

THE L2SLIBERIA OPERATING MODEL

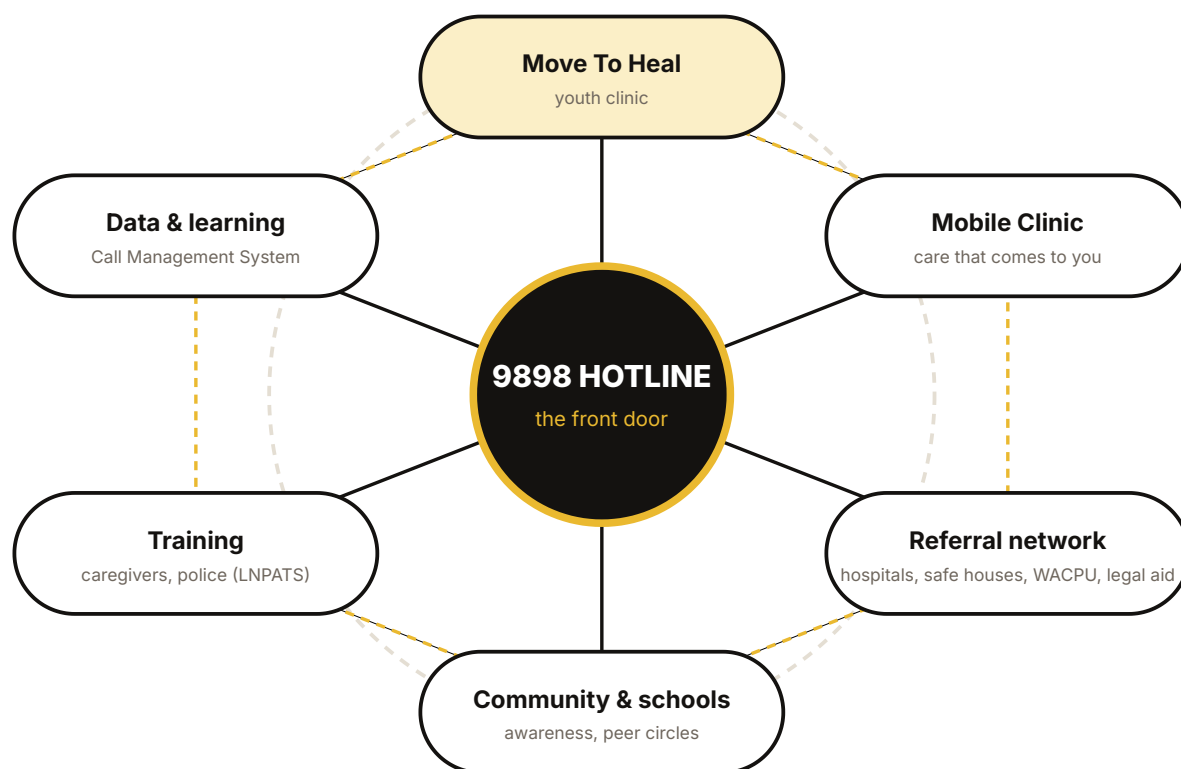
How one free call becomes a *connected* system of care

How Letters to Strangers Liberia works, creates value, delivers services and achieves impact. Written for donors, government, academic institutions, health partners and prospective collaborators.

THE MODEL ON ONE PAGE

One system, three pillars, one promise

"We answer, we listen, we connect you to care. Whatever you are carrying, you do not have to carry it alone."



1 · Toll-free hotline OPERATIONAL

The front door. Free, confidential, 24/7 support, crisis intervention and referral from any phone in Liberia, on 9898.

2 · Mobile Clinic OPERATIONAL

Care that comes to people: assessment, counselling, GBV response and screening in villages, markets, schools and churches.

3 · Community integration and referral OPERATIONAL

Bridges to hospitals, safe houses, protection services, schools, government, and faith and traditional leaders.

