Exploring the 'cultural' in cultural competencies in Pacific mental health

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Abstract

Cultural competency is about the ability of individuals and systems to respond respectfully and effectively to the cultural needs of peoples of all cultures. Its general attributes include knowledge, attitudes, skills and professional judgment. In Pacific mental health, 'the cultural' is generally understood to be ethnic culture. Accordingly, Pacific cultural competencies assume ethnic specific markers. In mental health Pacific cultural competencies has seen a blending of cultural and clinical beliefs and practices. This paper provides an overview of five key theme areas arising from Auckland-based ethnic-specific Pacific workshop data: language, family, tapu relationships, skills and organisation policy. Workshop participants comprised of Pacific mental health providers, Pacific consumers, family members of Pacific consumers and members of the Pacific community members. This paper purports that identifying the perceptions of different Pacific groups on ethnic-specific elements of cultural competencies are necessary to build and strengthen the capacity and capability of mental health services to provide culturally relevant services.

Introduction

Pacific peoples are a dynamic part of the New Zealand (NZ) population who have influenced this country's culture via sports, arts, music, television, academic, political and other mediums. Pacific motifs and languages have been adopted and incorporated into many facets of NZ life.

In terms of a demographic profile of Pacific peoples living in NZ, this population continues to increase age, and influence the demographic pattern, social cultural characteristics and overall health status of NZ. Currently they represent 6.9% of the total population. The largest Pacific group are the Samoans (49% of the Pacific population) followed by Cook Islands Maori (22%), Tongan (19%), Niuean (8.5%), Fijian (3.7%), Tokelauan (2.6%) and Tuvaluan (1%) groups.[2] The Pacific population is ethnically diverse,[3] with some commonalities and differences.[††]

When speaking of Pacific cultures, beliefs and values; it generally encompasses key principles such as respect, love, service and reciprocity. For the majority of Pacific peoples, good health is perceived as a balanced state of physical, spiritual, mental, family and relational wellbeing, that is, more than just an absence of disease. An individual's identity, health and well being are dependent on family connections, heritage, roles and responsibilities. Mental illness and addictions are perceived differently to western understandings and therefore the treatment sought is one that is matched to their understandings.[1] These treatments include the important role of kin networks in diagnosis and treatment recovery and the recognition of the role of traditional healers in treatment.

Current literature suggests that they are more exposed to risk factors for poor health, have high rates of mental illness and experience barriers to

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†† Commonalities include mythology, genealogy, belief in Christianity, and family importance. Areas of diversity include language, protocols, etiquette, belief systems, perceptions of illnesses and treatment and prevention (See Table 1 for a description of Anthropological diversities).

accessing any health service.[4-6] In terms of mental health, the National NZ Mental Health survey (Te Rau Hinengaro) conducted between 2003 and 2004 found that Pacific peoples had high rates of mental illness (25%) compared with 20.7% for the general NZ population. Pacific peoples also had a higher prevalence of suicidal ideation (4.5%) and suicide attempts (1.2%). Of those who had experienced a serious mental disorder only 25% visited any health service compared with 58% of the general population. The prevalence of mental disorder was higher among NZ-born Pacific people than Island-born Pacific people. Relative to need, Pacific peoples are less likely than the total population to access mental health services.[6]

Working with Pacific people in mental health requires working through the cultural nuances of their perceptions of illness, treatment and wellbeing. This process requires appreciation of the ethno-cultural beliefs and values of Pacific peoples. With most traditional Pacific groups, cultural competency includes understanding the spiritual aspects of Pacific mental illnesses and health belief systems.[7] This involves exploring notions of *tapu* (or the sacred). These concepts must be understood within their cultural contexts in order to have meaning. According to Sutton,[8] understanding the meaning frameworks of ethnic groups is "integral to eliminating health care disparities and providing high-quality patient care" (p58). Reports by the Ministry of Health,[9] and the Mental Health Commission,[10] highlight the need for more nuanced understandings of cultural competency.[‡‡]

