Youth and Mental Health in Samoa: A Situational Analysis

O Le Siosiomaga Society Inc.

Samoa Nurses Association

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Acknowledgments

We sincerely acknowledge the contribution of our stakeholders and partners in Samoa to progressing mental health concepts and making them easier for Samoan youths to relate to. They have also played an important role in highlighting the relevance of Samoan culture to maintaining mental health.

A big thank you must go to the school principals who provided support and assistance during our work with students. It is our hope that the students who were trained as mental health advocates will help make a significant contribution to the wellbeing of their peers.

Our aim is to expand our advocacy work and awareness programmes to reach many schools so that more young people will develop as responsible citizens who can contribute to building a safer, stronger and healthier Samoa.

When we began this programme, we tried to (1) see our contribution in terms of the big picture in our local context, and (2) present Samoan values and practices in a conceptual framework of mental health that grassroot-level communities could relate to easily. Working out these primary issues took a great deal of discussion and deliberation and this was made easier by the commitment and support of the community groups we worked with. We would especially like to acknowledge the contributions of the church leaders, youth groups who worked with us and community groups that also emphasised the significance of working effectively with youth.

To have had the opportunity to work directly with young people was made possible by the initiative of the O Le Siosiomaga Society through its partnership work with FSPI, in particular Margaret Leniston and the Regional Health team. We greatly appreciate the opportunity to have started this very important development programme for the youths of Samoa. No doubt this contribution will promote better life skills, new mindsets and healthier lifestyles among young people.

We express our appreciation to the Government of Samoa, which through the Ministry of Health, envisioned the need to establish our *Mental Health Act 2007* and *Mental Health Policy 2006*, thus setting the scene for our work in mental health.

Our commitment, as non-governmental organisations, to advocacy, awareness, education, research and sustainable livelihoods through this Youth and Mental Health Project aims to complement the hard work of the Mental Health Unit staff of the National Health Services.

We hope that through the combined efforts of all those committed to promoting mental health, we will ensure greater physical and mental wellbeing for the youth of Samoa.

Finally, we gratefully acknowledge Mrs Kate Watson-Horoi, the editing consultant, and Mr Ricardo Morris, the communications consultant.

Foreword
by the Honourable Minister of Health, Gatoloaifaana Amataga Alesana Gidlow

Youth and Mental Health in Samoa: A Situational Analysis is the result of collaboration between the Samoa Nurses Association (SNA), O Le Siosiomaga Society Inc (OLSSI) and the Foundation of the Peoples of the South Pacific International. These organisations came together in recognition of the fact that the mental health needs of our youth must first be identified and understood before they can be met.

The Youth and Mental Health (YMH) project supports the implementation of the Samoa *Mental Health Policy 2006* and the Samoa *Mental Health Act 2007*. The policy has a vision "for all people in Samoa to enjoy mental well being that is grounded in the '*aiga*' and nurtured through a multi-sectoral approach that provides quality care that is accessible to all people while recognising that mental, physical, social and spiritual health is indivisible." (*Samoa Mental Health Policy*, 2006)

This report aims to shed light on those areas of need and through its recommendations, to respond in an effective and sustainable way and improve the health outlook for all young Samoans.

The promotion of mental health is vital to the welfare of our youth and gives due recognition to the role of Samoan culture in supporting young people to lead happy and productive lives.

Firstly, it is essential to measure the status of youth mental health in order to determine and develop remedial measures where necessary. Where better to start than with youths' own experiences and perceptions of the culture they live in and the values they hold? Our youth are a valuable resource and are extremely important for the future development of Samoa.

This situational analysis draws on existing Samoan studies that highlight health, education and employment issues as they relate to youth and mental health. An important focus of this report is on promoting the conditions that are conducive to mental health rather than only dealing with the issue once problems occur.

I must express our appreciation for the support received from the Foundation of the Peoples of the South Pacific International, which enabled this situational analysis to be undertaken. My congratulations also to the Samoa Nurses Association, which co-ordinated this work and provided this report. It is hoped that the collaborative efforts initiated by these organisations will continue.

It is my privilege to introduce this ground-breaking work, which I trust will bring continuing benefits to the young people of our nation.

Gatoloaifaana Amataga Alesana Gidlow
Minister of Health,
Samoa

Message
from the Executive Director of O Le Siosiomaga Society Inc.

It is a pleasure to have been involved in this very useful Youth and Mental Health (YMH) project for Samoa. The process and methodology used in the partnership between FSPI, SNA and OLSSI demonstrated the strength of a collaborative approach in achieving a successful outcome.

The Prime Minister, in launching the project two years ago, highlighted this aspect and was appreciative of the initiative taken by FSPI and OLSSI as community organisations to secure funding and help implement the *Samoa Mental Health Policy* (2006) and the *Samoa Mental Health Act 2007*.

In the wake of the tsunami that hit Samoa in September this year, the relevance of the Youth and Mental Health Project was brought to the fore. The devastation caused by the natural disaster highlighted the fact that youth mental health should be given a high priority in Samoa, with future resources being committed to continuing its important work. So far, the project has made a large contribution to helping people to deal with the traumatic effects of the tsunami.

Those who received training and benefited from the Youth and Mental Health project in the communities, schools, NGOs, civil society, and government have been called upon to assist many peoples and communities to begin rebuilding their lives.

I wish to commend the work of the two co-ordinators, Eseta Faafeu Hope and Matamua Iokapeta Enoka, for their work in representing the Samoa Nurses Association as our local implementing partner. Their practical experience in this area and their immense contribution to developing the Samoa *Mental Health Policy (2006)* and the *Mental Health Act 2007* made them the agents of change in this project. Their focus on what works for Samoa, ensured anchorage on areas of traditional significance and cultural sensitivities. It will shape the outcome of our situational analysis report and serve as a basis to replicate its relevant experiences in other areas of Samoa.

We also recognise with appreciation the management role of FSPI Regional Health team and the funding from NZAID that has helped us implement this project. Their flexibility in allowing relevance to be the defining factor for the Samoa YMH situational analysis. This has demonstrated FSPI's willingness to have local experts drive the activities for an outcome that will be relevant to Samoa and can bring about the implementation of the components of the Samoa *Mental Health Policy* (2006) and the *Mental Health Act 2007*.

On behalf of the President and members of the Board of Directors of OLSSI, I congratulate all those who have been directly and indirectly involved in ensuring this report will deliver benefits for all Samoans.

Fiu Mataese Elisara
Executive Director
OLSSI

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Acronyms

ADB	Asian Development Bank
CRPD	Convention on the Rights of Persons with Disabilities
FSPI	Foundation of the Peoples of the South Pacific International
IEC	Information, Education and Communication
KVA	Kolone Vaai & Associates
MESC	Ministry of Education, Sports and Culture
MFHA	Mental Health Family Association
MHCP	Mental Health Care Professional
MHU	Mental Health Unit
MoH	Ministry of Health
MWCSD	Ministry of Women, Community and Social Development
NGO(s)	Non-Governmental Organisation(s)
NHS	National Health Services
OLSSI	O Le Siosiomaga Society Incorporated
SNA	Samoa Nurses Association
TALAVOU	Towards a Legacy of Achievement and Opportunity through Unity
WHO	World Health Organization
WST	(Western) Samoa Tala
YMH	Youth and Mental Health

Glossary

Agaga	spirit
Aiga	family or extended family
Aitu	thinking and thought process
Fa'alepō	dreams
Fale	house
Lagi e mama i lau afioga	metaphorical language that wishes back good health like the clear sky
Loto fuatiaifo	intuition
Malo le soifua	good health to you
Malosi	strength
Masalo	suspiciousness
Mauli	inner being
Ola	life, living elements, from birth to death
Soifua maloloina o le mafaufau	mental health
Tagata oti	absence of life will result in the person becoming deceased
Tagata vale	deviation from any of the three parts will result in the person becoming altered in normal functions
Tofāloloto	insight
Tofāmanino	vision

Executive Summary

Samoan society encourages youth to develop cultural competence in their roles and relationships and to make sound decisions that will prepare them to become responsible citizens and future leaders.

It is crucial that young people understand the importance of the choices they make to their health and wellbeing, so they are able to cope with change and adversity and be successful in their lives. To this end, O Le Siosiomaga, the Samoa Nurses Association and the Foundation of the Peoples of the South Pacific International worked in partnership on the Regional Youth and Mental Health project. The project was conducted in eight Pacific Island countries: Samoa, Papua New Guinea, Vanuatu, Solomon Islands, Kiribati, Tonga, Fiji and Tuvalu.

The SNA conducted youth mental health education and awareness, youth-to-youth mental health promotion and advocacy to facilitate the implementation of the *Samoa Mental Health Policy* (2006), legislation and recommendations on improvement and access to gender-sensitive youth services.

This study explored the situation of youth and mental health in Samoa. It suggests that youths' choices were not only strongly influenced by perceptions of themselves but also of their peers, their families, social and religions expectations and cultural beliefs.

While youths referred to friends, parents, family and pastors to provide support or refuge for them in times of need, many youth did not appear to seek advice. Youths were conscious of how their actions may reflect on their parents and families. Sometimes, if a wrong choice was made with resulting negative social implications, shame is frequently apportioned more to the family rather than the individual. Family might even be punished by the village council. This situation creates stress for both parents and young people.

Mental health promotion needs to acknowledge that while cultural strengths provide guidance and resilience it also may create additional stresses. Future YMH work must not only consider Samoan context but address external influences and find constructive avenues and means to facilitate effective ways for youth and their families to communicate and increase understanding on these issues and the impacts on all their lives.

The *Samoa National Youth Policy 2001-2010* (2001) recognises that the key challenges facing youth related to the impact of cultural change arising from global influences and urbanisation. These changes challenge traditional ways of living and the resulting tensions can bring about a range of stresses and anti-social behaviours. The *Strategy for Development of Samoa 2008- 2012: Ensuring Sustainable Economic and Social Progress* (2008) also recognises these factors and has developed indicators to assess the effectiveness of the implementation of its policies. These indicators include: a reduction in youth suicide, 'youth offender crime', violence and child sexual abuse.

Reducing sexual risk behaviour to prevent adverse impacts on youth health is another high-priority area. In particular, reducing the incidence sexually transmitted infections, HIV/AIDs-related conditions and teen pregnancy.

The current Samoa youth and development strategies aim to improve community development and by advancing social, economic and governance programmes such as the capacity of women's committees, micro-credit and village based development programmes. They also contain a commitment to parent education and the impact of divorce on young people. All strategies relevant to youth development acknowledge and commit to an improvement in education and employment, facilities and services development.