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STATUS KEY

OPERATIONAL

IN PREPARATION

PLANNED

PROJECTION / TARGET

01 · THE PROBLEM

A treatment gap held in place by three walls

44%

of Liberian adults had symptoms of PTSD; 40% had symptoms of major depression
Johnson et al., JAMA, 2008

2–3

psychiatrists reported for the whole country in 2018–2019
Carter Center 2018; MSF 2019

63%

of Liberians are under 25; 74.5% are under 35
UNFPA 2023; LISGIS Census 2022

~50%

of Liberians lived in extreme poverty in 2021
World Bank, 2022

1

Poverty

About half of Liberians lived in extreme poverty in 2021. The cost of transport to a clinic, let alone private care, is out of reach. Poverty also creates the stress, loss and insecurity that drive mental ill-health.

2

Geography

Specialist care is concentrated in Monrovia, and most counties have no dedicated mental health service. Roads are long, but mobile phones reach communities that roads do not.

3

Stigma

74% of respondents in an L2SLiberia survey would be embarrassed to seek help, and 61% attribute mental illness to spiritual causes. Suffering is hidden, and people turn first to healers.

Who we serve

Children and adolescents

Exposed to adversity, abuse and disrupted schooling.

Women and GBV survivors

Needing safety, counselling and protection.

Law enforcement personnel

First responders to crises, and exposed to trauma themselves.

Youth aged 15–35

Three in four Liberians are under 35 (Census 2022).

Rural and peri-urban communities

Far from any facility.

Any Liberian in distress

The hotline turns no one away.

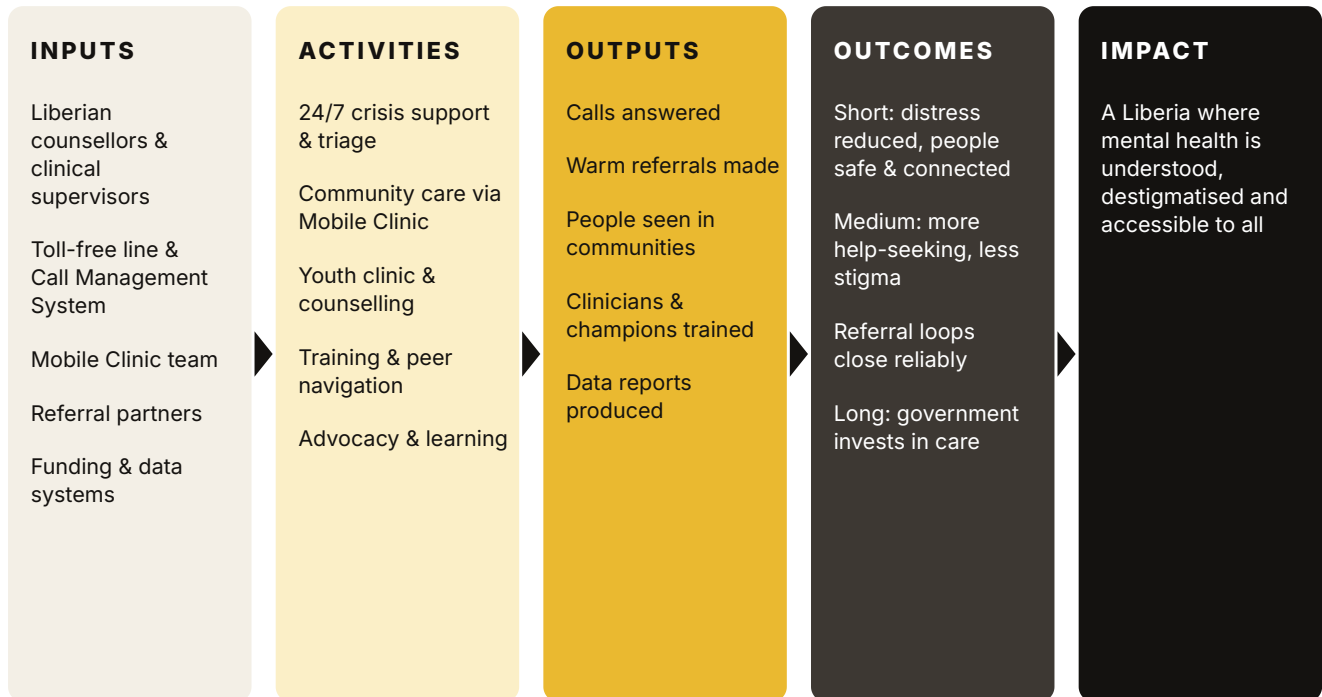
Unmet needs we address

- Depression, anxiety, PTSD, grief, psychosis
- Suicidal thoughts and crisis
- Gender-based and domestic violence
- Child abuse, neglect and exploitation
- Substance use
- Post-conflict and community trauma
- Trafficking and exploitation

