Between a rock and a hard place:
Analysing and Evaluating the Samoan Mental Health Policy for its Applicability to Policy Development in Niue

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Abstract

Mental health is a prevalent, but often ignored area of health. Mental disorders can significantly impact the mentally ill, their families, and the wider community. Access to proper care and treatment for the mentally ill can be hindered by availability, ignorance, discrimination, and stigma, and can result in human rights violations. This is especially true in developing countries where services may be inadequate or non-existent. National mental health policies can help this situation by improving and prioritising mental health services in terms of finance, legislation, advocacy, human rights, mental health training, and service delivery. In 2001 the WHO launched Project Policy to support this effort. Sixteen years later, Niue has yet to formally begin the process of developing their national policy, while their neighbour Samoa, has had a policy in place since 2006.

This research project seeks to determine if and how the Samoan mental health policy should be leveraged for Niue's future policy development. This desk-based research has been completed through a critical literature review that includes government documents, WHO publications and policy guidelines, Pacific Island Mental Health Network reports, academic literature, and mental health and rights-based organisational websites. This research is accomplished in several steps: critically analysing the WHO mental health policy guidelines that have been chosen as the framework for this report, detailing regional mental health considerations with a focus on Niue and Samoa, and evaluating and analysing the Samoan policy using the WHO framework. The findings from this allows for a discussion of strategies for Niue to best leverage Samoa's policy.

This research concludes, based on Samoa and Niue's cultural connections, their similarities in terms of mental health challenges and capacities, as well as the positive findings from the analysis and evaluation of the Samoan policy, that the Samoan policy is an excellent choice for Niue to leverage in their future policy work. While noting areas for improvement concerning finance and human rights, the remaining contents of the Samoan policy strongly align with the requirements and depth of information required by the WHO framework. Going forward, Niue would benefit from developing their mental health policy based on the precepts of South-to-South Cooperation by collaborating and sharing knowledge with their experienced neighbour Samoa.

Acknowledgements

> *… most people working in mental health, either as researchers or practitioners, would support the view that autonomy, justice and minimization of suffering are values which should provide a moral compass in their work.*
>
> *~Fisher & Freshwater (2015)*

I would like to extend a heartfelt thanks to those who have made this research possible.

Firstly, I would like to thank all the people at the District Health Board who supported me in this effort. Whether it was through words of encouragement, time off to attend activities required to meet my study needs, or allowing me to bounce ideas around to better understand mental health concepts and concerns. I see the values expressed in the quote above in so many of you; I am proud to work by your side.

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AusAid	Australian Aid
CRPD	Convention on the Rights of Persons with Disabilities
DHB	District Health Board
HRBAs	Human Rights-Based Approaches
HRC	Health Research Council of New Zealand
MDGs	Millennium Development Goals
MIC	Ministry of Information and Communications
MOH	Ministry of Health
MU	Massey University
NGO	Non-government Organizations
NSC	North-to-South Cooperation
NZ MFAT	New Zealand Ministry of Foreign Affairs & Trade
NZAid	New Zealand Aid Programme
PIC	Pacific Island Countries
PIMHNet	Pacific Island Mental Health Network
RNZ	Radio New Zealand
RRRT	Regional Rights Resource Team
SDGs	Sustainable Development Goals
SIDS	Small Island Developing States
SMHP	Samoan Mental Health Policy
SMOH	Samoa Ministry of Health
SPC	Pacific Community
SSC	South-to-South Cooperation
UDHR	Universal Declaration of Human Rights
UN	United Nations
WB	World Bank
WHO	World Health Organisation

CHAPTER 1: Introduction and Methodology

There is no health without mental health.
~ Vikram Patel (Patel, 2014)

Global Promotion of Mental Health and Policy Development

In their lifetime, it is likely everyone has encountered at least one person affected by mental illness based on a World Health Organisation (WHO) mental health survey on the diversity of disorder types and prevalence of experience by population (Kessler et al., 2009). Mental illness includes a wide range of conditions such as depression, anxiety, psychosis, and substance abuse, and affects people of all ages. The impact of mental illness on those experiencing the illness, their families, and the wider community can be significant. There is also strong evidence supporting the bidirectional relationship between physical and mental health, as noted in Patel's quote above; where one aspect of health cannot truly exist without the other (Kolappa, Henderson & Kishore, 2013; Patel, 2014). Yet, in terms of care, support and human rights, the international situation for people with mental disorders[1], in both developing and developed countries has been described as 'dire' (Minas & Cohen, 2007). For developing nations, mental health issues have been called the 'invisible problem in international development' (Chambers, 2010).

Mental health has not received the attention it deserves on the global development agenda for many reasons. The main cause is believed to be the stigma associated with mental illness (Jenkins, 2003; Gureje & Alem, 2000; Patel, 2008; Tomlinson & Lund, 2012). Chambers (2010) states that besides prejudice and discrimination toward people suffering from mental illness, mental disorders are less 'marketable' than other diseases, resulting in less funding. He believes that in developing countries, aid focuses on communicable diseases or conditions that generate public empathy through their visible symptoms or photographic images. The majority of mental health funding and research is typically clinically and scientifically based, failing to focus attention on evolving

[1] *The terms mental illness and mental disorders are used interchangeably in this report. The difference between the two terms is controversial and diagnostically influenced, however, this is not the focus of this research.*

mental health systems that are effective, appropriate, and affordable (Minas & Cohen, 2007, p. 1).

Within this seemingly dismal international picture, small steps have been taken towards bringing mental health issues into the global health agenda. The WHO has been a strong advocate in increasing the visibility and priority of preventing and treating mental illness. In addition to quantitatively demonstrating that ignoring the problem costs more than funding care and treatment (Chisholm et al., 2016), the WHO has also focussed on mental health policy as a mechanism for improving care and raising the profile of mental wellbeing as an important aspect of overall health. Following the findings that 40% of countries do not have a mental health policy and over 30% do not have a mental health programme, in 2001 the WHO launched their Policy Project (WHO, 2001, p. 8). This initiative is built on the understanding that a national policy is required to explicitly state the actions and procedures to be taken by the principle stakeholders for improving and prioritising mental health services across the spectrum of finance, legislation, advocacy, information systems, human rights, research, resource training and service delivery (WHO, 2001; Omar et al., 2010). The WHO have committed to support countries in developing mental health policies by providing evidence-based guidance packages, organising regional forums, establishing advisory networks and providing technical assistance.

Mental health policies are also important as they can address the tenuous relationship between mental health interventions and human rights; ensuring that when certain psychological conditions require it, compulsory treatment or detention is carried out in a humane and dignified manner. There is global concern, especially for developing countries where mental health services are inadequate or absent altogether, that caregivers may be "forced by lack of treatment and support services to restrain family members in unacceptable ways" (Minas & Cohen, 2007, p. 1). Human rights-based approaches (HRBAs) acknowledge the complexity of these situations, emphasising preventative strategies that balance risks with the individual's rights (Mann, Bradley & Sahakian, 2016).

Mental health and substance abuse, after exclusion in the Millennium Development Goals (MDG) 15 years ago, are now recognised in the Sustainable Development Goals

(SDGs) which were internationally adopted in September 2015 (WHO, 2016a). The SDGs, approved by all United Nations (UN) member states, are made up of 17 goals related to various economic and social outcomes to attain the larger objective of eradicating poverty and reducing inequality across the globe (UN, n.d.). WHO contends that acknowledging mental health in the SDGs will promote the importance and need for national development plans and international aid for this poorly resourced area (WHO, 2016a).

While all nations are affected by mental illness regardless of their wealth and the physical health of their citizens, it is understood that countries with underdeveloped health systems experience additional pressure when balancing psychiatric needs against other concerns such as poverty and communicable diseases (van Rensburg & Fourie, 2016). For developing countries without a national mental health policy, the challenge is even greater. These concerns are applicable in the small island developing states (SIDS) in the Pacific, as discussed in more detail below.

Mental Health Policy in the Pacific – Focus on Niue and Samoa

Near the time of the WHO Project Policy launch, it was determined that the Western Pacific regional disease burden attributed to mental and neurological disorders was between 15-27%, exceeding some other parts of the world (WHO, 2002, p. 9). In a 2005 situational analysis of the Western Pacific region, it was recognised that while there had been improvements in physical health over the preceding years, the mental health situation had worsened (Hughes et al., 2005). The analysis suggested that to successfully reduce the burden of mental disorders and improve services, policy frameworks, planning, and funding were required. Looking at the SIDS in the Western Pacific region since the WHO policy project launch in 2001, there have been varying levels of success in policy development. As of 2016, the small island nation of Niue, while recognising the need for a mental health policy, has yet to formally begin the process (Nosa et al., 2013). In contrast, the neighbouring island of Samoa launched its policy in 2006 (Samoa Ministry of Health (SMOH), 2006).

Given the importance of mental health policies, as made clear in the aforementioned, this research argues that a critical review of the Samoan Mental Health Policy (SMHP)

could inform and support Niue in their national policy development. However, before Samoa's mental health policy can be reviewed to determine its applicability to Niue, it is important to understand the context and current service delivery capacity of both countries, as well as the rationale for selecting Samoa over other Pacific nations in the region.

Figure 1: Map of Samoa and Niue

(The University of Texas at Austin, 2012)

Niue

Niue is a single island nation located within the South Pacific triangle of Tonga, Samoa and the Cook Islands (Government of Niue, 2015). Niueans have strong ties with two ethnic groups from Tonga and Samoa (Nosa et al., 2013). The island was a British protectorate, then annexed to New Zealand in 1901 until it adopted its own Constitution for self-government in free association with New Zealand in 1974 (New Zealand Ministry of Foreign Affairs & Trade (NZ MFAT), 2016a). The people of Niue are considered New Zealand citizens, with New Zealand maintaining responsibility for development in Niue (Sheehan, Tamate & Briasco, 2010). It is also important to note

that the island has experienced severe outward migration. As of the last census, there were 23,833 Niueans living in New Zealand (Statistics New Zealand, 2016) contrasted by the Niuean resident population of 1,611 (Pacific Regional Information System, 2012). Overall, Niue is geographically isolated, with a small, highly transitory population having close ties to New Zealand.

Within a mental health perspective, there is both a need for care and a lack of resources on Niue. According to the 2011 Niue country profile, a mental health screening of residents over ten years old indicated a 'substantial' number of people in need of assistance (Nosa et al., 2013, p. 4). Another study in the area specified that neuropsychiatric disorders constitute 16.8% of Niue's global burden of disease (WHO, 2011, p. 1). A 2005 report analysing mental health services in the Pacific Islands indicated that in Niue, support for people with all levels of mental illness relies on family, community, police and other health services since there were no mental health services available within existing community or primary care services (Hughes et al., 2005). The analysis goes on to specify that no mental health budget nor mental health education for health workers existed, and cited an overarching need to increase "focus on mental health at all levels of society" (p. 26).

The most recent situational analysis of Niue reflected little change since 2005, indicating there was still no budget for mental health, limited funding and availability of mental health medications, no psychiatric or community facilities for people with mental health disorders, no permanent non-government organisations (NGOs), no group support services available, and none of the public health nurses or officers have had specialised mental health training (Nosa et al., 2013). Given Niue's geographic and population concerns, the mental illness prevalence, and lack of progress in the last decade, a mental health policy could assist in bringing much needed attention to this aspect of health.

Samoa

Samoa shares some of the same challenges as Niue, but they are a larger, more populated set of islands. Samoa is a separate nation from American Samoa, and is

comprised of nine islands, four of which are inhabited (Foster, 2016). Previously administered by Germany, during World War I New Zealand took the role of trustee of Samoa until 1962, when Samoa became the first Pacific Island to gain its independence (NZ MFAT, 2016b). While Samoa is politically independent from New Zealand, the countries maintain a close relationship in terms of military and police cooperation, as well as a range of economic and social aid initiatives (NZ MFAT, 2016b). As of their 2011 census, Samoa had a population of 187,820 with a continued upward trend estimated for the future (Samoa Bureau of Statistics, 2015). Samoa also experiences a 'culture of migration' similar to other Pacific Islands (Connell, 2014), yet unlike Niue, the number of Samoans in New Zealand remains less than that of the islands themselves (Statistics New Zealand, 2016). With its larger population, Samoa has met the criteria to be included in the World Bank country income classifications; rated as a lower middle-income country (World Bank, 2016).

The mental health situation on Samoa has similarities and differences to Niue. As of the 2005 situation analysis it was indicated that as a whole, mental health was neglected, however, there were strategic plans in place to address creating a national mental health policy, improve a serious nursing shortage, review and reform the out-dated mental health legislation, and to construct a mental health unit in the main hospital (Hughes et al., 2005). As indicated in the analysis, Samoa did have a community programme running out of their hospital's mental health unit, but no inpatient facilities. In the event a person required admission, they would enter the general wards or be referred to the police in the event of psychotic emergencies or violent behaviour. The mental health model of care was 'family based' and considered to be working well, however, training for primary health care providers was considered necessary to improve service delivery (Hughes et al., 2005; Enoka et al., 2012).

Besides facilities, staffing and training, the other issues with mental health services cited in the analysis included inadequate access to medication, unavailable transport for outreach programmes, inappropriate therapies, limited NGO involvement, family neglect, stigma and discrimination towards those suffering from mental illness from within the community and health services, and no allocated budget for mental health (Hughes et al., 2005). Following on from the analysis in 2005, Samoa did launch its

mental health policy in August 2006 (SMOH, 2006), which will be analysed and evaluated in Chapter 4 of this report.

Rationale for Selecting Samoa's Mental Health Policy

The WHO policy development guidelines emphasise the importance of mental health policies in improving service delivery and suggest that policies from countries of "similar cultural and demographic patterns" should be leveraged where relevant (WHO, n.d., p. 2). When considering which Pacific countries are appropriate to share policy work and experience with Niue, there are challenges. As described above, Niue is culturally influenced by Samoa and Tonga, and is geographically located near the Cook Islands. However, when looking at population size, an important demographic attribute to consider, there is no other country in the area with such small numbers other than Tokelau. This is demonstrated in Table 1 below.

Country	Population	Source
Tokelau	1,411	http://stats.govt.nz/browse_for_stats/people_and_communities/pacific_peoples/2011-tokelau-census-landing-page/final-count-2011-tokelau-census.aspx
Niue	1,611	http://niue.prism.spc.int/
Cook Islands	17,784	http://www.mfem.gov.ck/statistics/census-and-surveys/census/143-census-2011
Tonga	103,252	http://tonga.prism.spc.int/#population-statistics-including-administrative-information-and-statistical-tabulation-of-the-2011
Samoa	187,820	http://www.sbs.gov.ws/index.php/population-demography-and-vital-statistics

Table 1: 2011 Population Censuses by Country

Another challenge is finding a similar country in the region with a national mental health policy. Other than Samoa, who has had a mental health policy since 2006, there has been limited progress by the countries in this table. The Cook Islands "Mental Health and Well Being Policy 2015 for public comment" is located on the country's MOH website (Cook Island MOH, 2015). While the name implies the policy is awaiting consultation, a news article on Radio New Zealand (RNZ) indicates the policy was endorsed in 2015 and launched in March 2016 (RNZ, 2016). Tonga has no mental health policy in effect, only a MOH plan for 2009 to 2012, which includes brief references to mental health (Kingdom of Tonga MOH, 2008). There is, however, a news

article from 28 September 2016 on the Tonga Ministry of Information and Communications (MIC) website discussing a workshop to draft the nation's first mental health policy (Tonga MIC, 2016). The Tokelau mental health profile indicates that a policy is to be finalised in the near future (Pearce et al., 2012), yet to date, no final policy can be located.

In sum, relating population, culture, and policy progress, it can be seen that while Tokelau is similar in population to Niue, it has no policy. With a large population difference, the Cook Islands are the next closest nation, and while not culturally linked to Niue, Niue has indicated they would prefer to participate with both the Cook Islands and Samoa in any mental health programme development (Hughes et al., 2005). The Cook Island policy, however, has only been in effect from 2016, so the nation's experiences with the policy will be limited. Tonga is much larger in size, but is just now in the process of drafting its first mental health policy. Although Samoa has the largest population in the area, based on its cultural connection to Niue, Niue's preference to collaborate with them, and Samoa's experience since their policy launch in 2006, Samoa is the most appropriate country to utilise when leveraging local experience for Niue's future policy development.

Research Aim, Questions and Objectives

Given the rationale outlined above, I argue that research into policy development in Samoa could be used to inform Niue in progressing their national mental health policy. Accomplishing this requires multiple steps. Firstly, the WHO mental health policy guidelines, chosen as the framework for this report, need to be critically analysed. This includes reflecting on how a top-down large global initiative with Northern influenced practices could impact Niue's policy development, as well as considering human rights and cultural implications to the policy development process and contents. Secondly, Pacific mental health considerations, with a focus on Niue and Samoa, need to be detailed to frame the remaining research. From there, the Samoan policy can be evaluated and analysed against the WHO Project Policy framework and the local context. The results and findings of these exercises allow for the discussion of viable strategies for Niue to leverage the Samoan work. This includes South-to-South

Cooperation (SSC), described in detail in Chapter 5, as a means to address the Northern influence concerns noted in the critical analysis. Figure 2 below outlines the process followed for this research.

Figure 2: Research Process

It is important to note that, due to time and travel constraints, this is a desk-based study. For that reason, the impact and effectiveness of the Samoan policy is not included, as that would require travel to perform fieldwork and in-country interviews, expanding the scope of this research.

Based on these ideas, this research aims to:

Evaluate the Samoan mental health policy and the applicability of leveraging the Samoan policy work for the island nation of Niue.

To achieve this, my research seeks to answer two main questions. The first question asks:

1. How does the national mental health policy of Samoa align to the WHO policy guidelines and existing policy literature*?*

There are two objectives designed to help answer this question:

i) To critically analyse the WHO policy framework components and guidelines within a development context.

ii) To analyse and evaluate the existing SMHP based on the analysis in objective one.

Utilising the information gathered from achieving the objectives above, the second research question asks:

2. How can the policy work in Samoa be leveraged by Niue in developing its own mental health policy*?*

Situating the approach used to accomplish this desk-based research is detailed in the Methodology section below.

Methodology

As with any research, it is important to understand the philosophical underpinning of the methods used to achieve this project's aim. This includes exploring my positionality as a researcher, reviewing ethics in relation to doing research as outlined by Massey University (MU), reflecting on Pacific Island cultural considerations, and defining the data collection methods employed to answer the research questions and achieve the objectives.

Researcher Positionality

It is understood that a researcher's positionality will inevitably influence their research process in some way, either through their own personal attributes, their ability to access research participants, or in their choices of data collection methods (Stewart-Withers, Banks, McGregor & Meo-Sewabu, 2014). Reflecting on this is important before undertaking any research; giving the researcher an opportunity to acknowledge, and thus limit, the impact of personal biases. For that reason, my background, motivation, and positionality are explored below.

I currently work in Mental Health and Addiction Services in a mid-sized New Zealand District Health Board (DHB) and appreciate the complexity and challenges of trying to provide high quality care to those impacted by mental illness when confronted with constrained budgets, lack of resources, and competing models of care. This is in a high-income country with a dedicated mental health policy, plan and programme. Additionally, working with our local NGO providers has given me a greater awareness of the need to deliver care instilled with cultural appropriateness and equitable service delivery strategies that ensure all people can maintain health and wellness based on their perceptions and beliefs.

Following a personal visit to Niue, referred to as "The Rock of Polynesia", and reading about some of the challenges Niue faces in managing mental illness, I researched existing literature concerning their mental health services. The treatment gap was concerning, even with Niue being supported by New Zealand in terms of aid and health care services. Further reading into mental health in the Pacific Island Countries (PICs) demonstrated that the work by Pacific Ministries of Health, the WHO, the Pacific Island Mental Health Network (PIMHNet), NZ MFAT, and other international players, has assisted in progressing mental health services in the last decade; but progress varies by country and a treatment gap continues to exist across the region.

While empathetic and dedicated to seeing positive outcomes for people dealing with mental illness, I must recognise my position within the context of this research, both as a non-Pacific student and an employee within a service that is heavily influenced by a Western medical model of care. As O'Leary points out, "there is no doubt that we make sense of the world through the rules we are given to interpret it" (2014, p. 50). I need to ensure my research methods and conclusions were not biased by my current role or cultural upbringing. It is important to note that when there are multiple perspectives to consider, legitimate results with credible conclusions can still be obtained when research is completed with rigour (O'Leary, 2014). This is especially important when it comes to mental health, a field that is highly complex with opposing discourses and views of what constitutes illness, wellness, treatment, and concepts of recovery (Fisher & Freshwater, 2015).