"Mental health is everyone's business" (WHO, 2002). Social problems that result in or from mental instability and illness, need to be recognised and referred to appropriate services early for confidential counselling, treatment and/or rehabilitation. Mental ill health is costly to any person's life. If not treated effectively, it reduces a person's ability to function well and to be productive. Families and carers need to learn to recognise the signs of mental ill health. If well informed, they can manage, support and care for family members and reduce the risk of preventable mental illness.

Samoa has a recently revised *Samoa Mental Health Policy* (2006) and a *Mental Health Act 2007.* Mental health facilities include a small, specialised unit with a community mental health service and a range of mental health services provided by NGOs,

religious organisations and traditional healers. These services provide a variety of programmes related to mental health care and support, suicide awareness, abuse victim support and alcoholic support services. There are also some general counseling services available. The informal services provide a significant component of the mental health support in both urban and rural areas, often filling the gap in the absence of sufficient specialist and primary services (Hughes, 2005). The Mental Health Unit does not record that NGOs refer people to the MH Unit. It is recommended that these groups form a network for Mental Health Family Association to provide the much needed family support services. (*Samoa Mental Health Policy*, 2006).

The Samoan expression for mental health is "*soifua maloloina o le mafaufau*", which means that mental health is not simply the absence of mental illness, it is a holistic state of wellbeing. This perspective on mental health is rooted in Samoan cultural philosophy, which provides a basis for understanding the essence of being a healthy Samoan individual who is integrated in society and includes the social, mental and physical aspects of wellbeing in balance. This approach is also the foundation for nursing education and practice in Samoa.

In Samoan philosophy, it is believed that an individual has three parts: *mauli*, *aitu*, and *ola*. *Mauli* encompasses the inner being (*tagata lilo*); vision (*tofāmanino*); insight (*tofāloloto*); dreams (*fa'alepō*); intuition (*loto fuatiaifo*); spirit (*agaga*); and suspiciousness (*masalo*). *Aitu* encompasses the thought process (*manatunatuga*, *fatua'iga o manatu*, *ma mafaufauga*). *Ola* encompasses life and living elements, from birth until death. Deviation from any of the three parts will result in a person becoming unbalanced in normal functions (*tagata vale*). Absence of life will result in the person becoming deceased – *tagata oti*. (*Samoan Philosophy of Nursing*, 1990).

These beliefs underpin the teaching of mental health in a holistic sense, that is, mental health before the appearance of mental ill health or illness. It is important to understand the mental health continuum – from wellness to mental illness or death – and its relationship to the aspect of the societal influences within which we care and raise children and manage relationships.

Adolescence is recognised as a time of change of rapid physical and emotional development, as well as vulnerability to behaviours which may risk mental ill health and illness. The recommendations contained in this report contain the common theme of other Samoan reports: that meeting youth needs in the education, employment and health sectors must be given a higher priority. Samoan society has an important role to play in reinforcing traditional cultural practices that support the mental health of youth.

The Samoan family, while it is the first social institution and the foundation of an individual's behaviours and attitudes, its stability and support is important to provide have appropriate care and guidance for youth. Therefore mental health awareness is vital and the signs of mental ill health and mental illness need to be recognised early and referred to appropriate to youth and gender sensitive services for confidential counselling, treatment and/or rehabilitation, to ensure young people's safety.

1.0 Introduction

1.1 Background

In many countries, mental health has been given a low priority as a public health issue and as a result, the burden of mental illness continues to grow throughout the world.

When people living with mental disorders are unable to access adequate care and treatment, they become less productive and often have little sense of fulfillment. The World Health Organization (WHO) and global and regional partners have been working to address this area of need by improving the quality and number of programmes and training available for health workers, updating mental health legislation and formulating new policies and plans and encouraging their implementation. These organisations are working both in communities and at the national and regional level, but there is still a long way to go before the quality of life for the mentally ill improves markedly.

In 2007, the Pacific Islands Mental Health Network (PIMHnet), funded by NZAID, was launched during the Pacific Islands Meeting of Health Ministers in Vanuatu. Countries in the network have pooled their collective experience, knowledge and resources to promote mental health and develop systems that provide effective treatment and community mental health and care. In consultation with countries in the region, PIMHnet has identified a number of priority areas, including advocacy; human resources and training; mental health policy, planning, legislation and service development; access to psychotropic drugs; and research and information. Network countries meet annually to develop work plans that address these priorities, to be officially endorsed by their Pacific Islands ministers of health.

PIMHnet has also developed strategic partnerships with NGOs and other agencies working in the Pacific region to build more co-ordinated and effective strategies to address the treatment gaps, improve mental health care and end stigma, discrimination and human rights violations against people with mental disorders.

The Samoa Nurses Association (SNA), through the Youth and Mental Health Project, under the auspices of O Le Siosiomanga Society Inc and FSPI Regional Health Team, has supported mental health education, awareness and advocacy to improve the support services for Pacific youth.

1.2 Community mental health services in Samoa

The Samoan Ministry of Health has 149 registered cases of people suffering from mental illness and about 70% of them are in the productive age group of 14-40 years (*Mental Health Policy, Situational Analysis*, MoH, 2005).

In Samoa, as in other Pacific Island countries, communities, churches and families play an important role in care of the mentally ill.

Samoa moved away from institution-based care two decades ago and now has a system where families and nurses share responsibility for the care and treatment of people with mental disorders within their families and communities.

The disadvantages of the previous model of care were:

- Dressing patients in a uniform of green and/or blue hospital trousers and tops led to stigmatisation
- On-the-hour schedules of medication and meals
- On-the-hour schedule of sleep
- On-the-hour schedule of time-out-walks around the hospital compound
- Some patients were continually locked up in small, dark rooms due to uncontrolled violent behaviour.

According to the SNA, the move from institutional to community based care has been beneficial to people with mental illness. The Ministry of Health has a Mental Health Unit, which is central to the care of the mentally ill in Samoa. The unit's family outreach service employs nurses who make home visits. During the visits, which lasted 1 to 1.5 hours, an initial general health assessment is carried out and the patient's daily activity patterns are discussed with carers and/or family members. The nurses note signs and symptoms of relapses and review medication compliance, efficacy and/or side-effects. If the patient is functioning well; taking their medication and showing no signs of side-effects; is contributing to family life by doing chores and is communicating well with others, the nurse will recommend continuing with the same care plan until the next visit. If a patient becomes unwell before the next visit, families must notify the Mental Health Unit clinic. When an assessment shows the patient needs medical attention, they are taken to hospital, either by a visiting nurse or

by the family. The SNA reports that community based care has resulted in better outcomes for people living with mental illness, which are evident in the following ways:

- better recovery due to early improved communication with family and nurses
- medication compliance is better
- interpersonal relationships with family are not disrupted and therefore, there is no need to be hospitalised
- being useful and contributing to society is better observed at home than in locked psychiatric facilities
- less introduced western methods of care,
- more chance of the ill person's care being tailored to specific needs within a family setting

In order to provide specialised staff for these services, Mental Health and Mental Illness studies were introduced to the undergraduate nursing programme at the National University of Samoa in 1993 and this was followed by a Post Graduate Diploma of Nursing in Mental Health, which was run once in 2004. There were six graduates from the course, three of whom are working in the Mental Health Unit.

In accordance with the *Mental Health Policy* (2006) and the *Ministry of Health Act 2007*, Mental Health Care Professionals (MHCP) are registered and appointed by the Minister of Health. All MHCPs undergo a Credentialing Programme every three years to ensure the quality and safety of their practice. Two mental health care professionals are court officials who are appointed by the Minister of Health to advise the magistrate in cases between a mental health professional, such as a psychiatrist or nurse, and a person who has been diagnosed as having a mental disorder, but refuses treatment.

1.3 The Youth and Mental Health Project

The Youth and Mental Health (YMH) Project is co-ordinated by the Foundation of the Peoples of the South Pacific International (FSPI) with financial assistance from New Zealand International Aid and Development (NZAID). The first phase of the project – from 2003-2006 – focused on Masculinity, Mental Health and Violence (MMHV). Participating countries included Papua New Guinea, Vanuatu, Kiribati and Fiji. The second and current phase (YMH) added four more countries to the project: Tonga, Solomon Islands, Samoa and Tuvalu.

The aim of the YMH project is to improve the mental health of Pacific youth. It includes awareness, education and sustainable livelihoods, applied research on the situation of YMH, youth-to-youth mental health promotion and advocacy to improve policies, legislation and gender-sensitive youth services.

Culture and family were identified as being significant factors in how young Samoans viewed life. Therefore, mental health in the Samoan context was explored an evaluated alongside international theories of mental health. This method allowed the researchers to identify and understand the unique values of the culture and how youths can utilise them to live a productive and happy life. Youth acknowledged that the family can play a positive role in enculturation and socialisation, however, the *Samoan Family Health and Safety Study* (2003) reveals this is not always the case. For example, parental violence can cause extreme stress and impair a young person's mental health.

As part of the project, youths were encouraged to reflect on and interpret their way of life and traditions and to identify the support systems available to them. Difficulties in voicing concerns related to emotional issues such as uncertainty, lack of self-confidence, unresolved anxieties, suicidal thoughts and all forms of abuse were addressed. The YMH project is designed to build their resilience, coping strategies and ability to make sound, safe and healthy choices. (Refer 5: YMH Education and Awareness).

The *Samoa Mental Health Policy* (2006), the *Mental Health Act 2007* and the *Strategy for the Development of Samoa – 2008-2012* were used to guide the work of the YMH project. The project used the FSPI *Mental Health Resource Kit* (2007) and drew from a pool of resources to conduct advocacy and education programmes.

There were four focus areas identified:

1. To explore the status of youth mental health in relation to knowing oneself and how to make optimal choices;
2. To highlight the key gaps in youths' capacity to access traditional avenues for support and empowerment;
3. To identify root causes of the gaps; and
4. To recommend solutions and actions to address the gaps in families, villages, schools and at the individual level.

This situational analysis describes the current situation of youth mental health in Samoa and establishes a platform for work in this area.

The Samoan Government recognised the need to steer the focus of youth towards their culture because it is through the already existing avenues of culture that young people can achieve a productive and happy life.

As part of the project, youths were encouraged to reflect on, interpret and critique their ways of life and their traditions and practices as a means of support. The reason being that, at the end of the day, the Samoan youth goes back to his or her family where all the nurturing, caring and counselling occurs.

The Youth Mental Health Project took the policy statements of intent and incorporated principles, methods and practices recognised by government strategic planning as attracting positive support from other community groups. Samoa's approach to mental health is integral and intra-dependent with its stakeholder partners in the public sector and non-governmental organisations.

Youths explored ways of making relevant choices in their families, schools, social environments and/or workplaces.