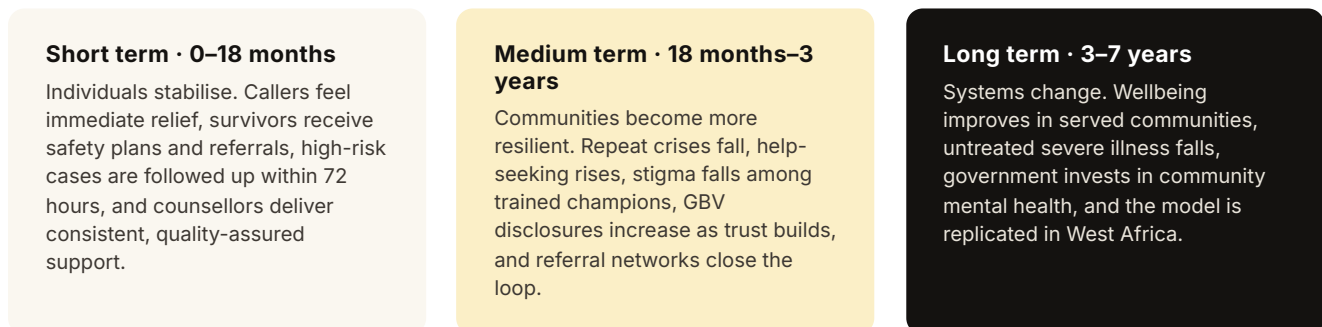
02 · THEORY OF CHANGE

From barriers removed to systems changed

Our Theory of Change rests on a simple causal chain. If cost, distance and stigma are removed, and care is trauma-informed and culturally grounded, and people are connected to the wider ecosystem, then individual healing multiplies into community and system change.



Outcome horizons



Source: L2SLiberia Theory of Change (2026). Outcomes are intended results, not yet demonstrated; see Section 09 on how they are measured.

02 · DISTINCTIVE APPROACH

Built for Liberia, by Liberians

Every design decision answers a specific barrier. This is not a transplanted Western model.

BARRIER
Cost

Free at the point of contact

The hotline is toll-free and the Mobile Clinic visits without charge. L2SLiberia carries the cost, not the person in need.

BARRIER

Distance

Available where people are

Phones reach communities that roads do not, and the Mobile Clinic goes to villages, markets, schools and churches.

BARRIER

Stigma

Culturally grounded, youth-led

Liberian counsellors work within people's worldview. Young people lead, and peer support normalises asking for help.

BARRIER

Fragmentation

Integrated, not isolated

A call can become a clinic visit, and a clinic visit a community programme. Warm referrals mean no one is handed a piece of paper and told to go somewhere else.

BARRIER

Trauma

Trauma-informed from the ground up

Safety, trust, choice, collaboration and empowerment guide every contact. We never judge and never re-traumatise.

BARRIER

Invisibility

Data-driven and accountable

The Call Management System captures patterns of distress, issues and geography, to inform services and, in time, national policy.

The THRIVE Framework

L2SLiberia's evidence-based blueprint for a community mental health system, grounded in WHO mhGAP, research on adverse childhood experiences, and community-centred care. Its six pillars are Task-sharing, Healing hubs, Restorative anti-stigma work, Integrated systems, Voice through letters, and Economic empowerment.

The BRIDGE approach

Trained Peer Navigators and warm referrals close the gaps where people are most often lost: hospital discharge, contact with police, and referral from schools, faith leaders and traditional healers. It is adapted from the Sequential Intercept Model (Munetz & Griffin, 2006).



03

The service ecosystem

A hotline, a mobile clinic, a youth clinic, community programmes, training and data, working as one connected system with the 9898 hotline as the front door.

