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1. INTRODUCTION
Mental Health is defined as a “state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2001)

The successful performance of mental function, resulting in productive activities; fulfilling relationships with other people, and the ability to adapt to change and to cope with diversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental Health as a concept needs to be considered within the context of the Samoan culture. Not only are mental disorders linked to certain physical illnesses and increased mortality from suicide, they also bear a complex and poorly understood relationship to many of the most toxic public health problems of our day such as interpersonal violence, criminality, addictions, homelessness and poverty.

This policy supports the mental health needs of the population and the mental health systems and services offered in Samoa. The needs of the population can be determined from factors such as prevalence and incidence data from rapid appraisals or formal research, determining what communities identify as problems and an understanding of help seeking behavior. This will lead to establishing priorities for mental health services.

It is essential for supports to be in place for all people in Samoa, whether young or old, whether living with a mental illness or not, to maximize their mental health and the betterment of a healthy society.

2. VISION
For all people in Samoa to enjoy mental well-being that is grounded in the aiga and nurtured through a multi-sectoral approach which provides quality care that is accessible to all people while recognizing that mental, physical, social and spiritual health are indivisible.

3. MISSION STATEMENT
Holistic, responsive and effective mental health care services that are evidence-based, culturally sensitive, affordable and accessible to all people in Samoa in an enabling and informed environment.

4. VALUES AND PRINCIPLES
a) Mental well being is grounded in the aiga and the community. The Samoan understanding of dignity and self-esteem is collective and relational in nature.
What is achieved or lost by the individual, is felt by the Aiga. In this context, the aiga is the natural and appropriate health care setting for the promotion of mental health and the management of mental disorders, with the exception of some severe disorders requiring hospitalization or seclusion.

b) Quality Mental health service that is accessible to all people
c) Respect the rights of all people to access mental health care
d) Recognition that mental, physical, social and spiritual health is indivisible and holistic approach best addresses this
e) Evidence-based treatment and therapy
f) Dignity of Family and Community
g) Rights of the family and community to quality information
h) Community recognition and respect for the rights and dignity of persons with mental disorders.

5. GOALS AND OBJECTIVES
   a. Strengthen the comprehensive community based programmes
   b. Provide evidence-based and cost-effective treatment to all people who need mental health care
c. Promote the human rights of people with mental disorders
d. Integrate mental health into general health care
e. Promote good mental health through sectoral and inter-sectoral initiatives and nurture the physical and mental well-being of Samoan residents
f. Protect, promote and restore the physical and mental well-being of Samoan residents
g. Develop a mental health board for sustained leadership and direction

6. KEY AREAS FOR ACTION
   a. Ensuring appropriate financing of prioritized services
   b. Legislation and Human rights
c. Organization of Services
d. Human Resources and Training
e. Facilitate and provide supports to affected families
f. Areas of focus for Promotion, Prevention, Treatment and Rehabilitation are:
   i. Suicide Prevention
   ii. Drug and Alcohol Abuse
   iii. Sexual Abuse: Child and Adolescent Abuse
   iv. Early Recognition and Management of Mental Disorders
   v. Domestic Violence
   vi. Dignity of the family
g. Ensure essential drug procurement and laboratory support
h. Build Capacity for Leadership and Advocacy
i. Quality Improvement
j. Improved Information Systems for more informed care
k. Strengthened Research, Monitoring and Evaluation
l. Community and Inter-sectoral collaboration
7. SITUATIONAL ANALYSIS

7.1 Overview of Current Mental Health Services

7.1.1 Legislation
The current Mental Health Ordinance 1961 is antiquated and largely unworkable. It focuses on involuntary treatment and not on patient rights. It has been completely revised to allow for a balanced approach to the subject and the development of this new bill is proceeding simultaneously with this policy.