From an ontology perspective, Overton and Van Diermen (2014) believe that doing research in developing countries requires a design that incorporates both quantitative and qualitative data analysis to ensure research uncovers not only the 'what' of an occurrence, but also the 'why'. I would agree. My personal journey working with health care data has taught me that while policy makers prefer to justify priorities and expenditures through quantitatively collected data; the realities of health benefits and outcomes are in the qualitative details that add nuance and context to the numbers. Based on this, my positionality would fit under O'Leary's (2014) term of the 'reflective researcher', where the methods chosen are based on the best possible way to answer the research question.

Ethics in Research

Ethics is an important aspect of any research project and encompasses a wide array of considerations that require reflection. Ethics includes principles such as "justice, truthfulness, confidentiality and respect for persons", but also takes into account power relationships and the impact that culture, gender, or other socio-economic differences can have on the research (MU, 2015, p. 4). While this research is desk-based, it is still important to consider ethics in terms of appropriately using the information and knowledge obtained. Research and reporting must be interpreted through a lens of respect and dignity; ensuring both subtle and overt power relationships do not negatively impact the "integrity of the knowledge produced" (O'Leary, 2014, p. 48).

Following a review of the MU Code of Ethics (MU, 2015), the Health and Disability Ethics Committee assessment criteria (MU, 2012), and completing the Development Studies in-house ethics peer review and approval process, this project was confirmed to be low-risk.

Pacific Island Research Ethical Considerations

Research within the Pacific brings additional ethical considerations into account due to cultural values that must be recognised and incorporated in the research design. This project will adhere to the MU Pacific Research principles that include respect for relationships and knowledge, reciprocity, holism, and beneficence (Meo-Sewabu, Hughes, & Stewart-Withers, 2016, p. 12). The Health Research Council of New Zealand's (HRC) guidelines, which are referenced within the MU Pacific Research protocol documentation, will also be reflected upon. The HRC established ethical and operational guidelines for the Pacific as a means to ensure health research has positive outcomes and causes no harm (HRC, 2014). They indicate four essential cultural values that Pacific health research approaches should include: communal relationships, holism, reciprocity and respect, as seen in Figure 3 below.

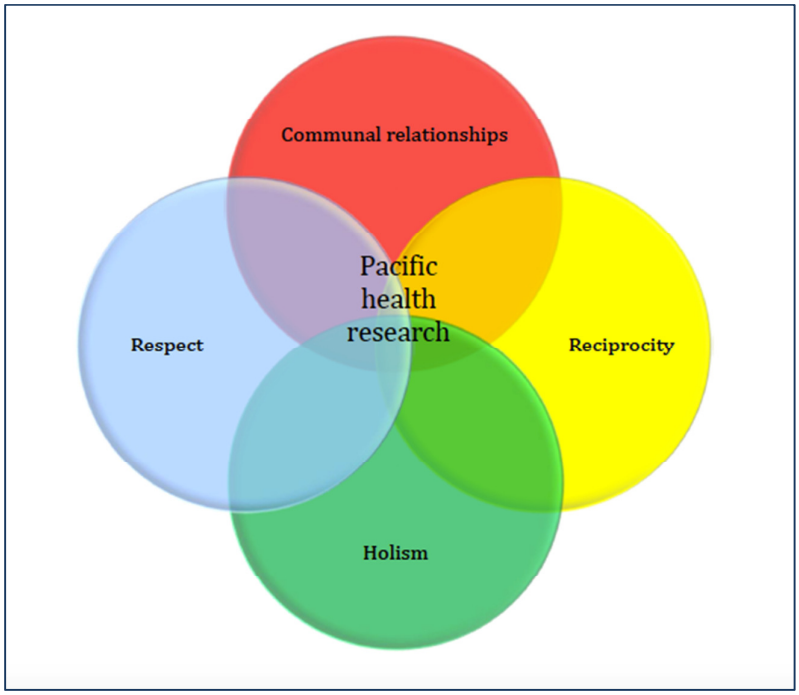


Figure 3: Cultural Values in Pacific Research

(HRC, 2014, p. 5)

Samoa promotes their view of ethics as the "indigenous concepts of *tapu* (the sacred) and *tofa sa'ili* (the search for wisdom)" (Tui Atua, 2007). Samu and Suaalii-Sauni (2009) expand on this, stating that cultural knowledge for Pacific mental health research and treatment requires an understanding of the holistic view of wellbeing, including *tapu* and the intergenerational bonds between people. Their findings indicate that Pacific cultural competencies need to reflect the fact that, while there are strong similarities between islands, there are also important ethnic differences that need to be recognised. This speaks to the idea that while the SMHP may have much to offer Niue, it cannot be applied without considering important cultural adjustments.

Data Collection Methods

This research is a desk-based analysis, whereby a detailed literature review has been undertaken. Given the specific questions and objectives, this includes government documents, WHO publications and policy guidelines, PIMHNet reports, academic literature, and mental health and rights-based organisational websites. It is important to note that there is limited research related to mental health in the Pacific Islands, with the

majority of information originating from, or funded by the WHO (Ménard, 2016). There are also limitations with using secondary information; it may be out of date and the bias of the authors cannot be easily identified (O'Leary, 2014). However, analysing the SMHP with the documentation available is still a worthwhile endeavour as it will frame the policy's usefulness and applicability to Niue's future policy development.

Research Report Structure

This research consists of five chapters. The above introduction and methodology discussion introduced issues around mental health and the importance of national mental health policies, background into the islands of Niue and Samoa, the rationale of the research aim, questions and objectives, and the methodology used in undertaking this research. Chapter 2 explores mental health at a global level. It reviews literature specific to national mental health policy promotion and the WHO Policy Project. This discussion speaks to research question one's first objective, which is to critically evaluate the WHO policy framework by considering positionalities of development principles, human rights approaches, and cultural concerns.

In Chapter 3, the focus is on the Pacific Islands. Mental health in the Western Pacific Region is discussed in relation to treatment concerns, partnerships, and mental health policy evolution in the last decade. The chapter explores mental health in Samoa and Niue in more detail, reviewing cultural perceptions and local strengths and capacities. This discussion frames the remaining research.

Chapters 4 and 5 are both discussion and findings chapters. Chapter 4 contains the analysis and evaluation of the SMHP; using the WHO policy framework to achieve research question one's second objective. Chapter 5 responds to the second research question by assessing the SMHP in relation to Niue's future policy development and discussing strategies, such as SSC that could be used in this endeavour. Chapter 5 concludes the research and poses questions for future research.

CHAPTER 2: Global Promotion of National Mental Health Policies and the WHO Framework Analysis

> *From the time when Pinel obtained the permission of Couthon to try the humane experiment of releasing from fetters some of the insane citizens chained to the dungeon walls of the Bicêtre, to the date when Conolly announced, that in the vast Asylum over which he presided, mechanical restraint in the treatment of the insane had been entirely abandoned, and superseded by moral influence, a new school of special medicine has been gradually forming.*
>
> ~ John Charles Bucknill, M.D. (Bucknill, 1853, p. 1)

Ensuring proper and humane care for those suffering with mental illness has been a global concern for centuries, as demonstrated in the above excerpt from the first issue of The Asylum Journal of Mental Science, written in London during the 19th century (Bucknill, 1853). It was not until 148 years later that the WHO launched their Mental Health Policy Project in an effort to promote the proper treatment and care for people with mental illness.

While this research report is related to Samoa and Niue mental heath policies, to understand mental health policy development in the Pacific region, it is important to locate it within a global perspective. This chapter begins by exploring the background of national mental health policy promotion as a mechanism for improving mental health care services across the globe. It then provides an overview of the WHO policy promotion and guideline framework. However, in order to quantify the benefits and limitations of the WHO guidelines, the framework itself will be critically explored from three significant contexts that impact policy development: development principles, human rights, and culture. This addresses the first objective in question one: ***to critically analyse the WHO mental health policy framework***.

Background to Mental Health Policy Development

In 2001, a WHO study determined that five of the top ten causes of disability worldwide were related to mental disorders, and while treatment options are available, only a small

minority requiring intervention actually receive them (WHO, 2001, p. 8). National mental health policies are argued to assist in remedying this situation. Policies can help improve the health and well-being of those suffering with a mental health disorder, their families, and the greater community; provided they meet international standards and are well-articulated, evidence-based, supported by governments and key stakeholders, and designed to improve the care and treatment of the mentally ill through maximising and coordinating limited resources (Ssebunnya, Kigozi & Ndyanabangi, 2012; Gureje & Alem, 2000). It is for these reasons, and those stated in Chapter 1, that the WHO launched the Mental Health Policy Project.

The WHO policy guidelines, in conjunction with regional forums and direct assistance, are to be used by nations to create, implement or review national level policies. In their Executive Summary outlining the Policy Project, WHO contends that mental health policies encourage stewardship, giving mental health a higher priority and act as the 'blueprint' for goals and actions to be achieved in the future (WHO, 2001). Another area highlighted in policy development is the relationship between mental health, culture, legislation, and human rights (WHO, 2001). WHO acknowledges that countries must determine their own local barriers to implementing effective policies, yet they must remain consistent with the *UN Principles for the Protection of the Rights of Persons with Mental Illness and the Improvement of Mental Health Care (1991)* (WHO, 2001, p. 16). Additional aspects on this and other UN rights-based bills, instruments and principles are reviewed later in this chapter.

Drawing on a review of mental health policy challenges by Jenkins et al., it is understood that international development funding methodologies have a fundamental impact on global policy initiatives (Jenkins, Baingana, Ahmad, McDaid & Atun, 2011). Shifts in aid from targeted programmes in the 1970s and 1980s to funding mechanisms that are based on national level health plans, have made national mental health policies essential to assure prioritisation relative to the burden of disease within a country. While the WHO act as advocates, advisors, and researchers, they are unable to invest substantially in mental health due to other ring-fenced priorities such as maternal and child health. Bilateral donors such as the Department for International Development, the European Union, and NGOs like the Nuffield International Foundation have supported mental health projects that include training, medication, community integration, and

policy development (Jenkins et al., 2011). This review suggests that dedicated donors are needed to assist developing countries draft and implement national mental health policies.

Providing support in mental health policy development is important, as mental health issues are a burden to the society as a whole, can negatively influence other development initiatives, and contribute to poverty (Jenkins, 2003). The UN principles state the need to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[2], hereby linking physical and mental health together as a basic human right (UN General Assembly, 1966). However, it is recognised that "all too often our services are departure points for exclusion when they should be stepping stones for social inclusion" (Jenkins, 2003, p. 14). To sufficiently address these concerns, funding mechanisms and policies must be sure to combat stigma and advocate human rights for individuals and their families at a national and service provision level.

Overview of WHO Policy Guideline Framework

To assist policy-makers in drafting and evaluating the adequacy of national mental health policies, WHO created a package of 13 interrelated modules designed to guide the process (WHO, 2016b). At the core of these modules is the Mental Health Policy, Plans and Programmes document, which is supported by the Mental Health Context, and supplemented with the remaining components as seen in Figure 4 below. These modules are available to the public on WHO's website (WHO, 2016b). Within the guidelines, it is stated that the package is meant to address a wide range of needs related to policy development and can be utilised based on each country's requirements. Each of the modules within the package is cross-referenced and can be employed together or individually. The modules can also be used for training policy-makers and stakeholders, or as a source for the promotion of mental health for the nation's politicians, health workers, and community.

[2] *This research will contain spellings for both the New Zealand use of 'ise' for author written text and either 'ise' or 'ize' spellings based on the original source of the information, therefore "recognize" is used in the quote instead of "recognise".*

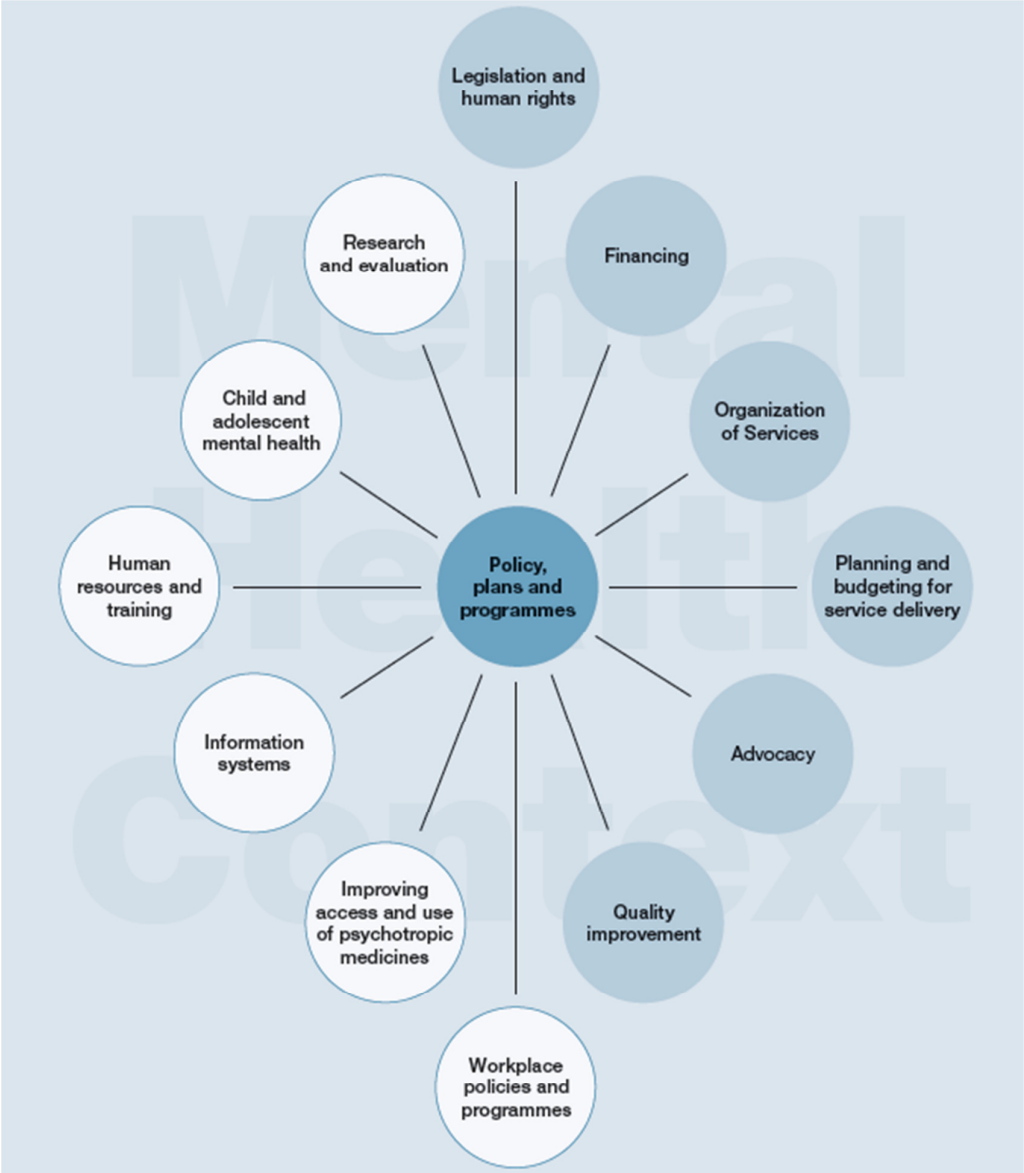


Figure 4: WHO Mental Health Policy and Service Guidance Package[3]

(WHO, 2005b, p. xi)

The Policy, Plans and Programmes module, centred above, outlines the differences between document types. It indicates that policies should contain broad objectives, be general in scope, and the level of detail should be sufficient to provide accountability, setting clear areas for action, while plans and programmes are then developed to implement the policy (WHO, 2005b).

[3] *Modules in white were incomplete in 2005*

The elements essential to policy development processes and contents are outlined in the WHO checklist (WHO, n.d.), which is included in the Appendices (see Appendix 1). The checklist is broken into two sections. The first section outlines the process components, including considerations around current situational analysis, leveraging other culturally similar countries' experiences, and understanding the stakeholder consultation process. The second section outlines the policy content components. According to WHO, these 22 components should be included in mental health policies to ensure they are adequate and effective.

In order to easily understand the component areas and range of aspects covered in the checklist, they have been summarised into nine high-level topics shown in Table 2 below.

#	Component topic	Criteria
1	Process	Mandates and approvals, situational analysis, consultation process, applicable research
2	Vision, Principles and Values	Realistic, clearly defined, consistent, and promoting human rights, social inclusion, evidenced based practice, collaboration and equity
3	Action Orientation	Clearly defined and demonstrating commitment
4	Financial	Equitable services and funding with physical health
5	Human Rights	Promotion and legislation
6	Organisation and Service Management	Dedicated positions for mental health (MOH, multi-sectoral oversight, rights review), service integration that includes prevention and rehabilitation, human resources and training, inclusion of all groups (i.e. severe disorders, youth, older persons, trauma)

#	Component topic	Criteria
7	Advocacy	Support consumers, families and raise awareness
8	Information, Research, and Quality	Support quality improvements, planning and decision-making, research and evaluation
9	Collaboration and Integration	Relationships with other health and government departments, NGOs, and support groups as well as with other national policies (i.e. Disability law, health policy, poverty reduction policy, development policy)

Table 2: Summary of WHO Checklist Components

Derived from (WHO, n.d.)

The purpose of this summary is to group analogous and overlapping policy components; providing a more succinct list of topic areas to review. These summarised component topics will act as the framework to evaluate the SMHP in Chapter 4.

WHO Mental Health Policy Framework Critical Analysis

Before analysing and evaluating any nation's policy using the WHO policy framework, it is imperative to first critically reflect on the framework itself. The intention of this is to provide insight into the framework and offer a deeper contextual understanding of the contents as they relate to development principles, human rights and culture. This enables a balanced evaluation of the Samoan policy that considers multiple perspectives.

The WHO state that their guidelines are based on the experiences of different countries and that the structure of each nation's policy is a government decision based on their own "history, culture, policies, the legal system, social structure, the type of health system and the meaning given to policy, plan and programme" (WHO, 2005b, p. 14). At the same time, the WHO Policy Project is a global initiative using a set of guidelines for all countries, regardless of their differing economic, cultural or social constraints.

This can be seen as misaligned from ideals that have evolved since the emergence of alternative development approaches. There is also a need to navigate through cultural issues that are essential to mental health initiatives, but at the same time, can conflict with human rights that must be protected by policies and legislation. Discussing the development principles, human rights, and cultural aspects of the mental health policy development process will be detailed below.

Development Principles of Top-down Approaches, Empowerment and Sustainability

Creating a national mental health policy is a complex and lengthy task that cannot be done quickly if it is to be done accurately, collaboratively, and provide effective guidance for future planning and programme development. In a case study of the Uganda national mental health policy, it was concluded that policy development is an iterative process mandating a wide range of stakeholder participation before a final draft can be accepted (Ssebunnya, Kigozi & Ndyanabangi, 2012). In another study of four African countries that developed different levels of mental health policies, the 'ideal' process was identified as a bottom-up approach that begins with a situational analysis and results in identified problems and needs being articulated so that strategies can be outlined to remedy them (Omar et al., 2010).

In contrast to these findings, the WHO Policy Project can be seen as a top-down programme, and what Laverack (2012) refers to as "pre-packaged and professionally driven"; it does not speak to the wider development issues of empowerment or the local political and social issues that contribute to the situation it is attempting to address (p. 64). Alternative development approaches have endeavoured to adjust for past power disparities and what it perceived as failures with initiatives in developing countries due to Western or imperialist approaches (Schuurman, 2014). In health care, it is suggested that a balance needs to be negotiated between local influence and government direction, providing a more empowered bottom-up approach than the top-down approach characterised by large scale, pre-prescribed health promotion processes (Laverack, 2012). The challenge to mental health policy development is leveraging local knowledge and expertise from the bottom-up to develop a nationally driven policy based on a top-down programme initiative.

There is also a debate within the psychiatric and anthropological community concerning the large international movement that is attempting to influence the mental health agenda, referred to as 'Global Mental Health' (Cooper, 2016). Cooper (2016) summarises the critic's arguments, stating that the global approach to mental health is a form of 'neo-colonialism' or 'medical imperialism' that attempts to operate within a Western psychiatric approach, ignoring and marginalising local cultural and traditional healing approaches. Patel (2014), a proponent of 'Global Mental Health', admits there is a concern of using developed country medical approaches and applying them to developing countries, especially when related to mental illness categorisations and treatments that are inconsistent across cultures. While biomedical perspectives of mental health have begun to acknowledge other perspectives, even in the West, they remain the dominant driver in diagnostic assessment, treatment, and policy development (Fisher & Freshwater, 2015).

