health clinicians who provide services on the ground to people with mental health conditions and epilepsy. Data analyses were conducted and descriptive statistics are provided below. The research in this study was approved by the **UL-PIRE Institutional Review Board.**

**Commento [u1]:** I think it would important to attach as an annex the letter of approval of the research by the IRB.

Key Questions:

The major lines of inquiry in the study focused on the following:



*Individuals with mental disabilities include those persons who answered yes to having a disability and answered that they had a chronic long lasting mental illness or an intellectual*

- Access to MH Services:
  - Use of and difficulty in accessing services and psychotropic medications;
  - Maltreatments and Aabuses in the health facilities.
- Inclusion of Persons with Mental Disabilities in CBR Programs in Liberia.
- Economic and Social Context for Persons with Disabilities especially Mental Disabilities:
  - Self-Help Groups' involvement;
  - Debts and microfinance initiatives;
  - Exposure to violence: domestic, interpersonal and



stranger violence;

- Nature of and interaction with law enforcement personnel;
- Knowledge of rights and exercising of those rights
- Factors that contribute to gaps in services and supports for Persons with Mental Disabilities:
  - Education and level of training of professionals and paraprofessionals;
  - Social contact with persons with disabilities;
  - Proximity to service areas by professionals such as MHCs and CBR Workes.

About the Research Participants:

**Commento [AMH2]:** I stand to be corrected but nothing was mentioned about informed consents signed by participants before their Participation in this study.

A majority of users reported experiencing epilepsy or convulsions (57%). Individuals who made up other disability groups included those who were blind or visually impaired (56%), those who were deaf or hearing impaired (32%), those with speech impairment or could not speak (29%), and persons with mental disabilities (64%). These categories are not mutually exclusive. The average age of the users was 26 years old and they were evenly split by gender. Users represented 61% of the survey respondents. Mental health clinicians represented the largest segment of the providers who responded to the survey.



## Preliminary Results

### Access to Mental Health Services / Attitudes and Practices Regarding Mental Health Disorders and People with Mental Disabilities

Focus group respondents were asked to discuss the prevailing community attitudes and behaviors towards persons with mental health conditions and epilepsy. All respondents (see Table 1) reported that community attitudes and behaviors towards persons with mental health disorders included discriminatory and abusive behaviors ranging from sexual and physical abuse, to forced labor and chaining or holding persons with mental disabilities against their will. All respondents believed that persons with mental disabilities were entitled to the same rights as other individuals in the society. Users in particular reported that the individuals with mental disabilities were often blamed for their condition. While all respondents reported that persons with mental illness who were violent were often chained or locked up only community health and social workers endorsed the practice. Age, gender and economic status were cited across the groups as contributing factors to abuse, neglect and lack of access to care. Females, especially younger females, were reported by respondents to be more likely to be raped. Males, especially young males, were reported to be more likely to be forced to work and age was also a factor in physical beatings. According to the respondents, economic status was also associated with access to treatment with well-off and wealthy individuals either being more likely to be shut in the house and or more likely to get formal mental health services in Liberia or abroad.

**Commento [u3]:** This may need a better elaboration....

### Major Themes Respondents Reported by Category on Community Attitudes, Causes, and Rights

Respondent Category	Community Attitudes <sup>3</sup>	Feelings <sup>45</sup>	Contributing Factors	Reports of abuse <sup>6</sup>	Rights
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<sup>3</sup> Ch=churches, TH=traditional healers

<sup>4</sup> Feelings were interpreted among users as attitudes/behaviors across the groups

<sup>5</sup> FL=Forced Labor, R=Raped

<sup>6</sup> C=Chained, R=Raped, L=Locked Up, B=Beaten

C\*=Among gCHWs/SWs in one community all participants believed that PWMHD who are violent should be chained or locked up



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Users	Blame	FL, Called witches, R	Age, Gender-based, Poor	C, R, L, B	Equal rights
MHCs	Discriminate, Abuse, FL,		Age, Gender-based, Poor	C, R, L, B	Equal rights
CBR Facilitators gCHVs & CSWs	Ch, TH	FL, Called witches, R	Age, Gender-based, Poor	C*, R, L, B	Equal rights

