Explaining Policy Change in Samoa's Mental Health System

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Abstract

Modern mental health systems are the products of successive waves of policy development and adaptation. This is particularly so in many low to middle income countries that inherited colonial mental health laws, and institutions often followed by legislative shifts at independence. But how otherwise do these systems change? And why do these systems change? This article applies historical institutionalism to consider policy change over time, in a single case study of a small island state, Samoa. In doing so, the article will consider three discrete policy change episodes to argue that national policy change in the area of mental health has been the result of foreign direction or influence. These three critical change events occurred leading to policy change: colonisation, independence and the intervention of an intergovernmental organisation. These findings are instructive for future, domestically-driven policy change initiatives, in providing the importance of historical policy development and the continuing importance of international policy advocates in promoting policy change.

Keywords: Historical Institutionalism; International Organizations; Mental Health; Public Policy; Samoa

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Introduction

Public policy and law in the modern nation-state are seldom novel creations. Instead, what we see rests upon the shifting sands of old and often decaying policies that have preceded them. This is true today for most states, whether they are former colonizers or the colonized. Yet, systematic study of these policies to better understand their unique legacies, a form of excavation, is seldom done. Since the early 1990s, one body of scholarship has sought to explore policy change in a historical context. This literature, known as historical institutionalism, has made great strides in creating a systematic approach to the study of policy movement (Krasner, 1984; Skocpol, 1992; Steinmo, Thelen & Longsreth, 1992). Yet, many of these studies have been conducted with the Organisation for Economic Cooperation and Development (OECD), and have not considered the transfer patterns within former European colonies and other developing and middle-income countries, despite these countries often having their own complex policy contexts and legacies.

This article aims to contribute to this growing literature on historical institutionalism through an examination of the establishment of Samoa's mental health system, exploring critical historical events in its establishment. The article contributes to the study of public policy development by exploring the interaction and mechanisms between local policy contexts, and international exemplars of policy and law. An additional contribution is made by presenting new research and insights into policy transfer within a non-European and non-North-American context, which has been, to date, under-represented in this literature.

This article will proceed in four parts. First, historical institutionalism is presented as a useful, theoretical framework for organising the study of the movements of public policy, particularly those transfers occurring over time. Second, the article will outline the qualitative methodology employed to consider the empirical circumstances surrounding three waves of policy transfer of mental health policy and law in Samoa. These policy change episodes are then considered before a final discussion, where it is argued that these events occurred due to exogenous factors: the first transfer was a colonial era movement of custodial mental health law, and the second update to the law occurred along with a raft of other law changes during decolonisation. The most recent transfer again occurred at the instigation of foreign actors, but this time enjoyed greater domestic participation in the policy and law-making process. These three policy change episodes are considered together in the final part of this article, where some observations about the increasingly democratic and participatory nature of the transfer process are made.

Historical Institutionalism

Historical institutionalism is a branch of the so-called "new institutionalism" scholarship concerned with the persistence of organisations in changing circumstances. Skocpol (1992) observes that the decisions made to establish particular institutions (or not) have enduring legacies. This phenomenon has been described as the institution, in essence, persisting (institutional stability or "equilibrium") until a sufficient force ("punctuation") is brought to bear on it, forcing change: this phenomenon is called "path dependence".[1] Hence, historical institutionalism might be seen as "an attempt to illuminate how political struggles are mediated by the institutional setting in which they take place" (Steinmo, Thelen & Longsreth 1992).

Krasner in his oft-cited “Review: Approaches to the state: Alternate conceptions and historical dynamics” (1984), extends the historical institutionalism notion of path dependence to broader implications for policy developments in other developing and developed nations (See also, Thelen, Steinmo & Longsreth, 1992; and Cortell & Peterson, 1999). He notes that once community "functions . . . are viewed as proper and legitimate” for state action and “are influenced by general international norms and practices", they become identified as "best practices", and thus play an agenda-setting role in developing nations (Krasner, 1984, p. 241). The effect is that "these characteristics come to be associated with the essential nature of the 'modern' state and cannot be ignored even by states with very different needs" (1984, p. 241). As an example of this, Krasner mentions the fact that, regardless of the resources needed for proper implementation, most countries have some manner of social security system and have identified education as a state responsibility. These are innovations made at the more developed nation level, yet persist in policy making decisions in developing nations.

In the particular context of the decolonisation following World War II, Krasner (1984) observes that, despite colonies lacking in several key capabilities of the modern nation-state, an aggressive decolonisation policy was pursued because, as he notes, "[t]he triumph of the national state in Europe became a triumph of the national state around the globe" (1984, p. 242). These regions became a part of the historical process of state creation, and the idea of a sovereign nation was transferred from developed nation to developing nation, making that option (independence and

[1]Also referred to within the public policy context as "policy trajectories" (see e.g. Thelen, 1999) and "policy feedback” (see e.g. Pierson, 1993).

statehood) the only acceptable, legitimate offer.

Mahoney and Thelen (2010) are amongst those scholars attempting to move the historical institutionalism debate beyond the narrow confines of punctuated equilibrium in understanding institutional change. The authors observe that recent research on path dependence (e.g. Pierson, 2000a & 2000b; Thelen, 1999) argues that "path-dependent lock-in . . . is exceedingly rare in actual institutional practice" (Mahoney & Thelen, 2010, p. 3). Instead, the authors suggest that "problems of rule interpretation and enforcement open up space for actors to implement existing rules in new ways" (2010, p. 4). This observation permits greater consideration of agency in the study of institutional change in various contexts, such as Falleti's (2010) study of health care reforms in Brazil as analogous to the mental health policy context.