1.4. Methodology

1.4.1 Sample Population

Youths aged 12 to 29 years were recruited to participate in group discussions and/or were given a semi-structured questionnaire to provide individual responses to questions. An additional number of people aged 29 to 39 years were accepted as respondents because they were active members of youth groups reached by the YMH project. In all, there were 250 young people in the sample group. The response rate was 82% (205 out of 250 distributed questionnaires were completed and returned).

A semi-structured questionnaire was developed by the first trainee group of nurses and was piloted during school pupils' mental health work and seminars for improvements and finalisation.

1.4.2 Data collection and methods

YMH co-ordinators and nurses were the main enumerators of information, conducting focus group discussions and semi-structured questionnaires. The returned instruments were analysed using data analysis programs for tabulations of quantitative data, while information collected from group discussions was classified and sorted to identify common emerging themes.

2.0 Samoa: An overview

Samoa is an independent country made up of 10 islands in the central Pacific Ocean. Its main islands are Upolu, Savai'i, Manono and Apolima. According to the 2001 census, Samoa's population was close to 180,000, with 25 per cent living in the capital, Apia, and the rest living in villages. Samoan people are strongly community oriented and the need to belong to and respond to the needs and demands of the social group is very important to them (*Samoa Family Health and Safety Study*, 2007).

The Asian Development Bank reported in 2007 that the political situation continued to be stable under the hegemony of the Human Rights Protection Party, which has ruled Samoa for the past 25 years. The government has engaged actively in public sector reform and the country is no longer classified as a Least Developed Country (LDC).

"Samoa has achieved a relatively high level of sustainable economic growth and human development and has emerged as a leader in economic and public sector reform in the Pacific." (ADB, 2007).

The Samoan Government recognises that engaging youth in the workforce and in communities is vital to ensuring the continuing economic development of the nation. For youth to utilise their most productive years, they must be equipped with knowledge and skills that will enable them to make a positive contribution.

The government's TALAVOU (Towards a Legacy of Achievement and Opportunity through Unity) initiative is an integrated youth development programme that aims to strengthen self-esteem, provide employment opportunities and encourage youth to be involved in the development of their families and communities. The participants learn about family communication, enhanced economic development and strengthening traditional structures to address social issues affecting communities (*Strategy for the Development of Samoa, 2008-2012*)

The National Policy for Women of Samoa 2007-2017 aims to expand opportunities for women and ensure progress is made in implementing the *Convention on the Elimination of Discrimination Against Women* (CEDAW); while the *National Policy For Children 2007-2017* outlines the planned direction for the care, protection and development of children in line with the *Convention on the Rights of the Child* (CRC). Both of these policies will be implemented by Ministry of Women, Community and Social Development (MWCSD) in collaboration with the ministries of Health, Justice and Courts and Administration, and Education, Sports and Culture. Areas of possible disadvantage of children covered in the policy are health, particularly in regard to mental health, children with special needs or disabilities, violence and exploitation, education and a range of other environmental and health needs.

FIGURE 1: Map of Samoa

2.1 The Samoan family

"The traditional culture of Samoa is a communal way of life. In the Samoan culture, all activities are done together." (Watson, 1919). The three aspects of Samoan culture that are strongly maintained are religious faith, family and societal organisation. Family is viewed as an integral part of a person's life. The *aiga*, or extended family, lives and works together. In Samoa, everyone has a unique place in the subdivided guilds of society and each guild has a societal role that reflects the status of each individual within it.

The traditional *fale*s (houses) have no walls and 10 or more people may sleep in them. During the day, the *fale* is the sitting and meals room and a place for relaxing and talking, while at night, it becomes the prayer and sleeping room. Following hurricanes and cyclones in the islands, many families replaced their damaged oval-shaped, thatched-roof *fale*s with aluminum-roofed houses, but retained the design of one large room for all family purposes.

While new influences are adopted into the Samoan lifestyle, the cultural values and beliefs remain largely intact.

3.0 Mental Health

The World Health Organization defines mental health as "the foundation for the well-being and effective functioning of individuals. It is more than the absence of a mental disorder. Mental health is the ability to think and learn, and the ability to understand and live with one's emotions and the reactions of others. It is a state of balance within a person and between a person and the environment. Physical, psychological, social, cultural, spiritual and other interrelated factors participate in producing this balance. The inseparable links between mental and physical health have been demonstrated." (World Health Organization Regional Office for the Western Pacific Region, 2002).

3.1 Mental Health in the Pacific

In its *Regional Strategy for Mental Health* (2002), the World Health Organization noted that in the Western Pacific Region, physical health had improved significantly in the past 50 years, however, mental health had worsened. This region has a higher rate of mental and neurological disorder compared to other parts of the world and mental health services are often scarce and poorly resourced (Hughes, 2005).

In 2003, at a meeting of Health Ministers from the Pacific Island countries in Tonga, mental health emerged as a 'major issue' requiring urgent attention. "The increasing incidence of suicides, substance abuse, etc., all point to the need to increase availability of services. The training of health workers in mental health is inadequate." It was decided that the training of nurses for mental health and psychiatric care required urgent attention as did the development of policies and legislation (*Tonga Commitment to Promote Healthy Lifestyles and Supportive Environment*, World Health Organization, 2003, p20).

When the Pacific Island Health Ministers met again in Samoa two years later, the meeting report summed up the region's mental health situation in a few lines: "Countries and areas should strengthen action on mental health and regional agencies should develop and sustain a Pacific island mental health network as one means of providing support through an alliance of mental health workers sharing mutual experiences and supported by technical advice and assistance." (*Samoa Commitment: Achieving Healthy Islands*, World Health Organization, 2005). The PIMHNet was launched at the next Ministers of Health Meeting held in Vanuatu in 2007.

"There is a wide range of informal mental health services. These include NGOs, religious organisations and traditional healers. These services provide a variety of programs related to mental health such as suicide awareness, abuse victim support and alcoholic support. There are also some general counseling services available. These informal services provide a significant component of the mental health care in both urban and rural areas, often filling the gap in the absence of sufficient specialist and primary services". However, there are insufficient services to available to meet the needs of young people.

It is recommended that these groups form a network for a Mental Health Family Association to provide the much needed family and youth support services. (*Samoa Mental Health Policy*, 2006).

3.2 The Samoan perspective on mental health

The Samoan expression for mental health is *"soifua maloloina o le mafaufau"*, which means that mental health is not simply the absence of mental illness, it is a holistic state of wellbeing.

This perspective on mental health is rooted in Samoan cultural philosophy, which provides a basis for understanding the essence of being a healthy Samoan individual who is integrated in society. The *Samoa Mental Health Policy 2006* refers to a multisectoral approach which involves partnerships with government and non-governmental agencies. It recognises that quality of care to be "accessible to all people while recognising mental, physical, social and spiritual health are indivisible." This approach is also the foundation for nursing education and practice in Samoa. In Samoan philosophy, it is believed that an individual has three parts: *mauli*, *aitu*, and *ola*. *Mauli* encompasses the inner being (*tagata lilo*); vision (*tofāmanino*); insight (*tofāloloto*); dreams (*fa'alepō*); intuition (*loto fuatiaifo*); spirit (*agaga*); and suspiciousness (*masalo*). *Aitu* encompasses the thought process (*manatunatuga*, *fatua'iga o manatu*, *ma mafaufauga*). *Ola* encompasses life and living elements,

from birth until death. Deviation from any of the three parts will result in a person becoming unbalanced in normal functions (*tagata vale*). Absence of life will result in the person becoming deceased – *tagata oti*. (*Samoan Philosophy of Nursing*, 1990).

These beliefs underpin the teaching of mental health in a holistic sense, that is, mental health before the appearance of mental ill health or illness. It is important to understand the mental health continuum – from wellness to mental illness or death – and its relationship to the aspect of the societal influences within which we care and raise children and manage relationships.

Adolescent health is a high priority as it is a time of change and emotional development, which may involve risk behaviours. (Refer 3.3). For this reason adolescent mental health must be given a high priority. Ideally, the Samoan values of love, respect and spiritual ethics are taught early in children's lives and can provide a strong foundation for them to negotiate the risks and challenges of adolescence.

Samoan youth are encouraged to be culturally competent in their roles and relationships with others, their responsibilities and in making sound judgments. To help youths to become good citizens and future leaders of Samoa, it is crucial they understand the importance of mental health and thinking positively so they are able to cope with change and adversity and be successful in life.

3.3 Mental health policy and legislation

The August 2006 introduction of the Samoa Mental Health Policy was an encouraging sign of the Government's commitment to giving a higher priority to this area of public health. It outlined 11 key areas for action. They were:

- Ensuring appropriate financing of prioritised services
- Legislation and human rights
- Organisation of services
- Human resources and training
- Facilitate and provide supports to affected families
- Areas of focus for promotion, prevention, treatment and rehabilitation are:
  - i. Suicide prevention
  - ii. Drug and alcohol abuse
  - iii. Sexual abuse: Child and adolescent abuse
  - iv. Early recognition and management of mental disorders
  - v. Domestic violence
  - vi. Dignity of the family
- Ensure essential drug procurement and laboratory support
- Build capacity for leadership and advocacy
- Quality improvement
- Improved information systems for more informed care
- Strengthened research, monitoring and evaluation.

(*Samoa Mental Health Policy*, 2006)

In 2007, at the meeting of Pacific Health Ministers in Vanuatu the report *The Vanuatu Commitment*, World Health Organization, 2007), noted that Pacific Island countries were making progress towards implementing mental health strategies and action. An example cited was that Samoa introduced a national mental health policy and supporting legislation.

There are several factors that have a significant external and societal influences on the increasing prevalence of mental ill health in Samoa. They are:

- **Increasing urbanisation:** More people are moving away from villages and therefore, away from their traditional support structures of family and community.
- **Hardship:** While Samoa's ranking on the Human Poverty Index is favourable in comparison to other Pacific Island countries, a significant number of people are suffering economic hardship. It can be both a cause and a consequence of mental illness and disorders. The stress caused by economic insecurity can lead to a mental disorder, while the periods of unwellness that often characterise mental illness may prevent a person from holding down a job.
- **Substance abuse:** The abuse of substances, particularly alcohol and marijuana, is increasing within the community, particularly among the young. Both alcohol and marijuana use are associated with a higher prevalence of mental disorders.
- **Migration:** With the loss of productive people through migration, there are fewer people to support older and disabled family members. The increased stress on the remaining carers can result in them developing a mental disorder or illness. Samoa is also losing experienced health workers through migration and this has an impact on the health system's ability to care for people with a mental illness.

3.3.1 Mental health services in Samoa

Samoa's acting head of the Mental Health Unit, Dr Ian Parkin, was quoted as saying in the *New Zealand Herald* that there were only three nurses

working specifically in the field of mental health and only one psychiatrist to help those with mental problems. (*NZ Herald*, June 14, 2007). The Mental Health Unit, which comes under the Ministry of Health, provides support for people suffering from a wide range of illnesses including long-term mental disorders such as schizophrenia, bipolar disorder, drug-induced psychosis and epileptic psychosis as well as some cases of depression, anxiety disorders or dementia. Staff levels in the unit have remained the same for the past five to six years. As of 2009, there were three full-time mental health nurses; three other mental health nurses working at different locations and one part-time psychiatrist.