This paper is an overview of the findings from five ethnic-specific Pacific workshops on cultural competency in mental health, held in Auckland, 2004. This paper argues that because of the heterogenous nature of Pacific cultures, Pacific cultural competencies must be flexible. It suggests that Pacific culture in mental health is about ethnic culture and so cultural competencies are defined by ethnic markers. Issues of language, family and *tapu* feature prominently as core to what constitutes these markers. Also important in the discussion of cultural competencies is how workers skills and organisational policies might employ cultural perceptions and markers to promote culturally relevant service provision for Pacific peoples. It is important to note that this paper is a synthesis of Pacific voices of the five ethnic workshops and a full discussion of each

> **This paper argues that because of the heterogenous nature of Pacific cultures, Pacific cultural competencies must be flexible.**

of the five workshops can be found online at: http://www.crrc.co.nz/publications.php.

Method

Data Collection

Five Pacific ethnic-specific workshops were carried out in 2004 on the concept of cultural competencies.[§§] These five ethnic groups include Cook Island, Tongan, Fijian, Niuean and Samoan ethnic groups. All focus groups were held in Auckland however some participants came from Wellington, Christchurch and Rarotonga[***]. The participants included Pacific mental health providers, Pacific consumers, family members of Pacific consumers and general community members. Participants were invited to participate in facilitated focus groups, in Auckland, to discuss indigenous perceptions of mental health and cultural competencies. There were approximately 200 participants collectively from the ethnic-specific workshops.

The focus groups provided discussion on these areas: ethnic culture and mental health; ethnic culture and mental health treatment; practical application skills; and evaluation and/or assessment and/or measurements of cultural competency. These areas derive from a framework that was adopted by the majority of the workshop groups. This was aimed to ensure a level of consistency in discussion areas. Focus group discussions from each workshop were conducted both in the English language and in the ethnic languages of Samoa, Tonga, Niue, Cook Islands and Fiji. Most of the focus group sessions were audio-taped and transcribed verbatim and comments in the differing ethnic languages were translated into English.

Analysis

Analysis of the focus group discussion data was informed by grounded theory and general inductive methodologies,[11, 12] whereby participants' experiences and dialogue formed the themes for analysis and discussion. However the level of analysis for this study does not extend towards the development of a theory which is customary with these methodologies. Analysis of the data involved collecting the data from the five workshops and dividing them into common themes that emerged. This collective thematic

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[‡‡] See Table 2 for more detailed description and definitions on culture and cultural competency. [§§]The research was carried out as an internal service project on behalf of the then Pacific Mental Health and Addictions Service (PMHAS), Waitemata District Health Board (WDHB). Written and verbal consent to participate was obtained from participants before focus group sessions began. [***] It is assumed that those participants who stated being from Rarotonga were in Auckland at the time of the focus group and so were invited to participate.

data was then summarised and presented under appropriate headings. To avoid interpretive bias and to triangulate the reliability and validity of the data the data was coded independently by the authors of this study and comparison of these was conducted.

Results

Five themes emerged from the collective data of the five workshops: language; family; tapu considerations; workers skills and organisational policy.

Language

Participants from the various workshops argued that efforts to destigmatise perceptions of mental health within the community require addressing the derogatory connotations employed by these terms (Table 3, no. 1).

The Samoan, Fijian, Cook Islands and Niuean workshops specifically talked about the need to examine the use of current ethnic specific words, in terms of the negative impacts they might have on mental health consumers. Words such as: neneva and pana'marama meaning 'stupid' or 'gone bonkers' in Cook Island Maori; ulu heketia and ulu kelea meaning 'silly' or 'mentally ill' in Niuean; cavuka, meaning 'broken' or 'snapped' in Fijian; and valea, meaning 'stupid' or 'crazy' in Samoan. Contemporary use of these terms is often derogatory. The Fijian workshop explained that the term cavuka usually describes the situation when a female becomes mentally ill following childbirth. This contextualises the types of situations in which these terms arise. As with the other ethnic terms noted above, the derogatory use of words like cavuka often occurs in colloquial spaces where harm is not necessarily intended. The Cook Islands workshop participants discussed how this colloquial use of terms can carry stigma and so inflict shame, whether intended or not.