Writing on the evolution of health care reforms in Brazil, Falleti finds that the traditional historical institutionalism analysis, with its emphasis on such punctuated equilibria as economic crises or other critical junctures, risks missing the layering or gradualist reforms of the Brazilian health system. She begins with a "crucial opening" that began a gradual process resulting in significant national health care reforms that played on the military regime's efforts to consolidate authoritarian rule beginning in the 1970s. Falleti's focus de-emphasises the critical juncture preoccupation in historical institutionalism in favour of a gradualist approach to change.

A more intensive case study approach to research is likely to yield more accurate insight into institutional change. In order to do historical analysis, one must rely on the historical record *in toto* and not on a selective reading to fit an existing model. However, given the influence of the underlying motivations for health sector reform in Brazil, the overarching ideological context of health systems, and sound public management principles, a question might be posed about what foreshadowed Falleti's "crucial opening", thereby making any institutional change possible.

In many ways, Tuohy's (1999) study of the general health sector as institution brings many of these various institutional strands together. As she observes, from the 1950s onwards a prevailing institutional norm developed encouraging increased access to health services whilst seeking to control the costs of care (1999, p. 18). By the 1990s, health care reforms were atop the policy and political agendas of most advanced industrial countries (1999, p. 3). Tuohy links these health sector reforms to overall neoliberal notions of limited state involvement in what would otherwise be a competitive market. The OECD further advanced these health care reforms by publishing many reports between 1992 and 1995 considering health care reforms

throughout OECD countries, and establishing a best practices model for adopting nations to rely upon in embarking upon their own reform endeavours. These OECD publications and policy ideas would inform World Bank efforts in promoting reform of the developing world's health systems.

In Tuohy's construction of health care, it is an institution that, once established, tends to develop a particular "logic" governing both actor behaviour and the trajectory of potential change (1999, p. 7). Given the complexity of health systems, systemic change occurs rarely, and when it does it is highly influenced by prevailing ideas of best practices during what Tuohy calls a "policy episode" (1999, p. 11). These episodes must themselves be significant in order to alter the inertial forces of entrenched institutional interests. A policy episode requires two central factors to make systemic change possible. Firstly, a political system must provide a "consolidated base of authority for political action" (Tuohy 1999, p. 11). Strong party control in the unitary, Westminster-style parliamentary system will typically suffice, but is not itself a prerequisite. Secondly, health care policy reforms, in particular, require high priority amongst key policy actors.

Importantly, Tuohy's construction of the health care institution isolates it from the broader health policy ideas context regarding health service delivery (1999, p. 12). Ideas about practice can persist for many years, even decades, before being formally adopted. Yet, eventual health reform itself will be highly influenced by such ideas. Success is likely to arise where there is convergence between the "strategy of a proposed change" and the "internal logic of the system" (1999, p. 13). System logics represent the institutional legacies of past events. Between times of acute change, they are shaped by the key actors' behaviour, which is itself shaped by the institutional context as well as other overlapping institutions. Similarly, Rochefort (1997) observes that mental health policy developments in core countries tend to coincide with changes to the larger health systems within which they were historically located. The health system changes emerged from within each nation-state, but have occurred for different reasons over time, such as fiscal demands on the public health system.

Methodology

This article focuses on a single case study of Samoa. The case study is part of a larger, two-country comparative analysis at the core of the author's doctoral dissertation. However, this article focuses on qualitative data obtained from a review of historical and contemporary textual sources, including parliamentary records, official

government reports, and other documents. In addition, for the final policy event, 13 key informants participated in semi-structured, in-depth interviews. While qualitative research does not claim to offer generalizable results, its value lies in creating thick descriptions of events to add to our understanding of discrete events, to explore these in a systematic way, and to form the basis for future research.

For the in-depth interviews, this study employed purposive sampling in order to identify those most engaged in the policy reforms in 2006-2007. Participants in this study were recruited using email or telephone to invite them to take part in an in-person interview. The researcher built on the initial core of participants identified in government publications or media reports through the technique of snowballing (Browne, 2005). This approach involves asking respondents to identify other possible, knowledgeable participants.

The respondents consisted of mental health workers and policy professionals employed by the Samoan government, national or community organisations, and international organisations who had been involved in the 2006-2007 policy and law reform process. Documentary sources from the New Zealand national and parliamentary archives were consulted for the first and second transfer events, since there were no living participants identified either in available media or other publications, or mentioned by study participants for the 2006-2007 transfer event. The sample of 13 total consisted of seven who were government officials, including those involved in policy development and mental health service delivery, four from three different domestic organisation representatives (Samoa Umbrella Organisation of Nongovernmental Organisations [SUNGO]; Goshen Trust; and Mapusaga o Aiga), and two from international organisations (World Health Organization, and Pacific Island Mental Health Network [PIMHNet]).

Case Study: Samoa's Mental Health System in Historical Perspective

This section is presented in three parts. Before turning to the most recent policy and law reform in Samoa, two historical policy episodes will be considered in order to provide historical context. First, in the early twentieth century, German institutions were established for the primary benefit of the colonial project in the region. These formed and grounded the institutional framework within which the current health sector, and its mental health sector, would later operate. This was a primary, coercive policy movement that brought not only physical structures (e.g. prisons and hospitals), but also discursive institutions such as medicine and law, and set dual categories of "European" and "Samoan" (and in the case of the hospital, a third,

"Chinese" category). This period marked the transition from disorder and civil war in Samoa. New Zealand's Samoa Act 1921 is a second brand of coercive policy episode marked by direct legislation for Samoa, though the period between 1921 and 1961 saw a gradual devolution of political responsibility to local institutions. Hence, the official health sector has its roots in the German institutions and the New Zealand regulatory framework provided by the Samoa Act 1921, policies largely turned over to Samoa at the lead-up to independence through numerous ordinances. In particular was the Mental Health Ordinance transferred to Samoa in 1961 along with several other health-related bills, a practice to be repeated in 2006 and 2007.

