

Leveraging the Samoan Mental Health Policy for Policy Development in Niue

Abstract

Mental health is a prevalent, but often ignored area of health. Mental illness can significantly impact the mentally unwell, their families, and the wider community, yet access to proper care can be hindered by availability, ignorance, discrimination, and stigma, and result in human rights violations. This is especially true in developing countries where services may be inadequate or non-existent. Mental health policies can alleviate this situation by improving and prioritising mental health services at a national level. Based on Samoa and Niue's similarities in terms of their mental health context and the positive analysis and evaluation of the 2006 Samoan policy, this paper concludes that the work done in Samoa is a viable choice for Niue to leverage in their future policy work. 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 neighbour Samoa.

Key words

Mental health, mental health policy, South-to-South Cooperation, Samoa, Niue, culture, human rights

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Introduction

While some contend that ‘there is no health without mental health’ (Patel 2014), this area within the wider health agenda is often overlooked and undervalued at a global level. The World Health Organisation (WHO), who have been strong advocates in increasing the visibility and priority of preventing and treating mental illness, launched their Mental Health Policy Project in 2001 (WHO 2001). The intent of this project was to emphasise the importance of developing national mental health policies and to support countries in those endeavours. Following the WHO Policy Project launch, a detailed situational analysis in the Western Pacific region revealed that, while physical health improvements had occurred over the proceeding years, the mental health situation had worsened (Hughes et al. 2005). The analysis suggested that to reduce the mental health burden and improve services, mental health policy, planning and funding were required. As of today, well over a decade later, the Pacific Island nation of Niue has yet to establish its own policy. In contrast, the neighbouring island of Samoa launched its policy in 2006 (Samoan Ministry of Health (SMOH) 2006). This paper argues that Samoa could collaborate with Niue to progress Niue’s policy development under the umbrella of South-to-South cooperation.

Mental Health in the Global Development Context

In their lifetime, it is likely everyone has encountered at least one person affected by mental illness (Kessler et al. 2009). Mental illness affects people of all ages and includes a wide range of conditions such as depression, anxiety, psychosis, and substance abuse. The impact on those experiencing the illness, their families, and the wider community can be significant. 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’¹, hereby linking physical and mental health together as a basic human right (UN General Assembly 1966:4). There is also strong evidence supporting the bidirectional relationship between physical and mental health (Kolappa et al. 2013). Yet, in terms of care, support and human rights, the international situation for people with mental disorders², in both developing and developed countries has been described as ‘dire’ (Minas and Cohen 2007:1) and labelled 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 (Gureje and Alem 2000, Jenkins 2003, Patel 2008, Tomlinson and Lund 2012). Chambers (2010) states that besides prejudice and discrimination toward people suffering from mental illness, mental disorders are less ‘marketable’ than other diseases. He believes that in developing countries, aid focuses on communicable diseases or conditions that generate public empathy through their visible symptoms or photographic images. Where funding and research are involved, it is typically clinically and scientifically based, failing to focus attention on evolving mental health systems that are effective, appropriate, and affordable (Minas and Cohen 2007:1). This is even in the face of research that

¹ *This paper 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.*

² *The terms mental illness and mental disorders are used interchangeably in this paper. The difference between the two terms is controversial and diagnostically influenced and is not the focus of this work.*

quantitatively demonstrates that ignoring the problem costs more than funding care and treatment (Chisholm et al. 2016).

Within this seemingly dismal international picture, some steps have been taken towards bringing mental health issues into the global health agenda. Mental health and substance abuse, after exclusion in the Millennium Development Goals (MDG), are now recognised in the Sustainable Development Goals (SDGs); internationally adopted in September 2015 (WHO 2016a). Another major initiative that has been helping to raise the profile of mental wellbeing for many years has been the WHO's focus on national mental health policy (WHO 2001).

Importance of Mental Health Policy

A national mental health policy is required to explicitly state the actions and procedures to be taken for improving mental health services across the spectrum of finance, legislation, advocacy, information systems, human rights, research, resource training and service delivery (Omar et al. 2010, WHO 2001). Drawing on a review of mental health policy challenges by Jenkins et al., the authors state that international development funding methodologies have a fundamental impact on global policy initiatives (Jenkins et al. 2011). They explain that 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 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 and Fourie 2016). For developing countries without a national policy, the challenge is even greater as mental health issues are a burden to the society as a whole and can negatively influence other development initiatives and contribute to poverty (Jenkins 2003).