Large international health agencies have come under criticism with concerns for their roles and agendas in promoting global initiatives for developing countries. Banerji uses Vincente Navarro's term of 'intellectual fascism' to describe the global programmes led by what he refers to as the 'triad' organisations of WHO, UNICEF, and the World Bank (WB) (Banerji, 1999, p. 227). Banerji (1999) contends that these organisations dictate specific health programmes on the poor to benefit the interests of rich countries, even when there is strong evidence questioning the scientific validity of the global initiative they are meant to support. He proclaims that these "prefabricated, technocentric, dependence-producing health programmes" are imposed on poor countries (p. 232), with health policy development degraded to represent health financing, neglecting the "essence of health policy formulation by hiding themselves in the jungle of the massive, programmed information onslaught" (p. 233). While Banerji's examples related to physical health initiatives in China and India, the relationship between his concerns for a global approach to health care can be applied to the WHO Policy Project, given its mandate, project scope, and its prescription of pre-packaged modules and guidelines. Others reinforce this perspective, believing that nations are encouraged to participate in large organisational pre-defined models and programmes as a way for those in power to conceal their true interests (Abrahamsen, 2006). The use of SSC as a strategy for Niue's

future policy development is explored in Chapter 5, specifically to mitigate these concerns.

Another risk with mental health policy and legislation is the potential to inadvertently marginalise and disempower the people they are meant to protect. Wilson, Carryer, and Brannelly (2016) contend that research done in New Zealand has shown that policy and legislative strategies, designated within the name of recovery, have consequently shifted responsibility to the consumer of mental health services instead of the State. Using Foucault's concept of discourse, which can be used to legitimise actions within a society or profession, they explain that 'biomedical discourse' has led to deinstitutionalisation, an increase in community services, the rise of crisis teams, and a higher level of acuity required to receive services; all of which forces the consumer and their family to self-manage and assume the risk and responsibility for care. It is suggested that low cost community care can be empowering to the community as it accepts more responsibility for the mentally ill, however, this strategy may also be viewed negatively as the State transfers their health care obligations to its citizens (McKenzie, Patel & Araya, 2004). While consumers instigated the concept of self-care, policy makers have endorsed its neo-liberal concept of individual responsibility and the reduced role of the State (Fisher & Freshwater, 2015).

Jenkins, who has written several articles on mental health policy, including as a representative of the WHO Collaborating Centre, stresses that key stakeholders are essential to ensure shared ownership of the policy, gain an understanding of the current situation, develop goals and strategic plans, determine key agencies to involve, and to assist with monitoring process outcomes (Jenkins, 2003, p. 14). While involving all parties in the process, the challenge is recognising and acknowledging varied opinions. WHO suggests that an "active compromise" is required to meet this aim (WHO, 2005b, p. 23), with the MOH acting as the negotiator. This can present additional challenges if the same government officials stigmatise or harbour harmful beliefs concerning the mentally ill (Jenkins, 2003; Gureje & Alem, 2000). In these instances, the participation of strong local community stakeholders can provide the checks and balances; ensuring the drafted policy promotes education and advocacy to combat these negative perceptions and actions.

There is also a two-fold relationship between sustainability and mental health that requires recognition. Firstly, mental health and sustainable development are both affected by equity, human rights, inter-sectoral collaboration, and social justice (Mental Health Foundation of New Zealand, 2011). The inclusion of mental health in the 2015 SDGs identifies the need to prevent non-communicable diseases and promote mental health, signifying global acceptance that good mental health contributes to other key indicators, including sustainability (Izutsu et al., 2015). Secondly, treatment and prevention strategies need to be sustainable to be effective. To do this, policies need to be evidence-based and reflect the availability of local resources and financing (Patel et al., 2007). It is believed that the adoption of the SDGs will lead to UN member states developing or strengthening their mental health and disability policies and legislation, and implementing strategies that will improve services for the mentally ill (Izutsu et al., 2015).

The critiques discussed above should be considered when nations develop or update their mental health policies. Local perspectives must be heard and appropriately integrated. This broader consideration will ensure that nations do not devalue their own strengths or attempt to employ Western practices that will not work within their own local context.

Human Rights and Legislation

The WHO policy guideline module for Mental Health, Legislation and Human Rights states that, "All people with mental disorders have the right to receive high quality treatment and care delivered through responsive health care services. They should be protected against any form of inhuman treatment and discrimination" (WHO, 2003, p. viii). The guideline contends that people with mental health issues are often vulnerable within their society; they are faced with stigma and discrimination and are likely to experience violations of their human rights. It also asserts that mental health legislation is necessary to provide the framework for protecting human rights, ensuring the availability of quality health services, and preventing exclusion or discrimination in areas such as education, employment, and accommodation. At the time of the policy guideline creation, 25% of countries had no national mental health legislation and 15%

that did, had legislation prior to the 1960s; before current treatment methods existed (WHO, 2003, p. 9).

WHO refers national mental health policy makers to the existing international conventions, principles and standards, to be used as guidance for 'good practice' in the area of mental health (WHO, 2003). While there are several that apply to people with mental health, the three that will be addressed in this research are the Universal Declaration of Human Rights (UDHR), the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles), and the Convention on the Rights of Persons with Disabilities (CRPD).

The significance of rights for all people has always been important, however, following the horrific acts of World War II, the United Nations was formed and quickly followed with the adoption of the UDHR in 1948 to formalise human rights principles (Morrall & Hazelton, 2004; Ménard, 2016). This declaration asserts that equal rights and dignity are the "foundation of freedom, justice and peace in the world" (UDHR, 1948, p.71). While its articles are applicable to all individuals, there are some that could be leveraged to explicitly protect the rights of people with mental illness. Article five refers to the protection from cruel or degrading treatment, article seven guards against discrimination of any kind, article nine speaks to arbitrary detention, and article 25 references the "right to a standard of living adequate for the health and well-being", which includes health care and social services that encompass illness, disability, and loss of livelihood (p. 76). All the articles were meant to represent everyone's inalienable rights as a human being.

While acceptance of this declaration was almost universal across the globe, the care and services of people with mental health did not improve. In 1991, the MI Principles were released (UN General Assembly, 1991). This document is made up of 25 articles, several of which overlap with the UDHR. Some principles are very specific to mental health concerns, such as when treatment or inpatient admissions are permissible without the person's consent, or when restraint and seclusion can be employed. The document also outlines the rights and conditions acceptable within a mental health facility and the right of a patient to be treated based on their cultural background. The principles state that there must be appropriate and qualified medical staff, as well as adequate treatment

and medication within a mental health facility. In 1996 the WHO drafted the *Mental health care law: ten basic principles* to assist nations with interpreting the UN's MI Principles in relationship to national mental health policy and legislation (WHO, 2003).

Another UN convention that directly impacts individuals with mental illness is the CRPD from 2006. Article one of the CRPD defines persons with disabilities as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (CRPD, 2006, p. 4). The CRPD articles share many of the health related MI Principles in terms of rights, equality, inclusion, dignity and non-discrimination. It also presents a broader approach than the MI Principles, expanding beyond medical considerations to look at social components such as employment and education, as well as disability specific concerns such as mobility. It is a far-reaching document that attempts to address all rights and freedoms that should be afforded a person with physical or mental disabilities.

These three documents, plus several others referred to in the WHO guidelines, provide the principles to be considered for inclusion when drafting a mental health policy, however, they are not universally accepted or embraced. While the UDHR is considered to be the launching point of the contemporary human rights movement, it has met with criticism. One concern is that Westerners wrote the declaration, and at the time of the UDHR acceptance, most African, Asian and Pacific nations were still dominated or influenced by Western colonial powers (Ménard, 2016). This Western perspective emphasises individual rights over all others, failing to consider cultures that are based on interdependence or are communally centred (Greenhill & Whitehead, 2010; Ménard, 2016).

The MI Principles and CRPD have also been criticised. One of the main concerns with the MI Principles is the belief that it is based on a Western medical model for diagnoses and treatment, as well as its endorsement of involuntary restraint, seclusion and treatment (Ménard, 2016). This is a contentious issue as people with a mental illness can experience conditions that prevent them from making sound decisions, or their behaviour may be considered dangerous toward themselves or others. To address this,

the WHO suggest that mental health legislation address actions such as supporting community care, eliminating seclusion rooms, and training health workers in alternative techniques when dealing with people in a crisis situation (WHO, 1996). While well intended, these suggestions do not recognise the constraints faced in many developing countries that may not have the capacity, funding, or resources to exercise these alternatives. The WHO also contend that by implementing mental health legislation in accordance with UN rights principles, the official review process provides patients the necessary scrutiny to protect their rights (Morrall & Hazelton, 2004; WHO, 1996; WHO, 2003). Unfortunately, a review process cannot undo the harm caused to those that have already been mistreated, and the mentally ill or their families may reside in countries where they are marginalised or discriminated against in a way that prevents them from attempting to access this avenue of recourse.

For mental health concerns, the CRPD only applies to people with a mental illness that qualifies as a disability. It is important to note that in the language used to define disability within the CRPD, as referenced above, there is sufficient ambiguity which requires individual nations to define it domestically (Szmukler, Daw & Callard, 2014). This makes the application of the CRPD subjective, and its interpretation could impact those needing protection under its articles. To ensure the convention is utilised to protect and support people with mental illness, the definition of disability needs to be clearly stated in a nation's disability policy and outlined within their mental health policy.

The CRPD also contradicts the MI Principles and much existing mental health practice as it relates to involuntary treatment and detention (Szmukler, Daw & Callard, 2014). It has been suggested that to comply with the CRPD, the MI principles and existing mental health laws would need to be totally abandoned (Ménard, 2016). A mental health policy needs to acknowledge an approach that balances individual rights with protecting the mentally ill and the community. It must define how the nation will provide access to the most appropriate treatment and care when individuals are unable to make their own decisions or require restraint.

Human rights-based approaches (HRBAs) are an attempt to address this conflicting situation between individual rights and the risks associated to illness or disability.

Rights-based approaches can be generically defined as "a framework that integrates the norms, principles, standards and goals of the international human rights system into the plans and processes of development" (Boesen & Martin, 2007, p. 9). These principles can then be applied to initiatives such as health, education, and security.

In a pilot study of HRBAs for risk assessment and management for people with learning disabilities, the authors found two key elements in adopting a rights-based strategy (Greenhill & Whitehead, 2010). The first concept discussed was capacity. The authors contend that individuals with extreme disabilities could potentially lack the necessary skills to access their rights based on an 'individualist Western model'. An HRBA strategy would promote supporting the individual to participate in decision-making based on their ability and to filter any decisions with a consideration of the person's best interest within a human rights framework. The other concept emphasised in the study was proportionality. The authors state that strategies must be appropriate instead of excessive, proactive instead of reactive, and balanced between rights and risks. While this study is based on learning disabilities, the concepts are applicable to people suffering from mental health conditions that restrict their ability to make decisions or exhibit behavioural risks.

In another study of HRBAs, it was concluded they offer an ethical, political, legal, and evidence-based rationale for inclusion in national mental health systems (Mann, Bradley and Sahakian, 2016). This study found that HRBAs could lead to cost-effective positive outcomes and most patients felt that their well being had improved. Unfortunately, several of their studies were performed in high-income nations such as Scotland, England and the USA, therefore, the challenges of exercising these HRBA strategies in a low or middle income country with little infrastructure was not fully investigated. In fact, in India, the results demonstrated that while there were some improvements in hospital and outpatient care, practices of restraint and a chronic lack of resources in the institutions remained. Overall, these studies credited HRBAs with improvements in care, suggesting that additional research in this area could be useful to inform future policy development.

Years after the establishment of UN conventions, principles and acts to protect human rights, there are still profound issues for people with mental health issues, both the gap

between the need and availability of services, and the rights violations they undergo in their actual treatment (Izutsu et al., 2015; Morrall & Hazelton, 2004; Ménard, 2016). Laws and treatment can affect human rights, and conversely, violations of human rights can negatively impact mental health (Mann, Bradley & Sahakian, 2016). Given this, the inclusion of human rights and legislation in national mental health policy is critically important. Yet, with the international debate between rights, freedoms, risk and capacity, this can be a challenging endeavour. Including a wide range of stakeholders who embrace human rights considerations during policy development can assist in building a well-rounded approach that takes into account local resources and culture while protecting and supporting individuals with mental disorders.

Cultural Implications

Given the PIC context of this report, understanding the cultural influences toward perceptions and treatment of mental health specific to these islands is crucial. However, before individual countries are explored, it is important to frame cultural impacts on the issues of stigma, discrimination, treatment methods and human rights within a global context. That will provide the background for situating the Niuean and Samoan cultural concepts, which will be explored in Chapter 3.

The WHO policy guidelines reference culture in an abstract manner. They suggest that policy values and principles should be culturally relative and include traditional healers and other informal health participants that play a contributory role (WHO, 2005b). They acknowledge that while different cultures have similar disorders, there are also differences that must be recognised during policy development. The WHO suggest that in developing countries, there is a role that traditional medicine can play; working in cooperation with primary care and with proper accreditation and regulation of 'traditional health workers' practices (WHO, 2005b, p. 68). WHO also recommends advocacy for mental health when local culture is a contributing source of stigma and discrimination, including activities for professional health workers, policy and political leadership, and the general population. The human rights section of the policy guidelines has one brief paragraph that recognises the importance of health services that protect indigenous ethnic groups and other minorities who are often vulnerable, marginalised, and usually have higher rates of depression, alcoholism, suicide and

violence (WHO, 2003, p. 45). At the same time, their advocacy module has no reference to culture in this regard, failing to address some of the barriers to adequate mental health care and the reduction of stigma and discrimination (WHO, 2003).

Jenkins, McCulloch, Friedli and Parker (2002) explain that from the earliest of written history through to current times, there have existed different cultural ways of identifying and explaining mental health disorders. The authors divide these concepts into four different groups; biological, psychological, spiritual, and existential. The biological grouping is considered the 'medical model', however, there has been recent agreement by many mental health clinicians that mental disorders can be both psychological and biological. The spiritual aspect of interpreting severe mental disorders often attributes conditions to spirit possession. While this may conflict with the medical model, the authors state that this occurs in all cultures, not just those in low-income countries, and that this perception is not always harmful or ineffective. The existential view of mental health issues, while less prevalent, considers what others classify as a mental disorder to be a different, yet acceptable way of being. Culture and religion also influence mental health within a given society in terms of symptoms and behaviour, the way in which services are accessed and managed by individuals and their families, and the level of acceptance and inclusion of people with mental illness within a community (Jenkins, 2003).

The ways in which culture influences mental illness perceptions affects policy development, both in communicating with stakeholders during the development process and in determining treatment strategies that will work within the local context. While deemed important, policy-makers in some African countries attempted to integrate culturally accepted traditional mental health practices within their service delivery policies without success (Gureje & Alem, 2000). Two of the main issues cited were incorporating traditional treatment delivery methods within their policy documentation and developing standards for this type of service.

There can also be conflict when attempting to simultaneously deal with the principles of equality and cultural diversity in developing a national mental health policy (George, Dogra & Fulford, 2015). For health care to be effective, individuals cannot always be treated equally if their cultural values are different. This distinction can be seen within a

New Zealand context, where indigenous Maori cultural views of mental health have gained recognition and altered some practices within the last few decades (Durie, 2011). Durie explains how patients and their *whanau* (family) have been disempowered by "the misapplication of diagnostic labels and the employment of culturally insensitive therapies" (p. 29), resulting in policy changes that now include *kaupapa* (Maori-centred) services and a framework that incorporates Maori cultural values. Focussing service delivery and policy strategies on the concept of equitable services, instead of the human rights mandate for equality, can ensure cultural values are represented and respected.

At the same time, it is important not to revere cultural or religious values if they are harmful or result in exclusion or stigma for those suffering from mental illness. Jenkins et al. (2002) contend that attitudes and beliefs of health and illness are bound by people's experiences and cultures, requiring that those viewpoints be considered when developing a policy. The authors suggest that it may not be necessary or helpful to confront certain harmful beliefs directly, instead, they suggest educating the population to distinguish between mental illness and ideas such as spirit possession. In a Tongan study of the methods and beliefs of traditional healers and Western-trained mental health staff (ward staff), the researchers found very different perceptions around causal effects, definitions of illness, and treatment methods (Vaka, Stewart, Foliaki & Tu'itaha, 2009). The study found that the Tongan community saw the Western medical model as a last resort, believing it failed to address the core issues around illnesses and hampered recovery. The researchers also revealed that traditional healers contributed to the stigmatization of those that accessed non-traditional methods. Their study concluded that for a coordinated approach to be effective, efforts to improve the relationship between the two groups would be necessary.

Integrating medical and traditional approaches into a mental health policy can be complex; yet it is important as both a potential avenue of care and in recognition of cultural beliefs that must be acknowledged. It is also essential to understand how cultural attributes can be leveraged in creating a sustainable mental health service. McKenzie, Patel and Araya contend that while "traditional care often reflects a lack of resources rather than an active choice, medical care does not always produce better outcomes" (2004, p. 1138). At the same time, the authors state that while disbursing

health care to different agents such as community support or traditional healers, this practice should not decrease the amount spent on services. Mental health policies should ensure that funds are channelled into supporting and empowering these alternate agents in the positive work that they perform (McKenzie, Patel and Araya, 2004).

Conclusion

From a global perspective, mental illness is still largely neglected, resulting in continued treatment gaps and human rights violations. Even with many nations drafting mental health policies, creating or updating local mental health legislation, and agreeing to uphold UN declarations and covenants, those suffering from mental illness are still left untreated or are treated inhumanely. This issue spans across many nations, regardless of their position on the development spectrum, their wealth, or their culture.

The WHO has been effective in leading initiatives that have contributed to increasing global attention for the mentally ill and supporting the notion that mental health significantly contributes to the global burden of disease. While WHO and the UN rights-based work has been criticised for its medical model and Western perspectives, these organisations have been able to influence action in protecting and providing treatment to this marginalised portion of the population. At the same time, recognising local capacity and cultural implications to mental health perceptions and treatments is essential to ensuring a policy meets the needs of its population. The WHO framework endorses local participation and a cultural context within the policy process, however, since it is aimed at a global level, it has left the details on how to accomplish that to the individual countries undertaking the task. Following the WHO Policy Project modules as a framework, coupled with a firm understanding of local needs and a respect for the voices of all participants in a well-represented stakeholder group, should provide the platform for a comprehensive and well thought out national mental health policy.

CHAPTER 3: Mental Health in the Pacific

> *I am not an individual; I am an integral part of the cosmos. I share divinity with my ancestors, the land, the seas and the skies. I am not an individual, because I share a 'tofi' (an inheritance) with my family, my village and my nation. I belong to my family and my family belongs to me. I belong to my village and my village belongs to me. I belong to my nation and my nation belongs to me. This is the essence of my sense of belonging.*
>
> ~Tui Atua Tupua Tamasese (Tui Atua, 2003, p. 51)

In the previous chapter, mental health and policy development were discussed in terms of the global perspective, where Western viewpoints have dominated. Yet in the Pacific, a person's health and wellbeing can be explicitly linked to perceptions of self, not as an individual, but in terms of connectedness, as illustrated by Tamasese's quote above. Understanding this provides the foundation for Pacific cultural definitions of health and mental wellbeing. It also underlies the need to weave culturally appropriate perspectives into a national mental health policy; creating an environment where people with mental health issues can be connected to their community and are given the opportunity to flourish within their society.

This chapter will explore those Pacific perspectives. It reviews policy progress in selected Western Pacific Region nations since the WHO Policy Project launch and delves more deeply into aspects impacting mental health services in the PICs. It finishes by narrowing the focus of human rights in mental health to a Pacific Island perspective, looking at progress and barriers that impact legislation and the treatment and care of people with mental disorders.

Mental Health Policy in the Western Pacific Region

Following the selection of mental health as the World Health Day theme in 2001, the WHO committed to increase their support in reducing the burden of mental illness for countries within the Western Pacific Region, as outlined in their 'Regional Strategy for Mental Health' (WHO, 2002). Their 'case for action' was based on the high percentage of regional disease burden noted in Chapter 1, as well as the challenges for the region, which included social factors, community awareness, stigma and discrimination, health staff shortages, out-dated legislation and approaches to treatment, and the positioning of

mental health as a low priority (p. 13). One of the six key strategies for the region included mental health policy and legislation, acknowledging that several countries in the region had no policy while others had outdated policies requiring review.