Policy Episode One: Colonialism, Mandate and Mental Health: German Colonial Ordinances, Mental Defectives Act (NZ) 1911, and the Samoa Act (NZ) 1920

While no definitive record apparently exists of any explicit mental health regulations for the German colony of Samoa, German occupation provided the foundation for several institutions integral to the modern mental health system, such as police, prisons, and hospitals, as well as ordinances providing for detention due to health status (quarantine) (New Zealand National Archives, 2011). The law and other institutions imported with the German colonial administration sought to enshrine order through certain liberal economic principles whilst assigning traditional Samoan affairs, such as lands and titles, to specialised judicial institutions.

Amongst these economic developments adopted between 1 March, 1900, and 15 August, 1914 were public order provisions (liquor and opium regulations, theft, police, prison and press regulations, roads); laws on various aspects of agriculture and animal maintenance (plants, poultry, and pig enclosures); public health laws (quarantine, plague, and rats); commercial laws (Samoa Trading Company, Seaman's Coastal Ordinance, tariffs, transport, weights and measures); and a category of "Samoan Laws", which presumably contained rules designed for the protections for Samoan culture (New Zealand National Archives, 2011). When New Zealand took possession of Samoa during World War I under a League of Nations Mandate, and later under a UN trust relationship, it continued the economic development practices begun under the German administration.

The Mental Defectives Act 1911 (NZ) served as the basis for Samoa's Mental Health Ordinance 1961. However, the 1911 Act itself was the object of a policy movement from the United Kingdom, and previous New Zealand mental health law was rooted in a transplant from Australia. The provisions of the Mental Defectives Act were first applied to Samoa under the Samoa Act 1921 (NZ). A "mentally defective person" was first defined in the 1911 Act as "a person who, owing to his mental condition,

requires oversight, care, or control for his own good or in the public interest". The law first found its applicability to Samoa under Part XII of the Samoa Act 1921, dealing with "Persons of Unsound Mind", and a separate section for those deemed "Criminal Lunatics". "Persons of Unsound Mind" could be arrested and sent to hospital or "other places" in Samoa (as well as, under certain circumstances, transported to New Zealand), which invariably meant the Upolu prison, where they would be housed alongside "criminal lunatics".

Following the Mental Defective Amendment Act 1921 (NZ) and the Samoa Act of the same year, the New Zealand portion of mental health law changed radically over the years between 1921 and 1961. These changes included at least 11 subsequent Amendment Acts, including the significant 1954 amendments, which changed the more offensive title from "Mental Defectives Act" to "Mental Health Act", the title used in all subsequent amendments and new legislation. The law itself, despite the many amendments, did not undergo a significant redraft until 1969. However, prior to this major overhaul, Samoa became an independent country and the Samoa Act 1921, as amended, ceased to apply in Samoa.

For reasons lost in the intervening decades, the 1961 Ordinance used the older 1911 definition and terminology over the more recent 1954 updates. The statute adopted the definition of "mentally defective person" as found in the 1911 definition, only without the subclasses of individuals found in the initial Act.[2] Significantly, while the overhauled New Zealand Mental Health Act would go on to be significantly amended, nearly fourteen times through 2007, the Samoa Mental Health Ordinance was not amended until it was repealed and replaced in its entirety by the Samoa Mental Health Act in 2007.

Between 1920-1962, New Zealand employed various policies to further promote Western-style government and institutions in Samoa. One element to this policy and law foundation was the inclusion of Part XII of the Samoa Act 1921, providing orders of medical custody for persons of unsound mind. Similar to the Mental Health Ordinance 1961, Part XII empowers a "chief medical officer" with making applications to the court for civil commitment. This Part requires a medical examination and the production of a certificate to the court that the individual is in fact of "unsound mind", and such custody is necessary "in his own interests or the safety of other persons". The court must find both elements to issue an order of

[2] For instance, there was a distinction between "persons of unsound mind" who could have a mental disorder at any age, and "mentally infirm" persons, who were those with cognitive problems resulting from age or some other apparently organic condition.

medical custody for a period not to exceed, in the first instance, six months, with the possibility of six-month renewals. Additional provisions in Part XII permit the removal of an individual (presumably a European) who is under an order of medical custody to New Zealand. Arrest without warrant was authorised so long as the individual was brought without delay before a "Judge or Commissioner of the High Court". Most striking is the provision labelled "*Criminal Lunatics*", dealing with individuals accused of crimes who are thought to have acted as a result of their mental illness. These sections are, with only minor revision, the exact language adopted in the Mental Health Ordinance 1961.

Policy Episode Two: Decolonisation and Samoa's Mental Health Ordinance 1961

In the lead-up to independence, the transitional government enacted a host of laws, known then as "ordinances", since they were pursued under authority of the Samoa Acts (as amended). The Honourable Tufuga Fatu[3] introduced the Mental Health Ordinance 1961, which had its first and second reading and committal all on 14 December, 1961 (Government of Samoa, 1961, pp. 118-24). The Bill had its third reading on 19 December, 1961, and received assent on 29 December, 1961, only three days prior to independence.