7.1.2 Specialist Services
The Mental Health Unit is located at the MOH compound at Motootua, which includes the clinical services at the Tupua Tamasese Meaole Hospital (TTMH). These services are responsible for all specialist mental health care in Samoa. Currently there is a medical officer in psychiatry who is the focal point for mental health in the Ministry of Health. She is overseas studying psychiatry and is due to return around 2008. Five Mental Health nurses are also employed within the unit having completed their postgraduate course at the National University of Samoa in 2004. Recently a part-time psychiatrist originally from Australia commenced working with the mental health unit. The focus of his work has been secondary consultation, supervision and training.

The current staffing of the Mental Health Unit consists of one part-time psychiatrist (9 hours a week), one full-time medical officer who is on leave without pay studying and working in New Zealand, and five nurse specialists working full time. The current nurse-patient ratio is 29.8 to 1.

The Mental Health Unit is responsible for providing community treatment for people with long-term mental disorders. The current updated number of patients receiving regular visits by the Mental Health Unit by April 2005 was 149. The majority of patients being treated by the Mental Health Unit were aged between 14 and 40 years (Mental Health Unit: 2005). No services are provided specifically for children and very few services were provided specifically for youth or elderly people.

There are limited mental health services for prisoners. Prisoners who have a mental illness can be taken to the Mental Health Unit for assessment or visited in prison by nurses following a phone call from the Ministry of Police, Prisons and Fire Services. In addition, the mental health unit visits patients at the prison and the recognition of a mental disorder relies on either the prisoner...
requesting assistance or prison officials recognizing that the prisoner might have a mental illness and requesting a mental health assessment.

Currently a majority of patients have been diagnosed with schizophrenia or other psychotic disorders. In addition, the Mental Health Unit provides continuous assessment and consultation to a wide range of other health programs including the hospital, community nurses and general practitioners. Referrals are also received from families, police, non-governmental organizations and private lawyers. According to Mental Health Unit records (2005), there were 92 referral cases from families, 26 from TTM-OPED, 14 self-referrals and the rest were from NGOs and Ministry of Police, Prisons and Fire Services. Therefore, the majority of referrals were from families.

There are limited acute inpatient treatment facilities. Patients requiring inpatient care are admitted to TTMH although there are no designated open beds for psychiatry for Mental Health. The current seclusion facilities for the management of violent patients require immediate renovation and reconstruction. People with a mental disorder who are at risk to others are detained by the police and taken to the police cells until psychiatric care is arranged. Where possible, the person receives treatment as a day patient from the mental health unit and is returned home to their families with community support or, if their behaviour is very disturbed, they may remain in custody until their symptoms stabilize and the risk of harm to themselves or others is reduced. These decisions are made by the treating team in consultation with the police, and using the Mental Health Ordinance 1961.

7.1.3 Mental Health Services in Primary Care
Samoan culture is based on the aiga and this should also be the focus of Mental Health assessment and management. Thus the preference should be for treatment in the community rather than in hospitals or health centres.

Nursing staff located at the District Hospitals and Community Health Services provide primary care services, including the recognition, referral and treatment of people with mental disorders. They need to work closely with the mental health unit who provide consultation and support to the community nurses. Most community nurses have received some training in the recognition and treatment of mental disorders. Clinical protocols are available to guide treatment. These protocols were written in 1990 and are currently being reviewed by the Mental Health Unit. The lack of
ongoing training for the community nurses, the limited resources of the mental health unit and the difficulties of the mental health unit providing outreach services hamper the effectiveness of this support. For example, the mental health unit has only one vehicle that is frequently out of service. At these times, no outreach services are available. This has caused problems with the continuity of treatment.

There is a small group of general practitioners available in Upolu and one solo practitioner in Savaii. While these doctors have expressed an interest in providing mental health care they are limited by the cost of private treatment, lack of training and some limitation of access to secondary and tertiary consultation from a psychiatrist. They often refer patients to the Mental Health Unit; about 5% of patients were referred cases from the General Practitioners’ Clinics.