03 · THE SERVICE ECOSYSTEM

What sits inside the system

9898 toll-free hotline

OPERATIONAL

Launched in 2021. 24/7 within Liberia; 7 AM–6 PM for callers elsewhere in Africa as part of the Pan-African Mental Health Hotline. Psychosocial support, crisis intervention, safety planning, warm referral.

Call Management System

OPERATIONAL

Central platform. Each contact is assessed, categorised, supported or routed, and patterns are captured for learning and policy.

Mobile Clinic

OPERATIONAL

Psychiatric assessment, counselling, psychoeducation, GBV response, basic health screening and awareness in Montserrado, Bomi and Margibi.

Referral network

OPERATIONAL

Hospitals, safe houses and shelters, the Women and Children Protection Unit, legal aid and community caregivers.

Peer support and expressive writing

OPERATIONAL

Peer circles, letter-writing and the Youth Resource Center, carrying forward the Letters to Strangers tradition.

School and community outreach

OPERATIONAL

Awareness, peer support training, stigma reduction and the annual World Mental Health Day campaign.

Caregiver Fellowship and training

OPERATIONAL

Training young Liberians in peer psychosocial support, early identification and referral. 75 clinicians trained to date.

Police Academy partnership (LNPATS)

TOT PILOT IN PREPARATION

A Training-of-Trainers model on MHPSS, ethics and safeguarding, crisis response and case management.

Move To Heal youth clinic

IN PREPARATION

Liberia's first dedicated youth mental health clinic: a stigma-free 'community living room'. In final preparation.

In-house counselling

IN PREPARATION

Sliding-scale individual counselling under licensed supervision, with free and subsidised sessions.

BRIDGE Line and Peer Navigators

PLANNED

A navigator-staffed sub-line for police, teachers, healers and community contacts calling on someone's behalf.

Innovation Lab

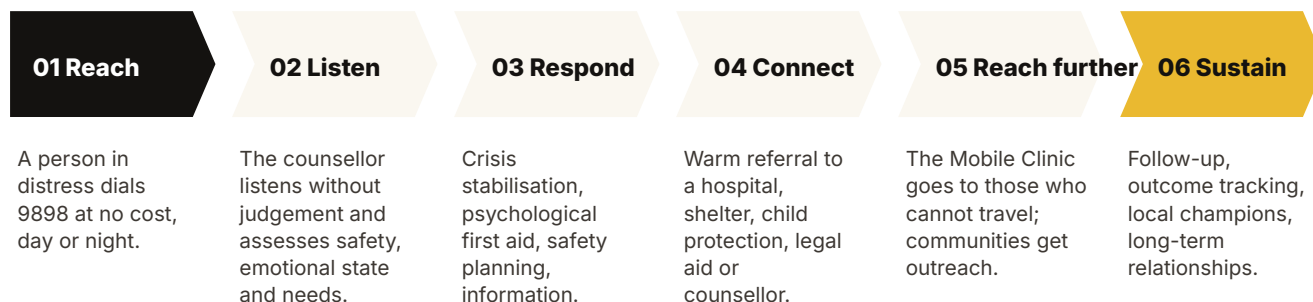
PLANNED

A pilot to develop and test new approaches, launched with the World Mental Health Day 2026 campaign.

04 · HOW PEOPLE MOVE THROUGH THE SYSTEM

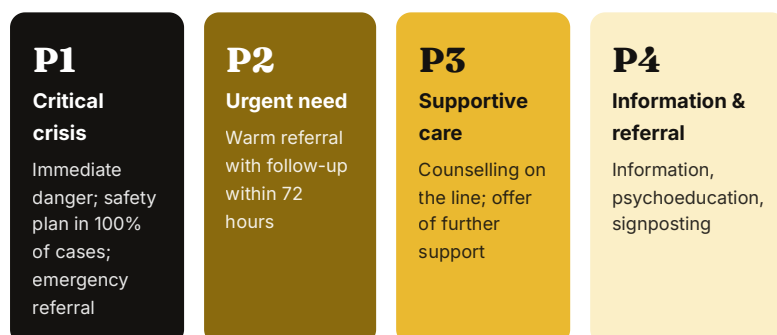
The journey from first call to lasting change

Every contact follows the same six-step journey set out in *Our Model*. The standard is an answer within three rings by a trained counsellor who speaks the caller's language.