During the process, there was an interesting and lively committee debate over a provision that made it a crime to have sexual intercourse with a "mentally defective female", first in the form of a hypothetical using one of the delegate's wives as the unfortunate specimen to have "contacted insanity", and left her husband without recourse to this marital right (Government of Samoa, 1961, pp. 118-24). The comment led to a perceptive response that the provision itself was terribly "one-sided" in that it proposed to protect a woman but not a man, and that the provision might read better as "mentally defective person". Yet, at the time, one would not engage in "sexual intercourse" with a man, and a woman was incapable of performing sexual intercourse on someone, so the language meant exactly what it purported to say and was left alone. At one point in the debate, there must have been the perception that the topic of sexual intercourse had become a bit of a joke: the Speaker admonished the assembled men of title to remember to "speak with respect on this matter as it deals with sick people, the mentally defective person" (Government of Samoa, 1961, p. 120).

Further, as support for leaving the language as it appeared, Fatu offered the

[3]The representative from Vaisigano Ward No. l, the capital of Asau district at the extreme western end of the island of Savai'i

following: "I wish to say that this new Bill was passed on the actual wording of the Samoa Act 1921, Article 127" (Government of Samoa, 1961, pp. 118-24). Notwithstanding the desire for consistency between the New Zealand law and the proposed ordinance, further arguments on behalf of the "future generations" of unborn children that the wording be changed from "female" to "person" throughout the Bill ensued. Here again, the argument met with resistance because it is not possible to have "sexual intercourse with a person", only for a male to have it with a female; therefore the language should stay as it is. It was at this juncture that another representative referred to a "Mental Health Explanatory Note" that apparently accompanied the proposed legislation provided by its drafters to explain the purpose of each clause of the proposal and how it related to provisions of the Samoa Act 1921.[4] The proposed change from female to person was defeated by only 15 votes (there were 13 in favour and 28 opposed to the proposal). There was no other debate on the Bill, and it was passed on 15 December, 1961, a little over two weeks prior to independence.

The 1961 law did not reflect the best practices on mental health of the time. In effect, the law created the legal mechanism for detention, or "control and treatment", as the ordinance referred to it, of those with mental illness. The ordinance had the early reflection of the need to secure rights by establishing a visiting board entrusted with supervising the personal welfare of individuals kept in medical custody. The ordinance emphasised the primacy of the "medical practitioner" as a qualified medical, and a "mentally defective person" as "a person who owing to his mental condition, requires oversight, care, control of himself or his property for his own good or in the public interest". If a medical practitioner feels an individual is a "mentally defective person", then he can either conduct or cause the individual to be transported to the capital for evaluation. If the person is uncooperative and seemingly dangerous, then a constable is required to transport the individual to Apia, acting on a warrant issued by the medical practitioner. Once at the institution, two medical practitioners must examine the individual and then issue reports to the Director-General of Health. Based on the findings, the Director-General then either discharges the individual or applies to the Supreme Court for an order of medical custody.

The court would determine whether the individual is "mentally defective and [whether] his detention in medical custody is necessary for his own interests or for the safety of other persons". If so, the court ordered the person to be held for up to six months with the possibility of renewal for six months (but could remain in

[4] Unfortunately, this accompaniment has apparently been lost and was unavailable in the Samoan Parliamentary Archive.

custody indefinitely with six-month reviews). Further, the Ordinance provides that "any person believed on reasonable grounds to be of unsound mind and to be dangerous to himself or others may be arrested without warrant by a constable or any other person", provided the individual was brought "forthwith" before a judge or magistrate who could order the individual held pending an application for medical custody and the process outlined above. The Ordinance also contained, unlike its 2007 successor, provisions for determining criminal culpability (which was restated in the criminal law and which are also currently under consideration by Samoa's Law Reform Commission). In fact, sections 11-15 of the Ordinance deal with this concern. In essence, these provisions create a rebuttal presumption of "sanity" that can be overcome by evidence establishing that the individual is a "natural imbecile", or of similar condition rendering him or her "incapable of understanding the nature or quality of the act", or "knowing that [it] was wrong".

Policy Episode Three: International Organisations and Policymaking: Mental Health Policy & Act 2007

Samoa's health sector reforms, which the Government of Samoa had prioritised since at least 1990, coincided with the broader turn towards market liberalisation and universal suffrage. The World Bank, for instance, credits these reforms with "macroeconomic stabilization and comprehensive structural reforms, which contributed to rapid real economic growth of 4 per cent per annum" between 1993-2006 (World Bank, 2008, p. 1). The political decision to focus on this sector, coupled with the availability of structural funding from international sources to support health sector development, helped to see gains in indicators such as life expectancy; maternal, infant and child mortality rates; reductions in infectious diseases; and the achievement of high immunisation coverage. However, success on these concerns has given rise to new health concerns due to the epidemiologic transition. These include the constant increase in urban population resulting in substandard living conditions and limited access to health services, the rise in NCDs, poor nutrition, the persistence of communicable diseases, and the increasing costs to government of maintaining secondary and tertiary health care brought about by changing disease patterns and demographic profiles. Yet these larger health sector reforms did not by themselves bring about mental health policy change. That change would come by the end of that decade, instigated by a new global health initiative of the World Health Organization.

In 1998, the World Health Assembly reaffirmed the "Health for All" policy in 1998 with an added emphasis on "humanitarian action and human rights" (WHO-WPR,

2003, p. 20).WHO, in pursuing the overall policy, dedicated itself to a number of goals, amongst which is to "develop an enabling policy and institutional environment in the health sector". It has identified "limited specific priorities", which are based on the "potential for a significant reduction in the burden of diseases using existing cost-effective technologies", and include mental health, along with several others (2003, p. 21). Health for All began to be implemented throughout the various WHO regions of the world in the years that followed its promulgation.

