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COUNTRY REPORT

Developing a culturally appropriate mental health care service for Samoa

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Abstract

Mental Health Care Services are part of the National Health Services for Samoa. Their function is to provide mental health care services to the population of Samoa, which numbers 180,000 people. However, like many other countries in the Pacific region, mental health is considered a low priority. The mental health budget allocation barely covers the operation of mental health care services. More broadly, there is a lack of political awareness about mental health care services and mental health rarely becomes an issue of deliberation in the political arena. This article outlines the recent development of mental health care services in Samoa, including the Mental Health Policy 2006 and Mental Health Act 2007. It tells the story of the successful integration of *aiga* (family) as an active partner in the provision of care, and the development of the *Aiga* model utilizing Samoan cultural values to promote culturally appropriate family-focused community mental health care for Samoa. Mental Health Care Services today encompass both clinical and family-focused community mental health care services. The work is largely nurse-led. Much has been achieved over the past 25 years. Increased recognition by government and increased resourcing are necessary to meet the future health care needs of the Samoan people.

Background

Samoa is a south-sea tropical country consisting of 10 islands, four of which are inhabited. The total population is 180,000 people mostly living on Upolu Island where the capital, Apia, is located. Samoa is classified as lower-middle income country (World Health Organization, 2011). The health care system has two components: the Ministry of Health and the National Health Service (NHS). The Ministry's role is regulatory, monitoring and policy development, while the NHS provides health care services to meet the needs of the country.

Samoans have a holistic understanding of health in common with other Pacific peoples (Ministry of Health, 2008). Physical, mental, social and spiritual health are considered indivisible (Tamasese *et al.*, 2005; Hope and Enoka, 2009). Mental wellbeing is grounded in the *aiga* (family) and community (Government of Samoa, 2006).

History of mental health care

In the early days, people with "madness and violence" were housed in prison. They were judged by their rudeness, loud antisocial behavior and filthy obscenities. Treatment was mainly custodial, psychotropic medications were rare and families never visited. The families believed that they suffered a form of *ma'i Samoa, ma'i aitu* (demoniac illness) and required treatment with traditional medicines made from concoctions of leaves and earth for relief and recovery.

Common psychotropic drugs became available in the 70s, initially antianxiety drugs and later chlorpromazine. In 1970, a new ward for people with mental

disorders was built. The location was highly inappropriate as it stood on top of the valley behind the main hospital and posed a risk for patients and staff. This indicated the thinking about care for people with mental disorders: families were fearful and neglectful of their relatives while the government did not recognize these citizens and accorded a very low priority to their health care needs. There were no trained mental health care workers to provide professional care. Accommodated in this small, isolated building for many years, the patients were both stigmatized and institutionalized.

Time for change

In the mid-1980s, a new way of thinking emerged; a reminder that one worked yesterday (past) for today (now) and today for tomorrow (future) encouraged a return to the roots. Questions were asked: "Why there are so many people clustered in this most inappropriate place, living like untrained animals without family support and visitation?" "What is happening to the traditional Samoan family roles (*nafa o aiga*)?" "Where are the values of the Samoan culture which gives the country the most treasured hospitable warmth and friendly people?" These questions guided major innovation, using the Samoan culture as it is rooted in the *aiga* as the focus of mental health care delivery.

The *aiga*: A partnership model of mental health care

The final model was informed by qualitative research undertaken by the first author (Enoka, 2001) who made home visits to the families of all 26 patients in the mental ward. The number of people in each family varied from six to 10, mostly head of family (*matai*), wife (*faletua* or *tausi*) and siblings (*tamaiti*) or extended family members. Duration of the visits varied, depending on the length of deliberations and the family response to the discussions. The strength of Samoan culture was reflected in the use complimentary greetings and other cultural etiquette and protocols. The language spoken inspired compassion and respect and allowed the family to express their feelings and share their honest thoughts about their institutionalized relative and the *aiga* conference outcome.

Drawing on the research findings, *Aiga* – A Partnership in Care through Continuous Collaboration was established and implemented as the community-based and family-focused model of mental health care service delivery for Samoa. The *Aiga* model works in three phases. Phase 1 includes the cultural approach between the mental health nurse and the family: entering the home; shaking hands; and taking a seat and listening to the host's greetings, usually the head of the family at this point. This phase will take time as it involves getting to know the family and trying to understand their thinking, attitudes and actions towards their sick relative and the total family response towards accepting the person. The nurse explains the client's illness and his or her behavior and the treatment involved, and counsels the family towards collaborating with the client in his or her treatment. The nurse also collaborates with the client in obtaining ongoing support from and for the family; whatever assistance they require. Listening is the most significant aspect at this phase as it allows the nurse to empathize with the family and the client.