Within Samoan workshop discussions, the term valea (meaning to act crazy, foolishly or with stupidity and or ignorance) is in formal public contexts increasingly being replaced by the more polite phrase 'gasegase o le mafaufau'. This phrase was coined to address the stigma attached to terms such as valea. (Table 3, no.2) provides a quote that illustrates this shift in the use of these terms.

All five workshops acknowledged that the issue of destigmatising terms used within the community to negatively or erroneously describe mental health clients involves a complex exercise of sorting through the nuances of ethnic and medical vocabularies. It is a task that all groups argued was nevertheless necessary. In particular, Samoan participants suggested that medical terms and conditions such as schizophrenia and bipolar disorders be incorporated into local language frameworks. This point was also suggested by a Niuean workshop participant (Table 3, no.3).

The case for developing new terminology was suggested by another Niuean participant, as something that is necessary more for the younger generation than the old (Table 3, no.4). In comparison, the Cook Islands workshop suggested a need to develop processes that can enable them to build a common language structure for destigmatisation in specific Cook Islands spaces. Coining appropriate terms capable of describing new contexts often requires negotiating the impact of replacing one with another. The origins of terms such as the Fijian cavuka described above, suggest, as noted specifically by the Tongan workshop, that appropriate consideration of the historical and cultural significance of terms are at least recorded before abandoning. Unpacking the cultural or traditional significance of old terms, metaphors, expressions, similes and proverbs is argued to be necessary in order to capture the traditional 'Pacific' way of life. This was specifically advocated for by both the Tongan and Samoan workshops. Of all the groups, the Tongan participants were the most adamant in their claim that Tongan values and culture could only be captured using Tongan words or expressions.

Family

All workshops assumed that working with families is central to Pacific cultural competence. When discussing how to best address the involvement of families in mental health treatment processes, the Samoan workshops cautioned against the assumption that all Pacific consumers have supportive families. The Samoan workshop suggested that there are Samoan mental health consumers who in fact rely more on the State, church or other types of support than on family. This raises interesting implications for the privileging of family in Pacific mental health service delivery practices.

Moreover, assumptions of extended family support often belie the reality in some Pacific families of a more nuclear arrangement. For many Pacific groups and individuals, while family is still a major focal point in their lives, it is one that is often configured more in nuclear than extended family terms. This raises another interesting point for closer examination. Either way, as one Samoan group participant noted, assessments of a consumer's mental health should involve assessments of his or her wider family context, namely an assessment of how the individual's mental illness might have also affected his or her mother, father, sister or brother. This participant assumes the centrality of family to the mental health process, namely to making appropriate assessments of the mental health condition, something that he suggests is reflective of the 'holistic perspective' employed by Pacific peoples (Table 3, no.5). There was caution

raised by some participants of making blanket applications of cultural guidelines or assumptions of family and reminds of the need to consider each case in its own context.

Tapu considerations

Each of the five Pacific groups, implicitly and explicitly, suggested a relationship between mental illness and breaches of *tapu*. For all five Pacific workshops, to talk of *tapu* relations is to talk about the sacred bonds between people. For Pacific people these bonds stem from their stories of creation and the cosmic and spiritual relationships between them, their environment and their god(s) (Table 3, no.6). These five groups suggest that to breach a *tapu* relationship is arguably to invoke the wrath of the god(s), ancient and/or Christian. In most cases this is the wrath of the ancient gods. This wrath is often manifested in, among other things, the sudden occurrence of mental illness.