The Mental Health Unit receives three to four referrals a week for mental assessment and consultation from the Tupua Tamasese Meaole (TTM) hospital, families and individuals. A four-bed ward was built at TTM hospital so that people with mental disorders could be treated as inpatients, however, the beds have not been officially opened. The hospital still does not offer inpatient care for the mentally ill. They may be placed in general hospital beds or for serious cases, in police cells. The unit has no structured rehabilitation programmes and there are no dedicated open beds for people with mental disorders. Families sometimes ask traditional healers to come and treat a relative who is believed to be mentally ill (*Samoa Mental Health Policy*, 2006). (Refer appendices II - Status of Mental Health Services 2005-2009and refer 1.2 'Community Mental Health Services in Samoa' for an account of the Samoa Nurses Association's vital role in the deinstitutionalisation and maintenance of community mental health services in Samoa.)

4.0 Issues facing youth

Since the 1980s, there has been a significant change in the age structure of the Samoan population. The fastest growing age group is 15-19 years (*Samoa National Human Development Report 2006*). Samoa's youth population – 12 to 29 years – is 57,505: males – 30,178 and females – 27,327. There are two-thirds more youth living in urban areas than rural areas (Bureau of Statistics, 2006). Youth are young people, '*not yet married*' who are not full adults in terms of responsibility (Shore, 1965). The Samoan Government defines a "young person" as someone aged from 14 to 21. However, the *Samoan Youth Policy 2001-2010* defines youth as 12 to 29.

The *Samoa National Youth Policy 2001-2010* identified the main issues facing youth as:

- cultural change
- at-risk sexual behaviour
- alcohol and substance abuse
- youth suicide
- juvenile delinquency
- lack of parent care and impact of divorce
- lack of skills training centres
- not enough sports and recreational facilities.

4.1 Employment

Last year, the Asian Development Bank (2008) reported that the nation had made significant progress towards achieving the Millennium Development Goals, but the creation of formal employment and income-generating opportunities was a critical issue for communities in both urban and rural areas. These issues were explained in an economic study by KVA Consultants Ltd (2007), which stated that "7.6 per cent of families were under the food poverty line".

This estimate was based on the cost of a minimally nutritious diet, with a daily energy value of "approximately 2,200 kilocalories per adult per day." In addition, the Population Census (Samoa Statistics Dept. 2001) stated, "about 49 per cent of the population in Samoa is economically inactive, while about 5 per cent of the economically active population is unemployed".

This information reflects the *aiga* as the social security of individuals where in many cases, only two or three people in a family of eight to ten earn wages. The rest of the family is taken care of by the few people with a source of income and this situation is seen as normal in Samoa.

An individual's contribution is not measured in terms of money earnings, but rather, what they do to support the family. Gender roles are specifically defined. For example, the male is consider *malosi*, meaning the strength of the family. The transition of a young person to adulthood is marked by mature judgement and not just by age. For young men, physical strength, service to elders and increasing judgement and responsibility are indicators of maturity. A young man of 21 years may be unemployed, but he cooks and plants banana and taro in the backyard or goes fishing to feed the family. For young women the expression '*teine talavou*' makes reference to the girls' virginity as well as to her unmarried, youthful status. While traditionally and culturally, girls are perceived to have a special role as sisters 'under the protection of their brothers', Samoa ratified the CEDAW in support of women human rights in 1992 (UNIFEM, 1995).

TABLE 1: Persons 15+ by main activities and sex, 2006

ECONOMICALLY ACTIVE	TOTAL	MALE	PERCENT	FEMALE	PERCENT
Paid job	28,179	17,714	63	10,465	37
Subsistence for sale	1219	749	61	470	39
Subsitence for family use	15,652	10,324	66	5328	34
Subsistence for sale and family use	8878	7691	87	1187	13
Look for work – employed between 2005-2006	46	31	67	15	33
Look for work – employed before 2005	199	138	69	61	31
Look for work – never employed before	462	249	54	213	46
Total	54,635	36,896	68	17,739	32
NOT ECONOMICALLY ACTIVE					
Attending school	13,358	6617	50	6741	50
Unable to work – old/disability	5315	2367	45	2948	55
Domestic work/housework	34,042	9444	28	24,598	72
Total	52,715	18,428	35	34,287	65
Not stated	2454	1329	54	1125	46
	109,804	56,653	52	53,151	48

Twice as many men as women were classified as actively employed. The unemployed were generally not considered a burden because of their contribution and the performance of assigned roles in the family.

For the unemployed people 15+, 89% were young adults aged 15 to 34 and 11% were in the older age group. The sex distribution in Table 1 shows that more than twice as many men as women were employed. This suggests that males may be more likely than females to seek and find employment or that females may be responsible for more unpaid work. It is likely that women have

less access to paid employment. This requires more research and analysis to understand the differences in employment opportunities between men and women and the impacts of these differences.

The YMH survey of youth indicated there was a lack of understanding about the contributions made by men and women through their defined roles in village councils and in village women's committees.

The Samoan National Human Development Report (2006) found that many students were leaving school with inappropriate skills to secure their own sustainable livelihoods. Parents' expectations often focused on academic attainment rather than vocational skills. It is important that a range of both technical and academic education and training opportunities exist so school leavers may support themselves and their families.

Young people leaving school are faced with limited options for formal employment and as a result, many rely on subsistence farming for survival, particularly those who were unsuccessful in their final-year exams. There is a need to strengthen trade, technical and vocational education at secondary schools and at tertiary level.

Youth want improved health, education and employment opportunities. One of the recommendations in the *Strategy for the Development of Samoa 2008-2012* is to improve access to life skills and continuing education for adults and youth. A priority is to develop a strategic approach to post-school education and training in the tourism, hospitality, technology, community and health services. This will improve the mental health outlook for young people as they will have the opportunity to learn skills to enable them to support themselves.

4.2 Poverty

Health-specific and social policy research findings may directly or indirectly inform us of risks related to mental ill health such as alcoholism and smoking. "Hardship is both a risk factor for and a consequence of mental disorders. For example, the stress associated with economic insecurity may precipitate a mental disorder. Similarly, the chronic and relapsing course of many mental illnesses may disrupt a person's ability to maintain employment and earn an income." (Ministry of Health, 2007).

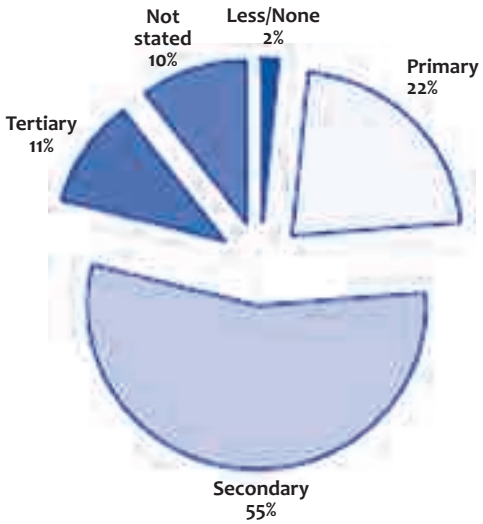
There is a growing realisation that "poverty of opportunity" is a serious problem. This type of poverty relates to access to education, health care, employment, material wellbeing, markets, job security and social freedom. Youth suicide is known to be linked to the expectations of young people and their parents in relation to education. "Each year, a new group of school leavers try to join the labour force, many of them prepared for white-collar jobs that do not exist." (*Samoa National Human Development Report*, 2006).

While extreme forms of poverty such as destitution and starvation are not evident in Samoa, there is significant hardship. The basic needs poverty line is estimated to be highest in Apia, while it is lowest in Savai'i. In urban areas, the relatively poor are mostly people who live on leased land with insufficient area to grow crops who live in flood-prone areas or on traditional lands with little access to transport, communication and water. In rural areas, the relatively poor are most likely to be youth, the elderly and people living inland who have limited or no access to market produce and basic services. These types of hardship can give rise to social problems and there is a need to promote mental health awareness in high-risk settlement areas.

4.3 Education

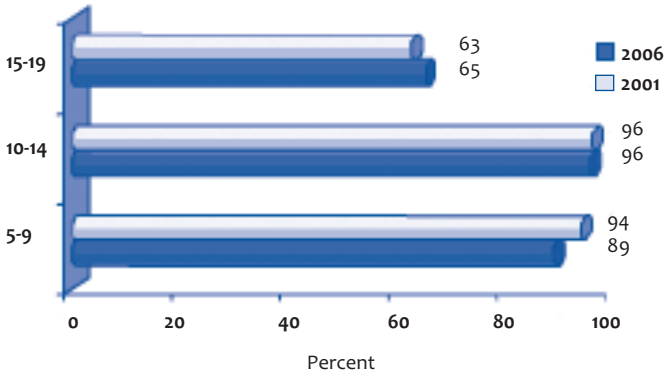
In 1959, formal education was made compulsory for children aged 5 to 14. The cost of having a child at school – WST 100-150 for primary and WST 200-400 for secondary students – is beyond the means of some parents and a large number of children from disadvantaged families drop out of school (ibid, pp 63). A review of schools found that most junior secondary schools were inefficient and that few students were able to move on to senior secondary school (ibid, p 63).

FIGURE 2: Population 15+ by educational attainment, 2006



In 2003, only 84% of primary school-aged males and 85% of females were enrolled at school. The Ministry of Education, Sports and Culture (MESC) claims 99.9% of 15-24-year-olds can read and write, but based on current enrolment statistics, that would seem unlikely.

FIGURE 3: Ratios of school attendance 5-19, 2001 and 2006



A drop in the proportion of children in early primary is a major concern and it implies that the policy for compulsory education has not yet been put into action effectively. This finding coincides with the increasing number of young children selling merchandise in the streets of Apia during school hours. It is an issue that needs to be addressed immediately by Ministry of Education, Sports and Culture and other appropriate authorities.

4.4 Disabilities

The United Nations defines disability (resulting from impairment) as a "restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being. One is more or less disabled based on the interaction between the person and the individual, physical institutional and social environments". The UN *Convention of the Rights of Persons with Disabilties'* (CRDP, 2006) definition recognises that "disability is an evolving concept" and that it "results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others". The UN CRPD states that "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments". Disability can affect people of all ages (PIFS, 2009). A disability inclusive approach would recognise that it is vital to invest in meeting the physical, mental (including the emotional and spiritual) needs of people living with mental illness, their families and carers.