Triage: matching response to risk

Callers are screened and prioritised. Our Theory of Change refers to structured SAFE screening and priority triage. The Problem Statement describes four levels:



Response details summarise L2SLiberia protocol documents and ToC indicators; final protocols are maintained by the clinical lead.

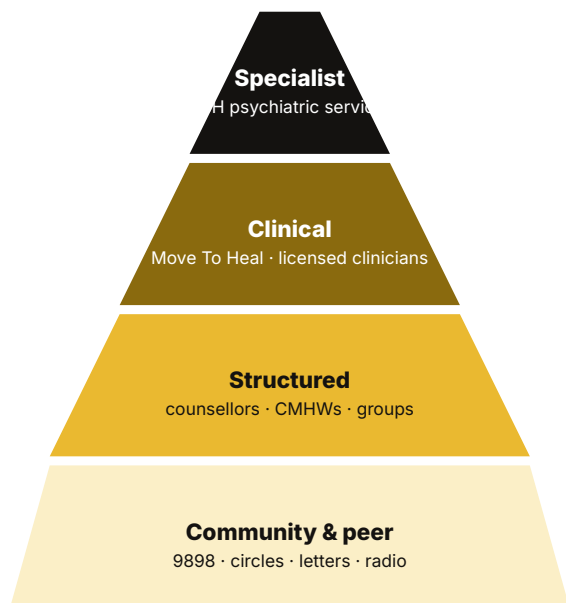


04 · HOW PEOPLE MOVE THROUGH THE SYSTEM

No wrong door

People reach care through many doors, not only the hotline. The BRIDGE approach treats every point of contact as a point of connection: police stations, hospital wards, schools, healers and community groups.

Stepped care



Most people are helped at the lower levels. People step up or down as their needs change.

BRIDGE intercept points **BEING ROLLED OUT**

- 1 Police contact**
Officers trained through LNPATS refer people to care instead of charging them, where appropriate.
- 2 Detention and release**
A Peer Navigator is assigned before release, so someone is waiting on the day the person leaves.
- 3 Hospital discharge**
A navigator plans discharge and makes check-in calls at days 3, 7, 14 and 30.
- 4 Community groups**
A 'no silent dropout' rule: two missed sessions trigger a check-in within 72 hours.
- 5 Schools, healers and faith leaders**
A referral card and a named contact; warm referral within 48 hours.

Source: THRIVE Framework, Section 7. The intercept model is designed; implementation is being phased in.

The Peer Navigator: the human thread

The navigator is the named, trusted person who makes sure no one who has asked for help is left alone with a piece of paper. Thirty peer navigators are to be trained in Move To Heal's first year.

05 · ENABLERS

What it takes to run the system

Workforce

- A youth-led core team of trained counsellors, hotline responders, mental health volunteers and community health workers.
- Clinical supervisors and mental health professionals who keep practice evidence-based.
- A Director of Programs leading the hotline, Mobile Clinic and community work.
- A Mobile Clinic field team of psychiatric clinicians, psychosocial workers and community health staff.
- Case managers, referral coordinators, and M&E and operations staff.

Partnerships

- **MoH Mental Health Unit:** accreditation, clinical oversight, policy alignment, joint campaigns, referral.
- **LNPATS:** Training-of-Trainers on mental health and crisis response.
- **Letters to Strangers HQ:** governance, technical support, a 72-country network.
- **Referral network:** hospitals, safe houses, WACPU, legal aid.
- **Community structures:** schools, religious institutions, traditional leaders, CHWs.

Technology

- Toll-free short code 9898, reachable from any mobile or landline network.
- Call Management System: assessment, categorisation, routing and pattern capture.
- Case management and data tracking; secure, confidential data storage.
- Monthly performance dashboard (committed in the 2026 Work Plan).

Infrastructure

- Office in Congo Town, Monrovia.
- A secure, confidential hotline workspace (relocation recommended in 2026).
- Mobile Clinic vehicle and clinical equipment.
- Move To Heal premises (two-year lease planned).
- A referral directory and partner agreements.