7.1.4 Informal Mental Health Services

There is a wide range of informal mental health services. These include NGOs, religious organizations and traditional healers. These services provide a variety of programs related to mental health such as suicide awareness, abuse victim support and alcoholic support. There are also some general counseling services available. These informal services provide a significant component of the mental health care in both urban and rural areas, often filling the gap in the absence of sufficient specialist and primary services. There is no formal linkage of networking with these NGOs. This is evident by a record of referral sources for patients of the Mental Health Unit, where none is shown to have been referred from an NGO group.

There are currently no self-help groups for the mentally ill or their families.

There are people who wander aimlessly in town and public places that often spend days away from their homes. Some families insist on seeking and taking their relatives back home but some do not bother anymore.

At present, counseling services in schools, workplace and community are not formally set up. These services, when they are provided, are given by people on the job who usually have no specific training or support.

7.1.5 Private Sector
There are very few private services. There are no private psychiatrists in Samoa. Until recently, two private psychologists worked in Apia but both left in mid 2005. The private hospitals refer patients with apparent mental disorders to the Mental Health Unit for treatment and follow up.

Basic data are available on suicide but not on antecedent causes and events. There is no suicide prevention strategy or program. Deliberate self-harm data showed about 56% of attempt suicide were women and 44% were men. As yet it is unknown how many deliberate self-harm events are in the context of clinical depression. There is no record of deliberate self-harm patients been followed up apart from the initial assessment at the hospital at the time of the incident.

Paraquat is a controlled substance but anecdotal evidence suggests that these controls are often not complied with. There is no record of networking with NGOs for referral of deliberate self-harm cases.

There is a high prevalence of mental disorders among people who abuse substances. Anecdotal evidence suggests that there is an increasing problem with alcohol and drug use (predominantly marijuana) in the Samoan community. Some anecdotal evidence suggests that most men in villages use marijuana and that alcohol abuse is common.

Domestic violence is associated with immediate stress related disorders and with later disorders amongst those who are exposed to it.

Sexual and physical abuse is correlated with an increased incidence of adult mental disorders.

Stigma and discrimination exists within the community. This can exist in families with a member with a mental disorder although they are usually much more knowledgeable and supportive. This stigma and discrimination exists within the health services. Mental health is the part of the nursing curriculum but it is not a part of any other curriculum. Current cultural beliefs present a stigmatized view of mental health disorders. This compromises the dignity of families involved and the individual with a mental health disorder. This acts as in impediment to treatment as well as producing its own stresses.
There is currently no systematic teaching of mental health issues in schools.

The range of psychotropic drugs available is limited and includes only a few of the newer classes of drugs (for example atypical antipsychotics or modern antidepressants). In addition to a limited range of psychotropic drugs, the supply of the available drugs has, at times, been erratic. For example, in 2002 no psychotropic were available for five months although those seen by the mental health unit are largely treated with chlorpromazine, haloperidol or a tricyclic anti-depressant. Modecate (fluphenazine decanoate) is the only long acting injectable antipsychotic available. There is a need to maintain a lithium clinic that can consistently provide the necessary monitoring and blood tests. A small number of patients who receive treatment from the mental health unit have previously been treated in New Zealand or other countries. These patients have access to atypical antipsychotics such as risperidone and clozapine.

Most of these newer drugs are now out of their patent period. Cheaper generics are now available from countries such as India and a limited range is now in Samoa. Lithium is available but cannot be safely used without a reliable means of assessing the blood level.

There is limited access to psychological treatments or rehabilitation from the mental health unit. Fortnightly psychotherapy supervision for counselors is provided by a group meeting including members of the Mental Health Unit and counselors in the community.

7.1.6 Substance Abuse Services
About 16% of all patients have drug induced related psychosis. They receive treatment for their psychosis but not proper programs for substance abuse. There are no specific substance abuse treatment services in the specialist or primary health sector. Non-government organizations provide support for people with alcohol related problems. A large number of prisoners are in custody for drug offences. The recent introduction of minimum sentencing for people convicted of possessing drugs is likely to increase the need for mental health and substance abuse treatment services in prison. Currently, there are no substance abuse services available.