In early 2002, ostensibly at the request of the Government of Samoa, WHO sent a short-term consultant to Samoa to gather information on the nation's mental health system, with an aim to develop a collaborative approach to establishing a suitable mental health programme in Samoa. The consultant was specifically charged with analysing "the situation with Government and other local people, and recommend the means of achieving and supporting the required change, e.g. advocacy, policy, legislation, programme introduction and evaluation" (WHO, 2004, p. 2).The consultant's report made several recommendations for Samoa, including to develop a national mental health programme (since there was none) and to "carry out legislative and regulatory reform and enforcement in the areas of alcohol and consumption, anti-discrimination legislation, and mental health legislation" (WHO, 2004, p. 3). The report referenced the move to community-based mental health services that occurred in the 1980s and 1990s, but raised the persistence of several problems, including the lack of a psychiatrist (a situation, which, at least for the time being, has been addressed); limited medication availability; limited nexus with alcohol and drug abuse or dependency matters; and rural transport complexities.

The consultant introduced mental health promotion as a conceptual framework with several key individuals. This framework was adapted from Australia's Victorian Health Promotion Foundation's Mental Health Promotion Plan, 1999-2002 (Victorian Health Promotion Foundation [VHPF], 1999) and included "interventions" (policy development, legislative reform, research, monitoring and evaluation, communication and advocacy, project development, and funding). The goal of this framework was to reduce the overall stress, anxiety, and depression levels in the population through these interventions, which would thereby reduce the overall occurrence of certain mental illness, including depression and anxiety. In addition, these reductions, and others, would result in decreased risk behaviours associated with drug abuse and crime, amongst other factors.

Further recommendations included the formation of a "multi-sectoral, multi-disciplinary committee" charged with review of the existing mental health services,

which was not "part of the terms of reference"; that Samoa establish some capacity for basic research and surveillance of mental illness including drug and alcohol abuse; that Samoa engage in project development on such topics as mental health counselling and mental health promotion, support for children with special needs attending schools, and mental health care givers (WHO, 2004, p. 10). In addition, the Government of Samoa should raise the public understanding of the link between suicide and mental ill health, and "explore further assistance [with mental health initiatives including] facilitating support from potential international donor agencies" (WHO, 2004, pp. 10-11).

Following this report, in February 2003 the WHO issued a *Country Cooperation Strategy for Samoa*. This made note of Samoa's epidemiological transition and the accompanying rise in NCDs. The report notes that, since 1983, Primary Health Care, Health Promotion, and the Healthy Island Principles (all WHO-inspired initiatives) have been behind health sector development (WHO-WPR, 2003, p. 7). Building on these, Samoa's economic and public sector reforms since 1996 are cited as central to Samoa Ministry of Health planning. In particular, the *Health Sector Strategic Plan 1998-2003* (Government of Samoa, 1999) is referenced for its aims at strengthening health institutions, primary health care, and health promotion on NCDs and women and children's health, as well as quality improvement through infrastructure and facilities development. Identified needs include specialist medical care (which would include psychological and psychiatric professionals), and the accompanying drain on the economy, since high fees are paid to treat individuals overseas, as well as the professional drain where locally trained professional staff move overseas in search of higher remuneration.

Applying this broad context to Samoa, from 2003-2007 WHO pursued a policy of supporting government work on healthy communities and populations; health sector development; and continuing focus on combating communicable disease (WHO-WPR, 2003, p. 22). It engaged in a "significant shift in roles, functions and modalities of support" to legislative and policy technical advice provision, as well as broadening its training support for health workers and nurturing "multi-sectoral collaboration and partnerships" and "play[ing] an increased role in coordination of donor assistance" and resource mobilisation (WHO-WPR, 2003, p. 23). Under the "building healthy communities and populations" rubric, NCDs are specifically said to include mental health, and WHO will assist "in the (re) drafting and reviewing of existing legislation, policies and strategies to be more in line with present practices in the field of NCDs in general and mental health. . . in particular" (WHO-WPR, 2003, p. 23). Furthermore, the effort will extend to developing "technical guidelines to address

risk factors and to ensure the delivery of quality community-based services for . . . mental disorders", and a mental health promotion framework (WHO-WPR, 2003, p. 23). Within three months of the issuance of this report, a mental health symposium was held in Apia (discussed below), gathering together key actors in Samoa for establishing broad directions and needs in mental health.

The Mental Health Act 2007

The need for updating the existing law was well recognised by the respondents in this study. As one former government official framed the problem:

> We inherited a piece of New Zealand legislation that was already 50 years old, so it never in my view, it never was effective or implemented and part of that is because we never had, before the 90s, we never had mental health professionals that could be or could undertake the sort of requirements and the responsibilities under the old act, we still don't. (SR3, Interview with Author. November 2010).

However, recognising the need to reform did not result in legislation. The health sector reforms, as mentioned above, presented the opportunity for a foreign consultant with extensive expertise in mental health to be embedded in the Samoa Attorney General's office. This would take some time, but, on the morning of 31 January, 2006, a press release from the Prime Minister's office announced the Cabinet approval of what was then called the Mental Health Bill 2005, which would provide for:

> The care, support, treatment and protection of persons with mental disorder and for related purposes . . . to minimize the restrictions upon the liberty of persons with a mental disorder and interference in their rights, dignity and self-respect . . . (and) [work] towards eliminating discrimination against, and abuse, mistreatment and neglect of persons with a mental disorder. (Samoa Government Press Secretariat, 2006)

It would take a further 10 months for the Bill to achieve its first parliamentary reading. On 16 November, 2006, the Prime Minister rose to move for a second reading of the Mental Health Bill 2006, a Bill of "39 clauses" and not "much volume" (Government of Samoa, 2006, p. 867). The need for an update was apparent since, as the Prime Minister observed in the proceedings, the original law, the Mental Health Ordinance, had not been amended since its implementation in 1961. He suggested that "up to this hour, it seems that there have not been any specific

conditions for the care of these people and now the Government has prioritised it" (Government of Samoa, 2006, p. 867). The motion was then approved and referred to the Health and Social Services, Internal Affairs, Community and Social Development Committee (Samoa Parliamentary Committee on Health and Social Services, Community & Social Development, 2006, 869). The Bill joined several others related to the health system in Samoa, including the Pharmacy Bill; Healthcare Professions Registration and Standards Bill 2006; and Nursing and Midwifery Bill, which would, upon adoption, constitute a wholesale rewrite of the Samoan health legislation framework.