Operational requirements identified in 2026

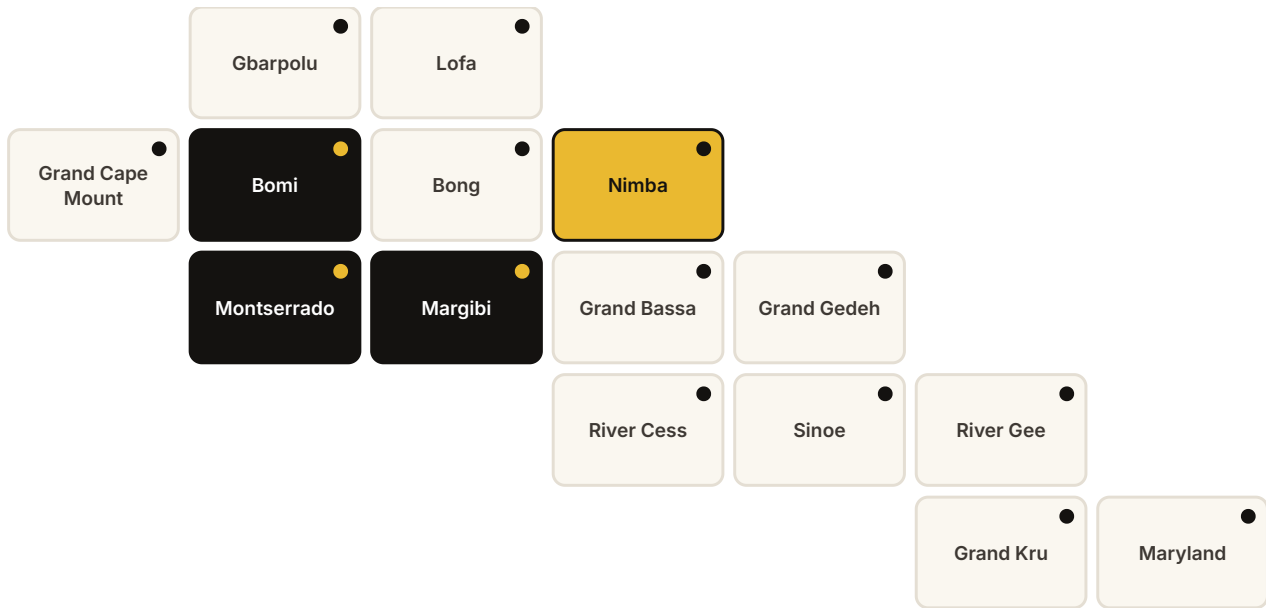
Relocate the hotline to a secure workspace to resolve confidentiality, safeguarding and data-protection concerns.

Complete a 24/7 on-call roster, and recruit a licensed counsellor or psychiatrist for clinical supervision.

Produce consolidated monthly data, with agreed definitions of a call and a referral.

06 · GEOGRAPHIC REACH

National by phone, local in person



■ Mobile Clinic & community operations ■ First outreach planned (Oct 2026) □ Hotline reach (callers from all 15 counties)

Schematic tile map. Counties are arranged approximately by relative position and are not drawn to scale or shape.

How we reach underserved communities

- **Phone first.** The hotline has received callers from all 15 counties, so need is visible far beyond the counties where we work in person.
- **Then in person.** Mobile Clinic and community operations run in Montserrado, Bomi and Margibi, reaching more than 32,500 people with integrated community health services in the past year.
- **Next county.** A first Mobile Clinic outreach visit to Nimba, Liberia's second most populous county, was planned for October 2026, with an introduction to the County Health Team.
- **Data-led growth.** Hotline data on where calls come from will guide which counties come next.



Where people gather

The Mobile Clinic goes to villages, marketplaces, schools and churches, places where trust already exists, rather than waiting for people to come to care.

07 · COMMUNITY, YOUTH PARTICIPATION AND STIGMA REDUCTION

Changing how a generation understands mental health

Stigma is not fixed. Our Theory of Change assumes that sustained, community-level work through trusted local actors can shift attitudes over the medium term. We treat this as a core part of the model, not an add-on.