Clinical records are currently held in the mental health unit providing an effective separation of record holding from the rest of the TTMH. This provides for ease of treatment in the Mental
Health Unit but means that patients presenting to the Accident and Emergency department do not have their clinical details of Mental Health care recorded in their general hospital files.

Formal systems for follow-up often need to be implemented.

Little research has been conducted on Mental Health issues in the country.

There are limited data available on prevalence and treatment of disorders in Samoa.

7.1.7 Expenditure

There are no specific data on the current expenditure on mental health services in Samoa. The budget for the Mental Health Unit is within the general clinical budget and individual line item cannot easily be extracted. The mental hospital (Ward 9) was closed ten years ago. No data are available on the cost of mental health services in primary care.

7.2 Demand for Mental Health Services

7.2.1 Population Data

The population of Samoa in 2001 was 176,847 of which 92,130 were male and 84,718 female (Mental Health Unit: 2005). The following table summarizes the age distribution of the population.

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<tr>
<th>Age Group</th>
<th>No. of People</th>
<th>Percentage (%)</th>
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<td>0-14</td>
<td>71,978</td>
<td>40.7</td>
</tr>
<tr>
<td>15-24</td>
<td>31,929</td>
<td>18.1</td>
</tr>
<tr>
<td>25-64</td>
<td>64,734</td>
<td>36.6</td>
</tr>
<tr>
<td>65+</td>
<td>7,904</td>
<td>5.5</td>
</tr>
<tr>
<td>Missing</td>
<td>303</td>
<td>0.1</td>
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Source: Mental Health Situational Analysis, 2003

Almost 20% of the population is aged between 15 and 24 and just over 5% is over 65. Almost half of the population (45.6%) lives in the urban area (Mental Health Situational Analysis: 2003).

7.2.2 Factors that influence the mental health status of the community.

There are several factors that are likely to influence the prevalence of mental disorders in Samoa. These include:

a) Increasing urbanization

Population changes in Samoa indicate a decrease in rural populations and an increase in the urban population. This shift
is also associated with a decreasing number of people living in traditional village structures and a decrease in the ability to rely on family systems to support people with a mental illness. Non-government and religious organizations are increasingly reporting issues such as homelessness among people with a mental illness. Homelessness has traditionally only been a problem in developed countries where the family and community supports are not adequate.

b) **Hardship**

While Samoa ranks favorably among other Pacific Island nations on the Human Poverty Index, there remain significant numbers of people who are economically disadvantaged relative to the rest of the population. Hardship is both a risk factor for and a consequence of mental disorders. For example, the stress associated with economic insecurity may precipitate a mental disorder. Similarly, the chronic and relapsing course of many mental illnesses may disrupt a person’s ability to maintain employment and earn an income.

c) **Substance Use**

Reports and anecdotal evidence suggests that there are increasing problems of substance use, particularly alcohol and marijuana within the community. These problems appear to particularly affect young people. Both alcohol and marijuana use are associated with a higher prevalence of mental disorders.

d) **Migration**

There is a net migration of people from Samoa. This migration results in the loss of experienced health workers weakening the overall health system. The loss of productive people within a family means that there are fewer people to support older and disabled family members and thus increasing the stress on the remaining carers. Such stress increases the risk of a carer developing a mental disorder. In addition, people with mental disorders who return to Samoa from developed countries may have expectations of a mental health service that is difficult for the current services to meet. Access to treatments not generally available to other Samoans may be available for people with mental disorders returning from developed countries. For example, in early 2005 there were two patients being treated by the mental health unit with clozapine, an atypical antipsychotic. Clozapine and a limited range of newer drugs are currently available.

e) **Utilization of Services**
The Mental Health Unit provides community support for people with long-term mental disorders. Most patients treated by the mental health unit have a psychotic disorder (e.g. schizophrenia, bipolar disorder, drug induced psychosis and epileptic psychosis). Until recently the Mental Health Unit provided treatment for people with epilepsy. These patients have now been transferred to the medical teams at the Tupua Tamasese Meaole Hospital, unless there is evidence of a co-morbid mental disorder such as psychosis. There is a limited number of cases presenting with depression, anxiety disorders or dementia.