There are many children with single or multiple disabilities in Samoa, attending both special needs and mainstream schools. There are, however, others who do not attend school. Of the 2874 people living with disabilities in Samoa, 396 were in the age range, 15-19 years. Thirty of them never attended school and 190 did not complete primary school.

TABLE 2: Population with multiple or single disabilities, 2002

Population	Multiple disabilities	Single disability	Total persons
School students	60	252	312
Community	1262*	1254*	2516
Institutions/NGO	30	20	50
Total	**1352**	**1522**	**2874**

SOURCE: Lene and Taaloga (2002) *Samoa Adult 15+ Disability Census Report and Key Recommendations 2003.*

There is a training programme for special needs teachers in the education faculty of the National University of Samoa and units have also been set up at some primary schools to teach special needs children. (Lene and Taaloga, 2002).

While the MESC acknowledges the right of students with disabilities to an education, this sentiment must be translated into action in terms of specific policy and activities. (*Samoa National Human Development Report*, 2006).

A national disability policy was passed by the Samoan Government in 2009 and is addressed in the Samoan Community Sector Plan 2008-2012 of the *Strategy for the Development of Samoa 2008-2012*. At the recent Pacific Islands Ministers Responsible for Disability in Cook Islands (PIFS, 2009), the Samoan ministerial representative raised the issue of the importance of ensuring access to health services, alongside education and employment opportunities. She also emphasised the need to consider practical and emotional support for families and carers. The meeting approved movement away from the "welfare, medical model" to a more human rights-based approach in keeping with the UN CRPD. The Samoan policy supports a rights-based approach as contained in the CRPD.

4.5 Health

The rapidly growing urban population and the opening of new residential areas have brought new health and environmental pressures to the fore. Many people in urban areas no longer have access to the land and sea as sources of healthy food and instead rely on more convenient foods

that have been linked to the development of non-communicable diseases such as diabetes and hypertension. In the new housing developments, the traditional support structures of the village are lacking. The urban lifestyles of smoking, drinking alcohol, eating fast food and being less physically active are having a negative impact on the health of Samoans and the demand for health services is increasing as a result (ibid, 2006). This, in turn, has negative impacts on people's mental health, e.g. weight gain, reduced self-esteem and depression.

4.5.1 Teen pregnancy

Teen pregnancy continues to be an issue for young women's health, but the numbers may be under-reported because of moral constraints in Samoa. (MESC, 2001). Factors contributing to this problem include:

- The lack of reproductive health programmes for teenagers;
- Easy access to nightclubs;
- Availability of alcohol leading to promiscuous sexual behaviour;
- Lack of communication between parents and teenagers;
- Lack of adequate programmes and information on sexuality (*Samoa National Human Development Report*, 2006).
- Sexual violence has also been cited as another cause of teen pregnancies (*The Samoa Family Health and Safety Study*, 2007, p103).

One-third of all annual births are to mothers aged 20-24 and two-thirds are to women below the age of 30. (*Samoa National Human Development Report, 2006*, p.73).

In 2003-04, of the 3407 mothers who gave birth at national health facilities, 303 were aged under 20. From 1999 to 2004, approximately 10 percent of all births annually were to mothers aged under 20. In 2003, a United Nations Population Fund study (2003) of all antenatal attendees showed that only 50 per cent of mothers under 20 were booked into antenatal classes. Of these, the study showed that about 40 per cent were single mothers, about 34 per cent were unmarried, but in stable relationships, and only 28 per cent were married.

Teen births place the health and wellbeing of both mothers and infants at risk due to the higher likelihood of premature labour, premature birth and low birth weight. Consequently, infant mortality is high among babies born to teenagers. Teen motherhood is often very stressful because of the interruption to education, isolation from the peer group and managing the demands of an infant if lacking the maturity to do so. Frequently, the responsibility for child rearing is undertaken by young mothers with little or no support or acknowledgement from the baby's father. Young women often rely on the support of their own families.

TABLE 3: Age and number of mothers who gave birth in national health facilities, 1999-2004

Age of mother	Financial Year				
	1999/2000	2000/01	2001/02	2002/03	2003/04
<20	330	317	327	341	303
20-24	1047	1091	1093	992	964
25-29	1005	1001	967	909	860
30-34	634	694	649	715	729
35-39	372	417	391	350	401
40-44	90	125	132	128	142
45+	12	4	9	9	8
TOTAL	3490	3649	3488	3444	3407

SOURCE: Ministry of Health Annual Report FY2002/2003-2003/2004. Cited in Samoa National Human Development Report, 2006, p73

4.5.2 Parenting responsibility

Encouraging young men and women to share parenting responsibilities would improve the health of both the parents and children.

In the *Reproductive health, knowledge and services in Samoa*, (UNFPA, 2002), survey, only 67% of men and 72% of women agreed with the statement, *"Men have the same responsibility as women for the children they father"*. Given that the question was put to married men and women, it was surprising that more did not perceive that responsibility for children should be shared equally (ibid, p50). There was greater support for the statement among tertiary educated men and urban men. There are clear implications for women, particularly young women, in terms of the support they receive in rearing children and the impact on children of not having two equally responsible parents. The responsibility for child care places greater demands on women in terms of time and emotional energy and may also limit access to employment and educational opportunities.

4.5.3 Sexual health

A research paper on reproductive health by UNFPA (2003) established there was a relatively low level of knowledge about sexually transmitted infections and a relatively high knowledge about

AIDS. It is recommended that the Ministry of Health give a high priority to educating the public on prevention, symptoms, mode of transmission and responsible sexual relations (ibid).

The emotions involved in sexual relationships are known to be overwhelming to some young people and may cause emotional and mental stress. Education in sexual health and gender relations is important so as to encourage healthy choices and reduce risks of sexually transmitted infections and unwanted pregnancies.

4.6 Abuse

4.6.1 Physical abuse

Family problems and disagreements were found to be the main reasons for domestic physical abuse. As well as the physical injuries sustained, many women suffer emotional problems such as severe depression, suicidal thoughts, anxiety and sleeplessness as a result of having been abused. Women who are abused tend to be unassertive and have low self-esteem.

Abusers were more likely to drink alcohol and to be frequent drinkers. In comparison with non-abusers, the abuser's drinking habits were more than twice as likely to cause money and/or family problems. They were more likely to have fought with another man and to have had an affair with another woman while living with their wife (*Samoa Family Health and Safety Study,* Table 2.13).

Women were more likely to express anger and frustration with their spouse verbally and this was reflected in the much higher incidence of emotional abuse (45% of those ever in a relationship). Sexual abuse was reported by 3% and physical abuse by 2%. Respondents who had been abused by their partner were more likely to have contemplated or attempted suicide (ibid. Tables 2.6, 2.8). Emotionally or sexually abused respondents were more likely to have contemplated or attempted suicide than were physical abuse victims.

Abuse has a profoundly negative impact on the children and youth who witness family violence. In the *Samoa Family Health and Safety Study*, 739 respondents who had ever had a partner had children aged 5-12 living with them at the time of the survey. The children of respondents who had ever been abused were more likely to have nightmares (34.9% compared with 28.2%), more likely to be aggressive (46.5% compared with 34.4%) and more likely to drop out of school (13.1% compared to 8.5%). Children of abused mothers were 35% more likely to be aggressive than children of mothers who were not abused.

Evidence suggests that abusive behaviour is likely to be passed down through families, with the children of abusers at risk of becoming abusers themselves (ibid).

4.6.2 Sexual abuse

Women who are sexually abused have an increased likelihood of having unwanted and early pregnancies and of having children who are at greater risk of going through the same experiences. They are also more likely to contract STIs.

In Samoa, most sexual violence reported to the police was either indecent assault or carnal knowledge and many of the victims were aged under 10 years, with one victim aged only three. The abusers were often relatives or someone in a position of trust. Rape was the third type of sexual violence most often reported to the police. Sexual violence can be damaging to mental health with depression and thoughts of suicide being common among female victims and for some it was difficult to have normal sexual relations when they married (ibid. Table 4.2).

4.7 Suicide

In 1995, the Apia Urban Youth Survey showed that 49 per cent of youth believed that suicide was the most serious problem they faced.

There were 42 suicide deaths recorded in 2004. More than 47% of suicide attempts resulted in death and those involved were mostly males aged under 29. In 2006-2007, there were 37 suicide at-

TABLE 4: Reported suicide attempts, outcomes, suicide deaths and deaths from paraquat injestion, FY1999/2000-FY2001/2008 (all hospitalised)

Year	Attempted suicide	SUICIDE OUTCOME			
		Deaths	Paraquat injestion deaths	Survivors	Unknown
1999/2000	43	26	14	16	1
2000/2001	26	10	5	16	-
2001/2002	24	7	4	17	-
2002/2003	28	12	7	16	-
2003/2004	42	20	8	22	-
2004/2005	45	21	17	24	-
2005/2006	22	11	6	11	-
2006/2007	37	16	11	21	-
2007/2008	31/a	17	7	14	-

SOURCE: Ministry of Health
Note: Period stated is a of Financial Year. (July-June)
a/: only cases from July-December 2007

tempts and 16 deaths, 11 of them from Paraquat, a particularly toxic herbicide. The Samoan Government has passed legislation to make Paraquat less accessible to potential suicide victims. (*Samoa National Human Development Report*, 2006 Table 7).

Youth suicide appears to be linked to youths' expectations and those of their parents in relation to education and clashes between the values of the modern world and conflict with aspects of the traditional system (Hooper, 1998).

While the published table is not sex disaggregated, the Samoa Mental Health Policy (2006) noted that *"Basic data are available on suicide, but not antecedent causes and events. There is no suicide prevention strategy or programme. Deliberate self-harm data showed about 56 per cent of attempted suicides were women and 44 per cent were men. As yet, it is unknown how many deliberate self-harm events are in the context of clinical depression. There is no record of deliberate self-harm patients being followed up apart from the initial assessment at the hospital at the time of the incident."*

5.0 YMH Education and Awareness

When the YMH Project was introduced, the emphasis was on understanding how Samoan values could contribute to youth and mental health. The goals of the Samoa YMH Project were to:

- Improve the education and awareness of youth issues and mental health within Samoan and other cultural contexts.
- Undertake Knowledge Action Practice (KAP) research in order to understand youth issues that create stress, and
- Advocate for improvements to gender-sensitive YMH services in Samoa

The purpose of the project was for youth to acquire knowledge and life skills that would prepare them to deal effectively with challenging situations. A YMH programme was organised and included workshops, camps, community outreach, interactive sessions and gender-balanced participatory activities. During the sessions, the workshops encouraged youth to:

- Develop their knowledge of the Samoan concepts of mental health and the differences between mental health, mental ill health and mental illness;
- Identify ways to improve their mental health through responsible decision-making, coping strategies and making healthy life choices;
- Identify risks they face and the actions to be taken to promote mental health;
- Recognise their needs and discuss ways to reduce their stress; and
- Identify the gender-specific support services needed to improve youth mental health services.