There is global concern, especially for 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 and Cohen 2007:1). Mental health policies can address the tenuous relationship between mental health interventions and human rights, ensuring that compulsory treatment or detention is carried out in a humane and dignified manner.

In 2001, a WHO study determined that (WHO 2001:8)

- Five of the top ten causes of disability worldwide were related to mental disorders.
- While treatment options are available, only a small minority of those requiring interventions actually receive them.
- 40% of countries do not have a mental health policy.

In response, the WHO launched their Mental Health Policy Project to assist policy-makers in drafting and evaluating the adequacy of national mental health policies (WHO 2001). This project is framed by a package of 13 interrelated modules that include specific topic components such as Financing, Advocacy and Legislation and Human Rights, all publicly available on WHO's website (WHO 2016b).

WHO Policy Framework: Critical Considerations

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 2005a: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. Understanding the WHO guidelines in the context of participatory development approaches, local cultural considerations, and human rights perspectives is an important step in determining its use as a framework for effective mental health policy development.

Participatory Approaches

Creating a national mental health policy is a complex and lengthy task if it is to be done accurately, collaboratively, and to provide effective guidance for future planning and programme development. The WHO guidelines provide a comprehensive list of key stakeholders to include (WHO 2005a:24). A case study of the Uganda national mental health policy supports this, concluding that policy development is an iterative process mandating a wide range of stakeholder participation before a final draft can be accepted (Ssebunnya et al. 2012). In another study of four African countries, the ideal process was identified as a bottom-up approach that begins with a situational analysis, results in recognised problems, and outlines strategies to address them (Omar et al. 2010).

Jenkins, an author of several articles on mental health policy, stresses that key stakeholders are essential to ensure shared ownership of the policy, aid in understanding the current situation, develop goals and strategic plans, and to assist with monitoring outcomes (Jenkins 2003:14). The challenge to this is recognising and acknowledging varied opinions. WHO suggests that an 'active compromise' is required (WHO 2005a:23), and that the Ministry of Health can act as the negotiator. This can present additional challenges if the same government officials stigmatise or harbour harmful beliefs concerning the mentally ill (Gureje and Alem 2000, Jenkins 2003). 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.

Local Cultural Considerations

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 2005a). The WHO suggests 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 2005a: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. At the same time, their advocacy module has no reference to culture and thus fails to address some of the barriers to adequate mental health care and the reduction of stigma and discrimination (WHO 2003).

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. It is also essential to understand how cultural attributes can be leveraged in creating a sustainable mental health service, while at the same time, ensuring that they are not revered if they are harmful or result in exclusion or stigma for those suffering with mental illness. McKenzie et al. 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: 1138). The authors emphasise 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, suggesting that national mental health policies should ensure funds are channelled into supporting and empowering these alternate agents in the positive work that they perform.

Human Rights Perspectives

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 inhumane treatment and discrimination. (WHO 2003: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 (WHO 2003). 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. WHO refers national mental health policy makers to the existing international conventions, principles and standards, to be used as guidance for ‘good practice’ (WHO 2003:3). While there are several that apply, the three central to people with mental illness 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).

These international documents, meant to protect the rights of people, 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 adoption, most African, Asian and Pacific nations were still dominated by Western colonial powers (Ménard 2016). It is also believed that Western perspectives on human rights emphasises the individual, failing to consider cultures that are communally centred (Greenhill and 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 (Ménard 2016). Some contend the CRPD contradicts the MI Principles as it relates to involuntary treatment and detention (Szmukler et al. 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). Another concern with the CRPD is that it only applies to people with a mental illness that qualifies as a disability. The

language used to define disability within the CRPD is sufficiently ambiguous, requiring individual nations to define it domestically (Szmukler et al. 2014). This makes the application of the CRPD subjective, and its interpretation could impact those needing protection under its articles.

These concerns are at an international level. Understanding the Pacific context of mental health, specifically in Niue and Samoa, is paramount to determining how Niue can best progress their national policy work considering both the WHO framework and potential collaboration with Samoa.

Pacific Mental Health – Focus on Niue and Samoa

At the time of the Western Pacific region situational analysis in 2005, only four of the 19 countries reviewed confirmed they had an existing mental health policy (Hughes et al. 2005). Since that time, there has been limited progress for those nations, and of those that are both culturally and geographically close to Niue (further detailed below), only Samoa (SMOH 2006) and the Cook Islands (Cook Islands MOH 2015) have an active mental health policy. With Samoa's 9 years of additional policy experience, and Niue's stated preference to collaborate with them on health concerns (Hughes et al. 2005), Samoa is the most logical choice to investigate for leveraging policy work in Niue.