The Mental Health Unit provides assessment and consultation for patients referred from a variety of sources. While there are no data on referrals the mental health unit estimates that they receive 3 – 4 referrals per week. Their commonest source of referral is the hospital, families and individuals.

While a four-bed ward was built at TTM hospital for the inpatient treatment of people with a mental disorder, the beds have never been officially opened. Instead the building is used as a day care facility and offices for the mental health unit. There are no structured rehabilitation programs at the unit. There are no dedicated open beds in the hospital for people with mental disorders. It is possible to admit people to the hospital, provided that they are not a significant risk. This requires that the mental health team negotiate access to a bed with the ACEO of Clinical Services.

8. **POLICY ISSUES**

8.1 **Finance**
A separate budget line for Mental Health Unit will allow the production of an annual budget with projections for future needs.

Any promotion of Mental Health is likely to result in increases in patient loads as some more of the number of people who are currently untreated seek treatment. This may be relatively small in promotions of schizophrenia as there is already a significant patient load. Mania is almost completely untreated in the country and may represent a significant number of people. Similarly, depression is largely untreated.

8.2 **Legislation**
The office of the Attorney General has undertaken the task of this revision which has been guided by the principles in the draft Mental Health Policy. Any mental
health act must be consistent with and support and enable official Mental Health Policy. Changes in one may need to be reflected by changes in the other.

8.3 Leadership
A lack of consistent leadership in mental health appears to have contributed to the decline in mental health services over the past few years. It is notable that the appointment of a medical officer as a focal point has resulted in significant improvements in mental health services.

8.4 Expanding specialist services
The quality of the mental health system is dependant upon the availability of an adequately trained, multidisciplinary skilled workforce.

In the near future, Nurse Specialists will be the cornerstone of Mental Health assessment and treatment. Over the years trained psychiatrists have come and gone but there has been an ongoing nursing presence. Long-term planning should include provision of training for all positions in the Mental Health Unit so that the loss of one person is not as critical as it has been in the past. Rotating medical officers through the unit is one method of providing them with some Mental Health training as well as exposing them to a possible career option. Similarly, general nurses could be rotated through the unit. Orientation of Rural Nurses should include Mental Health; the Mental Health unit should be part of their rotation.

Specialized areas such as forensic skills can be served by the recruitment of specialists with experience in these areas, by specialized training or by the use of overseas telephone or email consultation to augment in-country skills.

The capacity of specialist mental health services to provide tertiary health services needs to be enhanced. This requires the presence of experienced staff and an availability of tertiary consultation meetings as well as the possibility of obtaining urgent consultation when required.

One urgent gap is in the provision of acute psychiatric beds. While the investment in bed based services should be balanced with ensuring that the majority of services are provided in the community, nevertheless attention must be given to ensuring that people who are in need of hospital based services are able to receive treatment in an appropriate health setting. These beds need to be a mix of secure beds for patients who are at present held in police custody, and “open” beds where voluntary patients can be treated. These open beds would have limited use as a transition back into the community, which is the main focus of management. A block of two secure rooms is already present but was constructed with materials that have already been damaged by the few patients who have been admitted there. This damage renders these beds unusable for severely disturbed patients. There is space in the current building to create acute open beds but these would need adequate staffing levels before either could be
used. This could be achieved by flexibility to roster general nurses to assist when patients are admitted. For safety reasons, a minimum of two staff members should be present at all times when there is someone admitted to a secure bed.

This focus provides an overlap with Community Health Services but it is essential that the oversight of Mental Health management be under the direction of the Mental Health Unit. Thus assessment and treatment plans need to be made by the Mental Health Unit staff with some routine treatment delegated to the Community Health services.