This Committee was charged with "consider(ing) any bill . . . to examine the policy, administration and expenditure of the ministers and associated government organisations related to matters in Health and Social Services, Internal Affairs, Community and Social Development" (Government of Samoa, 2005). They invited public submissions, and, while there is no record of these proceedings, those who were disclosed as offering testimony include four senior Ministry of Health officials, including the Chief Executive Officer; the Assistant Chief Executive Officer for Strategic Planning and Development; the Assistant Chief Executive Officer for Nursing and Midwifery Services; and the Assistant Chief Executive Officer for Health Promotion and Preventive Services. Despite the efforts undertaken in the policy process to include various policy stakeholders, the legislative process received input only from bureaucrats after the initial vetting process.

The Committee spent "[five] sitting days in considering the Bill", and "noted that [it] provides for care, support, treatment and protection of persons with mental disorders . . . [T]he main objective [is to] help encourage non health care professional [*sic*] to be responsible in offering care and support to persons with mental disorders" (Government of Samoa, 2006c). Besides clerical adjustments to the Bill, no changes were submitted. The Bill's committee report occurred on 19 December, 2006, and was adopted without amendment; this was followed by a third reading on 16 January, 2007, at which time it passed the Legislative Assembly (SPDR, 2007, p. 1010). Despite its shortcomings and the resource constraints felt within the sector, the new Mental Health Act was seen as a positive step in its intention. As one respondent noted, the purpose was:

> To update the options in terms of mental health and the community. The in-patient or the community treatment order is an attempt to ensure that [….] the role of the community and mental health issues is formalized [to reflect] in some ways what is happening now and I think is an intent

> to (sic) bring it into the mainstream health system. (SR3, Interview with author, November 2010).

Occurring contemporaneously with the official law vetting process was the development of Samoa's written governmental mental health policy. The process of developing this policy will be found to be more participatory in nature, as set forth below.

The Mental Health Policy

The international movement of a policy involved in a policy event is, in essence, the practice of taking the international and making it local. In the mental health context, this involves taking international best practice on mental health policy, including scientific bases for mental health diagnoses and human rights claims for the appropriate treatment of individuals suffering from mental illness, and interpreting these central policy components in the indigenous context. Such policy episodes necessitate the involvement of domestic actors engaged in mental health broadly. Respondents indicated the central role the international context played in the localisation of mental health in Samoa. As one respondent suggested, the idea for the formation of an initial policy group of key stakeholders emerged from the influence of international relationships between international organisations (IOs) and the Government of Samoa. The attention to mental health occurred because:

> During the reforms, mental health was an issue, because at the time it was much highlighted at WHO Assemblies governments were attending [them] and then [there were] consultations by the WHO . . . . but when it comes to implementation . . . . I think we are caught in having very limited budgets at the same time. I think it all comes down to the people who are driving the service. (SR4, Interview with author, November 2010).

This context provided the basis for the policy development process. As an initial step, a Mental Health Symposium was organised to bring together key stakeholders for input on forming a mental health policy in Samoa.

Mental Health Symposium

Many respondents in the current study cited the "National Symposium on Mental Health Issues in Samoa", held April 2003 in Apia, as one of the originating forums in the process of mental health policy development. The conference that brought

together many key actors from government and civil society for a focused discussion on various aspects of the nation's mental health situation, context, and needs. Leaders from churches, villages, courts, and international funders participated. Amongst other things, the symposium was designed to attend to Samoa's mental health services by identifying needs and problems, and proposing a course of action to address them.

The symposium considered six key dimensions, including advocacy; service provision, mental health promotion; policy and legislation; research; and suicide prevention. The policy and legislation prong saw recommendations to prioritise policy and law development. Indeed, many participants recommended the development of a policy as instrumental. The local newspaper, the *Samoa Observer*, covered these proceedings and reported under the headline "Moves to improve mental health care" that the symposium, which was sponsored by the WHO and spearheaded by the Mental Health Unit and the Planning and Policy Division of the Ministry of Health (under local leadership in collaboration with AusAID), identified that the WHO definition of health as "a state of physical, mental and social well-being" was complemented in the Samoan context by including the spiritual dimension (2005). Due in part to the assistance of a WHO consultant, a medical doctor well-travelled in mental health policy development, the symposium produced recommendations that would serve as the basis for the mental health policy. The following principles were also established: mental well-being is grounded in the *aiga* (family) and *nu'u* (community); respect for individual rights; appropriate care without discrimination; and the "recognition that mental, physical, social and spiritual health are indivisible".[5] The overall goal was to develop quality mental health services in Samoa. Again, it is significant that this symposium closely followed the issuance of the WHO *Country Cooperation Strategy for Samoa* in February 2003. The combination of these two well-publicised events firmly placed mental health on the collaborative agenda.