To inform mental health promotion and improvements, WHO launched Project Atlas to compile situational analyses by country across the globe (WHO, 2005a). Shortly thereafter, a more detailed situational analysis was completed specifically in the Western Pacific Region[4] (Hughes et al., 2005). As seen in Table 3 below, there are a number of issues with the mental health policy situation at the country level.

Country	**Policy Status 2005**
Commonwealth of Northern Mariana Islands	Policy since 1976
Cook Islands	No policy, plans or programmes (interest expressed)
Federated States of Micronesia	Policy since 1986
Fiji	In development
Guam	Policy since 1983
Kiribati	Policy since 1999
Marshall Islands	No policy, plans or programmes (interest expressed)
Nauru	No policy, plans or programmes
New Caledonia	No policy, plans or programmes
Niue	No policy, plans or programmes
Papua New Guinea	Conflicting information – policy not verified, programme in place since 1962
Palau	Conflicting information – plan outlining needs from 2001
Samoa	In draft
Solomon Islands	No policy, but programme since 1999 and intent to draft policy
Tokelau	No policy, plans or programmes
Tonga	No policy or plans, acknowledged within one of 6 health priorities
Tuvalu	Conflicting information – unable to be verified

[4] *The information gathered for this situational analysis included desk-based documentation research, accompanied by limited interviews and surveys to triangulate the results. The authors acknowledge that the information was collected over a period of years from numerous sources, thus there is the potential for information to be out of date.*

Country	Policy Status 2005
Wallis and Futuna	No policy, plans or programmes
Vanuatu	No policy, plans or programmes, but MOH to develop programme with WHO consultancy

Table 3: 2005 Western Pacific Region National Mental Health Policy Statuses

(Derived from Hughes et al., 2005)

At the time of the analysis, only four of the 19 countries were confirmed to have an existing mental health policy. Of the remaining countries, three had conflicting information so their policy status could not be confirmed, two indicated their policy was in draft or being developed, four had a plan, programme or recognised mental health in another health agenda, and six had no specific initiatives or plans in place related to policy development. The two countries that indicated their policies were in progress, Samoa and Fiji, did finalise their national mental health policies, however, with a nine-year gap. Samoa's policy was launched in August of 2006; a 22-page document that contains many of the key elements outlined in the WHO policy guidelines (SMOH, 2006). Fiji's policy was delayed until 2015, requiring several iterations to arrive at the policy that is now in existence (Fiji MOH and Medical Services, 2015). This analysis, in addition to the rationale presented in Chapter 1, contributed to the research aim of analysing and evaluating the Samoan mental health policy as the best available resource for Niue's future policy work.

Mental Health Care and Treatment Strategies in Niue and Samoa

Drawing on the Pacific regional analysis in 2005, prior to the SMHP, both Niue and Samoa indicated a need to focus on mental health and concluded there was a high reliance on family, the police, and the community to support people with mental illness given the lack of nationally supported structures or services available (Hughes et al, 2005). Neither nation had a dedicated inpatient unit. At the time, Samoa would treat some mentally ill patients at their main hospital, but Niue's situation was further complicated by the loss of their only hospital due to a cyclone. From a primary care perspective, Samoa did have community services running out of their mental health unit, whereas no equivalent services existed in Niue. Both countries indicated that in certain emergencies such as severe psychotic episodes or where violence was involved,

prison or police cells were used to manage or contain these individuals. To manage these limitations cited in the regional analysis, both countries have managed to develop strategies to cope with mental illness based on the resources and capabilities available to them.

Niue – Mental Health Concepts, Capabilities and Challenges

An understanding of the current Niuean concepts and approaches to mental health are described in the country's 2013 situational analysis (Nosa et al., 2013). It states that in Niue, mental health is seen within the framework of traditional healing and Christianity, where mental illness is believed to be caused by *kai he tau aitu* (spiritual possession) or *tau kaiaalu* (a curse). Based on this perception, traditional treatments carried out by a *taulatua* (witch doctor) or Christian-based religious rituals such as fasting or prayer, are considered appropriate as they address the cause, not just the symptoms. The church is also seen as a resource for providing families with education, counselling, and spiritual support; it is a 'safe place' to discuss mental illness without fear or stigmatisation. The analysis indicates that in the absence of national services, families and the community are heavily involved in providing care, even in situations of severe mental health disorders. They are required to supervise individuals with mental disorders who are admitted to the general ward since there are no other facilities and limited staff to manage their care. In severe cases, when the Niue Foou Hospital is unable to accept a mentally ill patient, the individual may be flown to New Zealand for treatment. The analysis also contends that while Niue employs New Zealand mental health legislation, in practice, involuntary treatment or detention is carried out by family consent.

The sustainability of the current family-based Niuean model of care, as well as any future locally resourced services, is a concern. Attributed in part to the local circumstances, globalisation, and the appeal and ease of movement between countries, the island has endured a steady migration to neighbouring islands (Connell, 2008; McNamara, Blisimoni-Togahai & Smith, 2015). Since a population peak in the mid-1960s, a steep and steady decline has ensued, as demonstrated in Figure 5 below.

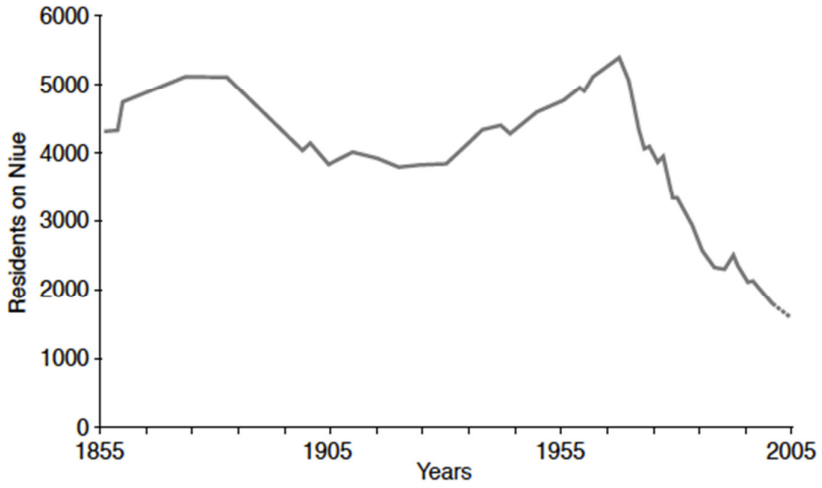


Figure 5: Population of Niue 1857 to 2001

(Connell, 2008, p. 1022)

This migration has had a negative impact on Niue, especially on those who have chosen to stay. As Connell (2008) observes, the outward flow of people is demoralising for those who remain, with rows of abandoned houses serving as a constant reminder of the departed. There is also a burden for those who stay; in addition to assuming the role of 'custodians of the land', there are fewer people to support the church, maintain the village, and participate in local social, sporting, and community activities (Connell, 2008). Another consequence of migration is that medically trained residents, as well as IT and skilled tradesmen, consistently take their knowledge overseas and rarely return (Connell, 2008). The Country Cooperation Strategy for Niue concurs, indicating that skilled health worker migration is a threat to all Pacific Islands' ability to implement their health programmes (WHO, 2012).

Samoa – Mental Health Concepts, Capabilities and Challenges

Understanding the Samoan concepts of mental health are important, not just to frame their policy development, but to also demonstrate the similarities and differences within the Pacific Islands when compared to the Niuean concepts. In a qualitative study of Samoan perspectives on mental health, the participants indicated that to understand mental health requires an appreciation of the four Samoan concepts that comprise the 'self' (Tamasese, Peteru, Waldegrave & Bush, 2005). The study describes the 'self' in

its relationship with other people, *tapu* (that which is forbidden) and *sa* (sacred), spirituality and Gods, and the view that a Samoan 'self' is comprised of physical, spiritual, and mental elements that cannot be separated.

In the quote at the beginning of this chapter, Tui Atua Tupua Tamasese, a former Prime Minister of Samoa, describes this strong connection of people to their wider surroundings and their levels of belonging, suggesting an all encompassing perception of an individual (Tui Atua, 2003). This is consistent with the system of *fa 'aSamoa*, the basis of Samoan customs and traditions. *Fa 'aSamoa* encompasses all aspects of society, including the social, organisational and family systems, as well as attitudes, ideas, values and beliefs; all inter-dependent of one another (Stewart-Withers & O'Brien, 2006, p. 214). Mental health is then a reflection of the whole person and their community, where if one aspect is in conflict, the individual's mental health becomes imbalanced. Based on this, assessment and treatment requires considering the root cause of the person's imbalance for proper healing to occur.

One finding in the 2005 Pacific regional analysis for Samoa suggested that many of the treatment approaches undertaken at that time had been culturally inappropriate, resulting in the systems theory development of a Samoan model of care known as *Aiga* (Hughes et al, 2005). *Aiga*, the Samoan word for the extended family, is described as the collective sense of the individual and is recognised as the most appropriate setting for care, assessment and management of mental illness, with the exception of severe disorders (SMOH, 2006). From a model of care perspective*, "Aiga* - A Partnership in Care through Continuous Collaboration" was created to transition clients from the historically inappropriate institutional care model to a community-based approach (Enoka et al., 2012). This model represents the relationship between the community, the family, and the client working together through a phased process. The process involves the nurse, client and their family meeting and 'listening' to each other to form a collaborative relationship, understanding the 'story' of the mental health issue, and working together to assist the family in taking the lead in diagnosing and implementing an agreed upon treatment strategy for the client. Enoka et al. (2012) conclude that similar culturally derived approaches could be used effectively within other Pacific Islands or with indigenous people, such as the work done with the Maori population in New Zealand.

The SMHP also noted a role for the *aiga* and community; they are assets in helping the Mental Health Unit to "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 [*sic*] to manage mental health problems" (SMOH, 2006, p. 21). This reliance on family, however, is not always possible or helpful. A commissioned regional analysis of Samoan mental health for youths recognised "while cultural strengths provide guidance and resilience it may also create additional stresses" (Hope, 2009, p. 9). One example cited that, due to the communal relationship in Samoa, shame and stigma are often associated to the family, not just the individual. Another concern with reliance on family and community within the Pacific region is globalisation and urbanisation, where traditional ways of living are being challenged, both in their ability to retain family support systems and in the tension and stress these cultural changes have brought about (Hope, 2009; McNamara et al., 2015).

In an article debating the Pacific Island mental health service model over a Western approach, the authors suggest that there are strengths in the Pacific that should be acknowledged and potentially learned from; both in a disorder prevalence and outcome perspective (Mulder et al., 2016). The authors believe, based on years of visiting and working in Samoa, that the prevalence of severe mental health disorders is significantly less than New Zealand's 12-month rate of 5.9% (p. 397). They surmise this lower prevalence is due to the 'collective tribal culture' and strong family ties that promote individuals to function with little disability amongst their community, or to minimise their symptoms with the encouragement of their community. They also suggest that factors such as less stressful work environments and the spiritual attribution of causes discourage mental disability. The authors acknowledge that the lack of available services can also contribute to individuals not knowing where to access care, therefore, misrepresenting lower prevalence. While they concede there is an unmet need, accept that their data is weak and their theories are based on hypotheses drawn from their own experience, they believe that Samoa's current strategies of dealing with mental illness require additional research and should preclude imposing a Western model of care on a practice that may bring better outcomes to its own people.

Summary of Mental Health Care in Niue and Samoa

As can be seen above, while not homogenous, the similarities between the two nations provide a sound basis for Niue drawing on Samoa's mental health policy work. Mental health and wellness in both countries has a strong spiritual component and a reliance on the family and community to provide support. Both nations have faced challenges with delivering services due to globalisation, with Niue's migration being a major concern. Understanding the relationship between what the nations share and where they differ would aid in determining the Samoan policy contents that should be leveraged, and those areas that may require specific Niuean considerations.

Pacific Mental Health Network (PIMHNet)

Historically there has been concern that many of the PICs have not been well prepared to handle the degree of mental health problems in the region (Tone, 2007; Hughes, 2009). In response to the challenges and issues recognised during the Ministers of Health for the Pacific meetings in 2003 and 2005, the Pacific Islands Mental Health Network (PIMHnet) was launched in 2007 (WHO, 2007a; WHO, 2007b). Funded by the New Zealand Aid Programme (NZAid) and supported by the WHO, PIMHNet's mission is to "facilitate and support cooperative and coordinated activities within and among member countries that contribute to sustainable national and sub-regional capacity in relation to mental health" (WHO, 2014b, p. 1). Through this collaborative network, countries of similar geographical and cultural backgrounds have the opportunity to maximise limited resources by sharing knowledge and experience, reducing duplication of work, and allowing existing resources to go further (WHO, 2007b).

PIMHNet membership is open to all PICs based on the request of their MOH, and at its inception, Niue and Samoa were among the network's founding 16 member countries (WHO, 2007b). Within its guiding principles, PIMHNet is meant to serve as the 'primary vehicle' for mental health initiatives and act as the 'key mechanism' for coordinating resources for those initiatives with participating countries (WHO, 2007b, p. 5). Decisions are made through the contributions of participating network countries

and fundraising by PIMHNet and member countries is an important aspect to ensure the network's sustainability. The network's initial priority action areas were advocacy, policy, legislation, planning and service development, human resources and training, research and information, and access to psychotropic medicines (WHO, 2007b, p. 8).

In 2009, NZAid completed a review of PIMHNet's activities and outputs for the years of 2005 to 2008 (Heywood, 2009). The review included desk-based consultations, country visits to Fiji, Kiribati, Tonga and Vanuatu, and national contact questionnaires completed by email[5]. Overall, the findings were very favourable. Highlighted activities included PIMHNet visits to Samoa to assist with policy and legislation review, as well as visits to five other countries to provide technical support on country information, planning and policy activities. The review stated "developing mental health policy is a priority for all partners" (p. 6). The policy statuses in the region at the time of the review are represented in Table 4 below.

Status of policy	Countries	
	N	%
Policy endorsed and costed	1	6%
Finalised, awaiting approval	1	6%
Final draft, not yet approved	3	19%
Progressing well	8	50%
No policy, or needs review	3	19%

Table 4: 2009 Western Pacific Region Mental Health Policy Status Summary (Heywood, 2009, p. 6)

Reflecting on the statistics above, the review suggested that with 81% of the participating countries actively working on policies, there was good progress in the region given that policy development is a lengthy process that involves many stakeholders (Heywood, 2009). The review also indicated that PIMHNet's contributions, via workshops and in-country support, were seen as 'invaluable' in achieving these results.

[5] *Limitations included lack of participation (10 of the 16 member nations participated in the review) and deficits in both the information and documentation submitted by participants.*

From an initiative perspective, the review suggested that PIMHNet performed well in a short time frame in terms of setting up the network structure and communication channels, involving participant countries, and increasing awareness of mental health (Heywood, 2009). The project framework was seen as an excellent model; responding to each country's needs based on their stage of development while facilitating ownership. However, in terms of ownership, member country feedback was mixed, with one quote stating "Of all the WHO stuff imposed upon us this is probably one of the most beneficial" (p. 14), revealing an undercurrent of frustration with the number of WHO programme directives and reporting streams.

At the same time, it was believed that WHO participation was beneficial, both in their linkages and networks, and in their ability to assist with governance and human rights monitoring (Heywood, 2009). It was acknowledged that not all participating nations were capable of forming an in-country network or to be represented by a viable national contact. There was also some dissatisfaction regarding funding, both in the availability of in-country funds and the process for obtaining funding. The recommendations from the review included the development of a 'concise' monitoring and evaluation framework to better measure achievements in policy implementation, as well as a focus on gender and rights issues. Overall, the review indicated that the project had been 'good value for money' and encouraged a meeting with NZAid, WHO, the New Zealand MOH and Australian Aid (AusAid) for future project support.

Since the review, mental health has continued to receive attention in the region, gaining some ground but still contending with many challenges. In a more recent Pacific Health Ministers Meeting, these issues were summed up to include the myths around mental illness, human rights violations, stigma and discrimination, lack of legislation, insufficient data to inform policy, shortage of financial and human resources to meet the disease burden, and the division of mental and physical health (WHO, 2013, p. 6). PIMHNet has continued to receive funding and is now networking with 21 member countries. In the last available PIMHNet meeting report from September 2014, they acknowledged the completion of eight country situational analysis reports, one of which is Niue, as well as in-country training to scale-up services for seven countries, which included Samoa (WHO, 2014a, p. 8). The meeting ended with several countries developing a plan; out of the 14 participating countries, seven included a project for

mental health policy and plan development.

Unfortunately, there is limited literature concerning PIMHNet which is not WHO generated or funded. The one and only review of the project from an outside source is the aforementioned, sponsored by NZAid (Heywood, 2009). This review provided positive feedback in terms of achievements, as well as suggestions for improvement, especially around documentation, monitoring and evaluation. It was suggested that the review process itself was "beneficial as a supportive intervention to implement perhaps yearly" (p. vii). This does not appear to have happened; therefore, accountability, ownership and oversight are missing from the project. That is not to say that PIMHNet has not provided support in the region. Indeed, they are seen as a pivotal initiative in improving mental health services since their inception (McGeorge, 2012). Now that they have been operating for over a decade, another in depth review of the project would be worthwhile; enabling them to acknowledge progress to date and provide another round of recommendations for future improvement.

Pacific Human Rights and Legislation

As established in Chapters 1 and 2, human rights are a global concern for people with mental illness due to stigma, discrimination, disability issues, and concerns related to treatment consent and involuntary detention. This is no different in the Pacific. Even with the involvement of WHO and PIMHNet, the scaling up of mental health policies and services in the Pacific has made slow progress in the past decade, with human rights and legislation evolving at an even slower pace. While there are several UN rights instruments that are meant to protect the rights of people with mental illness, in the Pacific, only a few countries in the region have adopted these; attributed in part to the 'Western' view of human rights that does not align with Pacific cultural perceptions (Ménard, 2016). Working with nations to achieve appropriate legislation and human rights representation in mental health policies while respecting cultural practices is a balance that must be achieved.

The PIMHNet project review of 2009 reported the status of legislation in the Western Pacific region at the time; represented below in Table 5.

Status of legislation	Countries	
	N	%
Acceptable legislation in place before PIMHnet	1	6%
Finalised & in law	1	6%
Final draft, not yet approved	2	12%
Needed but not yet commenced	9	57%
None/NZ by default	3	19%

Table 5: 2009 Western Pacific Region Mental Health Legislation Status Summary (Heywood, 2009, p. 7)

This work indicated that 76% of the participating nations had not yet commenced legislative work, had no national legislation, or were defaulting to New Zealand's Mental Health Acts.

The PIMHNet review addressed human rights as a 'cross-cutting issue' to mental health (Heywood, 2009). It indicated that, while PIMHNet recognised the challenge of addressing human rights, there are some countries that continue to tolerate isolation, violence, and abuse toward people with mental illness. The review stressed that the WHO policy guidelines do not 'tolerate' human rights breaches, however, the issue must be addressed 'tactfully and carefully' (p. 20). It also mentioned the use of 'informal mechanisms' to tackle serious human rights issues using non-Western approaches. These were not articulated, citing the sensitivity of documenting issues of this sort and suggested that PIMHNet has been working innovatively with governments and NGOs to encourage them to take control of this area.

PIMHNet is not the first or only organisation to work with human rights in the Pacific. The Regional Rights Resource Team (RRRT), a programme of the Pacific Community (SPC), has been working since 1995 with its 22 Pacific country members to "increase observance to international human rights standards through improved service delivery, access to justice and effective governance" (SPC, 2017). SPC and RRRT supported a situational analysis of human rights in the Pacific between the years 2012 and 2016 (SPC, 2016). The analysis studied member country's human rights infrastructures, such as policies, laws, and institutions, and was framed using the Universal Declaration Model due to its international endorsement in the field of human rights. The analysis cited limitations due to the lack of published information and knowledge of human rights protection systems in the area. It also had no specific inclusion of the rights of

people with mental health and mental health was not mentioned in its list of urgent but understudied areas. The analysis does include an area for reviewing the rights of the disabled but does not define the term 'disability', therefore its inclusion of mental illness is unclear or an omission.

The SPC analysis is still worthwhile for consideration as it provides some human rights information that can be referenced within a mental illness context. For example, the country analysis section for Niue indicated they were not a member of the UN, have not ratified the CRPD, but have adopted their own National Disability Act (SPC, 2016). Samoa's human rights profile indicates that they have signed but not ratified the CRPD. The review suggested that Samoa displays a commitment to human rights through a range of policies that "promote rights and empowerment for vulnerable groups" (SPC, 2016, p. 108). Later in the same country report, it is stated that Samoa provides no protection from discrimination related to disability, age or sexual orientation. There is a brief mention of improvements within the existing prison system with the opening of the Mental Health Treatment Centre, suggesting this alternate facility will now be responsible for individuals with mental health issues as opposed to the prison system.