Table 1: Community Attitudes, Causes and Rights As Reported by Study Participants

This report of poor access was reinforced in the survey where more than half (62%) of respondents who were users reported that they did not get access to mental services when they needed it. Among users with mental health disabilities including those in Montserrado County (where Monrovia is located), 49% did not have access to mental health services when they needed it. In counties with CBR activities, 65% of users with mental disabilities did not have access to mental health services. A vast majority of the users surveyed were regularly taking medications (75%). Most (65%) did not experience a problem getting their medicines. The proportions of persons with mental health and or epilepsy who took medications regularly were higher (76% and 97%) respectively. The proportion of these individuals who had difficulty accessing their medicines regularly was higher (40%).

**Commento [u4]:** I think here we need to be a bit more analytical between the counties with CBR activities (where we distribute phenobarbital) and Montserrado where they can be treated with other drugs, not only for epilepsy.

**Commento [u5]:** I do not understand this sentence. It looks in contradiction with the previous one. Both of them are "regularly" taking medicines????



## Inclusion of Persons with Mental Disabilities in CBR programs in Liberia

As Table 2 shows, professionals and paraprofessionals with the exception of the mental health clinicians reported that persons with mental disabilities did not receive mental health services in communities where they worked. In Bong and Margibi, CBR facilitators indicated that persons with mental

disabilities were involved in CBR activities. When asked which group was most excluded however, CBR facilitators in all three counties, Bong, Nimba and Margibi referred to individuals with mental disabilities. Among the reasons given for exclusion were individuals did not want to participate and their families refused to access care. Reports from users reinforce this lack of access to CBR services. Users in focus groups of Bong, Nimba and Margibi indicated there were no persons with mental illness in the CBR activities in which they were engaged. All groups of users in these three counties indicated persons with epilepsy were served. When discussing individuals who were excluded from CBR activities in these three counties, people with mental disabilities were described, and several reasons were given to justify their exclusion. For example, one participant noted “(a) mentally ill patient who is a drunk is not in the CBR project.” Users also commented that CBR facilitators were unaware of the existence of persons with mental disabilities in their communities. In another county, users noted that CBR projects needed to be better publicized.

### Focus Group Facilitators Guide

#### During our talk “mental disabilities” means:

Stress, anxiety, broken heart,  
heart spoiled, not happy or tired  
Socially being unstable  
Completely dull person; zep-say;  
someone who is not sound.  
Someone with ‘mud’ in the brain  
Always afraid of certain things;  
nervousness or constant shyness  
about something or situations  
Thinking and doing the same  
thing all the time like washing  
hands, counting, doing certain  
rituals, Bo-bo, Spell, Worrying  
plenty and feeling that  
something bad will happen.

Persons with mental disabilities are not served by other community-based professionals either. Participants of the focus groups of community health and social workers reported that they did not provide mental health services and there were no services within their communities for people with mental health conditions.

Mental health clinicians were most likely to serve persons with mental disabilities but were least likely to serve individuals with other disabilities. Only in Grand Gedeh did mental health clinicians indicate that they served individuals with disabilities other than mental disabilities and epilepsy. They indicated they served individuals with physical and sensory disabilities.

Table 1 shows reports by all categories of respondents that persons with mental disabilities face discrimination and exclusion. Common attitudes and behavior were to blame and discriminate against persons with mental disabilities according to focus group participants.

**Commento [AMH6]:** How did the users know CBR Facilitators were unaware of the existence of persons with mental disabilities in their communities?

**Commento [u7]:** I think we should be more precise in saying “users”: how many of them? Only one, two or plenty?



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*Table 8 Major Themes Respondents Reported By Provider Type on PWDs, Services & Training*

Provider Type	PWDs Served <sup>7</sup>	PWDs not served	MH Svs in Community	Work w. MH Professionals	Training on MH/Disability
MHCs	MH/PWDs <sup>8</sup>	various	Yes	N/A	MH & Disability
CBR Facilitators	EPS, MHD <sup>9</sup>	PWMHD	None	1 county <sup>10</sup>	MH & Disability
gCHVs & CSWs	Referral EPS	PWMHD	None	No	Training to identify PWMHD