Policy Development

The policy development process proceeded with deliberate speed. From its inception with the symposium, the next stage was to form a Mental Health Policy Working Committee, a local stakeholder group who started work in March 2005, and produced a first draft of the policy in December of that year (SMoH, 2006a, p. 3). This draft, crafted in collaboration with the WHO, adopted a typical policy document structure and adopted two definitions of "mental health" – both from international sources. The

[5] For a more fulsome discussion on these concepts, please see Iati (2000).

first is provided by the WHO and states that mental health is a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001, p. 1), a definition offered repeatedly by research participants. The third paragraph of the draft begins with the notion that "[m]ental health as a concept needs to be considered within the context of the Samoan culture", and affirms the association of "mental disorders" [a term undefined] with physical illness, suicide and social ills such as "violence, criminality, addictions, homelessness and poverty" (SMoH, 2006a, p. 3).

The draft policy sets forth a vision that "all people in Samoa enjoy mental well-being that is grounded in the *aiga* and nurtured through a multi sectoral approach" (SMoH, 2006a, p. 3), which precedes the "values and principles" portion of the document. These "values and principles" include that "mental well-being is grounded in the *aiga* and the community"; and that the "Samoan understanding of dignity and self-esteem is collective and relational in nature" (SMoH, 2006a, p. 3). Furthermore:

> What is achieved or lost by the individual, is felt by the *Aiga*. In this context, the *aiga* is the natural and appropriate health care setting for the promotion of mental health and the management of mental disorders, with the exception of some severe disorders requiring hospitalization or seclusion. (SMoH, 2006a, pp. 3-4)

The document identifies, amongst other areas, the need for the development of institutional structures for the continued, necessary diligence in this policy area, and proposes a mental health board to organise indigenous actors into an institutional arrangement to ensure continued attention. In addition, the need for legislation and human rights and focal areas including suicide prevention; drug and alcohol abuse; sexual abuse/child and adolescent abuse; domestic violence; and dignity of the family are all formally recognised as key areas for action (SMoH, 2006a, p. 4).

The policy also re-asserts the "Samoan context" from a policy perspective under the heading "Mental Health Services in Primary Care", as based on the *aiga*, and this should be the focus of mental health assessment and management. Thus the preference should be for treatment in the community rather than in hospital or health centres (SMoH, 2006a, p. 6). This is a powerful statement in that the basis for community care is not based on an international best practice (though this is also the international model at the moment), but on a key strength of the Samoan culture. This tracks closely with Enoka's (2000) introduced informal practices as embodied in

Ministry of Health service models beginning in the mid-1980s to be discussed below. Furthermore, this theme has been continued in recent responses to the marginalisation of Samoan perspectives on mental health in New Zealand (Tamasese, Peteru, Waldegrave & Bush, 2005); 2009 tsunami in Samoa (*Radio New Zealand International*, 2012); and on developing mental health services in Samoa generally (Enoka, Tenari, Sili, Tago & Blignault, 2012).

The informal mental health sector in Samoa is said to consist of a "wide range. . . of services . . . including NGO's, religious organisations and traditional healers" (SMoH, 2006a, p. 7). These groups address issues on suicide awareness and victims of abuse, and alcohol abuse. These services are described as a vital gap-filler between specialist and primary services. Yet, these informal services are not linked to the formal health structure, as reflected in no identifiable referrals coming from the informal sector. In addition, there are no "self-help groups for the mentally ill or their families", and people are left to "wander aimlessly in town and public places" (SR10, Interview with author, May 2011).

Related to this in the draft policy is a separate subsection dedicated to "private services", of which there are few in Samoa; counselling services to women were one type available at the time of this research. However, this section contains the most comprehensive discussion of suicide in the document. It is pointed out that there is no "suicide prevention strategy or program", and this section contains other areas of association with other social ills, including the relationship between mental disorder and substance abuse[6]; domestic violence being associated with "stress related disorders"; and sexual and physical abuse being correlated to mental disorders in victims in their teenage and adult years (SMoH, 2006a). These items read more as fact-statements that would seem to suggest a call to arms, though this is not made explicit. Instead, the section shifted into the matter of stigma and discrimination in the community, noting that:

> Current cultural beliefs present a stigmatized view of mental health disorders [that] compromise the dignity of families involved and the individual with a mental health disorder [which in turn] acts as an impediment to treatment as well as producing its own stresses. (SMoH, 2006a, p. 8)

In justifying a mental health policy, the draft policy borrows from many themes

[6]The report notes that approximately 16 per cent of mental health admissions have drug-induced psychosis (SMoH, 2006a, p. 9).

advanced in the international literature as influencing the prevalence of mental disorder: urbanisation; economic disadvantage; substance abuse and migration – all of which are related to the Samoan context as factors influencing mental health and wellness there.[7]

This discussion culminates in the draft policy in the identification of mental health system areas of need. Besides the ever-present need for greater financial resources, legislation tops the list of needs, followed by leadership, and expanding specialist services, including the need for "acute psychiatric beds". There is, as mentioned earlier, the need for substance abuse treatment and for the promotion of mental well-being, and for the prevention of the incidence of mental illness. It is in this portion of the draft policy that a second attempt to define mental health is found. The draft notes that:

> Mental health should be explained in terms that are acceptable to all communities. Religious, traditional, and western scientific/medical perspectives should all be recognized as having a role in healing people who are mentally unwell or ill.
> One discipline should not be prioritised over the other. Instead the National Health Sector should develop a collaborative strategy. (SMoH, 2006a, p. 15)

In addition, the document suggests that "research" should be carried out as well as "education and awareness programmes" in the community, including schools, workplaces, health workers, and Parliament, which shall "give equal emphasis to the traditional, religious and western scientific/clinical perspectives" (SMoH, 2006a, p. 15).