In the Tongan workshop discussions, it was noted that beliefs about the relationship between the body and spirit and between life and death is sacred, and breaches of *tapu* occur when this sacredness is not respected. *Te'ia* and *Fakamahaki* are Tongan accounts of mental illness involving, among other things, 'running to the graveyard' and 'making references to the deceased'. Both suggest a possible connection between mental illness and possible breaches of a *tapu*. The Samoan workshops provided the most detailed account of notions of *tapu.* They note that it is a concept that affects all human relationships. The list offered ranged from individual relationships with the ancient gods or Christian God to relationships between chiefs; between parents and children; between brother and sister; and between husband and wife. Curses such as *malamatua* (curses by parents)*,* and *mala o le ilamutu* (curses imposed by sisters as *feagaiga*[†††] or other *feagaiga*). The significance of the Christian God to other contemporary Pacific contexts is noted in discussions by the Cook Islands groups on the Holy Spirit. Here the Cook Islands workshops implied that spirituality not only includes notions of the Holy Spirit, but that this notion of spirituality as Christian-oriented is central to what they describe as 'human wellness' on the one hand, and to perceptions of 'mental illness' as 'sinful' on the other. The Niuean argument that breaches of the holistic self are breaches of *tapu* resonates with the other four groups. A breakdown of this holistic self is believed to result in mental illness, most commonly the possession of one's body and mind by a demon or ghost. In Niuean the common term for spiritual possession is *hu aitu*. This is similar to the Samoan term, *ma'i aitu*. Both mean 'to be possessed by a demon or ghost'. To be possessed in this way is, according to one Samoan participant, to lose "your sound mind". For the Fijian group, cultural principles governing Fijian social relationships, such as the *tau-vu* principle, reflect the sacred connection between peoples through the explicit acknowledgment of a common ancestry and land and the ability to trace this ancestry back to their gods of creation. Hence, *tapu* relations or bonds assume inextricable links between the mind, body and spirit – the three parts of a Pacific person. These bonds and the bonds of 'land, kinship and spirituality' are each part of the 'holistic' self, as suggested by the Niueans. Breaches of these bonds are breaches in the *tapu* essence of this self and its inextricable relations other living things.

Collectively participants from the five workshops expressed the view that the gifts of traditional healers are *tapu*. Traditional healers often specialise in 'treating' a particular type of mental illness believed to be a direct result of a breach in *tapu*. To restore harmony traditional healers are usually called upon. According to the discussions of the five workshops, today the Christian pastor can also play a role in restoring the harmony upset by these breaches. The tools of a traditional healer include traditional massage techniques and herbal remedies, concocted through the special recipes of different healing traditions. In case of *hu aitu* or *mai aitu*, massage using herbal combinations is usually prescribed. Christian prayers may also be used to support the work of traditional healers.

Worker skills

Competence in a Pacific language was considered by all five ethnic focus groups as necessary to working mostly with 'older' or 'non-English' speaking clients or family members. That is, with those clients or family members who were more comfortable or could only converse in their mother tongue. In situations where staff do not have ethnic language competence, access to and use of translators is considered important. Being able to translate foreign English medical terms appropriately was highlighted as another dimension to language competence.

Competence in ethnic cultural protocols also requires competence in ethnic language(s). The Tongan workshops suggested that in working with families, or in more workplace-based settings, the services of skilled orators may also become necessary. Skilled orators have considerable status in all five ethnic cultures and can provide cultural supervision of workers if required, at least in terms of developing

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[†††] A Samoan expression meaning: a covenant between two or more parties.

language competency. Discussion from the Samoan and Tongan workshops raised the importance of conceiving language competence as inclusive of non-verbal forms of language, such as understanding humour, body and other communication forms. The Fijian and Tongan workshops explicitly noted that humour is nuanced in ways that if used inappropriately can cause great offence. All focus groups highlighted the point that a key part of language competence is the skill of listening.

For all five ethnic workshops, knowledge of cultural relationships was about knowledge of relationships between people as members of families, villages, island-groups, confederacies or other political configurations. The principle of the Fijian *cross cousin*[11] and *parallel cousins*,[12] the Samoan *feagaiga* and the Tongan *Mehikitanga*[14] relationships provide particular examples of gender-specific relationships. Having knowledge of the specific differences in Pacific cultural relationships infers the ability to build appropriate rapport and give respect to the different cultural contexts of Pacific clients and their families. The importance of the notion of reciprocal service was also addressed particularly in the Samoan workshop where this is referred to the notion of *tautua* (service).

All five groups noted the value of utilising a combination of clinical, spiritual and/or traditional healing practices to address Pacific mental health problems. Participants also noted that being able to make appropriate professional judgements involves appropriately assessing their cultural or clinical limitations and to be able to draw support from appropriate cultural or clinical supervision or training, or for translators or orators.