**Economic and Social Context for Persons with Disabilities, especially mental disabilities**

Livelihood and Empowerment are two of the five components of the CBR matrix and in developing the study investigators tried to tap into constructs of both of these components of the matrix that might predict inclusion in CBR activities. According to survey respondents, who were users, 37% belonged to a self-help groups and 9% belonged a DPO (disabled persons organization). Given that most of the formal self-help activities took place outside of Montserrado, study investigators sought to understand whether the rate of self-help group and DPO participation would be higher in CBR counties. Indeed when the Montserrado sample was separated from the rest of the data, among users nearly half (48%) belonged to self-help groups and 13% to DPOs. Users with mental disabilities were less likely among this group to belong to self-help groups and users with epilepsy had an equal likelihood of belonging to self-help group (see Chart 1). Bong and Nimba counties had higher rates of participation in self-help groups by persons with mental disabilities than all the counties as a whole. Membership in DPOs also changed when you considered users with mental disabilities. More users with mental disabilities were members of DPOs (15%). Bong County again stood out as a county where DPO membership was high for users with mental disabilities.

<sup>7</sup> The MHCs in Montserrado limited discussion to Persons with Mental Health Disorders (PWMHD)  
<sup>8</sup> MHCs in Bong and Grand Gedeh report serving a persons with a range of disabilities: physically-challenged in Bong, Sensory and physical disabilities in Grand Gedeh  
<sup>9</sup> EPS= epilepsy. Only one focus group of CBR facilitators across the counties served people with mental disabilities  
<sup>10</sup> Bong County working with AIFO Johnny Sele

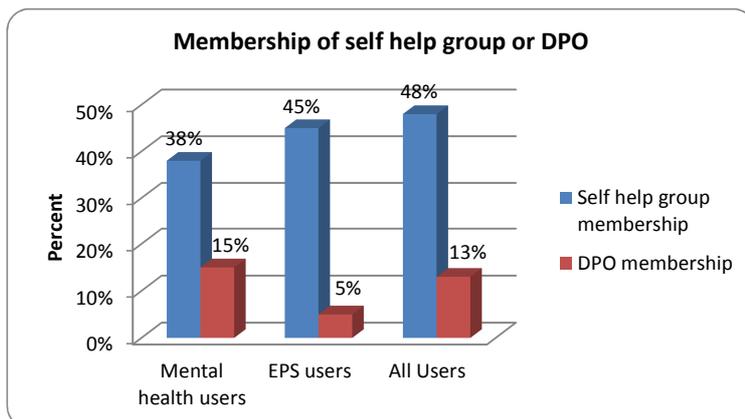


Chart 1: Self-help Group and DPO Membership among Users: by Mental Disabilities, Epilepsy and All Users.

One third of the persons surveyed reported that themselves or someone in their households had problems with debt. Compared to the overall group, users and people with mental illnesses were slightly less likely to have problems with debt (29%). Among all groups, community health and social workers were most likely to be in debt or have someone in their household in debt (75%). This rate dwarfs the other professionals (mental health clinicians 24% and CBR workers (26%). (See chart 2).

Problems with debt varied by county. The proportion of respondents from Bong who reported problems with debt were higher than any other county (54% vs. 39% Montserrado, 27% Margibi, and 13% Nimba).

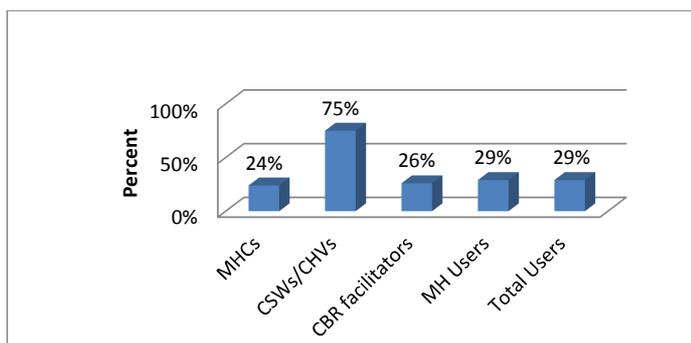
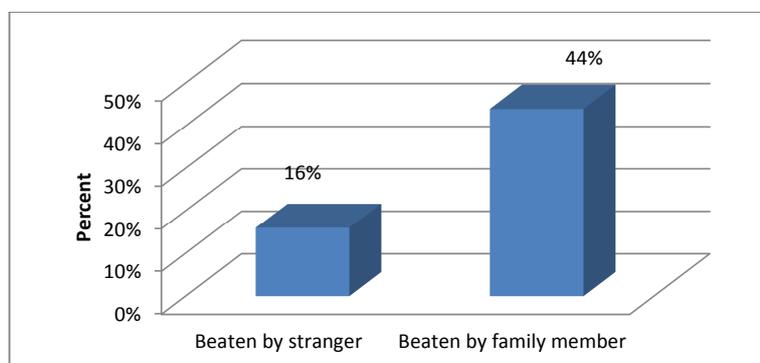