The SPC analysis reports that Samoa established a National Human Rights Institution through their Office of the Ombudsman in 2013, which is responsible for the protection, monitoring and raising awareness of human rights within the country (SPC, 2016). The analysis cites a conflict between human rights and *fa'a Samoa*. It quotes Maiava Iulai Toma, the Samoan Ombudsman and Human Rights Commissioner, explaining that while Europeans and Samoans have different beliefs of human rights, they are 'equivalent in nature' and underpinned by similar core values. His distinction is that that Samoan beliefs 'guide social interaction' and include respect, dignity, security, love and service, whereas a Western approach to human rights includes equality but exclude love and service (p. 113).

Based on concerns for the rights of people with mental illness, a study was recently undertaken in the Pacific region, focussing on mental health law reform and human rights. Ménard's (2016) fieldwork concentrated on the nations of Tonga, Fiji, and Samoa as nations that had undergone recent law reforms. The author states that this reform has been motivated by global human rights movements and initiatives, and some

key individuals with political influence, but they have been "aspirational rather than substantive" due to a lack of political commitment, a shortage of financial and professional resources, and cultural practices that create barriers to implementation (p. xv). Ménard (2016) recognises Samoa's 2007 Mental Health Act as a significant improvement from its 1961 pre-independence ordinance, but points out that the Act excludes certain beliefs and actions that people with mental illness are usually discriminated against.

In an attempt to integrate culture into law, the Samoan government has developed initiatives to allow for traditional mediation and community-based supervision given their perception that Western court systems erode traditional village structure and the practices of *fa'a Samoa* (Ménard, 2016). It is unclear how this initiative interacts with the Mental Health Act 2007 which mandates that the court is responsible for reviewing treatment orders in conjunction with the law (SMOH, 2007). Unless transparent systems of monitoring and evaluation are in place, should the traditional villages or communities treat the mentally ill poorly, the laws can be easily ignored with severe consequences to those that are requiring protection under the Act. This is especially concerning as Ménard (2016) has indicated that there are no independent reviews of involuntary detention, and that complying with the Act is subject to 'available resources', allowing an avenue for failing to maintain one of the mandates of a rights-based approach.

Harmonising culture and rights-based legislation is a challenging but important aspect of protecting the rights of people with mental health issues. Ménard (2016) cites several of Jalal's articles, written on behalf of RRRT, relating to the complexity of balancing culture and human rights advocacy. These articles were all written before the Samoan Mental Health Act 2007. One of the main concerns expressed by Jalal at the time was aid allocation to rights-based organizations (Jalal, 2005). She indicated that when PIC governments are responsible for the control of aid from bilateral and mulitlateral donors, it is usually dispersed based on their priorities; leaving rights-based NGOs unable to receive sufficient funding for their proposals. She also suggests that people working within the human rights agenda are often accused of not representing their own culture and are instead, imposing Western values, donor agendas, and threatening the patriarchal nature of Pacific society. There are no recent articles by Jalal on this topic, therefore, perceptions of human rights work following the efforts of RRRT, WHO and

PIMHNet are not available.

To further mental health legislation in the Western Pacific region, PIMHNet continues to work with member countries on these matters. In the Fourth Meeting held in New Zealand in 2014, WHO provided the rationale for this work, and outlined the steps required to implement mental health legislation, as seen in Table 6 below.

Steps	Actions
1	Set up committee to prepare and oversee drafting of legislation.
2	Prepare analysis of all existing laws.
3	Carry out consultation and negotiation.
4	Draft legislation.
5	Ensure adoption of legislation by law-making body.
6	Appoint body to oversee implementation of legislation.
7	Prepare regulations, codes of practice and other guidelines.
8	Train people affected by the legislation.
9	Undertake awareness-raising campaigns.
10	Prepare adequate resources for implementation of legislation.
11	Monitor implementation of legislation.

Table 6: Steps for Developing Mental Health Legislation
(WHO, 2014a, p. 10)

During the meeting, representatives from Samoa described their lessons learned from developing their mental health legislation in 2007 (WHO, 2014a). They also highlighted the cultural differences in the Pacific when trying to frame concepts of law from outside the region, as well as issues around local resources and situations.

Conclusion

The Pacific, similar to other parts of the world, struggles with implementing mental health policies, programmes and legislation to meet the needs of their people. This is further complicated by critical human resource constraints, geographic isolation,

funding, and cultural concepts, which can be a barrier to treatment and care. At the same time, some countries in the Pacific region have managed to utilise key aspects of their culture to benefit people with mental illness, through a model of care that draws on family, community and the church.

Policy and legislation in the region has evolved differently for all the islands. Niue is considerably further behind than Samoa, and their population size and relationship with New Zealand complicates service delivery. Both islands have similarities in that family, community, and spiritual relationships underpin concepts of good mental health. Policy development and service delivery strategies must reflect this and acknowledge that medical models do not always provide the best outcomes in all circumstances. Mulder et al.'s (2016) work in Samoa exemplifies this, bringing awareness to a model of care that seems to be more appropriate and effective in that environment. At the same time, cultural beliefs that cause harm must be addressed. This requires a sensitive approach with advocates who understand cultural norms and who can work within the political context to make change. Policy and legislation alone cannot make this happen. These documents must be supported by local government, both in concept and in practice, and followed through with resources and funding where necessary.

CHAPTER 4: Analysis and Evaluation of the SMHP – Findings and Discussion

> *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.*
>
> ~SMOH (2006)

In the previous chapters, the status of mental health and policy development were explored from both a global and a regional perspective. This included concerns related to development principles, culture and human rights. At the same time, the importance of mental health policy to improve service delivery for those in need was established, as well as the policy framework outlined by the WHO to assist nations in this process. As noted, Samoa was one of the first PICs to develop a mental health policy; established just a few years after the WHO policy project launch and during the time PIMHNet was being established. Their policy vision statement, quoted above, demonstrates the nation's expectations for its people's mental health. This chapter will now analyse and evaluate the SMHP in the context of the literature presented thus far, satisfying the second objective of question one and providing the final piece of groundwork before considering the applicability of the Samoan policy to Niue's future policy development.

Framework and Policy Analysis Process

The framework used for this report's policy analysis is the summary of the 28 components of the WHO policy checklist that was introduced in Chapter 2, Table 2. The analysis process consists of aligning the contents of the SMHP to one or more of the summarised component topics. Breaking down the SMHP in this way will assist in articulating the areas that have been represented within the policy, determining where local cultural traditions are recognised, and allowing for an in-depth evaluation of each topic area within the policy. The steps taken to complete this process are outlined in Figure 6 below.

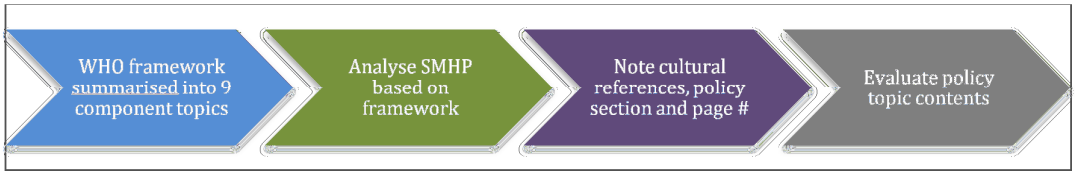


Figure 6: Analysis and Evaluation Process

The full policy analysis of the SMHP, based on the summarised component topics, is located in Appendix 2. However, for ease of reference, each component topic can be found within its specific evaluation section below. The analysis consists of the following headings:

TOPIC: The summarised component topic from the WHO checklist (referred to as *Topic*).

POLICY CONTENTS: A brief statement representing the associated policy content.

CULTURAL: A notation that the policy content includes a cultural, religious or traditional healer reference, indicated with an asterisk (*).

SECTION/PAGE: The policy section heading and page number where the content is located, to be used for cross-reference purposes (referred to as *Section*).

Limitations and qualifications

Aligning the policy contents to the summarised components is a subjective exercise. The presence of a statement within the policy does not reflect the statement's quality, and some statements are applicable to more than one *Topic*. To apply rigour to my process while taking these factors into account, I have attempted to align statements within the policy only when they have an action associated to them or specifically qualify a concern that requires focus within the policy.

As an example, the 'Introduction' *Section* of the policy, as seen in Figure 7 below, contains five paragraphs representing:

1. The WHO definition of mental health
2. An elaboration of that definition
3. An association of that definition to the Samoan cultural context

4. A statement recognising that population and prevalence data should be used to establish priorities
5. A statement that the definition represents all of Samoa

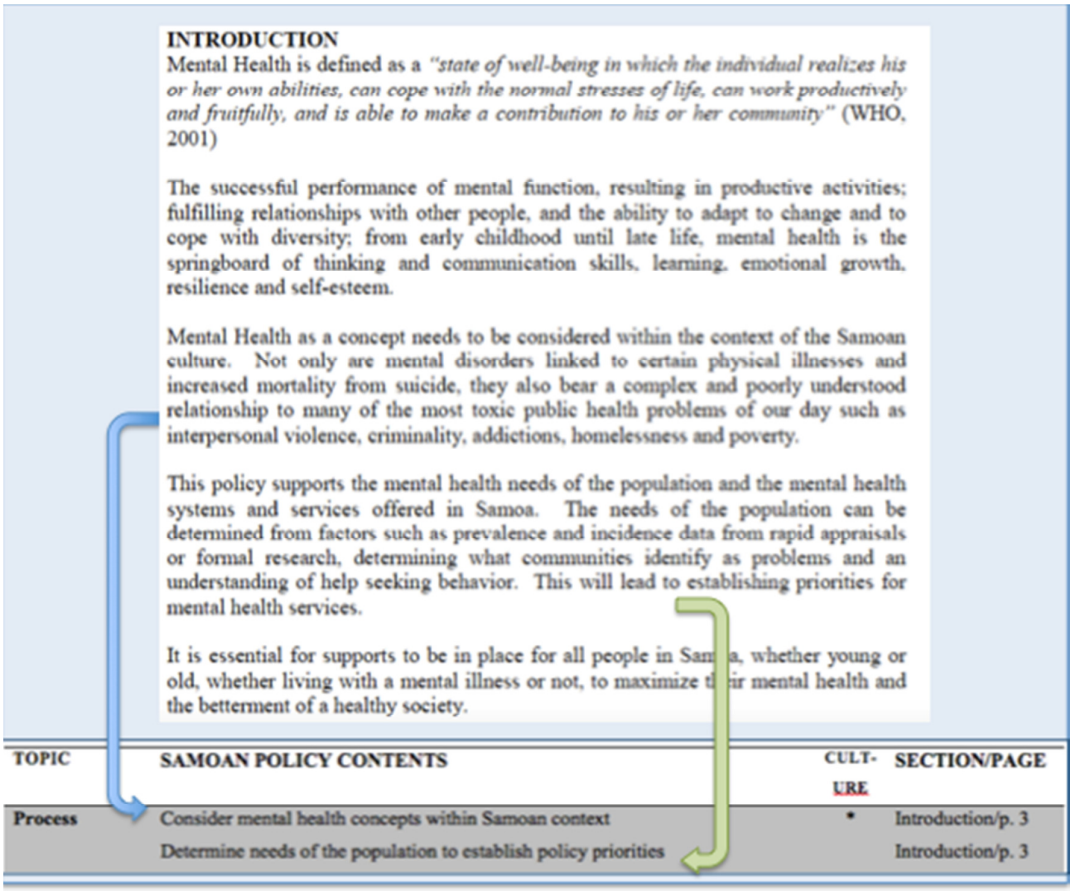
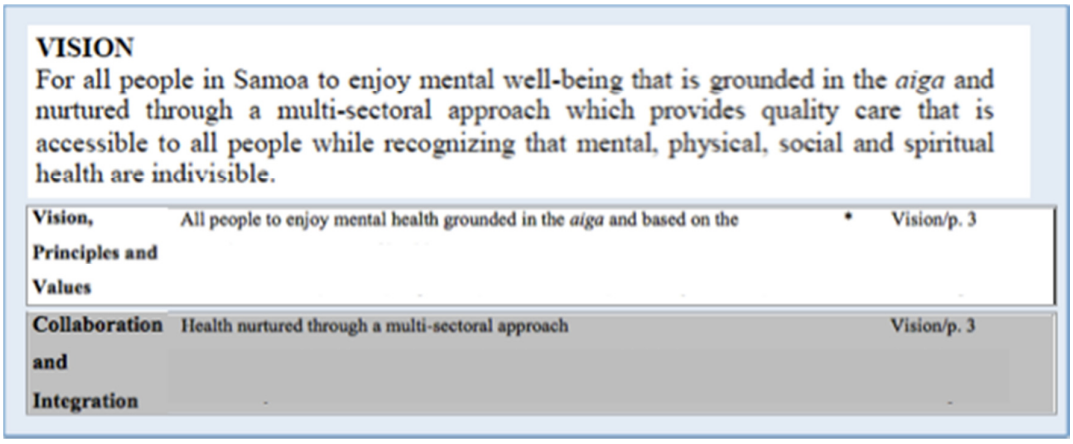


Figure 7: Policy Alignment Example 1

In this example, the first, second and fifth paragraphs are definitions and are therefore excluded from the analysis. The third paragraph is included within the Process *Topic* since it articulates the fact that mental health definitions must be understood within a local context; framing this important relationship for the remaining policy contents. The fourth paragraph is also included as a Process *Topic* as it recognises the need for relevant data when formulating policy priorities.

There are also aspects of the policy that can be found in one *Section*, but the contents relate to more than one *Topic* area, as can be seen in Figure 8 below.



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.

Vision, Principles and Values	All people to enjoy mental health grounded in the *aiga* and based on the	*	Vision/p. 3
Collaboration and Integration	Health nurtured through a multi-sectoral approach		Vision/p. 3

Figure 8: Policy Alignment Example 2

In this example, the SMHP vision statement includes references to *aiga*, a multi-sectoral approach, and recognises that all aspects of health; mental, physical, social and spiritual, are indivisible. This statement is represented in the Vision, Principles and Values *Topic* because it is a clearly articulated vision statement. It is also included in the Collaboration and Integration *Topic* since it recognises the importance of multi-sectoral approaches. The portion of the contents that recognises the *aiga*'s role in mental health and the Samoan conceptual nature of health is a cultural reference, so it is indicated with an asterisk (*) within the Vision, Principles and Values *Topic*.

Policy Evaluation Based on Framework Analysis

By allocating the contents of the policy into each of the *Topics* as described above and shown in Appendix 2, the SMHP addressed each summarised area represented in the framework. This analysis now provides the basis for the evaluation of the policy contents in relation to the framework.

In the nine sections below, each of the *Topics* are represented as follows:

- ***Topic***: Name
- Excerpt from the full analysis related to that specific *Topic*
- Evaluation of the *Topic,* where references to the *Section* of the policy are noted within single quotes (‘’)

Topic: Process

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Consider mental health concepts within Samoan context	*	Introduction/p. 3
Determine needs of the population to establish policy priorities		Introduction/p. 3
Strong political and organisational commitment consistent with MOH broader policy frameworks		Statement, p. 17
Situational analysis		Situational Analysis pgs. 5-12
• **Revise antiquated legislation, focus on patient rights**		
• **Specialist services through Mental Health Unit**		
• **Primary care – *aiga* focus of assessment and management**	*	
• **Informal services – NGOs, religious organizations, traditional healers**	*	
• **Private sector – few services, no psychiatrists**		
• **Areas of concern, based on limited evidence**		
o **Suicide prevention - paraquat**		
o **Substance abuse**		
o **Domestic, sexual and physical abuse**		
o **Stigma and discrimination – cultural foundation**	*	
o **Limited psychotropic and other drugs**		
o **No inpatient unit, risk-based use of general ward or police cells**		
• **No exposure to mental health budget, within general expenditure**		
• **No clear data on demand, prevalence and referrals, estimates only**		

The first area of evaluation within the WHO framework relates to the Process *Topic*. WHO suggests that policy development should be undertaken with high-level national mandates, approvals and a well-rounded consultation process (WHO, 2005b). Within the SMHP 'Introduction' and 'Situational Analysis' *Sections* of the policy, there are no details on the development process, the participants or what consultations occurred to draft or endorse the policy. There is, however, one sentence within the 'Policy Statement' *Section* stating there is a "strong political and organizational commitment in Samoa to develop a mental health policy" (SMOH, 2006, p. 17).

The ‘Introduction’ *Section* details the linkages between mental health and public health issues such as suicide, poverty, and interpersonal violence. This implies discussions with groups that include finance, social welfare and the criminal justice system. While there is a lack of specifics within the policy, given the level of detail in the ‘Introduction’ and ‘Situational Analysis’, and the representation of all the summarised *Topics* within the policy, the process appears to have included many stakeholders and a broad approach that encompassed the interdependent relationship of mental health to other areas of national concern.

Another important element within the Process *Topic* is the WHO suggestion that the policy should be based on relevant data from a situational analysis or needs assessment (WHO, 2005b). The SMHP contains several pages of a thoughtfully constructed situational analysis, covering many aspects of existing services, legislation, and the local influences and areas of concern related to mental health. The policy ‘Introduction’ acknowledges that the needs of the population should inform policy priorities while the ‘Situational Analysis’ concedes that there is limited data available on disorder prevalence. Later in the policy it states that the basis for policy priorities was anecdotal but consistent with public perceptions and a 2003 community consultation process (SMOH, 2006, p. 20). This highlights the circular logic of two important aspects of policy development for developing countries, when information systems are needed to inform policy, but a policy is required to influence funding for information systems when they do not already exist.

Further information related to the policy development process is presented in Fadgen’s doctoral thesis on policy transfer for Samoa and Tonga (Fadgen, 2013). In his research, Fadgen (2013) consulted with SMOH officials who reported that there was large stakeholder participation in the policy drafting process. His research indicates that while the policy clearly followed the WHO format for a ‘good’ policy, it also managed to hybridise the international framework with Samoan cultural imperatives. Fadgen contends the process was,

> … largely operated outside of the traditional Samoan political power process and outside of the traditional cultural power institutions, there were more opportunities for the inclusion of various perspectives, along with those of the

> professional organizations and IOs all clamouring for space in the finished document (p. 162).

Fadgen (2013) asserts that a pre-policy development initiative provided a mental health system solution that was culturally and economically appealing to Samoa. He was referring to the shift from institutionalism to community treatment and the *aiga* model of care described in Chapter 3. Fadgen's interviews into the policy process suggest that, due to the shared aspirations of the indigenous participants to implement a mental health policy for Samoa, both those that were less informed in mental health but politically empowered, and those with 'insider' mental health experience within a cultural context, were able to participate with the international and bilateral organisation's contracted experts to collaboratively draft the 2006 policy.

Topic: Vision, Principles and Values

POLICY CONTENTS	CULT-URE	SECTION/PAGE
All people to enjoy mental health grounded in the *aiga* and based on the Samoan concepts of health	*	Vision/p. 3
Effective services; holistic, responsive, evidence-based, culturally sensitive, affordable, and accessible	*	Mission/p. 3
Eight values and principles that address 5 key areas		Values/p. 3-4
• ***Aiga* as the appropriate health care setting**	*	
• **Respect and rights for persons with mental disorders, the family and the community**		
• **Recognition of the holistic approach to mental health**	*	
• **The need for evidence-based treatment and therapy**		
• **Quality mental health for all people**		

In the WHO checklist, the remaining topics suggested for inclusion in a mental health policy are related to the contents, which begin with the summarised *Topic* of Vision, Principles and Values (WHO, n.d.). The WHO guidance package suggests that a policy's vision should set high expectations for what is desired, while being realistic in terms of available resources and technology (WHO, 2005b). It recommends that the vision be the 'final state' after years of implementing the policy; acting as an inspiration for stakeholders. Given Samoa's situational analysis, limited resources, and lack of

technology at the time the policy was drafted, balancing a desired outcome with realism would be difficult. Their vision statement includes 'all' people in Samoa, quality care centred with the *aiga*, and consideration for all aspects of health based on the local cultural perception that holistically embraces spiritual health. The attainability of that vision, should the policy be implemented as outlined, could be attainable for most people in Samoa.

Regarding values and principles, the WHO guidelines suggest that these 'underlie' policy statements and represent the differing values that countries have based on their own concepts of mental health and mental illness (WHO, 2005b). The guidelines provide a list of examples of values and principles; however, they are sourced from Canada, the United Kingdom and Chile, therefore, dissimilar in nature to the PICs (p. 28). The Samoa policy values and principles include the Samoan perception of mental health and stress the importance of the *aiga* as both impacted by the health of individuals and as an appropriate setting for health care, with the exception of severe disorders. The values also stress a quality service, reference the rights of people in terms of access, respect, dignity and information, and include the need for evidence-based treatment and therapy. With the concerns expressed in the 'Situational Analysis' in terms of the cultural foundation of stigma and discrimination, addressing rights, respect and dignity are an important inclusion in the policy values and principles.