Organisational policy
The Fijian and Samoan workshops were most explicit in their address of organisational policy. In particular, they suggested the need to develop policy and management systems that are capable of incorporating Pacific health beliefs, are efficient and of high quality. In terms of cultural supervision, the implication from all groups was that management structures be able to assess the efficacy of incorporating cultural experts (in culturally sensitive ways), not only in the provision of cultural supervision where appropriate, but also in the design and assessment of 'cultural' training or supervision packages.

The Tongan workshops suggested the need for professional standards that ensure the incorporation of cultural and clinical competence; and for management support structures that are to give (culturally) safe avenues for staff, clients or family members, to express any concerns about their cultural or clinical or professional safety.

The Niuean workshops noted the value of interagency collaboration. This, together with the findings for service efficiency and quality assessors, suggests the need for a governance or management structure that is capable of enabling the incorporation of cultural into professional standards without compromising the integrity of either.

As with most health or social services, appropriate resourcing is an ongoing need. The different types of resourcing needs highlighted by the five workshops include:
- appropriate cultural supervisors;
- appropriate clinical and cultural training resources;
- appropriate Pacific specific consumer-centred services;
- appropriate treatment models (including easy-to-read information on medication types and effects, illness symptoms and/or various rehabilitation models);
- information about care options (e.g. respite care);
- information about inter and intra ethnic differences (i.e. across Pacific ethnic groups; between 'Island-born' and 'NZ-born'; and between 'young' and 'old'); and information about creating greater Pacific community responsiveness.

The formula for accessing or defining what resources a service might need depends on the size and make-up of the service's Pacific clientele.

Discussion
Mental health services in NZ have traditionally focused on a medical model that prioritises disease and disorder. It has only been in the last 10-15 years that NZ health services have recognised the importance of working within a framework that is sensitive to the diversity of the NZ's ethnic make up.[14] This greater awareness and growing sensitivity to the impact of culture in the presentation, assessment and treatment of serious mental illness has led to the recognition of the need for culturally appropriate frameworks and/or services.[15]

The discussion on cultural competencies is not a new one but has involved a gradual process of discussions and debates both at District Health Board (DHB) and

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[11]The notion of first cousins who share sibling parents of the opposite sex. [12]First cousins who share sibling parents of the same sex. [14]The Mehikitanga refers to a female of high status on the father's side, usually the eldest sister or a female cousin of the father.

Non-Governmental Organisation (NGO) level (Table 4). The importance of cultural competence is that cultural appropriateness may be the most important factor in accessibility so developing culturally-sensitive practices helps reduce barriers to effective treatment and reduce disparities in health.[16]

A number of important factors need to be considered in the design of an appropriate cultural competency framework. In terms of language competencies discussions were raised regarding the development of new terms. However this is a complicated process and attempts to destigmatise key terms or phrases assumes at a minimum, the availability of a common lexicon, language structure and network of meanings. While all five ethnic groups raised the importance of developing a 'destigmitisation' campaign that can meet culturally-specific productions of stigma, the issue for the Cook Islands workshops also involved concerns of the more structural-type. Also important for participants' was the exercise of unpacking the cultural histories associated with certain terms or concepts, some of which were considered derogatory, others less so. In some cases, especially in the efforts of the Fijian workshops, the benefit of removing and discussing the layers of meaning associated with some terms, such as *cavuka* for example, was unquestioned – especially for their younger participants. For the purposes of this exercise, all five workshops confirmed the expectation that language is a *taonga* or treasure and as such is core to the preservation of ethnic identity and culture. In Pacific mental health services, a large proportion of all five groups are fluent speakers of the English language. These differences need to be accounted for in Pacific cultural competence packages addressing language. Careful examination of the language issues of Pacific youth is also important and requires consideration of ethnic, religious, neighbourhood, age and/or gender differences.

The other important factor to consider for cultural competency frameworks is family. Focus groups ideologies of the importance family assume that Pacific families are an integrated part of the lives of most Pacific mental health consumers. This is not at issue here, what is, is the suggestion that models of Pacific families are fixed and incommensurable. The practical implication of adopting such a position on families is that strategies or programmes designed accordingly may well overlook those Pacific families that do not conform to the model. Models of family that purport to reflect the changing dynamics of

Pacific consumers and their families must be flexible enough to account for these changes.