Chart 2: Problems with Debt in Household by Respondent Category



Violence was a significant factor in the lives of the individuals surveyed for this study. Nearly two-fifths of those sampled reported that they or someone in their household experienced violence – being beaten or gotten hurt (37%), with interpersonal violence being high in the last 12 months. Compared with domestic or interpersonal violence (44%), those in the survey experienced a lower rate of stranger-related violence (16%) (See chart 3). For users rates of violence (being beaten or gotten hurt) were slightly lower (37%). Nearly half of all users reported domestic or interpersonal violence in the last year (46%). Stranger-related violence was higher among users (21%) compared to group as a whole. For persons with mental disabilities and epilepsy, rates of domestic (29% and 45%) or interpersonal violence (32% and 33%) were lower but rates of stranger-related violence mirrored those of other users (21% and 22%).

Among professionals and paraprofessionals rates of exposure to domestic and interpersonal violence was higher than among users. CBR facilitators reported the highest likelihood of exposure for domestic violence (62%) compared to community health workers (45%) and mental health clinicians (29%). Exposure to interpersonal violence was also high among this group with community health and social workers having the highest rate of exposure (45%) followed by CBR facilitators and mental health clinicians (29%). Among the group of service providers, only CBR works reported having anyone in their households beaten by a stranger (25%).



**Chart 3:** Domestic and. Stranger-related violence in the last 12 months in household reported by Respondents

As in the country as a whole, experience with rape is widespread. For the entire sample, 10% reported that within the last 12 months someone in their household had been raped. Among users, 15% reported that individuals in their household had been raped within the last twelve months. The proportion of those with mental health problems who reported that a member of their household had been raped in the last year was much lower (6%). This data is particularly relevant since the national survey of sexual



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and gender-based violence contains substantial (67%) missing data on disability status (Dziewanski, 2011). Moreover recent unpublished data on perceived increased susceptibility to SGBV due to disability show that among a sample of residents from West Point and Peace Island in Monrovia (N=649) that between 57%-82% assumed persons with disabilities were more vulnerable to rape due to their disability (Schroeder, 2012). A woman with mental illness was perceived by 72-76% of the sample (Peace Island and West Point respectively) to be more vulnerable for rape compared to non-disabled women or women with epilepsy. Women who were “blind, deaf or “crippled”” were perceived by 72-82% of the sample to be more vulnerable to rape than other women who were disabled or non-disabled (Schroeder, 2012). Among children, those with mental health conditions were perceived to have the most vulnerability (71-75%)(Schroeder, 2012). See Chart 4. So self-reports of SGBV among the disabled takes on added importance given the data void in official statistics and the unpublished reports of perceptions from a “general public” sample. Reports from focus group discussions of users all pinpoint rape and being “beaten” as common factors among those who have a mental health disability. “Girls are more likely to be raped”, said one user. This theme was echoed among providers with one community health and social worker remarking “A girl is raped by motor cyclists constantly” referring to his rural community. Surprisingly, health and social welfare professionals including CBR facilitators reported lower or no levels of exposure to rape or by someone in their households within the last 12 months. Mental health clinicians and CBR facilitators reported that neither they nor anyone in their household was exposed to rape. Nine percent of the community health and social workers reported that they or someone in their household had been raped in the last 12 months.