A key element of this focus is the provision of the infrastructure to allow for community outreach. This includes such factors as vehicles, drivers, as well as information and communication systems such as computers and two-way communication to allow for tertiary consultation at the village level.

Enhanced availability of secondary and tertiary consultation will provide better support for the general practitioners. This can be provided by better communication links and availability of time.

8.5 Developing a workforce
There is an urgent need to develop a workforce plan that will address the numbers, skills, training and budget. This may include people with a variety of disciplines.

8.6 Developing substance abuse treatment services
There is an urgent need to develop substance abuse treatment services in Samoa. There is evidence that this is a significant and growing problem. Substance abuse services could be located within either the mental health unit or a non-governmental organization.

8.7 Infrastructure development
One of the major impediments to the efficient operation of the mental health unit is the lack of infrastructure support. Patients’ treatment areas, transport, and communication systems are the main needs.

8.8 Promotion, Prevention
Mental health promotion involves any action to enhance the mental well being of individuals, families, organisations and communities. In Samoa these actions particularly refer to a genuine multisectoral response based on equal partnerships and ownership.

Mental Health Prevention refers to both action and policy that may in some way decrease the incidence of mental unwellness and mental illness. This may be realised through a number of collaborative approaches addressing drug and alcohol abuse awareness, the recognition for traditional and modern counseling support services, life skills and sustainable livelihoods training.
8.8.1 Defining Mental Health

It is important to recognise that every person at some point will experience some form of mental unwellness. This reflects the notion that mental health exists as a continuum where good mental health is located on one end, and mental illness on the other. Most people may fluctuate between good mental health and somewhere in the middle (mental unwellness) for a period of time. A few may fall into mental illness.

It is crucial that those who are mentally unwell and those suffering from mental illness are equally prioritised.

Addressing bad stress needs to be prioritised amongst vulnerable groups. Drug and alcohol abuse, unemployment, and crime are mostly a result or symptom of bad stress. In socio-economic terms it is this area of mental health that is more costly.

8.8.2 Perspectives of Mental Health

Mental Health should be explained in terms that are acceptable to all communities. Religious, traditional, and western scientific/medical perspectives should all be recognised as having a role in healing people who are mentally unwell or ill.

One discipline should not be prioritised over the other. Instead the National Health Sector should develop a collaborative strategy.

8.8.3 Research, Education and Awareness

It is important that research is carried out to gauge the extent of Samoa’s mental health problem. Such research should address both mental unwellness and mental illness issues.

Exhaustive research on different types of drugs and their intentions should be carried out. Cultural behavior that is acceptable to a person and his/her community but not to western medical classifications should be scrutinised in favour of what is best for the individual and the community. Medication intended for children should be seriously scrutinised.

Education and Awareness programmes need to be provided for all sectors of society including communities, schools, workplaces, health workers and Parliament. Such programmes will give equal emphasis to the traditional, religious, and western scientific/clinical perspectives.

8.8.4 Advocacy
People living with mental unwellness and mental illness should be Samoa’s key advocates for mental health issues. Affirmative and anti-discrimination/stigma policies need to be developed for all formal sectors.

Key areas would include equal opportunity to education and employment and support throughout, access to affordable, and effective treatment, care and medication within dignified settings.

People living with a mental illness should be consulted with regards to all drugs brought into the country intended to treat them. Special attention should be paid to drugs intended for children.

People living with a mental illness are coping within society should be supported within a medium that they feel most comfortable so that they can be heard.

People living with a mental illness should be afforded the best care and treatment in any care facility.

People living with a mental illness should not be put penalised as criminals nor should they be incarcerated within the local prisons.

8.9 Quality Improvement, Information Systems and Research
An effective mental health system relies on integrating quality improvement into the mental health sector, ensuring the collection and analysis of information and promoting research on mental health issues.

Better integration of records that served the needs of efficiency and patient care is necessary. Key data should be recorded.

Better systems need to be implemented to ensure consistent follow-up by Mental Health Unit staff and by community nurses.