Under the heading of "Advocacy", the importance of individuals with mental illness participating in policy and lawmaking processes is affirmed. Anti-discrimination and stigma policies should be adopted throughout government and individuals with mental illness should be "consulted on all drugs brought into the country to treat them", and be supported "within a medium that they feel most comfortable" to ensure that their voice is heard. In addition, these people should receive the "best care and treatment in any facility", and they should not be "penalized as criminals nor should they be incarcerated within the local prisons" (SMoH, 2006a, p. 16).

[7] For a discussion of these concepts within the New Zealand context, see Tamasese, et al. (2005).

The draft policy recognises that:

> There is a strong political and organisational commitment in Samoa to develop a mental health policy. A mental health policy needs to be informed by broader policy frameworks and be consistent with the objectives of the Ministry of Health. Changes in the social and economic structures within Samoa appear to contribute to an increased prevalence of mental disorders. Mental health policy should be formulated aiming at reducing the burden of mental disorders in the *aiga* and the community. (SMoH, 2006a, p. 17)

The section titled "Constraints" formally recognises the dearth of data on mental health in Samoa and that the application of the "abundance" of overseas data to the Samoan situation is either "uncertain or unknown" (SMoH, 2006a, p. 20). It is at this point that a further definition of mental health is offered. This definition is taken from the Pacific *Regional Strategy for Mental Health* document on mental health and is presented in the draft as the:

> Foundation for the well-being and effective functioning of individuals. Mental health is the ability to think and learn and the ability to understand and live with one's emotions and the reactions of others. It is a state of balance within a person and between a person and the environment. This balance is a product of a number of interrelated factors, including physical, psychological, social, cultural and spiritual. (SMoH, 2006a, p. 20)

The report notes that "mental illness" refers collectively to all mental disorders. It is the second leading cause of disability and "premature mortality" (SMoH, 2006a, p. 20). Mental disorders are, in turn, defined as "health conditions that are characterized by alterations in thinking, mood, behaviour or some combination thereof associated with distress and/or impaired functioning" (SMoH, 2006a, p. 21).

Community Consultation of Policy

This final version of the policy went out for community consultation in February 2006, a process that included the "Samoa Community, government ministries, non-governmental organisations as well as the Ministry of Health staff" (SMoH, 2006b, p. 3). Four consultations were held, two on the main island of Upolu, and two on neighbouring Savai'i. Two of these were public, and two were open only to Samoa Ministry of Health staff. In the latter, presentations were made and small group

sessions held to address a set of questions including the policy's relevance to Samoa and any omissions or other thoughts on effective implementation and monitoring (SMoH, 2006b, p. 3).

The key findings of this consultation process included public support for a mental health policy in order to "encourage the Samoan people to support and respect the rights of those with mental disorders" (SMoH, 2006b, p. 4). Further, central issues raised by participants related to staff training, making available adequate resources for care, and expanding specialist care (SMoH, 2006b, p. 4). Amongst the issues missing, participants indicated a need to "improve . . . communication and [that] there should be an independent board for Mental Health" (SMoH, 2006b, p. 6) and increased public awareness through trainings for the community and through media campaigns to promote individual rights (SMoH, 2006b, pp. 5-6). From here, the Mental Health Policy Working Committee referred to the consultation outcomes and finalised the draft mental health policy before submitting it to the Cabinet Development Committee, where it was finally adopted in August 2006. There appear to be only minor changes to the draft policy and the final version, as most of the public comments did not appear to any significant degree to form the final product. The policy is only part of the mental health system story; the Mental Health Act 2007 completes the recent mental health policy transformation in Samoa.

Conclusion

The data presented above suggests changes in several mental health policy episodes have occurred in Samoa over roughly one century of time. The three episodes can be organised around critical events: the colonisation of the first half of the 20th Century, decolonisation in 1961-62, and an international policy movement around mental health in the early 21st century. The findings here suggest a form of coercive transfer during the colonial period, a later form of relative indifference in the promulgation of the Mental Health Ordinance, and a more participatory, yet largely foreign-inspired, policy and law in the early 2000s. The data suggests that mental health continues to be an area of relative marginal policy importance in Samoa.

At the same time, the conclusion on the different perspectives and constructions of the Samoan context suggests that future transfer events, if following the apparent pattern presented in this article, would benefit from beginning from the Samoan perspective and considering what, if any, international models or exemplars would be beneficial in expanding the Samoan construction of the mental health needs of the people. This shift in perspective would bring policy development in the mental health

space to a Samoan-initiated form of policy that would more likely secure wide-spread political engagement and lead to policy success. Moreover, such an approach would well serve as a model for grass roots, participatory policy making for use in the Pacific region, as more and more countries experience the epidemiologic transition, and experience increasing incidence of non-communicable disease, such as mental illness.

The findings in this article focus on a single case located within the Pacific region.[8] Small island states and other countries located elsewhere might well have had different experiences with policy transfer events generally, and in the area of mental health in particular. However, all former colonies who experienced decolonisation in the so-called "second wave" of democratisation during the mid-20th century are likely to have experienced the first two waves considered above. The nuance—and indeed opportunity—for future studies would be to conduct larger, systematic examinations of these and other policy areas across many countries in this rather sizeable cohort of nations to identify common and atypical experiences. Such knowledge will help domestic policy makers and international policy champions to better ensure local leadership in making future policy transfer events truly local, grass roots initiatives. Indeed, in many ways, as the world becomes closer through globalisation and its technological change, the final elements of semi-coercive policy transfer will continue to disappear only when the policy making process becomes truly local in character.

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[8] The author has considered implications of similar processes on the legal context in neighbouring Tonga: Fadgen (2015; 2016).

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