Overwhelmingly the respondents thought rape was a problem in Liberia (94%). However, this perception varied by category. Users were less likely to report this was a problem compared to professionals and para-professionals (90% vs. 100%). Similarly interpersonal and or domestic violence was perceived to be a significant problem in Liberia with 90% of the respondents. However, among users this figure, while still high, dropped to 82%.

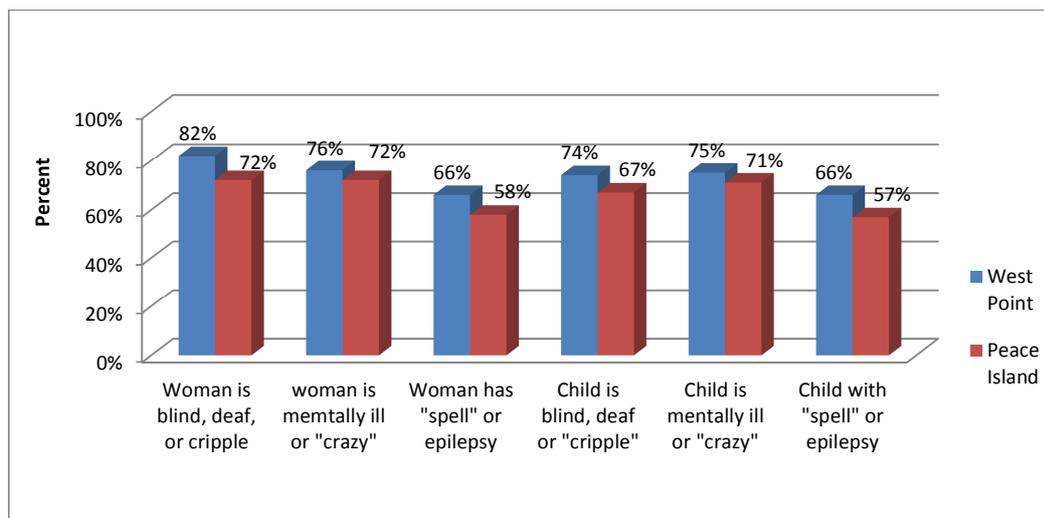


Chart 4: Perceived increased susceptibility to SBV due to disability

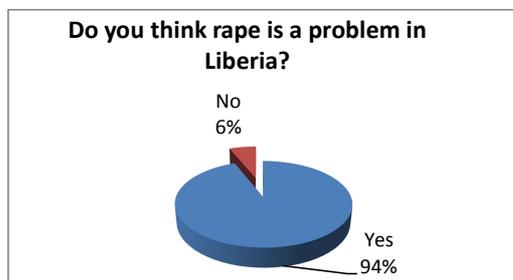


Chart 5 Perception of rape as a problem in the country

The post-war constituted Women and Children Protection (WACP) Unit is charged with addressing domestic, interpersonal and stranger-related violence and is the first point of law-enforcement contact for rapes and sexual violence. WACP's effectiveness has come into question with the low rates of reported cases of rape and sexual and gender-based violence (Schia and de Carvalho, 2009). A recent study further suggests there was limited effectiveness in the WACP as currently structured and implemented (Schia and de Carvalho, 2009). Respondents in the study showed variation in their knowledge of WACP with high levels of awareness among professionals and para-professionals and low levels of knowledge among users. Nearly all these workers had heard or knew the WACP unit (94-100%).



By contrast only 53% of users had heard of or knew about the WACP unit. Mental health users (65%) and those users with epilepsy (64%) were more likely to know about the WACP unit than other users. There was variation by county among users with respondents from Bong having a higher level of awareness regarding WACP (72%) and followed by Nimba and Montserrado (52% and 53%) and then Margibi (35%) (See chart 6).