Rosa (left) illustrates her sad feelings about her blindness.

Youths and elders of Matafaa village at the YMH Education and Awareness workshop.

Students from Feifiti and St Joseph's colleges presenting their ideas on YMH.

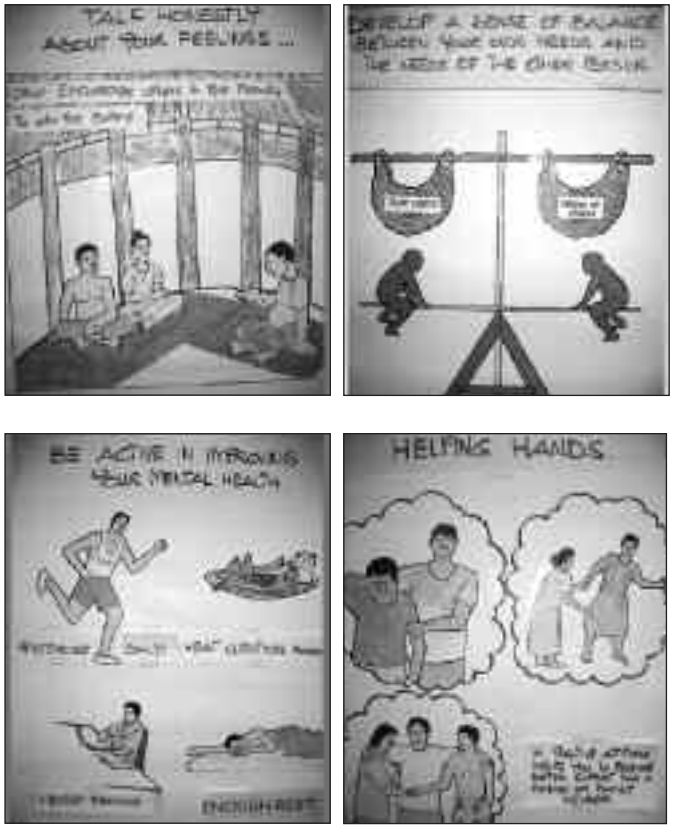
Student nurses at a workshop on Advocating for Mental Health

A conceptual framework was introduced to youth groups and communities with the aim of gauging their understanding of the differences between mental health, mental ill health and mental illness. Opportunities were also provided for young people to reflect and comment on the concepts relevant to Samoan culture and traditions. Modern theories of mental health were also discussed. The *Mental Health Resource Kit* (FSPI, 2007) was used to stimulate discussion. The students were encouraged to develop their ideas and to create information, education and communication (IEC) materials, which were later used on posters for mental health promotion.

The posters explored their understanding of mental health in Samoa. For example, some used the imagery of a *fale* to represent what mental health meant to them. A female college student presented her group's work and explained how they viewed the Samoan fale (poster pictured below) as being like the support structures for children within a family. According to the group, if the foundation was not strong enough, the fale would

not withstand even light winds and could collapse. This was equated to a child having inadequate family support and being unable to deal effectively with even small stresses.

The foundations of the fale were equated to the supportive role played by parents and the *aiga* and how the *fale* space could promote honest and open communication between family members. By its physical nature, the *fale* is an open, well-ventilated space that is conducive to the exchange and free flow of ideas.



Other concepts reflected in the posters included:

- The importance of a healthy lifestyle – exercise, diet, recreation and rest – in maintaining mental health;
- The importance of having a sense of balance between their own needs and those of others;
- A positive attitude helps a person to be supportive of others.

Primary and secondary schools were a focus for the promotion of healthy thinking and choices. From this work, the SNA identified youth advocates and peer educators. They were enthusiastic and willing to champion mental health promotion and communicated the issues in a creative way. The youth who were selected as advocates and peer educators chose the following ways to promote healthy thinking and healthy choices:

- Singing or playing a musical instrument
- Exercise programmes in villages
- Participation in village and church groups
- Developing street campaigns to reduce smoking and alcohol abuse and to 'say no' to cannabis use as these issues were identified as particular problems for young males.
- Organising outreach programmes in marketplaces with youth and church groups

Iva Youth Group advocating for "Say no to Drugs" at one of the MoH campaigns on non-communicable diseases in Savai'i in which YMH was a key focus.

YMH facilitators from the Samoa Nurses Association monitored and evaluated the workshops with feedback from the participants. Their evaluations revealed a number of improvements that could be made in future workshops. These recommendations were to:

- Make presentations shorter and use fewer words in overhead and Power-point presentations;
- Use more visual illustrations and photos as youth enjoy them; and
- Use Samoan youth case studies to encourage more active participation and reflection.

The facilitators noted that theory based concepts were poorly understood. This was revealed as youth attempted to demonstrate what they had learnt. Visual presentations and drawings as a methodology proved much more creative and useful. It is planned to develop criteria for the selection of youth peer educators and advocates in future YMH work.

5.2 YMH survey findings

"It is important that research is carried out to gauge the extent of Samoa's mental health problem. Such research should address both mental unwellness and mental illness issues." (Ministry of Health, 2007).

Determining the "extent of Samoa's mental health problem" has been an important aspect of the YMH project and has informed its education and awareness work with communities. This study has provided invaluable insights into youth mental health through the perspectives and ideas of young people. It has also examined the cultural strengths they can utilise to benefit their mental health. One of the distinctive features of the YMH project was the involvement of the Samoa Nurses Association and other stakeholders in focus group discussions. They advised youth on where they could find support within their families, villages and communities.

The youth and mental health support services and contacts table (see Appendix 2) has been compiled as a reference and referral guide. The study revealed the importance of collaboration between the Samoan Government and non-governmental agencies to improve YMH and increase youth awareness of how they can access support services in their communities. However, more services to support young people are required (refer Recommendations).

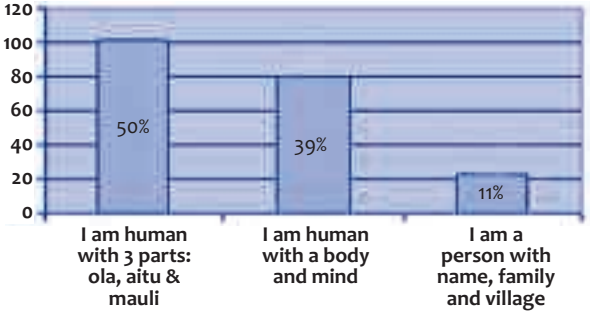
The survey provided valuable insights into how youth perceived themselves, how they maintained their dignity and self-respect, how they made decisions and coped with particular situations. Unfortunately, not all of the data was tabled in such a way that adequate gender analysis could be undertaken (refer Samoa Nurses Association).

5.2.1 *Self*

In Samoan culture, high importance is placed on the individual knowing him or herself. The survey results on self-perception related to daily activities, lifestyles and culture. Fifty per cent of youths described themselves in a holistic way; in physical, spiritual and mental terms.

Thirty-nine percent described themselves as the body and mind only, without acknowledging a spiritual self. Eleven percent described themselves according to labels given to them after birth such as names, village of birth, marital status and occupation. Samoan society values a more holistic view of the self as all labels ascribed after birth have the potential to change, while the self remains intrinsically the same.

FIGURE 4: How do you describe yourself?



5.2.2 *Self respect and dignity*

The youths recognised that social networks were important to their sense of self and sought support from within their families, villages and/or church organisations.

Samoan culture was valued as contributing to their sense of self-respect and dignity. There was a range of behaviours youth acknowledged as being important in this regard and this included showing respect to others in order to gain respect; using respectful language when communicating; maintaining eye contact when talking, particularly for elders; or offering a seat to older people on a bus. Notably, the young men placed a greater emphasis than young women on "offering a seat on a bus to an old lady or man", a behaviour they would be required to do as students.

When asked "how do you maintain your self-respect and dignity?", young women placed a higher value than young men on the use of verbal and body language as a means of conveying respect, particularly to elders. Twice as many young women as young men felt they maintained self-respect and dignity by "abstaining from sexual activities". The answers may reflect specific gender-role expectations, for example, young women not being promiscuous or losing their virginity before marriage.

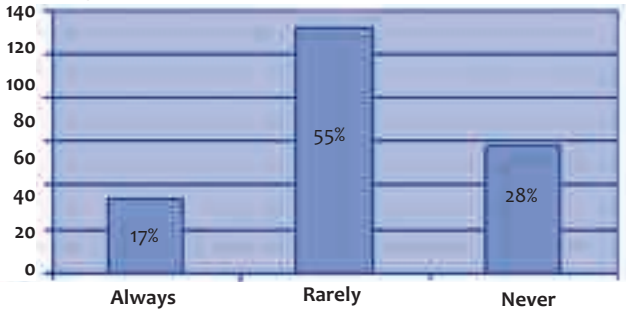
5.2.3 *Decision-making*

The youth were asked "How often do you seek help in making serious decisions?" The majority suggested that their decisions were based on what they "saw" or "the facts", while a minority of people likened the choice of their decisions to "fantasies". Seventeen percent said they "always" sought advice, 55% said they "rarely" sought advice and 28% said they would "never" seek advice.

The responses could be interpreted as half of the youths being very confident in making decisions, but the relatively high percentage of those

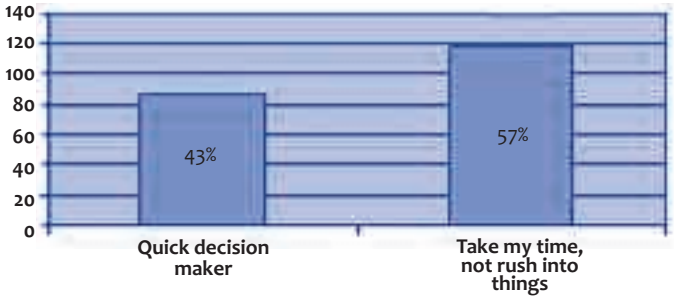
who do not seek advice could be a matter of concern. The contention is that youths' decisions require some consultation, especially when serious matters are involved.

FIGURE 5: How often do you seek help in making serious decisions?



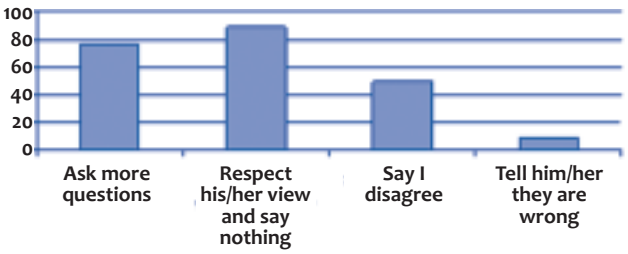
Though there is concern about the large number who do not seek advice, 57% of respondents said they did take their time in making decisions, which indicated they were considered in their approach or were '*indecisive*'. Almost 43% claimed to be '*quick decision-makers*'. This response could indicate that they were decisive or that some decisions may not be adequately considered. It was important for youth to recognise how these skills could be used to make wise rather than impulsive choices. In future, Samoan case studies will be useful during YMH awareness and education sessions for youth to apply real-life situations to look at the implications of different decisions.