Topic: Action Orientation

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Six goals and objectives spanning multiple areas of policy contents		Goals/p. 4
Development of mental health board for leadership		Goals/p. 4
Protect, promote, restore mental well-being of Samoans		Goals/p. 4
12 key areas for action (counted within specific topics)		Action/p. 4
Appointment of medical officer as focal point for services		Issues/p. 13
Identify stress within vulnerable groups and recognise socio - economic factors		Issues/p. 15
Strong political and organizational commitment in Samoa		Statement/p. 17
Establish National Mental Health Advisory Committee to coordinate strategies, policy and planning, and monitor		Strategy/p. 17

POLICY CONTENTS	CULT-URE	SECTION/PAGE
policy implementation		
Roles and responsibilities established with MOH and key stakeholders (identified various ministries, plus NGOs and Attorney General)		Roles/p. 21
Mental Health Unit work with *aiga* and community to explore approaches to managing mental health issues	*	Roles/p. 21

In the WHO checklist, the Action Orientation *Topic* mandates clear objectives that are consistent with the policy vision and principles, a description of what is to be achieved, and policy language that demonstrates commitment and action (WHO, n.d.). The SMHP is strong in this area. There are six goals and objectives in the policy, several of which span the other *Topics*. In terms of action, the policy contains a goal to "develop a mental health board for sustained leadership and direction" (SMOH, 2006, p. 4). That, plus a strategy later in the policy planning to establish a National Mental Health Advisory Committee indicates a desire to follow through with the policy contents after adoption.

The policy also contains 12 specific actions, which are referred to in the SMHP as 'Key Areas for Action'. Table 7 below demonstrates the relationship between the policy action area and its alignment to the other WHO framework *Topics*.

#	Key Area for Action	WHO Framework *Topic*
1	Ensuring appropriate financing of prioritized services	Financial
2	Legislation and human rights	Human Rights
3	Organization of services	Organisation and Service Management
4	Human resources and training	Organisation and Service Management
5	Facilitate and provide support to affected families	Organisation and Service Management
6	Areas of focus for promotion, prevention, treatment and rehabilitation	Organisation and Service Management
7	Ensure essential drug procurement and laboratory support	Organisation and Service Management

#	Key Area for Action	WHO Framework *Topic*
8	Build capacity for leadership and advocacy	Advocacy
9	Quality improvement	Information and Quality
10	Improved information systems for more informed care	Information and Quality
11	Strengthened research, monitoring and evaluation	Information and Quality
12	Community and inter-sectoral collaboration	Collaboration and Integration

Table 7: Key Areas for Action and *Topic* Alignment

(SMOH, 2006, p. 4)

As seen above, there is a strong emphasis for action on Organisation and Service Management, with five of the 12 *Topics* relating to it. Information and Quality represent three of 12 *Topics*, with the remaining four actions evenly divided between the *Topics* of Finance, Human Rights, Advocacy, and Collaboration and Integration.

Topic: Financial

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Appropriate financing of prioritised services		Action/p. 4
Separate budget line needed – caution on patient load increase due to current untreated population		Issues/p. 12
Estimates should reflect the need and mental health planning and budget		Strategy/p. 17

The WHO checklist states that policies should indicate how funding will promote equitable services for mental health in relation to physical health and allocate an appropriate percentage of the nation's budget to mental health (WHO, n.d.; WHO, 2005b). The SMHP is weak in this area. There is one line in the 'Key Areas for Action' *Section* of the policy that states the intent of "ensuring appropriate financing of prioritized services" (SMOH, 2006, p. 4). Within the list of 'Policy Issues', there is reference to requiring a separate budget line, but at the same time, the policy cautions that patient loads will increase should the treatment gap be addressed. The 'Strategy' *Section* of the policy states that financial estimates must meet the need, planning and

budget, however, as referenced above, obtaining data to provide estimates based on prevalence is challenging when there is no information system, nor the funds to put one in place. Overall, the few financial references within the policy are vague or cautionary, suggesting a challenge ahead for the nation to fund future programmes or services.

Topic: Human Rights

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Right to access care and information for all		Values/p. 4
Community recognition of rights and dignity for family		Values/p. 4
Promote human rights		Goals/p. 4
Legislation and human rights		Action/p. 4
Attorney General to revise Mental Health Act consistent with policy		Issues/p. 12
Mental Health Act to be updated and align with policy		Strategy/p. 17

Related to human rights, the WHO checklist suggests action areas that promote legislation and human rights within the policy and set up a review body to monitor it (WHO, n.d.). The WHO guidelines accentuate the fact that a mental health policy "can promote or violate human rights, depending on the way in which it is formulated or implemented" (WHO, 2005b, p. 32). They suggest that laws, accompanied by evidence-based service guidelines, are needed to ensure barriers to proper care are overcome. This stresses the importance of documenting human rights succinctly within policy and legislation.

Unfortunately, while the SMHP does address both rights and legislation, it appears to fall short on this topic when compared to other areas in the policy. The 'Values and Principles' *Section* of the policy references rights in several different contexts; the right to access care, the right to quality information, and in terms of the community, recognising and respecting the rights and dignity of people with mental illness. These touch on, but do not explicitly address the existing stigma and discrimination within the community and health services that impede treatment, compromise dignity, and produce stress, as noted in the 'Situational Analysis'.

Human rights are listed as one of the seven 'Goals and Objectives' of the policy, and rights and legislation are included as one of the 12 'Key Areas for Action' bullet points. The 'Policy Issue' references this area only in terms of the Attorney General revising the legislation to be consistent with the mental health policy. The only other reference in the policy to human rights or legislation is in the 'Strategies' *Section*, which reiterates the need of the MOH and Attorney General to maintain a consistent legislative and policy approach. Specific to legislation, the policy 'Strategies' do not include many of the components suggested in the WHO guidelines such as rights to informed consent, housing, employment, criminal justice, promotion and prevention (WHO, 2005b, p. 48). Given the acknowledged tension between human rights, mental health, and Pacific cultural values, the policy missed an opportunity to provide a contextualised human rights foundation that would support the implementation of future plans and programmes.

Topic: Organisation and Service Management

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Strengthen community-based programmes		Goals/p. 4
Evidence-based and cost-effective treatment		Goals/p. 4
Integrate into general health		Goals/p. 4
Organise services		Action/p. 4
Human resources and training		Action/p. 4
Facilitate and support affected families		Action/p. 4
Focus areas of promotion, prevention, treatment and rehabilitation (specified)		Action/p. 4
Essential drug procurement and laboratory support		Action/p. 4
Expand specialist services – adequately trained, multi-disciplinary skilled workforce needed		Issues/p. 13
Need for acute psychiatric beds, both secure and open, but retaining care oversight with community Mental Health Unit		Issues/p. 13
Develop workforce plan		Issues/p. 14
Develop substance abuse treatment services		Issues/p. 14
Infrastructure development – facilities, transport, and communication systems		Issues/p. 14
Expand specialist services, training, and focus on *aiga*	*	Strategy/p. 17
Develop community support groups (i.e. suicide survivors)		Strategy/p. 18

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Encourage community and religious groups in urban areas to provide housing and rehabilitation services	*	Strategy/p. 18
Develop task force to progress workforce strategies		Strategy/p. 18
Develop substance abuse treatment service		Strategy/p. 18
Infrastructure development – accommodation, communication and transport		Strategy/p. 19
Reliable supply of psychotropic drugs		Strategy/p. 19
Rehabilitation at core of managing disorders, including cultural Therapy	*	Strategy/p. 19

According to the WHO checklist, there are several different Organisation and Service Management aspects that should be included in a mental health policy. These include developing dedicated mental health positions, integrating mental health into general health, and promoting community health and deinstitutionalization (WHO, n.d.). The checklist also suggests that working conditions, recruitment, retention, and training for human resources should be comprehensively addressed. From a service delivery perspective, interventions such as promotion, prevention and rehabilitation should be included in the policy, and they should consider the needs of all people, regardless of age and disorder severity. Given the undeveloped nature and constraints impacting mental health services on the island as seen in the country analysis in this report's Chapters 1 and 3, along with the policy 'Situational Analysis', it is logical that this area be heavily addressed in the SMHP.

Within the SMHP, three of the seven 'Goals and Objectives' address this *Topic*, related to community-based programmes, integrating mental health into general health, and providing services for "all people who need mental health care" (SMOH, 2006, p. 4). There are several strategies to promote community-based health care within the policy. One strategy includes structuring the provision of care with specialist nurses as the main point of contact, with a focus on the *aiga* as the setting for assessment and management. The policy also suggests the creation of support groups as an informal mental health service, as well as encouraging organisations such as schools and workplaces to provide counselling services in the community. The increased need for community-based accommodation and rehabilitation in urban areas was highlighted, suggesting that community and religious groups should be encouraged to continue those services. This

demonstrates not just adherence to retaining care within the community instead of institutionalisation as suggested in the WHO guidelines, but also a dependency on community structures to provide the care.

There was no relationship in the SMHP between high levels of community support and any financial incentives or assistance to do so. This may be reflective of the Samoan collective culture that assumes this responsibility with little or no State support, or a neoliberal attempt by a globally driven initiative to shift responsibility away from the State back to the individual or community. Research suggests that 'despite decades of indigenous mental health innovations in Samoa", formal policy development was triggered by "neoliberal institutional reforms" that were happy to formally adopt the predominantly *aiga*, community-based care model that Enoka had evolved (Fadgen, 2013, p. 233).

Another area of concern for Organisation and Service Management is the constraints affecting mental health service delivery in the PICs associated with staff training and retention, as referenced in Chapter 3. In the WHO policy guidelines, they stress that health care systems depend on staff who have the right knowledge and skills to meet the needs of the population, and that social and cultural factors must be taken into account when articulating strategies (WHO, 2005b). In the SMHP, human resources and training are one of the 'Key Areas for Action', and the concerns around workforce needs are detailed in the 'Issues' *Section* of the policy. The 'Issues' include the inability to retain trained psychiatrists and the need to train nurse specialists so they can become the 'cornerstone' of national mental health services. In terms of strategy, the policy states that a task force will be set up to develop a workforce plan to treat the types of mental disorders that are seen in Samoa. There is no specific mention of working conditions or retention of health providers; however, this issue may be inferred under the workforce development caveat to "ensure that these needs are met well into the future" (SMOH, 2006, p. 18).

In terms of service delivery, the policy lists six Areas of Focus for Promotion, Prevention, Treatment and Rehabilitation within its 'Key Areas for Action' *Section*. To demonstrate the level of commitment to each of the focus areas, Table 8 below lists the

area, followed by the policy *Section* where the area is represented, and the number of times that area is addressed within the section in parentheses.

#	Focus Area	Policy *Section*
1	Suicide prevention	Situational Analysis (2) Policy Issues (1) Strategy (2)
2	Drug and alcohol abuse	Situational Analysis (4) Policy Issues (3) Strategy (2)
3	Sexual abuse: child and adolescent abuse	Situational Analysis (1) Strategy (1)
4	Early recognition and management of mental disorders	Situational Analysis (2) Policy Issues (1)
5	Domestic violence	Situational Analysis (1) Strategy (1)
6	Dignity of the family	Situational Analysis (1)

Table 8: Focus Areas for Promotion, Prevention, Treatment and Rehabilitation
(SMOH, 2006, p. 4)

As seen above, drug and alcohol abuse is a highly targeted area, with nine references within the policy. Besides the 'Situational Analysis', it is recognised in the 'Issues' *Section* as significant problem and included in the 'Strategy' *Section* related to training and primary treatment services, especially in the prisons. Suicide prevention is another area of high concern. It is referenced in the 'Situational Analysis', stating that there is no suicide prevention programme and no follow up after an initial assessment in hospital after an event. The analysis also suggests that controls around the use of paraquat, an herbicide used to self-harm or to commit suicide, are often ignored. Research in 2006 related to Samoan suicide prevention and social capital speaks to this issue, indicating that paraquat abuse has been an ongoing issue in Samoa for a number of years (Stewart-Withers and O'Brien, 2006, p. 217).

From a strategy perspective, the SMHP suggests development of support groups for survivors and the promotion and prevention of suicide through "mental health awareness campaigns to reduce stigma, integrating mental health issues into the school curricula and developing suicide prevention strategies" (SMOH, 2006, p. 19). There are also a couple of passive strategies suggesting that a review of the current paraquat legislation would be 'useful' and that the MOH will encourage policing the substance at a local level.

Of the other focus areas, the only two that have strategies within the policy are sexual abuse and domestic violence. Dignity for the families is only referenced within the 'Situational Analysis'; its omission in the 'Strategy' *Section* corroborates the absence of a clearly defined human rights commitment within the policy.

The policy also addresses areas not explicitly referenced in the WHO checklist, but suggested for consideration in the policy guidelines. This includes acknowledging the need for drug procurement and laboratory support, the inclusion of psychotropic drugs and infrastructure development, the demand for acute psychiatric beds, and other infrastructure needs including vehicles, communication systems and adequate accommodation. Recognition of these concerns within the policy highlight areas that require attention to enable staff to deliver services, positioning them for inclusion in subsequent plans and programmes following the policy implementation.

Topic: Advocacy

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Build capacity for leadership and advocacy		Action/p. 4
Mental Health Prevention - decrease through collaborative approaches (including traditional)	*	Issues/p. 14
Education and advocacy programmes for all sectors of society with equal emphasis on traditional, religious and western perspectives	*	Issues/p. 15
People with mental illness should be key advocates		Issues/p. 16
Develop anti-discrimination/stigma policies for all sectors		Issues/p. 16
People with mental illness should not be penalised or incarcerated		Issues/p. 16

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Mental health awareness campaigns to reduce stigma, suicide and targeting at risk groups		Strategy/p. 19
Recognition of advocacy and collaboration with other ministries and groups • **Village councils and women's committees** • **Ministry of Women, Community and Social Development** • **Ministry of Education, Sports and Culture**		Strategy/p. 20

The WHO checklist states that policies should address advocacy by supporting consumers and family organisations, raising the awareness of mental health issues and effective treatments, and provisioning for people with mental illness (WHO, n.d.). In the WHO policy guidelines, they suggest that MOHs can advocate for people with mental illness directly by influencing human rights, indirectly through supporting NGOs, families and those dealing with mental illness, or through public media and advocacy activities (WHO, 2005b). In the SMHP, there is one 'Area of Action' to build capacity for leadership and advocacy, followed by two strategies related to advocacy through collaboration with village councils, women's committees, and the Ministries of Women, Community and Social Development and Education, Sports and Culture. This collaborative approach toward advocacy is important as it recognises the complexity of the issues faced by people and families dealing with mental illness, acknowledging that mental illness is not just a health issue; it requires support from various agencies and organisations at a local and national level.

Under the subheading of 'Advocacy' within the 'Policy Issues' *Section*, it states that people with mental illness should be afforded equal opportunities in education, employment, treatment, care, and medication, and that they should not be penalised as criminals based on their illness. It also specifies "affirmative and anti-discrimination/stigma policies need to be developed for all formal sectors" (SMOH, 2006, p. 16). While this recognition is important, in the 'Strategy' *Section* of the policy there is only brief mention of these concerns; promoting mental health awareness campaigns related to stigma and adding mental health and suicide prevention strategies into the school curricula. Failure to include strategies related to education, employment,

treatment, care, medication, or penalising the mentally ill from both an advocacy and human rights perspective is an omission of concern.

Topic: Information, Research and Quality

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Quality improvement		Action/p. 4
Improve information systems to inform care		Action/p. 4
Strengthen research, monitoring and evaluation		Action/p. 4
Need research for prevalence, drugs, cultural interpretations of behaviour, and child medication	*	Issues/p. 15
Require collection and analysis of information for effective health system		Issues/p. 16
Need research for evidence-based treatment and programme decisions		Issues/p. 16
Need suicide audit for targeted prevention		Issues/p. 16
Develop integrated and efficient method to improve patient records and follow up		Strategy/p. 19
Institute regular collection of treatment and prevalence data		Strategy/p. 19
There is limited data for mental health issues, information is anecdotal but consistent with public perception		Constraints/p. 20

The WHO checklist states that policies should incorporate actions aimed at high quality evidence-based interventions and processes that will measure and improve the quality of services delivered, including research and evaluation (WHO, n.d.). As noted in the Process *Topic* evaluation above, information systems are required to guide future policy, planning and service development. The SMHP 'Situational Analysis' notes limited data as a deficit and it is cited as a constraint later in the policy. Within the policy's 12 'Key Areas for Action', Information, Research and Quality are included as three separate bullet points. There is detailed recognition of this *Topic* within the 'Policy Issues' *Section*. It suggests the development of information systems for a suicide audit to target interventions and quantify the scope of Samoa's mental health issues. One of the 'Policy Issues' specifically states that "cultural behaviour 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" (SMOH, 2006, p. 15). Recognition of this cultural concern is important to note,

however, it was only mentioned in relation to research and was not referenced in the 'Strategy' *Section* of the policy.

Failure to adequately promote information systems within the policy, as mentioned previously, perpetuates the circular issue of providing evidenced-based interventions without supporting data. However, given the treatment gap that Samoa was facing at the time, prioritising information systems over services would have been a challenge. The inclusion of these components appear to be more in line with meeting the WHO framework; acknowledging their importance while at the same time, alluding to a lower priority by the lack of concrete strategies within the policy. On a broader scale, mental health was not included in the MDGs at the time the policy was drafted, so unlike today with its inclusion in the SDGs, the need to report on mental health goals and targets was not on the global agenda.

Topic: Collaboration and Integration

POLICY CONTENTS	CULT-URE	SECTION/PAGE
Health nurtured through a multi-sectoral approach		Vision/p. 3
Promote mental health through sectoral and inter-sectoral initiatives		Goals/p. 4
Community and inter-sectoral collaboration		Action/p. 4
Mental Health Prevention - decrease through collaborative Approaches (including traditional)	*	Issues/p. 14
Recognise all perspectives of mental health; religious, traditional and western through a collaborative strategy	*	Issues/p. 15
Improve liaison between Mental Health Unit, community nurses, police, and GPs		Strategy/p. 18
Continue accommodation and rehabilitation services through community and religious groups	*	Strategy/p. 18
Encourage community, government and NGO organizations, schools, emergency services, and workplaces to provide counselling services		Strategy/p. 18
MOH to work with Ministry of Women, Community and Social Development on paraquat policies		Strategy/p. 20
MOH to work with Ministry of Education, Sports and Culture on educational programmes related to mental health and		Strategy/p. 20

POLICY CONTENTS	CULT-URE	SECTION/PAGE
domestic violence		
MOH to work collaboratively with stakeholders (various ministries, NGOs and community groups and Attorney General)		Roles/p. 21
Mental Health Unit to work with *aiga* and community for culturally sensitive ways to manage mental health	*	Roles/p. 21

The WHO checklist speaks to Collaboration and Integration from several different perspectives; intrasectoral, intersectoral, and through existing policies and laws (WHO, n.d.). The type of collaboration, as well as the WHO suggested collaborating party, policy, or law is represented in Table 9 below. It is followed by a checkmark to indicate if the SMHP includes content within the 'Area of Action' or 'Strategy' *Sections*, and if a role has been defined for that collaboration item.

Type	Party/Policy/Law	Inclusion	Role
Intrasectoral	Planning		
	Pharmaceutical	✓	
	Human resource development	✓	
	Child health		
	HIV/AIDs		
	Epidemiology and surveillance		
	Epidemic and disaster preparedness		
Intersectoral	Relevant government departments	✓	✓
	NGOs	✓	✓
	Consumer and family groups	✓	✓
Policy/Law	Mental health law	✓	✓
	General health law		
	Patient's rights charter		
	Disability law		
	Health policy	✓	
	Social welfare policy		
	Poverty reduction policy		

Type	Party/Policy/Law	Inclusion	Role
	Development policy		

Table 9: Collaboration Policy Inclusion and Roles

(WHO, n.d., p. 6)

This illustrates that while there is some collaboration included in the policy, less than one half of the areas suggested by the WHO are there, and those that are present do not always include a defined role[6]. It is important to note that this may be by omission, or due to the fact that some of these agencies or divisions were not separately defined within the Samoan government structure at that time. For example, there is no link in the policy between mental health and disability law since Samoa had not signed the CRDP and according to the SPC analysis noted in Chapter 3, had no laws related to disability and discrimination in 2006. While the SMHP connects mental health and poverty in the 'Situational Analysis', acknowledging that economic insecurity can be "both a risk factor and consequence of mental disorders" (SMOH, 2006, p. 11), there are no strategies related to economic or development collaboration and its relationship to mental health.