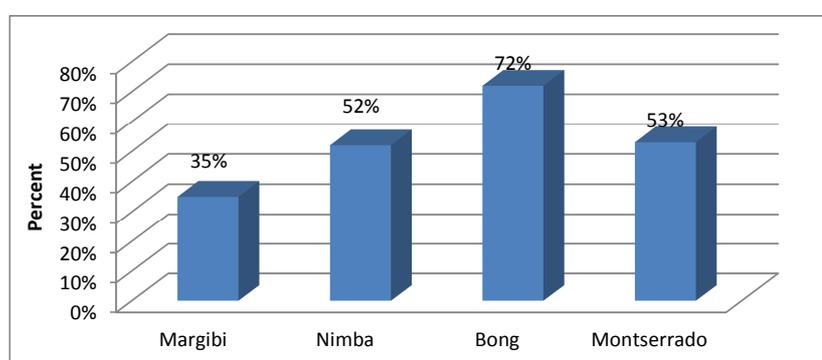


Chart 6: Proportion of users with knowledge of WACP Units by county

Interaction with law enforcement officers differed among individuals surveyed, as did the quality of the interaction. For the group as a whole, more reported having interaction with the UN Peacekeepers (32%) than with the police (29%). Among users interaction with both peacekeepers and police were lower (24% and 16% respectively). However, within the group, some individuals were more likely to interact with the police compared to peacekeepers. Among the sample of users in Montserrado County, interaction with law enforcement was significantly lower (3% and 10%) for peacekeepers and police respectively. For users of mental health services in the other counties interaction with peacekeepers was 32% and police 12%. Professionals and paraprofessionals had a much higher likelihood of interacting with law enforcement. CBR workers had the highest proportion of workers who engaged with the police and peacekeepers (81% and 75% respectively), followed by community health and social workers (64% equally); and then mental health clinicians (26% and 20%) respectively. (See chart 7).

Among the entire sample 13% of respondents reported wrongful detention by the police of themselves or their family members. Among professionals and paraprofessionals, mental health clinicians were the least likely to report being wrongfully detained by police. CBR workers (12%) and community health and social workers (18%) were more likely to report wrongful detention by police. For users, this rate was slightly higher at 15% than the group as a whole (See chart 8). Among different groups of users, reports for being wrongfully held by the police were lower for those with mental health problems (12%) but



higher for individuals with epilepsy (16%). Moreover, persons with disabilities from Bong County had a higher likelihood of being wrongfully detained (22% vs 15%). Individuals in Nimba and Margibi were less likely to report being wrongfully detained, 11% and 12% respectively.