FIGURE 6: Are you a quick decision maker or someone who takes time and does not rush into things?



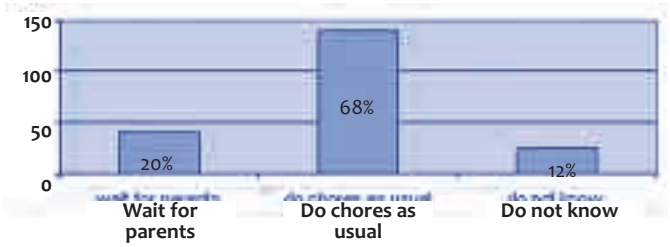
Showing respect and accepting another person's view is a logical approach to decision-making. This requires listening and considering another person's point of view before responding. In assessing their interpersonal relationships, interviewers asked youths how they handled situations in which they disagreed with another's views. Most (85%) showed they were in favour of showing respect and accepting the other person's point of view, while others' responses were either to ask more questions or to openly state disagreement.

FIGURE 7: When someone else is talking and you disagree with his/her view, what do you do?



Another area of questioning relating to youth autonomy in decision-making was explored with the following situation: when a youth returns home and finds his/her parents out, what do they do?

FIGURE 8: You came home and found your parents had gone to a village meeting. Do you wait until they come back or do you take charge of house chores?



Over two thirds (68%) of respondents stated that if their parents "were not home", they would "take charge" and do the chores as usual. The usual domestic chores for the Samoan male youth were grass-cutting, hibiscus fence-trimming, collecting rubbish and firewood and doing the outside cooking of taro, bananas, breadfruit or yams. The girls were more inclined to work inside the house: cleaning, cooking soup, grilling meat or fish and doing the laundry. Sometimes, if parents were not home by evening prayer time, children would lead the prayers themselves. Twenty percent, however, said they would "not do anything" but await the arrival of their parents and 12% "did not know what to do". Ideally, young people would take opportunities as they arise to prove they are capable of becoming independent and considerate in such situations. Many showed a dependency on parents, while others took charge and functioned in a responsible, self-motivated way. There decisions seemed role-specific based on gendered expectations of young men and women.

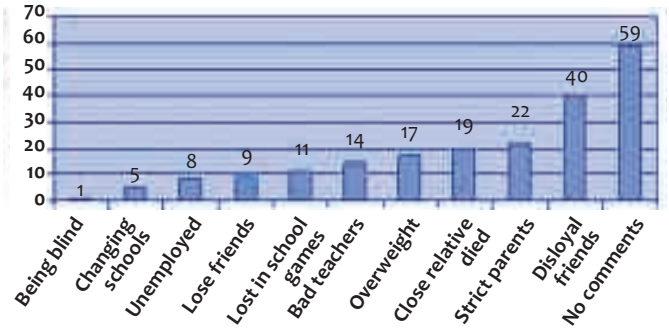
5.2.4 *Happiness and Unhappiness*

It was the intention of the project that youths become more responsible for themselves and be certain of what to do to ensure their own safety.

When asked if they saw themselves as being happy about life, 64% responded that they were.

However, about one-third (29%) considered themselves to be in a neutral zone ("50/50") between happiness and unhappiness and about 7% were "not happy at all". The figure below, which asked about "obstacles to a happy life", revealed that the factors they blamed for impairing their happiness were related mostly to school, the self and home.

FIGURE 9: Obstacles to a happy life



A large number of youth (59%) had no comment to make about the obstacles to happiness. Around 50% of obstacles to happiness centred on friendships and relationships with peers. Issues such as "disloyal friends" (40%) or "losing friends" (9%) featured highly, while about a quarter referred to "strict parenting". At home, youths mostly related to parenting styles where some parents were seen as "too strict" and "insisted on the final say on issues affecting them" (22%), for example, deciding which school youths would attend ``whether they liked it or not".

A large number referred to "being overweight" as a problem for different reasons (lower self-esteem, or ill health). There were also many references to grief and loss for events such as "losing a game", "losing friends" or "when a close relative died" (19%). Some youths were unhappy about being unemployed (8%), however, many were students and were not expected to be employed. In schools, some identified "bad teachers" or "changing schools" as obstacles to a happy life. Some mentioned specific disabilities such as "being blind" were a source of unhappiness.

5.2.5 *Coping skills*

The concept of "coping" was explored through an open-ended question. Facilitators asked youths to list "the ways they dealt with daily problems or stresses". The youths identified a range of coping mechanisms they used; crying, praying and/or "going somewhere quiet" to think things through. Some dealt with stress by talking over their problems with another person, either a parent, sister, aunt or close friend, while others sought friends to play with. The project can respond by encouraging youth to engage in group activities and by increasing the range of coping skills they have in order to build their resilience.

5.2.6 *Support systems*

When the youths were asked, "What practices do you see in your community which are helpful to support your life?", young males found support in team games (21%), while only 15% of young women did. Church and youth activities featured highly for young men (31%) and women (42%). It is interesting to note that only young men acknowledged the support of village council meetings and activities and only young women valued the support of village women's activities. These results indicate that young men and women valued their own gender-specific activities and did not appear to acknowledge the contributions made by the activities of the other gender. For example, women did not rate village council meetings as being "helpful to support" their lives and in the same way, men did not acknowledge village "women's activities". Schools and hospitals were important support services for both men and women.

5.2.7 *Lessons learned of YMH Awareness and Education*

YMH workshops are a valuable means of increasing youth awareness of how to maintain their wellbeing and a balance in their lives. Youths' perceptions of themselves and others set the tone for how they build relationships in their lives as students, partners, parents or colleagues.

The YMH workshops must explore more creative ways to communicate this mental health knowledge to youth in the future so they can develop a well-balanced 'self' who relates to others in a respectful way. Difficulties in communication are often the root cause of stress and poor interpersonal relationships. It is therefore vital that young people learn how to communicate effectively. Listening and tolerance are essential in establishing and building relationships.

A strong and healthy self-perception prepares young people for the stresses of adolescence and adulthood and empowers them to resist peer pressures to engage in risky or unhealthy behaviours.

The provision of relevant Samoan case studies would be useful in promoting critical thinking and rational decision-making. If youth are encouraged to reflect on how they make decisions and to discuss the implications of these choices, they would become better informed about the impacts on their own and others' lives.

The need to face obstacles is a fact of life. The youth recognised issues that diminished their sense of happiness. Critical thinking, learning and coping strategies are useful means to build resilience and prevent unhappiness and depression. Future workshops could have youth develop case studies to stimulate discussion as a means of encouraging discussion, for example, choices about whether or not to drink alcohol, smoke cigarettes or cannabis or have sexual relations need to be seriously considered and managed to reduce risks.

Building coping skills and resilience to use when under stress are important for youth, particularly in the prevention of suicide. It is important for young people to learn about goal-setting and longer-term planning for the future, including making education and employment choices.

Parents, guardians and school teachers were identified as sources of youth help and they can play a vital role in advising their young people. However, parents need to acquire the appropriate skills and create an enabling, open environment to facilitate communication. Mental health awareness and education in the future could focus on developing the skills for young people and adult discussions on key issues and develop peer-to-peer youth counselling support and teacher counsellors. For those youth who did not seek support and advice, further work is required to build their knowledge on how and where to seek help. A local social service directory for youths to refer to could be developed further and expanded on (refer to Appendix 1).

6.0 Conclusions and Recommendations

The importance of youth development – particularly in education, employment and health – to the social and economic future of the region has been acknowledged in a number of recent Samoan reports. The recommendations contained in these reports have had a common theme: that meeting youth needs in these three sectors must be given a higher priority. In recognition of those critical areas of need, the Youth and Mental Health project focused on improving the outlook for Pacific youth.

The project conducted education and awareness of youth mental health, youth-to-youth mental health promotion and advocacy to improve policies and access to gender-sensitive youth services .

The *Samoa National Youth Policy 2001-2010* (2001) recognised that the key challenges facing youth related to the impact of cultural change arising from global influences, migration and urbanisation.

These changes challenge traditional ways of living and the resulting tensions can bring about a range of stresses and anti-social behaviours.

The *Strategy for Development of Samoa 2008-2012* has developed indicators to assess the effectiveness of the implementation of its policies. These indicators include: a reduction in youth suicide, 'youth offender crime', violence and child sexual abuse. Reducing sexual risk behaviour to prevent adverse impacts on youth health is another high-priority area, in particular, sexually transmitted infections and teen pregnancy.

Both national strategies aim to improve community development and to advance social, economic and governance issues such as the capacity of women's committees, micro-credit and village-based development programmes. Parenting skills and addressing the impact of divorce on young people are other key priorities in the Youth Policy (2001). All strategies relevant to youth development acknowledge and commit to an improvement in education and employment, facilities and services development (*Strategy for the Development of Samoa 2008-2012*).

The *Samoa Mental Health Policy* (2006), the *Mental Health Act 2007* and the regional *Pacific Youth Strategy 2010* (SPC, 2006) set the stage for identifying the key issues to be addressed in strengthening mental health programmes and the capacity of mental health educators in schools and communities.

"Mental health is everybody's business" (WHO, European Ministerial Conference on Mental Health, 2005, p. 2). Mental ill health is costly to any person's life. If not treated effectively, it reduces a person's ability to function well and to be productive. Families and carers need to learn to recognise the signs of mental ill health. If well informed, they can manage, support and care for family members and reduce the risk of preventable mental illness. The key recommendations include:

6.1 Establish a Mental Health Family Association (MHFA)

As the Ministry of Health is committed to fostering this sector through collaboration with civil society groups, it is timely that a mechanism be established to support the development of a Mental Health Family Association (MHFA). It is recommended that a MHFA be established to advocate for improved gender-sensitive and youth services and the protection of the rights of people living with mental ill health and mental illness. "Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments." (WHO, 2002)

The intention of the *Samoa Mental Health Policy 2006* is to promote mental health and treat mental illness and to be well informed on Samoa's mental health status and services. Individuals living with mental illness should be able to realise their potential to be self-reliant and to be supported to become responsible, functioning productive people There is a need for a legally recognised association to encourage agencies working with youth and mental health to collaborate and create activities that are responsive and appropriate to improve community mental health standards.