Youth participation

- Young Liberians design, deliver and lead our work, and are employed as responders, peer supporters and coordinators.
- More than 10,000 young people reached through peer circles and expressive writing.
- The Caregiver Fellowship turns young people into the first line of support in their own communities, and offers a pathway into meaningful work.
- The World Mental Health Day 2026 campaign put young people's lived experience at its centre: 'Lived Experiences Heard: Real Voices, Real Change'.

Stigma reduction

- Awareness and peer support training in schools across Montserrado, Bomi and Margibi.
- Work with employers, faith leaders, traditional healers and community radio.
- Public moments, such as a 5K run/walk and community rally, that put mental health 'on the streets'.
- Community champions trained in psychological first aid and referral.
- Pre/post measurement of stigma scores (a CMAP target of a 25% reduction).

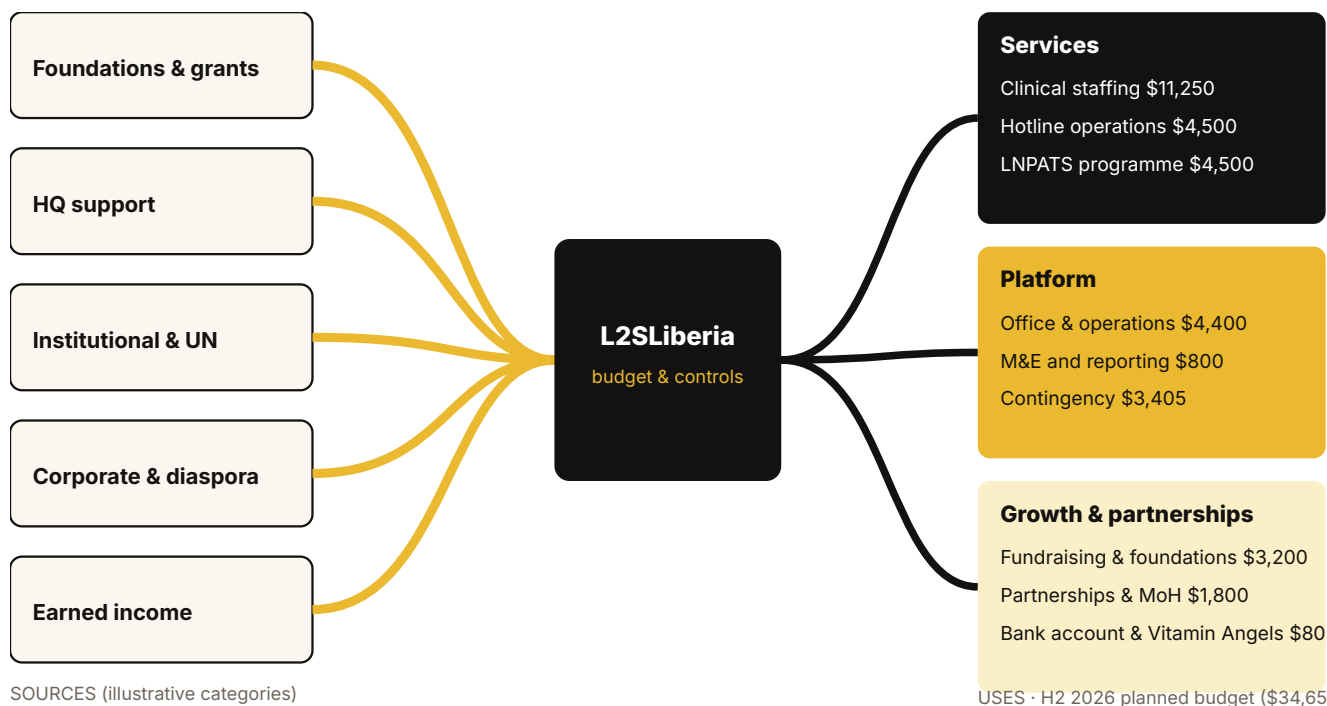


Storytelling ethics. Written informed consent comes before any identifiable story, image or quote is used. Anonymity is the default, and no child is identified.