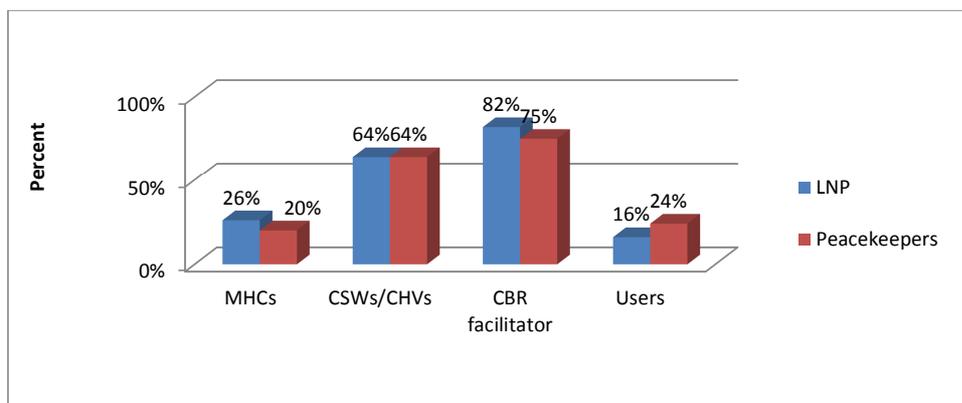


Chart 7: Interaction with law enforcement officers by category of respondent

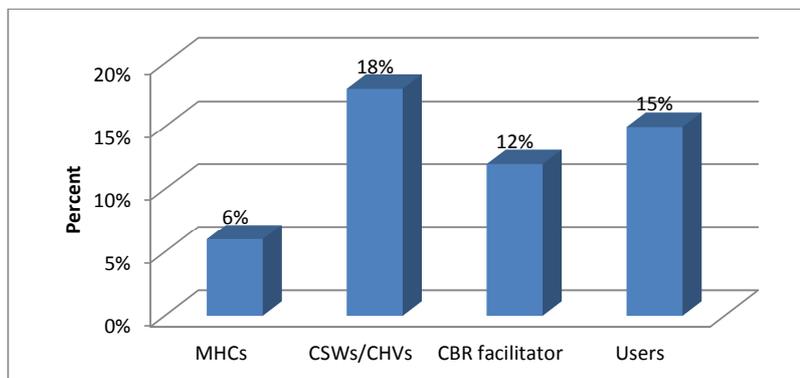


Chart 8 Wrongful Police Detention Reported by Study Participants

**Rights and Community Involvement:**



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CBR’s rights-based approach has been credited with enhancing access to services for people with mental disabilities and better integrating them into the community (Biggeri et al., 2012). Overall, 73% of survey respondents reported that they vote. Users as a group were the lowest proportion of respondents to vote (62%) with all CBR facilitators and community health and social workers reporting that they vote (100%). Among users 71% and 73% of persons with mental disabilities and persons with epilepsy reported that they vote. By contrast, 67% of mental health clinicians reported that they vote.

One indicator of community participation is attendance at community meetings. Over 64% of respondents said that they attended community meetings. Users were less likely to report attending community meetings (52% compared to the group as a whole and to CBR facilitators (94%)) and community health and social welfare workers (100%). By contrast, 67% of mental health clinicians reported that they vote.

Respondents reported that schools and churches were high on their list of trusted sources for education and information on their rights. All groups listed schools among their top three choices of information sources on rights’ education. Church and police were close second choices. Other options listed included community legal advisors, international NGOs and friends or word of mouth. (See Table 3).

Provider Type	School	Police	Church	INGO	CLA	LNG O	Friends/Words	Women
MHCs	X	X	X					
CBR Facilitators		X				X		X
gCHVs & CSWs	X			X	X			
Users	X		X				X	

Table 2 Top Three Choices Respondents Reported that They Trusted when They Want to Learn about their On Rights and Liberia



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### **Factors that contribute to gaps in services and supports for Persons with Mental Disabilities**

Table 2 shows that nearly all providers report they received training on mental health and on disability. CBR facilitators and community health and social workers reported that, with the exception of CBR facilitators in Bong County, they did not work with mental health professionals. Half of the community health and social workers in one of the two counties reported that they did not have any formal training in mental health. These workers were also less likely to have training in disability-related areas. All CBR workers and 97% of mental health clinicians reported in the survey that they had disability related training were as only 27% of community health and social workers reported that they were similarly trained. Predictors of willingness to work with individuals with disability and with reduced social distance with persons with disabilities is whether providers have a disability themselves or have a family member living in their household with a disability. Nearly one-quarter of CBR facilitators who responded to the survey had a disability compared to 9% and 6% of community health and social workers and mental health clinicians respectively. Nearly 70% of CBR facilitators reported that they had a family member who lived in the same house with a disability. Nearly half of community health and social workers (45%) and 17% of mental health clinicians lived in the same house with a family member with a disability. Among the providers, there appeared a similar proportion of individuals who had been treated for a mental illness or with a loved one who had ever been treated for a mental illness (18-23%).

Providers report different levels of formal education. Mental health clinicians reported the highest levels of formal education, a university degree or higher (84%), followed by community health and social workers (36%) and then by CBR facilitators (16%). CBR facilitators reported the highest proportion of providers with high school education or less. These workers however were more likely to report working and living in the same catchment area. Nearly 90% of CBR facilitators worked in the communities in which they lived compared to 45% of community health and social workers and 33% of mental health clinicians. Not surprisingly, these CBR facilitators worked with more people with disabilities on average than mental health clinicians or community health and social workers. The average number of persons with disabilities in the catchment area covered by CBR facilitators was 55, compared to 15 for community health and social workers and 9 persons on average for mental health clinicians. When it comes to individuals with mental disabilities, mental health clinicians have on average many more persons in their catchment areas, 92 compared to 11 for CBR facilitators and 7 for community health and social workers.

### **Summary of Findings**

The data presented confirm investigators' hypothesis that persons with mental disabilities were largely excluded from community-based rehabilitation programs. Persons with epilepsy were included in CBR programs in general and to a greater degree than persons with mental disabilities. CBR facilitators and community health social workers had different training and skills in working with persons with mental



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disabilities, while community health and social workers having less training and feeling least prepared to address the needs of persons with mental disabilities. Mental health clinicians were more likely to be prepared and to treat people with mental disabilities but for the most part, except in Grand Gedeh, did not report treating persons with other disabilities.