A MHFA would have a membership of people living with mental illness, families and other interested persons. "The association will stand for advocacy of better accessibility and quality services." (WHO, 2002). It would:

- Be given statutory powers to express independent views on the Mental Health Service. It could function as a secretariat for the MHFA, organise an association of members and advocate for the protection of the interests of people needing and using the services.
- Advocate for the establishment of social protection systems and gendered youth services to implement the *Samoa Mental Health Policy* (2006)
- Be a voice for communities and for people living with mental illness and their families and carers.
- Undertake mental health promotion campaigns to assist Samoans to have a better understanding of mental health so that stigma and discrimination against those with mental illness is reduced.
- Advocate and promote the human rights of the people living with mental illness so they are better respected and protected (CRPD, 2008).
- Capacity building for health care professionals and communities to be able to recognise, identify and refer people who are showing symptoms of unstable mental health to appropriate health professionals. (This will be done in accordance with the DSM IV and/or WHO ICD10 index)

6.2 Youth-friendly gender-sensitive services

Specialised youth service centres to be established in the areas of education and training, employment and health.

- A comprehensive, confidential counselling service (personal development advice) made available in areas where youth, particularly at-risk youth, can access support. If the service is available where they are, it is more likely to capture their attention and address key areas of concern.

These health education and employment 'one stop shop' services must be accessible, available, affordable and appropriate to facilitate young people to make use of them in order to meet the specific needs of young men and young women.

6.3 Producing Samoa MH Information, Education and Communication materials

The SNA is keen to continue working with communities, youth groups and civil society to promote the maintenance of mental health and to develop resource maencourage coping strategies that will reduce the risks of mental ill health.

- Mental health awareness programmes for in-school and out-of-school youth and improvements in the capacity of parents and educators to discuss mental health issues should be continued strengthened and developed to support the implementation of the regional Pacific Youth Strategy 2010.
- Youth-to-youth and mental health promotion materials and awareness campaigns to reduce stigma and discrimination are needed.
- Extend and support the current YMH programme to continue advocacy work and awareness and education programmes in schools and communities.

6.4 Research

Research can be seen as a critical assessment of the degree to which services fulfill their stated objectives. It can provide information to develop indicators to monitor and evaluate the effectiveness of programmes and specific interventions. The mental health sector would be better informed with quantitative data that is disaggregated by sex, age and location. It is vital to have accurate information on these variables, particularly gender, to ensure sound analysis and to guide the development of gender-sensitive services.

- This study has revealed the need for further research into aspects of youth and mental health such as: Samoan suicide characteristics and prevention strategies; 'at risk youth' behaviours and their impact; and parenting and its influence on youth mental health.
- Undertake community based, qualitative research on mental health issues and build the capacity of youth to participate in this.
- Undertake consultation and research best practice models of the development of youth and mental health-related service providers.

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Appendices

APPENDIX 1: Samoa organisations in Youth and Mental Health services and support

ORGANISATIONS	YOUTH/MENTAL HEALTH SERVICE SUPPORT	CONTACTS	PHONE/EMAIL
Congregational Christian church Youth Organisation	CCC Youth Groups provides help and support to youths seeking support for individual spiritual and social developments	Rev. Iakopo Ieremia	(685) 30544
Victim Support Organisation	Provides supports to victims of physical and mental abuse of many forms.	Ms Cathy Schmidt	(685) 28548
Mapusaga o Aiga Organisation	Prioritise focus on Women and Children in domestic violence	Faoliu Wendt, Senior Programme Officer	(685) 22640
Alamagoto Youth Organisation	Church Youth Group promoting Christian Life principles for youths	Rev. Ieriko Sopoaga	(685) 22116
Faatoia Youth Organisation	Developing Youth Group Traditional Dancing and Entertainment for formal ceremonies	Faaaliga Setu-President of Youth Organisation	(685) 26552
Iva Congregational Christian Church	Focus is on advocacy programs on Prevention of Drug and Alcohol Abuse	Rev. Tonu Sipaia	(685) 51229
Matafaa Youth Organisation	Community Development for Methodist Church Village Youth Group, Health and Environment	Rev. Fepai Kolia	(685) 7592387
Leiffifi College, St Josephs Col Levaula Coll,	Support Secondary Schools for Youth Mental Health Promotion	Mr Falefata Tuaniu Mr Michael Godinet Rev. Ulurima Faasii	(685) 21911
School of Nursing and Health Science, National University of	Advocacy Group for Mental Health Work	President of School of Nursing Student Association	(685) 20072 Ext 105/110
Family Health Association	Provides family planning services and Sexual Reproductive Health of Adolescence	Mr Apineru Wright, Chief Executive Officer	sfha@lesamoa.net 685 770038
Faataua Le Ola Organization	Provides Counseling services for Suicide related problems and conduct a HotLine phone service	Mrs Ofeira Salevao CEO	flo@samoa.ws 800 5433
Mental Health Services, MOH	Provide all mental health services and treatment for mental illness	RMN Aliilelei TenariClinical Nurse Manager	(685) 66600 685 7518253
O Le Siosiomaga Society	Coordination of the Youth and Mental Health Project with Samoa Nurses Assn./FSPI	Fiu Mataese Elisara	685 25897 fiuelisara51@yahoo.com
Samoa Nurses Association	Coordinates and implements the Youth Mental Health project in Samoa in collaboration with the OLSS	Taulapapa F Nielsen - President	685 24439 samoanursing@lesamoa.net

APPENDIX 2: Samoa Mental Health Status 2005 and 2009 (Adapted from Hughes, 2005)

WHO ATLAS POLICIES AND LEGISLATION 2005	SAMOA NURSES ASSOCIATION REVIEW 2009
Mental Health Policy A mental health policy is absent. Substance Abuse Policy A substance abuse policy is absent. National Mental Health Programme A national mental health programme is absent. National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1994. There is a drug policy approved in 2001 and awaiting an implementation plan. Mental Health Legislation There is a Mental Health Law. The latest legislation was enacted in 1961.	**Mental Health Policy 2006** National Mental Health Programme A national mental health programme is absent. National Therapeutic Drug Policy/Essential List of Drugs A Narcotic Act 1967 Mental Health Act 2007
MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is tax based.	**MENTAL HEALTH FINANCING** Via other health service budgets and other NGO support
MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. There are no disability benefits for mental illness or disabilities.Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Community based mental health service is family focussed.Regular training of primary care professionals is not carried out in the field of mental health. However, family care givers are receiving training. Community nurses working in the field have received focused short term (3 weeks) training sessions in 1998/99.There are community care facilities for patients with mental disorders. Community mental health care is family focussed and is completely provided by nurses.	**MENTAL HEALTH FACILITIES** Persons with mental disorders treatments are free and fully subsidised by government. There are no disability benefits for mental illness or disabilities
PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0.2 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0.2 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 0.5 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0	**PSYCHIATRIC BEDS AND PROFESSIONALS** Remains the same as reported in 2005
NON-GOVERNMENTAL ORGANISATIONS NGOs are not involved with mental health in the country. NGOs are involved in counselling and suicide awareness groups.	**NON-GOVERNMENTAL ORGANIZATIONS** Partnership work with NGOs is establishing and developing between MH Unit services and NGOs e.g. Samoa Nurses Association coordinates the Youth and Mental Health program having the OLSSI the main regional partner with the FSPI, Suva Fiji. Refer Appendix 1 for other youth and mental heallh NGO support

WHO ATLAS POLICIES AND LEGISLATION 2005	SAMOA NURSES ASSOCIATION REVIEW 2009
INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. There was an Annual Report by the Department of Health in 1997 &1998. The country has data collection system or epidemiological study on mental health. A report is prepared every month and sent to the health planning and information section.	**INFORMATION GATHERING SYSTEM** Needs to improve and strengthen
PROGRAMMES FOR SPECIAL POPULATION The country has specific programmes for mental health for indigenous population, elderly and children. There are programmes to look after dementias in elderly and mental retardation and developmental problems in children and also victims of abuse and suicide.	**PROGRAMMES FOR SPECIAL POPULATION** This work is done in collaboration with the Loto Taumafai Organisation who is the main organisation providing special needs education for those living with mental retardation and intellectual disabilities
OTHER INFORMATION **ADDITIONAL SOURCES OF INFORMATION** Aiga – A partnership in Care through Continuous Collaboration A culturally appropriate perspective especially appreciating cultural beliefs, values, traditions and the nature of the Samoan being, that is, the Samoan person does not exist as an individual, but as in a collective context of identity and be longing, genealogical lineage, roles, responsibilities and heritage foundation of the culturally appropriate "family-focus community based mental health care service in Samoa. ■ AusAid and WHO funded two training sessions for RNs in mental health care. ■ Mr. K. Kellehear – Consultant from UTS facilitated training which helped increase human resources for mentalhealth care. ■ Continuous in-service training conducted for small staff working in mental health care. **Model essentials:** – Knowledge of the beliefs, traditions, customs and values of the AIGA. – Strong understanding in the cultural background of the client and AIGA. – Willingness to go to the homes and be committed to the work. – Ability to communicate effectively and listen attentively to AIGA.	**OTHER INFORMATION** **ADDITIONAL SOURCES OF INFORMATION** Credential programmes for Mental Health Care Professionals (nurses) was conducted by Sept 2008, coordinated by Mr. K. Kellehear. The programme is conducted every two years to ensure safety of practice by Mental Health Care nurses of Samoa

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Aiga model influenced by systems theory and philosophy of nursing in Samoa: – the AIGA model operates from the heart – true care begins at home – striving to help a Samoan person in the presence of the whole family to express what he or she is experiencing is "doing it the Samoan way" through sharing experiences and stories. **THE STRANDS OF MENTAL HEALTH CARE** ■ Strand 1: Recognising the need to change ■ Strand 2: Use of *aiga* (family) as strength of culture to facilitate care ■ Strand 3: Integration of mental health care into community health nursing services ■ Strand 4: Specialist mental health care **DEVELOPMENT OF MENTAL HEALTH EDUCATION** ■ A course in Mental Health & Mental Ill Health for the undergraduate degree program is included in the curriculum. ■ Mental Health is one of specialty area in nursing. ■ Postgraduate Diploma in Mental Health was offered this year 2004 by Faculty. ■ Competency standards have also been developed for specialist practice. **INTEGRATION OF MENTAL HEALTH INTO COMMUNITY HEALTH NURSING** ■ Implementation of the AIGA model is expressed through specific roles characterising Samoan nurses: – "*pae ma auli*" (peacemaker) counseling and advocating for families; problem-solving; – "*faioa*" (wealthmaker) collaborate with families promoting well-being and health; – "*ositaulaga*" (leader in worship) offer comfort through being there, encouragement during spiritualdistress; – "*taulasea*" (healer) heal the physical, psychological and spiritual needs to achieve holistic care	

Notes

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