It is important to give credit to the SMHP for recognising some of the main issues related to mental illness that are addressed in the 'Promotion and Prevention' subsection of the 'Strategy' *Section*. This includes integration of mental health into the school curricula and information programmes with village councils and women's committees. The policy also contains a suggestion to create strategies aimed at addressing sexual and physical abuse, as well as locally policing paraquat through collaboration with the Ministry of Women, Community and Social Development. Another 'Strategy' plans to 'encourage' the Ministry of Education, Sports and Culture to implement programmes related to mental health, domestic violence, and sensitivity to mental health disorders. These relationships are included in the 'Roles and Responsibilities' *Section* of the policy, with additional inclusions of the Ministry of Justice and Court Administration, the Office of the Attorney General, and the Ministry of Policy, Prisons and Fire Services. This reflects Samoa's intent to work collaboratively with various national

[6] *Seven of 18 are included in the policy and only four of those have a role identified.*

ministries and other local agencies to deal with the complex issues that impact mental health.

Discussion About the Analysis and Evaluation

As seen by the analysis and evaluation of the SMHP above, there are many areas of the policy that encapsulate the suggested WHO policy guidelines and checklist contents. Each summarised *Topic* was addressed within the policy, but at different levels of detail and within different representative *Sections* of the policy. It is possible to quantitatively represent the relationship between the WHO summarised *Topics* and their inclusion in the SMHP. To do this, each policy content item represented in the analysis in Appendix 2 was counted.

By example, using the analysis completed for the 'Process' *Topic*, there were two content areas in the 'Introduction' *Section*, one in the 'Statement' *Section*, and eight main content areas present in the 'Situational Analysis' *Section* of the policy. Together, these total to 11 components within the Process *Topic,* within three different *Section* areas. This same methodology was completed for each of the policy contents as they related to their aligned *Topic* and *Section*. The occurrence of culture within the policy was also counted within each *Topic* and *Section*. The numeric representation of this exercise can be found in Appendix 3, and is further described below.

Topics by Policy Section

There is a different level of intent for a given *Topic* component based on where it is referenced within the policy. For example, including suicide and self-harm within the 'Situational Analysis' or 'Policy Issues' acknowledges the concern, but putting language into the 'Areas of Action' or 'Strategy' *Sections* displays a commitment to address the concern beyond the current policy development process. A visual depiction of the relationship between the *Topics* and the *Sections* from the data compiled in Appendix 3 is represented in Figure 9 below.

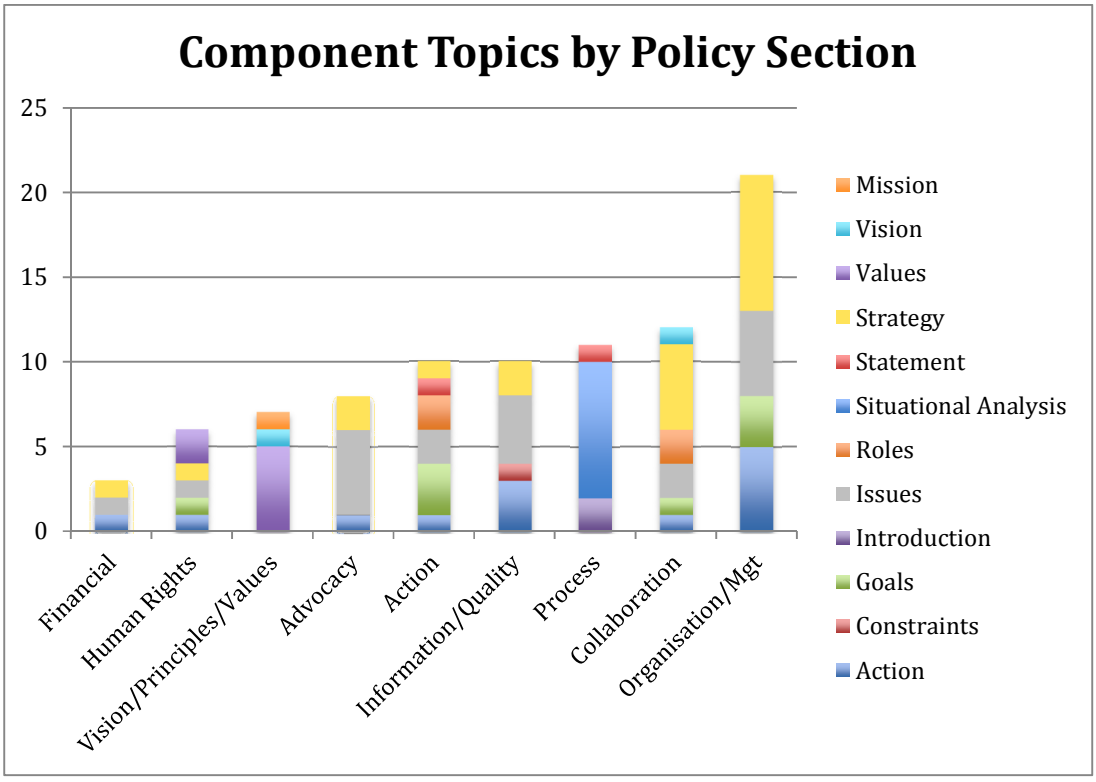


Figure 9: *Topics* by Policy *Section*

By charting the *Topics* by their policy *Section* as shown above, it becomes evident that the 'Policy Issues' (grey) *Section* represents a substantial portion of the various *Topics*, especially for Advocacy, Information and Quality, and Organisation and Management, indicating what the policy needed to address. Correspondingly, the Organisation and Management *Topic* had the largest number of contents within the 'Strategy' (yellow) *Section* of the policy. This would align with what was likely perceived as the greatest need at the time the policy was developed. This also demonstrates the high level of attention in the policy toward Collaboration and Integration, which was also well represented within the 'Strategy' *Section* of the policy.

It can also be seen that the 'Action' (bottom-most dark blue) *Section* of the policy was reflected within all the *Topics*, with the logical exception of the Process and Vision, Principles and Values components. This is a positive illustration, indicating that each component has an intention for future planning or programme development. This chart also highlights the two areas with the least recognition within the policy, Financial and Human Rights. This would also be consistent with the literature reviewed concerning

the contentious nature of human rights in the Pacific and the challenges of aligning rights-based language to local culture.

Culture within Component Topics

The reference of each culturally significant policy component calculated in Appendix 3 can be seen visually in Figure 10 below.

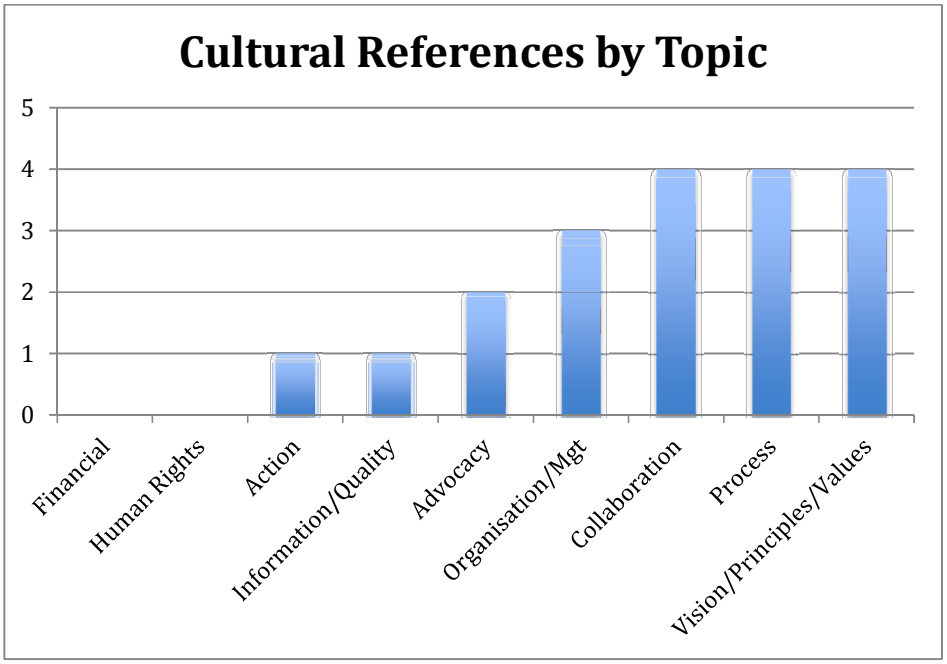


Figure 10: Cultural References by *Topic*

It is clear from this figure, that culture was referenced the most within the Process, Collaboration, and Vision, Principles and Values *Topics* of the policy. All three of the SMHP *Sections* that made up the Vision, Principles and Values *Topic* contained cultural aspects. The 'Mission Statement' positioned the policy to include mental health services that are culturally sensitive and holistic while the 'Values and Principles' *Section* of the policy referenced the *aiga*, specifically stating:

> 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 (SMOH, 2006, p. 3).

Inclusion of the Samoan perception of mental health and the family's role in providing a health care setting is a valuable inclusion within the policy. It frames the use of the *aiga* throughout the rest of the policy, providing context to what is seen within Samoa as a valuable asset and strength for those needing mental health care within the nation. Within the Collaboration and Integration *Topic*, there are also several references to Samoan culture within the policy, including representation in the 'Strategy' and 'Roles' *Sections*. This recognises, as suggested in Chapter 3, that one of the main strengths Samoa has to offer in mental health service delivery is its strong and *aiga* grounded values.

However, looking at Figure 10 above, there is an obvious omission of any direct cultural reference within the Human Rights *Topic,* even though the policy itself has six references to rights. Given the culturally influenced situation of stigma and discrimination, and its impact toward compromising the dignity of the mentally ill and their families, the policy could have been stronger in this area; cementing a national commitment to improve the relationship between rights, as defined within a Samoan context, and those dealing with mental disorders.

Conclusion

The SMHP is a detailed document that touches on all the summarised *Topics* outlined by the WHO checklist. The level of detail and inclusion of all the suggested policy *Topics* indicates a commitment to follow the WHO framework. It may also be reflective of the work done by the WHO to assist Samoa in developing this policy, as suggested in news articles from both the New Zealand Herald and the Samoa Observer (Tone, 2007; Samoa Observer, 2006). The policy has a detailed 'Situational Analysis', and while not based on substantiated data, it attempted to acknowledge the known issues impacting the delivery of mental health services in Samoa. The policy also contains a clear vision and is supported by principles and values that are specific to Samoa and their cultural

viewpoints. There are also clear actions represented within the policy, showing intent to implement certain policy contents.

At the same time, there are two main areas that could be strengthened within the policy; financial and human rights. The financial components found in the policy are ambiguous. Even though a policy is meant to be evidenced-based, a more specific commitment to equitable funding could have been present while recognising the lack of available data at the time the policy was drafted. The human rights components mainly referenced the Mental Health Act, which was completed the following year. The policy recognised the need for rights and dignity, but had no clear strategy on how that could be achieved. This national document was the prime opportunity to clearly align the Samoan culture perspective of human rights into a strategy, but it failed to do so. This may be because of the WHO influence during the policy drafting, or an omission due to the conflicts between Western and Samoan concepts of human rights.

Overall, the SMHP is a strong, well-constructed document that aligns with the WHO guidelines and checklist. It would be a valuable reference for other PICs in developing or updating their mental health policies; giving them an opportunity to improve on areas where clearer strategies could have been included, leveraging those areas that were well represented, and weaving local cultural considerations into the WHO global initiative framework.

CHAPTER 5: Niue Discussion and Conclusion

> *Mental health services in Niue are beset with many challenges including a lack of health professionals with specialist skills in mental health. There is no mental health policy and only outdated and unworkable legislation.*
>
> (Nosa et al, 2013, p. 3)

The quote above from Niue's most recent country profile recognises the challenges Niue faces in their mental health delivery and emphasises the concerns of lacking a national mental health policy and current legislation. Following the analysis and evaluation of the Samoan policy, this chapter will discuss the applicability of leveraging the Samoan policy in Niue to assist them in developing their own policy in an effective, positive, and culturally sensitive manner, answering the second research question of this report. The research is then concluded by summarising the key findings, exploring the implications of policy transfer and SSC, and providing suggestions for further research.

Application of Samoa's Policy Work to Niue's Policy Development

As previously noted, national mental health policy development is a complex process that requires time, political support, and extensive stakeholder participation. Utilising mental health policies from other countries is supported as one of the steps within the WHO process and framework (WHO, 2001; WHO, n.d.). The rationale for selecting the Samoan policy included demographic and cultural considerations and Samoa's years of experience since their policy was launched, as detailed in Chapters 1 and 3. Following the predominantly positive evaluation in Chapter 4, it is evident that the SMHP is a worthwhile example to be used in the Niue policy development process.

Understanding the parallels between the mental health situations of both nations further demonstrates how the SMHP can benefit Niue's policy development. Niue's most recent situational analysis was outlined in Chapter 1. The SMHP's situational analysis, while anecdotal, provided a foundation for the policy action areas and highlighted key concerns that the nation acknowledged and planned to overcome. To understand the linkages and contrasts between the countries, the list of Niue's recent mental health concerns have been aligned to the SMHP policy situational analysis in Table 10 below.

A check mark (✓) is used to designate alignment, and when there is not a direct association, a note indicates the variation.

Niue Country Profile 2013	SMHP 2006
Out-dated legislation	✓
Alcohol abuse is not considered a major problem	Noted Issue
Cultural perceptions impact stigma and discrimination	✓
Population and resource decline due to migration	✓
Limited human rights participation	Not referenced
Poverty is non-existent	Some hardship
No mental health budget	✓
No mental health community facilities	Mental Health Unit
No psychiatric beds in hospital	✓
Limited data on mental health prevalence	✓
No mental health trained professionals	Limited
Limited access to psychotropic drugs	✓
Severe cases transferred to New Zealand for treatment	N/A
Reliance on family and community networks for support	✓
Churches - resource for support and education	✓
Traditional healing - important cultural role in care	✓
Aggressive or self-harming individuals contained in prison	✓
No committee to coordinate collaboration	✓
No service user groups or family associations	✓

Table 10: Niue Situation Comparison to the SMHP

(Nosa et al, 2013; SMOH, 2006)

As seen above, Niue's most recent situational analysis aligns with a majority of the concerns noted in Samoa's policy analysis from 2006. There are some areas of difference where Niue has specifically indicated they do not have concerns, such as poverty and alcohol abuse, two areas deemed problematic in the Samoan policy. There is no reference in the Niue current country profile related to suicide, which is often cited in the Samoan policy. This difference may require more consideration when developing the Niue policy as other sources indicate that while the numbers are small, in proportion

to the population; suicide is a "significant public health issue" for males between the ages of 15 and 59[7] (Sioneholo, Carter, Vaha, Marsh &Tatui, 2012, p. 4). It is also important to acknowledge that unlike Niue, Samoa already had locally staffed services in place with a Mental Health Unit and other mental health trained professionals. Another significant difference is that Niue, unlike Samoa, does not have a reciprocal relationship with New Zealand in terms of citizenship and health care for their people.

Even with the noted differences, this exercise indicates a high degree of similarity between the two nations regardless of the seven-year gap. Based on this and the findings in Chapter 4, Niue could leverage the SMHP work, utilising the applicable and positive aspects of the SMHP while introducing improved contents around the components that could have been strengthened. This would require some caution. For example, the Samoan policy demonstrated a high reliance on the *aiga* that could be problematic in Niue given their high migration levels and small population. They may need to incorporate policy strategies for integrating faith-based and traditional healing services into their mental health model of care, provided they are done safely and without stigma and discrimination. Overall, much could be leveraged and learned from the Samoan policy, putting Niue in a good position to develop an effective policy to meet the needs of their specific population.

Policy Development Strategies for Niue

Given the work that has been done by the WHO and the policy development in other nations, especially in Samoa, Niue is well positioned to leverage existing knowledge and regional guidance to develop their own national policy. This work can take place in many forms and through different processes, two of which are policy transfer and South-to-South Cooperation (SSC). In the previous chapter, the work of Fadgen (2013) was referenced specific to policy transfer in Samoa. However, given the concerns voiced in Chapter 2 related to the Western influences in development, including policy development, the principles of SSC as a means for Niue to leverage the Samoan policy experience is worth considering. Both of these strategies will now be explored in more detail.

[7] *Five deaths between 1997-2011 equating to 61.6 per 100000 (Sioneholo et al., 2014, p. 34).*

Policy Transfer and Lessons Drawing

Dolowitz & Marsh (1996) define policy transfer and lesson drawing as "a process in which knowledge about policies, administrative arrangements, institutions etc. in one time and place is used in development of policies, administrative arrangements and institutions in another time and/or place" (p. 344). They also assert that lesson drawing implies a voluntary choice by policy actors, whereas policy transfer can be either coercive or voluntary in nature. Fadgen (2013), who draws heavily on the work of Dolowitz and Marsh, explains three different ways in which policy transfer can occur, as depicted in Table 11 below.

Policy transfer level	Description
Formal	Prescriptive - professionals acting on behalf of States requiring assistance
Quasi-formal	Aspirational – developed collaboratively using participatory processes
Informal	Normative – professional service practices merged with cultural contexts and beliefs

Table 11: Policy Transfer Levels

(Fadgen, 2013, p. i)

Regarding Fadgen's (2013) definition above for informal policy transfer, it is important to reflect on the implication of merging professional service practices within the Pacific mental health cultural context. In this region, services are often delivered by visiting specialists (Mulder et al., 2016; Nosa et al., 2013) or highly migratory medical officers who are trained or transferred from overseas (Brown & Connell, 2004). These particular professionals, while not always, are more biased toward a medical model of care, bringing Western influences from their backgrounds to the policy development process. As concluded in an investigation of Samoan culturally appropriate mental health services, " it cannot be assumed that developmental theories, therapeutic interventions and mental health service practices that have evolved in cultures with individual concepts of self, will necessarily be relevant for people from collective based cultures" (Tamasese et al., 2005, p. 306).

As referenced in Chapter 4, Fadgen's (2013) research asserted that the Samoan policy was undertaken with a hybridised version of policy transfer where information transfer of cultural practices emerged years before the actual policy transfer was initiated formally by foreign experts. Those Samoan practices, driven by the work of Enoka (2012), may not be applicable to the Niuean context in terms of available mental health trained professionals and resident family members given migration concerns. Niue will need to secure strong advocates with both mental health and local cultural knowledge to influence the policy development process, especially when tackling the more difficult topics of human rights and advocacy.

South-to-South Cooperation (SSC)

Throughout this paper, the term 'Western' has generally referred to developed nations and the ideologies associated within that framework. These same nations can also be referred to globally as the 'North'. These terms, while contested, are comparable as they are more socio-economic and politically based than geographic. SSC refers to a development approach that was endorsed by the UN General Assembly in 1978, urging developing countries work together to transfer knowledge, experience, and resources to strengthen capacity and self-reliance (UN Office for South-South Cooperation, 2017). This approach is considered a joint process that, unlike traditional development assistance, has a lower cost-base, is less structured, and is "explicitly framed in terms of solidarity and operates largely free of an historical legacy of colonialism" (Burges, 2012, p. 227).

In a special report on SSC in health in Latin America and the Caribbean, the authors suggest that the 'Southern consciousness' occurred long before the UN SSC endorsement; stemming from inequalities between the developed nations in the north and developing nations in the south, and the ineffectiveness of traditional international development systems, which are referred to as North-to-South Cooperation (NSC) (Roa & de Santana, 2012). The report contends that traditional aid practices prioritised the donor's needs over those of the recipients, asserting that Northern cooperation intended to "export local products, services, and capital; to secure access to strategic materials; and to obtain political privilege" (p. 369). The report states SSC advantages include the sharing of knowledge and techniques that align more closely between partners, shared

responsibility, reduced conditionality, increased ownership, and inclusion of local cultural identities. At the same time, SSC shares some of the similar pitfalls as NSC, including fragmentation and a lack of coordination and alignment with the recipient's agenda.

Leveraging Samoa's experience and knowledge could reduce the time and cost of policy development for other nations in the region. There would be, however, considerations in terms of how other actors currently involved would participate in the process. This would include New Zealand as a health partner, the WHO as a policy actor, and PIMHNet as a regional collaborator. Triangular cooperation is a model endorsed by the WHO that includes "development partners, countries, and international organizations providing financial or technical support to facilitate development activities between 2 developing countries" (WHO, 2017). Abdenur and Da Fonseca (2013) suggest that triangular cooperation can reduce the costs related to "expensive Northern consultants", but at the same time, warn that this type of cooperation allows the North to maintain their influence by the continued "transference of principles, norms and practices" (p. 1484).