There is little debate amongst the workshop participants of the continued importance of *tapu* relations and the contemporary significance of Christianity to Pacific peoples, both in NZ and in their island homelands.[3,17] In Pacific mental health the relationship, even if somewhat philosophically uncomfortable, between ancient Pacific *tapu* beliefs and Christianity is also generally accepted.[1] This is illustrated in the working together of traditional healers and Christian pastors in Pacific mental health sector.

A point of interest that this work seeks to raise is how best to address the spirituality needs of Pacific youth. The issue is that the 'Pacific youth' population may be considered a population group capable of being distinguished from their 'elder/older' counterparts. This raises interesting points not only for philosophical debate but also for advancing discussion on how best to operationalise 'cultural competency' markers for population groups within ethnic groups (such as youth), and what the ramifications might be of doing so. These points are raised as 'food for thought' in the project of advancing this work.

In terms of cultural knowledges and skills, the core points for discussion surround the general issues of 'knowledge of cultural relationships'; 'language competence' and 'cultural supervision'. There is a lot of debate currently engaged in by the Pacific mental health sector on how best to approach these issues. At a DHB level there have been initial steps taken to implement cultural advisory groups that may be seen as vessels in which workers can draw these cultural knowledges from.

Cultural competency, like cultural appropriateness and cultural safety, seeks to challenge those involved in the exercise of governing, managing and delivering services to Pacific peoples and their families in NZ, and to always remember who the service is for. As such cultural competency is as much a strategic exercise as it is a professional, philosophical and ontological one. The impetus for this work was to generate debate and find effective ways to continue to provide appropriate services to Pacific peoples. Developing cultural competency frameworks that privilege the needs of clients can remind workers of the importance of culture and cultural differences in the politics of service delivery.

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[15] Tangata whenua refers to the indigenous Maori peoples of Aotearoa/New Zealand. The seminal work of Maori psychiatrist Mason Durie for example on Maori measures of wellbeing is of obvious significance to Pacific developments of the same (see for example, Durie,M. 2006. Measures of Maori Wellbeing see online: http://twor.ac.nz/docs/pdfs/Papers%20by%2 0Mason%20Durie.pdf. Measuring Wellbeing of Communities, The Genuine Progress Index. Porirua, Takapuwhia Marae) [Accessed 21 October 2008].

Whilst there have been efforts to progress work on cultural competency in NZ[1] (Table 4), in order to establish any real foundation for policy recommendations, there is a need to combine these efforts or have them aligned. This will help to ensure that efforts are not unnecessarily duplicated. A streamlining of the Pacific cultural competency work would therefore benefit from appropriate regional, if not national, coordination. This is the first step towards making policy considerations.

Cultural competency must be seen to permeate and influence within health all areas when providing care for Pacific people. The supposition of this work is that to create successful outcomes for Pacific mental health service delivery it is important to identify what the Pacific cultural markers in cultural competencies. Successful processes needed for wellbeing and recovery need to be contingent on well-designed innovative initiatives. These initiatives need to incorporate holistic approaches and beliefs; include appropriate cultural and clinical competencies; are practiced by competent health workers (both at clinical and cultural levels); are based on Pacific models of health and Pacific belief and values;[1] and that has key elements of Pacific involvement in governance and management. If services do not adopt these concepts in the design of their initiatives then they may encounter barriers that limit successful outcomes for mental health services.

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Developing cultural competencies among mental health service workers; from medical through to community support staff involves integrating cultural and clinical knowledge and applying this knowledge to service delivery. Attempts to develop cultural competency frameworks, guidelines and/ or performance specifications capable of covering its wide reach are complicated. The politically contentious nature of any attempt to define culture, let alone cultural competency, plays a significant role in the difficulties associated with the project. Nevertheless, in health and social services the importance of culture to people's behavioural patterns is well accepted. Determining how best to understand and operationalise competency frameworks based on culture is the challenge. Acknowledging the place of *tangata whenua*[15] is perceived by the mental health sector generally as a basic core component of working 'culturally appropriately'.[18]

This project records Pacific people's perceptions and practices of cultural competency in Pacific mental health. Identifying key perceptions and elements of cultural competencies from different ethnic Pacific groups are necessary to build and strengthen the capacity and capability of mental services to provide access to Pacific peoples who are considered a high needs group.