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 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 and Trade (NZ MFAT) 2016a). The people of Niue are New Zealand citizens, with New Zealand maintaining responsibility for development in Niue (Sheehan et al. 2010). It is important to note that Niue 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).

Within a mental health perspective, there is both a need for care and a lack of resources on Niue. While one mental health screening of residents over ten years old indicated a 'substantial' number of people in need of assistance (Nosa et al. 2013:4), an earlier study specified that neuropsychiatric disorders constitute 16.8% of Niue's global burden of disease (WHO 2011:1). The most recent situational analysis of Niue indicates there is 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).

A 2013 situational analysis details the nation's mental health capabilities and strategies (Nosa et al. 2013). It suggests that 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 or Christian-based religious rituals are considered appropriate as they address the cause, not just the symptom. Due to the absence of national services, families and the community are heavily involved in providing care, even in situations of severe mental health disorders. The church is seen as a resource for providing families with education, counselling, and spiritual support without fear or stigmatisation. Families or the police 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 hospital is unable to accept a mentally ill patient, the individual may be flown to New Zealand for treatment or retained in a prison cell until they are stable. 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 (Nosa et al. 2013).

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 2014:73), yet unlike Niue, the number of Samoans in New Zealand remains less than that of the islands themselves (Statistics New Zealand 2016).

Mental health services and concepts in Samoa have similarities and differences to Niue. While there is no recent mental health situational analysis, a 2005 study indicated that as a whole, mental health was neglected, with 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). The analysis indicated that Samoa had a community programme running out of their hospital's mental health unit based on the '*Aiga*³ – A Partnership in Care through Continuous Collaboration' (2005:35) model of care. The island, however, had no inpatient facilities. In the event a person required admission, they would enter the general wards or be referred to the police for psychotic emergencies or violent behaviour.

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 et al. 2005:300). 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. 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

³ *Aiga* refers to the Samoan concept of family.

and beliefs; all inter-dependent of one another (Stewart-Withers and O'Brien 2006:214). 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.

While not homogenous, the similarities between the two nations provide a sound basis for Niue drawing on Samoa's mental health policy work. The way in which this can be achieved is described below.

Means to Leverage the Samoa 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.:2). Given the two nation's similarities described above, Niue is positioned to leverage existing knowledge and regional guidance from Samoa to develop their own national policy. Two ways in which this can happen are by policy transfer or SSC.

Policy transfer

Dolowitz and Marsh define policy transfer as a process where 'knowledge about policies, administrative arrangements, institutions etc. in one time and place is used in the development of ...[the same] in another time and/or place' (1996:344). Fadgen (2013), who draws heavily on Dolowitz and Marsh's work in his doctoral thesis of the SMHP development, asserts that the Samoan policy was undertaken with a hybridised version of policy transfer. He contends that information transfer of cultural practices emerged years before foreign experts formally initiated the policy. Fadgen indicates that the policy clearly followed the WHO format while including Samoan cultural imperatives, as well as professional and other international organisational perspectives within the framework.

With policy development, it is important to understand the implications of merging service practices and concepts from foreign experts with local mental health cultural perspectives. In the Pacific, services are often delivered by visiting specialists (Mulder et al. 2016, Nosa et al. 2013) or highly migratory medical staff who are trained or transferred from overseas (Brown and Connell 2004). These professionals, while not always, can be more biased toward a medical model of care, bringing Western influences 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. 2005:306).

Another note of caution in terms of policy development is the participation of the WHO and the use of their framework in Samoa's policy development (Fadgen 2013). The WHO Policy Project can be seen as a top-down programme, 'pre-packaged and professionally driven', and failing to tackle the wider development issues of empowerment or the local political and social issues it is attempting to address (Laverack 2012:64). 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).

South-to-South Cooperation

In contrast, SSC refers to a development approach whereby 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 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' (Borges 2012:227). A special report on SSC in health in Latin America and the Caribbean suggests the concepts of SSC grew in response to the inequalities between the developed nations in the north and developing nations in the south, and the ineffectiveness of traditional international development systems; referred to as North-to-South Cooperation (NSC) (Roa and de Santana 2012). 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.

The participation of foreign experts and the WHO in the Samoan policy development process can be seen as a form of NSC. Banerji warns against global programmes led by what he refers to as the 'triad' organisations of WHO, UNICEF, and the World Bank (WB) (Banerji 1999:227). He proclaims that these 'prefabricated, technocentric, dependence-producing health programmes' are imposed on poor countries, 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' (1999:232-233). 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.