The participation of foreign experts and the WHO in the Samoan policy development process can be seen as a form of NSC. Even though Samoa was able to retain significant cultural recognition through the *aiga* model of care within their policy, as pointed out earlier in this research report, it also reduced the State's burden and aligned with the Western neoliberal edict to shift responsibility back to the individual and their family while failing to address financial support to the *aiga* in fulfilling this obligation. The SMHP development Process *Topic* discussion in Chapter 4 indicated wide stakeholder participation and strong Samoan political endorsement. This suggests that it is possible to have Northern influence and utilise a Western-driven framework and still create a culturally appropriate policy. However, some of the shortcomings noted in the policy could have derived from conflicting notions of culture and human rights between the participating parties.

Given their proximity in the Pacific region, their cultural connections, and their similarities in mental health service delivery needs, collaboration between Niue and Samoa in Niue's policy development seems an ideal SSC endeavour. Samoa's

experience from their policy development, in addition to over a decade of practice in working within their SMHP context would provide Niue with an opportunity to collaborate with a partner from a similar background who understands their challenges and strengths. Forging this relationship could provide new and different opportunities for both nations in terms of mental health resources and training. There is also the potential to create agreements within the region to provide economies of scale in terms of medication or to work together on other health initiatives or in response to natural disasters (Roa & de Santana, 2012). Navigating SSC within the existing mental health regional structures would require consideration of all of these aspects to obtain the best possible outcome for Niue.

Conclusion

The aim of this research report was to evaluate the development of the Samoan mental health policy and its applicability for Niue's future policy work. The first task to achieve this was to answer the question of how the SMHP aligned to the WHO policy guidelines and existing policy literature. This was accomplished by meeting two objectives. The first was to critically analyse the WHO policy framework and guidelines, completed in Chapter 2. This demonstrated that the framework was viable; it considered the multi-faceted approach required to develop a policy, addressed the areas of concern referenced in policy literature, and endorsed the recognition of local capacity and culture. There was also the caveat acknowledging that not all nations identify with the Western interpretations of human rights, stressing the importance of ensuring cultural perceptions of mental health are clearly expressed within the policy to guarantee it meets the needs of the indigenous population.

The second objective was to analyse and evaluate the SMHP based on the WHO framework. After framing Pacific mental health in Chapter 3, this objective was completed in Chapter 4, where it was established that the policy addressed all the elements of the WHO framework. Areas of strength were noted in organisation and management and various forms of collaboration, while the areas of human rights and finance could be improved upon for any nation using the SMHP as an example.

The second question of this report was to determine how the policy work in Samoa could be leveraged by Niue in developing its own mental health policy. This was addressed above by acknowledging the similarities of needs between the nations and reviewing the benefits of utilising the Samoan policy through policy transfer or the potentially more regionally appropriate method of SSC.

In conclusion, this research has demonstrated the importance of mental health in development, the critical need for a national mental health policy to set a nation's direction in this aspect of health, a critical understanding of the WHO policy framework, an analysis and evaluation of the Samoan policy based on that framework, and a discussion of how Niue can leverage this knowledge to develop their own policy. While a mental health policy will not solve all the challenges Niue faces in delivering care to people dealing with mental illness, it is my hope that this research highlights both the importance of a national policy and the benefits of utilising the work already done by Samoa; allowing Niue to create a policy through collaboration with its experienced neighbour in order to meet the needs of its own population.

Further Questions

There are two areas of additional research that would be worthwhile in terms of the overall aim of this project, however, these were not included as an objective within this report as they would require in-field research that goes beyond a 60-credit desk-based research report. The first, as referenced in Chapter 1, would be to investigate the effectiveness of the Samoan mental health policy since its implementation in 2006. This would involve completing a current situation analysis in Samoa and measuring the outcome of the policy's actions and strategies in relation to it. Another area worth further exploration is a more detailed analysis of the cultural similarities and differences between Niue and Samoa, especially in terms of mental health perceptions, social structures and local capacity to support mental health care. Both of these could better inform the Niuean policy development in terms of the work done in Samoa.

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Appendices

Appendix 1: WHO Mental Health Policy Checklist

CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY.

Introduction

Once a policy/draft policy has been drawn up in a country, it is important to conduct an assessment of whether certain processes have been followed that are likely to lead to the success of the policy; and whether various content issues have been addressed and appropriate actions included in the policy. This checklist is intended to assist with this evaluation.

While the checklist is limited in that it does not enable assessment of the quality of the processes or contents of the policy, evaluators are encouraged, when completing the checklist, to consider the adequacy of both the process and content. Particularly where a response is "no" or "to some extent", it is suggested that they provide either an action plan to remedy the situation or a comment (in some instances the comment may, for example, merely be that a particular action is covered in a different policy, or that it is not possible to implement given the current resources available). The different modules in the WHO Mental Health Policy and Service Guidance Package can be consulted for more guidance on how to address relevant sections and for a better understanding of the policy issues mentioned in the checklist.

This checklist may usefully be completed by those who drafted the policy and/or by employees in the government itself. However, it is also important to have independent reviewers. Those involved in drawing up the policy may have personal or political interests or may be "too close" to the policy to see anomalies or provide critical input. Ideally, therefore, an independent multidisciplinary team should be convened to conduct an evaluation. A team is also advantageous as no single person is likely to have all the relevant information required, and debate is crucial for arriving at an optimal policy for the country. Furthermore, when relevant interest groups have been involved in the process of the development of the policy and/or in their evaluation, which leads to changes being made to the policy, it is likely that they will be more effectively implemented. It would be useful to include consumer organizations, family organizations, service providers, professional organizations and NGOs, as well as representatives of other government departments affected by the policy.

Finally, although the checklist should be "scored" in terms of the mental health policy document, it is important to have, or be familiar with, other relevant and related documentation. Often items are not covered in the mental health policy because they are comprehensively covered elsewhere. For example, policies on health information systems or human resources may include mental health and are therefore deliberately not repeated in the mental health policy. This explanation should then be noted in the relevant section.

CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY			
Please use the following rating scale to rate each item: 1 = yes/ to great degree 3 = no/not at all 2 = to some extent 4 = unknown	Rating	If "yes" or "to some extent" please state how. If not, please state reason(s).	Action required (if any)
PROCESS ISSUES			
1a. Was there a high-level mandate to develop the policy (e.g. from the Minister of Health)?			
1b. At what level has the policy been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health).			
2. Is the policy based on relevant data:			
-- From a situation assessment?			
-- From a needs assessment?			
3. Have policies relating to mental health that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?			
4. Has a thorough consultation process taken place with the following groups:			
-- Representatives from the Health Sector, including planning, pharmaceutical , human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions.			
-- Representatives from the Finance Ministry?			
-- Representatives from Social Welfare and Housing Ministries?			
-- Representatives from the criminal justice system?			
-- Consumers, or representatives of consumer groups?			
-- Family members or their representatives?			
-- Other NGOs?			

-- Private sector?			
-- Any other key stakeholder groups? If so, please list them			
5. Has an exchange taken place with other countries concerning their mental health policies and experiences?			
6. Has relevant research been undertaken to inform policy development, (e.g. pilot studies)?			
CONTENT ISSUES			
1. Is there a realistic vision statement?			
2. Are values and associated principles which inform the policy included?			
3. Do these values and associated principles emphasize and/or promote:			
-- Human rights?			
-- Social inclusion?			
-- Community care?			
-- Integration?			
-- Evidence-based practice?			
-- Intersectoral collaboration?			
-- Equity with physical health care?			
4. Have clear objectives been defined?			
5. Are objectives consistent:			
-- With the vision?			
-- With the values and principles?			
6. Are the areas for action clearly described to indicate the main policy directions and what will be achieved?			
7. Are the areas for action written in a way that commits the Government (e.g. do they state "will" instead of "should")?			

8. To what extent do the areas for action comprehensively address **coordination & management?**			
(a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services?			
(b) Does the policy establish or refer to a multisectoral coordinating body to oversee major decisions in mental health?			
9) To what extent do the areas for action comprehensively address **financing?**			
(a) Does the policy indicate how funding will be utilized to promote equitable mental health services?			
(b) Does the policy state that equitable funding between mental health and physical health will be provided?			
(c) If health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it?			
10. To what degree do the areas for action comprehensively address **legislation and/or human rights?**			
(a) Does the policy promote human rights?			
(b) Does the policy promote the development and implementation of human-rights-oriented legislation?			
(c) Is the setting up of a review body envisaged to monitor different aspects of human rights?			
11. To what extent do the areas for action comprehensively address **organization of services?**			
(a) Does the policy promote the integration of mental health services into general health services?			
(b) Does the policy promote a community-oriented mental health approach?			
(c) Does the policy promote deinstitutionalization?			
12. To what extent do the areas for action comprehensively address **promotion, prevention and rehabilitation?** Does the policy make provision for:			
(a) The prevention of mental disorders?			

(b) Interventions that promote mental health?			
(c) Interventions for the rehabilitation of people with mental disorders?			
13. To what extent do the areas for action comprehensively address **advocacy?**			
(a) Is the policy supportive of consumers and family organizations?			
(b) Is there emphasis on raising awareness of mental disorders and their effective treatment?			
(c) Does the policy promote advocacy on behalf of people with mental disorders?			
14. To what extent do the areas for action comprehensively address **quality improvement?** Does the policy			
(a) Make a commitment to providing high quality, evidence- based interventions?			
(b) Include a process to measure and improve the quality of services?			
15. To what extent do the areas for action comprehensively address **information systems?**			
(a) Will mental health information systems be set up to guide decision-making for future policy, planning and service development?			
16. To what extent do the areas for action comprehensively address **human resources and training?**			
(a) Does the policy commit to putting in place suitable working conditions for mental health providers?			
(b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers?			
(c) Are training in core competencies and skills seen as central to human resources development?			
17. To what extent do the areas for action comprehensively address **research and evaluation?**			
(a) Does the policy emphasize the need for research and evaluation of services and of the policy and strategic plan?			

18. To what extent do the areas for action comprehensively address **intrasectoral collaboration** within the health sector? Does the policy::			
(a) Emphasize collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions, within the health sector?			
(b) Contain clear statements of what role each department will play in each area for action?			
19. To what extent do the areas for action comprehensively address **intersectoral collaboration**? Does the policy:			
(a) Emphasize collaboration with all other relevant government departments?			
(b) Emphasize collaboration with all relevant NGOs, including consumer and family groups?			
(c) Contain clear statements of what role each sector will play in each area for action?			
20. Have all of the following groups been considered:			
-- People with severe mental disorders?			
-- Children and adolescents?			
-- Older persons?			
-- People with intellectual disability?			
-- People with substance dependence?			
-- People with common mental disorders?			
-- People affected by trauma?			
21. Given resources available in the country, has a reasonable balance been achieved between the above groups?			
22. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's:			
-- Mental health law?			

-- General health law?			
-- Patients rights charter?			
-- Disability law?			
-- Health policy?			
-- Social welfare policy?			
-- Poverty reduction policy?			
-- Development policy?			
Taking into account the financial and human resources available in the country, comment on the general feasibility for implementation of the policy.			

(WHO, n.d.)

Appendix 2: Samoan Policy Analysis

Summary of WHO checklist associated to Samoa policy contents

TOPIC	SAMOAN POLICY CONTENTS	CULT-URE	SECTION/PAGE
Process	Consider mental health concepts within Samoan context	*	Introduction/p. 3
	Determine needs of the population to establish policy priorities		Introduction/p. 3
	Strong political and organisational commitment consistent with MOH broader policy frameworks		Statement, p. 17
	Situational analysis		Situational Analysis pgs. 5-12
	• Revise antiquated legislation, focus on patient rights		
	• Specialist services through Mental Health Unit		
	• Primary care – *aiga* focus of assessment and management	*	
	• Informal services – NGOs, religious organizations, traditional healers	*	
	• Private sector – few services, no psychiatrists		
	• Areas of concern, based on limited evidence		
	o Suicide prevention - paraquat		
	o Substance abuse		
	o Domestic, sexual and physical abuse		
	o Stigma and discrimination – cultural foundation	*	
	o Limited psychotropic and other drugs		

TOPIC	SAMOAN POLICY CONTENTS	CULT-URE	SECTION/PAGE
	○ No inpatient unit, risk-based use of general ward or police cells • No exposure to mental health budget, within general expenditure • No clear data on demand, prevalence and referrals, estimates only		
Vision, Principles and Values	All people to enjoy mental health grounded in the *aiga* and based on the Samoan concepts of health	*	Vision/p. 3
	Effective services; holistic, responsive, evidence-based, culturally sensitive, affordable, and accessible	*	Mission/p. 3
	Eight values and principles that address 5 key areas		Values/p. 3-4
	• *Aiga* as the appropriate health care setting	*	
	• Respect and rights for persons with mental disorders, the family and the community		
	• Recognition of the holistic approach to mental health	*	
	• The need for evidence-based treatment and therapy		
	• Quality mental health for all people		
Action Orientation	Six goals and objectives spanning multiple areas of policy contents		Goals/p. 4
	Development of mental health board for leadership		Goals/p. 4
	Protect, promote, restore mental well-being of Samoans		Goals/p. 4
	12 key areas for action (counted within specific topics)		Action/p. 4
	Appointment of medical officer as focal point for services		Issues/p. 13

TOPIC	SAMOAN POLICY CONTENTS	CULT-URE	SECTION/PAGE
	Identify stress within vulnerable groups and recognise socio-economic factors		Issues/p. 15
	Strong political and organizational commitment in Samoa		Statement/p. 17
	Establish National Mental Health Advisory Committee to coordinate strategies, policy and planning, and monitor policy implementation		Strategy/p. 17
	Roles and responsibilities established with MOH and key stakeholders (identified various ministries, plus NGOs and Attorney General)		Roles/p. 21
	Mental Health Unit work with *aiga* and community to explore approaches to managing mental health issues	*	Roles/p. 21
Financial	Appropriate financing of prioritised services		Action/p. 4
	Separate budget line needed – caution on patient load increase due to current untreated population		Issues/p. 12
	Estimates should reflect the need and mental health planning and budget		Strategy/p. 17
Human Rights	Right to access care and information for all		Values/p. 4
	Community recognition of rights and dignity for family		Values/p. 4
	Promote human rights		Goals/p. 4
	Legislation and human rights		Action/p. 4
	Attorney General to revise Mental Health Act consistent with policy		Issues/p. 12
	Mental Health Act to be updated and align with policy		Strategy/p. 17
Organisation	Strengthen community-based programmes		Goals/p. 4

TOPIC	SAMOAN POLICY CONTENTS	CULT-URE	SECTION/PAGE
and Service Management	Evidence-based and cost-effective treatment		Goals/p. 4
	Integrate into general health		Goals/p. 4
	Organise services		Action/p. 4
	Human resources and training		Action/p. 4
	Facilitate and support affected families		Action/p. 4
	Focus areas of promotion, prevention, treatment and rehabilitation (specified)		Action/p. 4
	Essential drug procurement and laboratory support		Action/p. 4
	Expand specialist services – adequately trained, multi-disciplinary skilled workforce needed		Issues/p. 13
	Need for acute psychiatric beds, both secure and open, but retaining care oversight with community Mental Health Unit		Issues/p. 13
	Develop workforce plan		Issues/p. 14
	Develop substance abuse treatment services		Issues/p. 14
	Infrastructure development – facilities, transport, and communication systems		Issues/p. 14
	Expand specialist services, training, and focus on *aiga*	*	Strategy/p. 17
	Develop community support groups (i.e. suicide survivors)		Strategy/p. 18
	Encourage community and religious groups in urban areas to provide housing and rehabilitation services	*	Strategy/p. 18
	Develop task force to progress workforce strategies		Strategy/p. 18

TOPIC	SAMOAN POLICY CONTENTS	CULT-URE	SECTION/PAGE
	Develop substance abuse treatment service		Strategy/p. 18
	Infrastructure development – accommodation, communication and transport		Strategy/p. 19
	Reliable supply of psychotropic drugs		Strategy/p. 19
	Rehabilitation at core of managing disorders, including cultural therapy	*	Strategy/p. 19
Advocacy	Build capacity for leadership and advocacy		Action/p. 4
	Mental Health Prevention - decrease through collaborative approaches (including traditional)	*	Issues/p. 14
	Education and advocacy programmes for all sectors of society with equal emphasis on traditional, religious and western perspectives	*	Issues/p. 15
	People with mental illness should be key advocates		Issues/p. 16
	Develop anti-discrimination/stigma policies for all sectors		Issues/p. 16
	People with mental illness should not be penalised or incarcerated		Issues/p. 16
	Mental health awareness campaigns to reduce stigma, suicide and targeting at risk groups		Strategy/p. 19
	Recognition of advocacy and collaboration with other ministries and groups • Village councils and women's committees • Ministry of Women, Community and Social Development • Ministry of Education, Sports and Culture		Strategy/p. 20
Information,	Quality improvement		Action/p. 4

TOPIC	SAMOAN POLICY CONTENTS	CULT-URE	SECTION/PAGE
Research, and Quality	Improve information systems to inform care		Action/p. 4
	Strengthen research, monitoring and evaluation		Action/p. 4
	Need research for prevalence, drugs, cultural interpretations of behaviour, and child medication	*	Issues/p. 15
	Require collection and analysis of information for effective health system		Issues/p. 16
	Need research for evidence-based treatment and programme decisions		Issues/p. 16
	Need suicide audit for targeted prevention		Issues/p. 16
	Develop integrated and efficient method to improve patient records and follow up		Strategy/p. 19
	Institute regular collection of treatment and prevalence data		Strategy/p. 19
	There is limited data for mental health issues, information is anecdotal but consistent with public perception		Constraints/p. 20
Collaboration and Integration	Health nurtured through a multi-sectoral approach		Vision/p. 3
	Promote mental health through sectoral and inter-sectoral initiatives		Goals/p. 4
	Community and inter-sectoral collaboration		Action/p. 4
	Mental Health Prevention - decrease through collaborative approaches (including traditional counselling)	*	Issues/p. 14
	Recognise all perspectives of mental health; religious, traditional and western through a collaborative strategy	*	Issues/p. 15

TOPIC	SAMOAN POLICY CONTENTS	CULT-URE	SECTION/PAGE
	Improve liaison between Mental Health Unit, community nurses, police, and GPs		Strategy/p. 18
	Continue accommodation and rehabilitation services through community and religious groups	*	Strategy/p. 18
	Encourage community, government and NGO organizations, schools, emergency services, and workplaces to provide counselling services		Strategy/p. 18
	MOH to work with Ministry of Women, Community and Social Development on paraquat policies		Strategy/p. 20
	MOH to work with Ministry of Education, Sports and Culture on educational programmes related to mental health and domestic violence		Strategy/p. 20
	MOH to work collaboratively with stakeholders (various ministries, NGOs and community groups and Attorney General)		Roles/p. 21
	Mental Health Unit to work with *aiga* and community for culturally sensitive ways to manage mental health	*	Roles/p. 21

(Derived from SMOH, 2006)

Appendix 3: Policy component counts by *Section* and Culture

Component Topic	Policy Section	# Components	# Culture
Process	Introduction	2	1
Process	Situational Analysis	8	3
Process	Statement	1	
Vision/Principles/Values	Vision	1	1
Vision/Principles/Values	Mission	1	1
Vision/Principles/Values	Values	5	2
Action	Goals	3	
Action	Action	1	
Action	Issues	2	
Action	Statement	1	
Action	Strategy	1	
Action	Roles	2	1
Financial	Action	1	
Financial	Issues	1	
Financial	Strategy	1	
Human Rights	Values	2	
Human Rights	Goals	1	
Human Rights	Action	1	
Human Rights	Issues	1	
Human Rights	Strategy	1	
Organisation/Mgt	Goals	3	
Organisation/Mgt	Action	5	
Organisation/Mgt	Issues	5	
Organisation/Mgt	Strategy	8	3
Advocacy	Action	1	
Advocacy	Issues	5	2
Advocacy	Strategy	2	
Information/Quality	Action	3	
Information/Quality	Issues	4	1
Information/Quality	Strategy	2	
Information/Quality	Constraints	1	
Collaboration	Vision	1	
Collaboration	Goals	1	
Collaboration	Action	1	
Collaboration	Issues	2	2
Collaboration	Strategy	5	1
Collaboration	Roles	2	1
Total		**88**	**19**