A climate of research will improve the management of Mental Health issues by enhancing support of evidence-based treatments and providing necessary data to inform programme decisions.

Although some evidence basis for treatment can be obtained from overseas research, the ongoing evaluation of treatments here can provide valuable data to assist and inform ongoing management decisions.

A specific suicide audit to determine antecedent causes and events would allow for better-targeted prevention.

9. POLICY STATEMENT
There is a strong political and organizational commitment in Samoa to develop a mental health policy. A mental health policy needs to be informed by broader policy frameworks and be consistent with the objectives of the Ministry of Health.

Changes in the social and economic structures within Samoa appear to contribute to an increased prevalence of mental disorders. Mental health policy should be formulated aiming at reducing the burden of mental disorders in the aiga and the community. This will lead Samoa towards achieving our Mental Health Policy vision.

10. STRATEGIES FOR IMPLEMENTATION

10.1 Finance
Financial estimates shall meet the need and reflect the planning and budgeting for Mental Health.

10.2 Legislation
The Ministry of Health shall advise Attorney General of any changes in Mental Health Policy and to provide sufficient instructions in relation to necessary amendments to Mental Health Act. The office of the Attorney General shall monitor that the Mental Health Act remains consistent with the Mental Health policy and enforces values, objectives and principles highlighted in the policy as it is from time to time. An up-to-date Mental Health Act will provide a legislative basis for appropriate mental health care in Samoa.

10.3 Leadership
The Mental health policy shall promote consistent and ongoing leadership within mental health. In order to achieve this policy objective, a National Mental Health Advisory Committee shall be established. This committee shall ensure the coordination of mental health strategies at a national level, provide broad stakeholder input into policy and planning processes, and monitor the implementation of the mental health policy.

10.4 Expanding Specialist Services
Planning for the training of staff based on projected needs of the service and likely retirement or loss of personnel shall ensure a continuity of staffing levels. Levels of specialist nursing staff members must be consistent with the patient workload.

Training shall be provided in a broad range of specialist skills required within the Samoan community. The employment of staff with these skills will enhance the diversity and range of skills available.
Structuring the provision of services with specialist nursing staff being the main points of contact and then appropriate tertiary consultation will ensure an efficient use of available resources.

Services shall be geared towards the focus on the aiga as the usual place of assessment and management.

Communications with staff on call or those on community visits shall be ensured.

Better liaison between the Mental Health Unit, Community nurses, Ministry of Police, Prisons and Fire Services and general practitioners shall be provided in order to ensure appropriate patient care.

10.5 Informal Mental Health services
Creation of better liaison links with the various informal mental health services shall be improved and maintained to provide for better working relationships and thus more effective services for families and those with mental disorders.

The development of one or more support groups including one for survivors of self-harm/suicide attempts shall be actively nurtured.

There is an increasing need for community-based accommodation, particularly in urban areas, that combine housing and rehabilitation services. Community and religious groups have previously organized these services and they should be encouraged to continue.

The Ministry of Health shall encourage the community, government and non-governmental organizations including schools, emergency services and other workplaces to institute and maintain counseling services.

10.6 Developing a workforce
A taskforce group shall be set up with terms of reference to assess future and ongoing needs and to recommend strategies to ensure that these needs are met well into the future. This group shall take into account the requirements for working with different life stages (e.g. children, youth, adults and the elderly) and a capacity to use the different therapeutic skills (e.g. biological treatments, counseling and rehabilitation) required in the varied mental disorders seen in Samoa.

10.7 Developing substance abuse treatment services
Training for primary and specialist mental health workers in substance abuse treatment shall be coordinated. Primary treatment services shall be provided, particularly in the prison.
10.8 **Infrastructure development**
Infrastructure support for a community focus shall be provided. This includes adequate accommodation, communication and transport. The secure block shall be renovated to a level where it is substantially damage proof and secure.

An infrastructure development plan for mental health care shall be created and updated. The special needs of those in custody with mental disorders shall be considered.