Following the edicts of SSC, leveraging Samoa's experience and knowledge could reduce the time and cost of policy development for other nations in the region, such as Niue. There would be, however, considerations in terms of how other actors in the region would participate in the process. Should other development partners, countries or international agencies become involved, this would lead to a model referred to as Triangular Cooperation (TrC) (WHO 2017). Abdenur and Da Fonseca (2013) suggest that TrC can reduce the costs related to high-priced Northern consultants but warn that this type of cooperation allows the North to maintain their influence by the continued 'transference of principles, norms and practices' (2013:1484).

With these different and competing views of policy development methodologies, understanding the strength and relevance of the Samoa policy will determine if it is a valid body of work to leverage.

Samoa Policy Analysis and Evaluation

In a Master's research report analysing and evaluating the SMHP, it was concluded that the policy aligned with the WHO policy guidelines in terms of content, but at different levels of detail and with the varying levels of intent (Corcoran 2017:49-69). The research detailed each of the main areas of policy content within the SMHP via a list of summarised WHO guideline topics, which can be summarised as follows:

1. Limited information regarding the policy development process followed by a detailed situational analysis.
2. The inclusion of a vision statement along with Samoan principles and values that should underlie the policy.
3. Demonstration of commitment and action-oriented goals and objectives.
4. Mention of respecting the rights and dignity of people with mental illness, but little in the way of strategies to address the stigma and discrimination described in the situational analysis.
5. Few financial references that were either vague in detail or cautionary in terms of future challenges that would lie ahead.
6. Strong and concise organisational and service management concerns and strategies.
7. Several issues and concerns noted for mental health advocacy followed by suggestions to reduce stigma and suicide, and some specific organisational work to increase intersectoral collaboration.
8. Mention of, but at a noticeably and justifiably lower priority level, the need for information systems, research and quality.
9. Several strategies that recognise the need for collaboration and integration, especially in terms of mental health awareness, suicide prevention and sexual and physical abuse.

The research report indicated that the SMHP demonstrated a strong correlation between the *aiga* (family) and its role in providing support for people suffering from mental illness within the collective and relational nature of the Samoan culture (Corcoran 2017). At the same time, the report suggested that the policy failed to tie Samoan cultural perspectives within the WHO guidelines of the human rights topic, pointing out that this omission must be framed within the cultural context of Samoa. A situational analysis of human rights in the Pacific⁴ cited a conflict between human rights and *fa'a Samoa* (Pacific Community (SPC) 2016). The SPC analysis quotes the Samoan Ombudsman and Human Rights Commissioner, who explains that while Europeans and Samoans have different beliefs of human rights, they are 'equivalent in nature and underpinned by similar core values' (SPC 2016:113). The distinction is further explained; Samoan beliefs guide social interaction and include respect, dignity, security, love and service, whereas a Western approach to human rights includes equality but excludes love and service.

The inclusion of the WHO guideline topics, along with these cultural caveats suggest that the SMHP is a well constructed document that would be a valuable reference for other PICs in developing their policies; giving them the opportunity to improve on areas where clearer strategies could have been included while leveraging those areas that were well represented in both content and cultural considerations.

⁴ *Between the years of 2012 and 2016*

Samoan Policy Applications to Niue

Understanding the parallels between the mental health situations of both nations further demonstrates how the SMHP can benefit Niue’s policy development. The SMHP’s situational analysis provided a foundation for the policy action areas and highlighted key concerns that the nation acknowledged and intended 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 1 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 1: Niue Situation Comparison to the SMHP
(Corcoran 2017:76)**

Even with the noted differences, this exercise indicates a high degree of similarity between the two nations regardless of the seven-year gap.

Conclusion

This working paper has shown the importance of mental health in development and the vital role that a national mental health policy plays in setting a nation’s direction in this aspect of health. It has critically considered the WHO policy guidelines as a framework for policy development and examined ways in which Niue could approach leveraging the SMHP in their future policy work. To further demonstrate the paper’s aim, it has provided supporting information related to the Niuean and Samoan demographic and mental health service situations and briefly summarised the analysis and evaluation of the SMHP in

relation to the WHO framework. Finally, the paper compared the Samoan and Niuean mental health concerns based on situational analyses to demonstrate the two nation's similarities and differences. Based on this literature review, collaboration between Niue and Samoa in Niue's future work 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.

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