Persons with mental disabilities experience widespread abuse with all respondents frequently referring to physical and sexual abuse. Those reports of abuse were less evident in the survey data of respondents with mental disabilities reporting lower rates of violence. However the prominence of violence in the society was evident with nearly 40% of all respondents reporting that they or someone in their household had “gotten hurt” or beaten. Violence was most often committed by someone known to the survivor with rates of stranger-related violence under 20%. Among service providers exposure to violence was also high with elevated rates of domestic violence and stranger-related violence reported by CBR facilitators.

Other aspects the study related to human rights included reports of wrongful detention by police, interactions with law enforcement and sources of information about rights. Users were more likely to report being wrongfully detained than providers. Community health and social workers were at the highest risk. CBR facilitators reported the most engagement with law enforcement than any other group. Mental health clinicians were the least likely to engage with police and peacekeepers. Schools, churches and police ranked as the top trusted choices on sources for information on their rights that respondents reported.

Financial services and access to credit is an important component of livelihood programs within CBR. Study respondents reported problems they or someone in their household had with debt. Users with mental disabilities were less likely to have problems with debt than other users. Among providers, there was a high proportion of community health and social worker who reported problems with debt.

Users also reported on membership in self-help groups or DPOs. Compared to other users persons with mental disabilities were less likely to report participation in self-help groups and slightly less likely to report membership in DPOs.

#### **Recommendations and Action Steps.**

Inclusion:

Implement programs and incentives that promote inclusion of persons with mental disabilities into CBR and other programs at the community level. Promote the treatment of persons with other disabilities by mental health clinicians.



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Address systematic abuse including sexual abuse and violence of persons with disabilities. Require harsher mandatory penalties for persons who are more vulnerable such as individuals with disabilities especially those with mental disabilities. Train individuals with disabilities in self-protection and reporting for abuse. Require that all data on violence and abuse include specific data on disability status including national information on sexual and gender-based violence.

Some aspects of the violence experienced by persons with disabilities can be prevented or addressed by better engagement between police and mental health clinicians. Police and clinicians should work closer together to ensure that persons with mental disabilities do not have their rights violated, that they can effectively get justice when they need it and that they are not wrongfully detained. Police and clinicians can be jointly trained to support persons with mental disabilities when they interact with law enforcement personnel.

Since schools, churches and police were identified as trusted sources of information about the law, some systems should be put in place to ensure that they are conveyors of accurate information. Community legal advisors were mentioned in the top three choices of one group. Efforts should be made to strengthen this sources of information.

One surprising finding of this study is that users with mental disabilities have low rates of problems with debt reinforcing the notion that potentially they can be good stewards of borrowed money and can be low-investment risks or credit risks. This information can be used as leverage to access credit and microcredit efforts for individual with mental disabilities.

Membership in self-help groups and participation in DPOs are strong indicators of empowerment. As a group self-help group and DPOs memberships were low, less than 50%, but users with mental disabilities were even lower. Users should be encouraged to participate and given incentives to support self-help and group leadership.



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### Research participants

Participants	# of FGDs	# of FGDs participants	Questionnaires Administered
Users	6	43	92
MHCs	6	25	31
CSW/CHW	2	11	11
CBR Facilitators	3	16	16
TOTAL	17	95	150

### Research Activities per County

Counties	Users		CHW/CSWs		MHCs		CBR Facilitators	
	FGD	Quest	FGD	Quest	FGD	Quest	FGD	Quest
Nimba	2	27	0	0	0	0	1	5
Margibi	1	18	1	4	0	0	1	5
Bong	1	17	1	7	1	4	1	6
Monrovia	2	30	0	0	4	21	X	x
Grand Gedeh	x	x	x	x	1	6	X	x
Total	6	92	2	11	6	31	3	16

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Mathew Nyenplu	Data Collector
Bindu Butler	Data Collector
Johnny C Sele	Co-Research Coordinator & Data Collector
Sylvester Roberts	Data Collector
Boakai Nyehn	Data Collector
Sehwah Sonkarlay	Data Collector
Josephine Howe	Data Collector
Alonzo Dixon	Data Collector



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