08 · FUNDING FLOWS, RESOURCE ALLOCATION AND COST

How money moves through the model

Care is free at the point of contact, so the model is funded by others: Letters to Strangers headquarters, grants, partners, donors and, increasingly, earned income from sliding-scale counselling. The diagram uses actual budget lines from the July–December 2026 plan for uses. The source categories show the funding channels; their proportions are not reported here.



Key unit costs (2026 plan)

Telecoms & call platform	\$150 / month
Hotline on-call staffing	\$750 / month
Licensed clinician (contract)	\$1,500 / month
Researcher (contract)	\$750 / month
Office rent & utilities	\$300 / month

Cost considerations

- Free access means demand drives cost: more calls require more responders.
- Clinical supervision is the largest single line, and the most important for quality.
- Promotion must follow capacity, so unanswered demand does not erode trust.
- Higher call volume also raises telecom costs.

Sustainability levers

- Diversified grants and multi-year partners.
- Sliding-scale counselling and fee-based training.
- Student volunteers through university MoUs.
- Task-sharing to trained non-specialists.
- MoH integration and, in time, public co-financing.

09 · MONITORING, EVALUATION, LEARNING AND IMPACT

How we know the model is working

We separate what we count (outputs) from what changes for people (outcomes) and from lasting change (impact). Today our strongest evidence is at the output level. Building outcome measurement is a priority in the 2027–2031 Strategic Plan.

OUTPUTS · DOCUMENTED

Calls received (cumulative)	140,000+
Referrals made	5,000+
People reached by mobile outreach	32,500+
Young people in peer programmes	10,000+
Clinicians trained	75

OUTCOMES · BEING BUILT

Calls answered in 3 rings	95%+
P1 calls with safety plan	100%
Referrals followed up in 72h	85%+
Callers felt heard and safe	90%+
Distress score change (returning callers)	From month 6

ToC targets; not yet reported.

IMPACT · LONG TERM

- Help-seeking and stigma in served communities
- Untreated severe illness in programme areas
- Government investment in community mental health
- Replication of the model

Assessed through external evaluation.

Learning rhythm

Monthly hotline dashboard from the CMS	Monthly
Quarterly reporting against ToC indicators	Quarterly
Clinical supervision review of calls (random sample)	20% per week
Community feedback sessions in programme areas	Twice a year
Annual programme evaluation with external review	Annually
Theory of Change revision	Annually

Being candid. The February–October 2026 Hotline Report found no consolidated monthly dataset for the period. It recommended a monthly dashboard, a retrospective data pull and agreed definitions. These are the first MEAL priorities.

10 · REPLICATION, SCALABILITY AND SYSTEMS INFLUENCE

A model designed to travel

The conditions that produce mental health crises in Liberia (poverty, post-conflict trauma, weak health systems, stigma and isolation) are found across West Africa.

	Consolidate	Prove	Expand	Region
Phase 1 · Liberia	Full national coverage across all 15 counties through hotline and Mobile Clinic			
Phase 2 · Sierra Leone & Guinea		Adapt and deploy the hotline model with local partners		
Phase 3 · Regional scale			West African support network	

Phasing from *Our Model* (2026). Timeframes depend on proving and documenting the Liberian model first; see Strategic Plan, Priority 5.

What makes it replicable

- Low-cost entry point: a toll-free line
- Task-sharing to trained non-specialists
- Documented protocols and frameworks (THRIVE, BRIDGE)
- Partnership with ministries, not parallel systems

What changes in each place

- Languages and cultural adaptation
- Local partner organisations
- Referral directories
- Regulatory and licensing routes

Systems-level influence

- Hotline data as a basis for a national mental health intelligence system
- Police training embedded in the Academy
- Youth-friendly care modelled at Move To Heal
- Advocacy for public investment in community mental health



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One free call can open the door. A connected system makes sure no one is left alone once they walk through it.

“No one should suffer alone, in silence, without hope.”

CONTACT

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NEED SUPPORT NOW?

9898

Toll-free mental health hotline, 24/7 within Liberia

Alternative line +231 77 576 3208

REGISTRATION

Registered Liberian non-profit organisation, established 2019

Tax Identification No. 501463377

Business Registration No.

053085784

Accredited by the Ministry of Health as a mental health provider