10.9 **Quality Improvement, Information System and Research**
These are critical issues in ensuring that any reform to the mental health sector results in improved mental health for the Samoan people.

A more consistent integrated and efficient method of record keeping shall be provided to improve patient records.

Adequate systems for follow up shall be ensured.

A research culture and capacity shall be fostered.

A regular data collection of treatment and prevalence as available shall be instituted.

10.10 **Treatment and Rehabilitation**
A reliable supply of reasonable range of newer and older psychotropic drugs shall be ensured through appropriate sourcing.

Rehabilitation is a core element in the management of mental disorders and may include counseling, educational, occupational and cultural therapy with the ultimate aim of the person gaining employment if that is appropriate.

10.11 **Promotion and Prevention**
Priorities shall include conducting mental health awareness campaigns to reduce stigma, integrating mental health issues into the school curricula and developing suicide prevention strategies.

An evidence-based suicide prevention strategy shall be implemented. A suicide audit to gather data about self-harm incidents and completed suicides shall be conducted.

Targeted programs for at risk groups shall be formulated and implemented for at risk groups.
Village councils and women’s committees shall be provided with information programs. A review into the success and the effectiveness of the current legislation to prevent the abuse of paraquat would be useful.

A harm minimization approach to marijuana shall be adopted. Education programs on the risks of alcohol may help to reduce its abuse.

Awareness programs of the harmful effects of sexual and physical abuse shall be provided aimed at reducing the incidence. The Ministry of Health in collaboration with the Ministry of Women, Community and Social Development shall work closely to encourage the policing of paraquat at the local level.

The Ministry of Education, Sports and Culture shall be encouraged to implement educational programmes on the various major mental disorders and on the effects of domestic violence with the assistance from the Ministry of Health and the National University of Samoa.

The Ministry of Education, Sports and Culture shall be encouraged to ensure that all education programmes nurture an enlightened and supportive approach to those with mental health disorders and integrate mental health subjects into the educational curriculum.

11. CONSTRAINTS
There is very limited data of mental health issues in Samoa. There is an abundance of overseas data but its applicability to Samoa is either uncertain or unknown. Those data that have been collected in Samoa have not been collected specifically for the purpose of health planning. Much of the information upon which this policy is based, is anecdotal. However, many of the recommendations of this policy are consistent with general public perceptions of what is required as indicated by the outcome of the Mental Health Symposium 2003 and from community consultation of this policy.

12. DEFINITIONS
The Regional Strategy defines mental health as the “foundation for the well-being and effective functioning of individuals. Mental health is the ability to think and learn, and the ability to understand and live with one’s emotions and the reactions of others. It is a state of balance within a person and between a person and the environment. This balance is a product of a number of interrelated factors, including physical, psychological, social, cultural and spiritual”. (WPRO, 2001)

Mental illness refers collectively to all mental disorders. It is the second leading cause of disability and premature mortality.
Mental Disorders are health conditions that are characterized by alterations in thinking, mood, behavior or some combination thereof associated with distress and/or impaired functioning.

Stakeholders are defined as people or organizations that have vested interests in this policy.

13. **ROLES AND RESPONSIBILITIES**

Ministry of Health has to work collaboratively primarily with its stakeholders in their local mental health system. Other key stakeholders include:

- Ministry of Women, Community and Social Development
- Ministry of Justice and Court Administration
- Ministry of Police, Prisons and Fire Services
- Relevant NGOs and Community Groups, and
- Office of the Attorney General
- Ministry of Education, Sports and Culture

Mental Health Unit will contribute to:

- Seeking out strengths and abilities within aiga and communities to help them manage and address mental distress, deal with social and cultural stresses contributing to mental disorders, and explore how such approaches could be used in a holistic and culturally sensitive ways to manage mental health problems.
- Supporting local groups and networks so they can be partners in developing and improving mental health care services.

The success of the Mental Health working group will be dependent on the group members being linked formally to local partnerships and organizational structures. Support, supervision and co-ordination of the Mental Health working group activities require discussion and detailed planning.