Phase 2 includes "storytelling". The family tells their story in their own words and the nurse allows their expressions of the story to become a reality. The nurse listens attentively to the context of the story and pays close attention to the full story, developing an understanding of the family's beliefs and values and their preference for treatment modalities. Some families will go to great lengths in telling their story and can be quite exhausting; the nurse continues to encourage them to get to the crux of the issues. The story is then analyzed and put into clear perspective so that the family is able to recognize their worth in contributing to the client's mental health care and treatment, and to help them understand their own perspectives on mental health care.

Phase 3 allows the family to take the lead in determining what could be the problem and what to do about it. They can identify and help look for treatment that they think is appropriate or they can refer them to the Mental Health Unit for further assessment. The family is comfortable in taking care of their relative and is concerned about their mental health. Family members have a practical understanding of the mental disorder, diagnosis and treatment and are supportive of the sick person. The nurse in her role of wealth maker (*faioa*), that is health as the best wealth, continues to support the family and provide necessary treatment for the client.

According to the Samoa Nurses Association (cited in Hope and Enoka, 2009) the move from institutional to community-based care has brought about many benefits. These include better recovery due to early improved communication between the family and nurses, greater medication compliance, more tailored

treatment, and less disruption to interpersonal relationships and regular activities. This approach also maintains the dignity and human rights of people with mental disorders.

Mental health workforce, organization and financing

In order to provide specialized staff for the new model of care, mental health and mental illness studies were introduced into the undergraduate nursing program at the National University of Samoa in 1993. Community nurses in the field received three weeks in-service training in mental health in 1998/99. A Postgraduate Diploma of Nursing in Mental Health was run once in 2004. There were six graduates, three of whom are now working in the Mental Health Unit, which is located in the Ministry of Health compound that also includes the Tupua Tamasese Meaole Hospital.

Mental Health Unit staff are accountable to the Manager of Clinical Health Services for the delivery of clinical services and to the Manager of Nursing and Integrated Community Health Services for nursing-related matters. While the Unit is headed by a part-time psychiatrist most of the work is nurse-led. The position of Chief Mental Health Officer (not restricted to a doctor) is filled by the psychiatrist or by one of the nurses if he/she is out of country.

Mental Health Care Services have both a clinical component (including holistic assessment, management, security, seclusion and rehabilitation) and a family-focused community component. The Mental Health Act 2007 incorporates two types of treatment order: an Inpatient Treatment Order and a Community Treatment Order. Whichever is executed depends on the mental status examination of the client and their general behavior. The Mental Health Unit also receives voluntary admissions and provides outpatient treatment.

After discharge, patients are followed up daily for the first week, then fortnightly, then monthly. Those who live far away are followed up by the local community nurse who reports back to the Mental Health Unit. The mental health nurses visit all islands on a quarterly basis. In the villages, community nurses are the first point of contact for patients and their families. If a person shows signs of mental illness, advice is sought by phone from the Mental Health Unit. Difficult and violent patients are taken to the Mental Health Unit or the prison where the mental health nurses providing a visiting service. Disagreements between the family and nurses about management are resolved by discussion and negotiation. The family plays a major role in rehabilitation, encouraging their recovering relative in activities of daily living, employment and education.

A National Mental Health Policy was officially approved in June 2006, following consultation with key stakeholders and the general public. It envisions "a multi-sectoral approach which provides quality care that is accessible to all people" (Government of Samoa, 2006, p. 3). However, the budget allocation for mental health barely covers operation of the existing limited government services.

Conclusion

Over the past 25 years, Samoa has moved away from a standalone mental institution to a system where families and nurses share responsibility for the care and treatment of people with mental disorders in the community. Despite shortages in the professional mental health workforce, funding limitations, poor facilities and a lack of political awareness, a great deal has been achieved. Increased recognition by government and increased resourcing are necessary to meet the health care needs of the Samoan people in the future.

Importantly, the transformation in mental health practice described has been informed by local research and, in involving family, builds on the strengths of the Samoan culture. Similar culturally based approaches to mental health research and service development have been effective with Maori and Samoan communities in New Zealand (Tamasese *et al*., 2005; McClintock *et al*., 2012). This way of working may have relevance for other Pacific Island and Indigenous peoples.

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