Acknowledgements

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[15]Tangata whenua refers to the indigenous Maori peoples of Aotearoa/New Zealand. The seminal work of Maori psychiatrist Mason Durie for example on Maori measures of wellbeing is of obvious significance to Pacific developments of the same (see for example, Durie,M. 2006. Measures of Maori Wellbeing see online: http://twor.ac.nz/docs/pdfs/Papers%20by%20Mason%20Durie.pdf. Measuring Wellbeing of Communities, The Genuine Progress Index. Porirua, Takapuwhia Marae) [Accessed 21 October 2008].

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Table 1: Anthropological diversities of 5 Pacific groups

Main Pacific ethnic groups	Geographical differences	Language differences	Political structures
Cook Islands	15 islands spread across the Pacific	3 main ethnic languages: Cook Island Maori, Pukapukan and arguably Tongareva	Traditional Ariki system that is island-based
Fiji	An archipelago of 300+ islands. But only 100 islands are inhabited. A further 200+ are too small for human habitation	(Not including Indian) Indigenous Fijian language have many dialects	Traditional federation of chiefs that is province-based
Niue	A single coral island	Mixture of Tongan, Samoan and Pukapukan speech	A village-based political system with no formal national chiefly system
Samoa	3 main islands	One homogenous language across the islands	Traditional Matai system
Tonga	An archipelago of 170 islands but only 36 are inhabited and divided into 3 main groupings	One homogenous language across the islands	A Feudal monarchy system

Table 2: Definitions of culture; cultural competency and Pacific cultural competency

Themes	Definitions	Authors
Culture	[Culture] refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.	Cross, T., Bazron, B., Dennis, K. (1989). Towards a culturally competent system of care (Vol. 1). Washington: Georgetown University Child Development Center, CASSP Technical Assistance Center.
Culture	A process; not fixed, not predetermined: constructed by individuals, expressive of interplay between individual subjectivities and collective objectiveness	Airini (1997). Dreams of woken souls: the relationship between culture and curriculum. PhD thesis, University of British Columbia.
Cultural Competency	Competency is having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours and needs presented by consumers and their communities	Cross, T., Bazron, B., Dennis, K. (1989). Towards a culturally competent system of care (Vol. 1). Washington: Georgetown University Child Development Center, CASSP Technical Assistance Center.
Pacific cultural competency	[Is] the ability to understand and appropriately apply cultural values and practices that underpin Pacific people's worldview and perspectives on health	Tiatia, J., Foliaki, L. (2005) Pacific Cultural Competency Framework for DHBs (Draft 4). Unpublished report.

Table 3: Some quotes from ethnic-specific workshops

No	Theme	Workshop	Quotes
1	**Language**	Niuean workshop	It's embarrassing [the] stigma attached to mental illness [labels]…that's another reason why Niueans haven't moved on with the [de]stigma[isation process], because of the culture and things like that.
2	**Language**	Samoan workshop	In my opinion and to my understanding, this phrase we use now to describe mental health, '*gasegase o le mafaufau*', well, when I was growing up in Samoa, I never heard this phrase used to describe someone who was mentally ill. The only thing I recall was that whenever someone acted strangely, in the village or family, people would call them '*valea*', they would say that they were '*valea*'. Or when referring to the family, they would say, the family with the '*valea*' person. But the other thing is, we didn't really take much notice of the impact of the words, the phrase '*gasegase o le mafaufau*', well we used to live together with people of our family, who now we know were weak in mind, but they lived with us in our homes, we didn't ostracise them, we treated them as if they, as the palagis say, were '[a] normal person'. They would do chores, they would be given responsibilities in the home and in the church (Translation of the original).
3	**Language**	Niuean workshop	There is no Niuean name for schizophrenia or bipolar, psychiatrists have their own tools so I believe that's what we should look at to find [our] names [for] these diagnoses, getting it right.
4		Niuean workshop	Young people are okay because they understand English in comparison to older folks…you're lucky with the young ones, at least they are brought up with the [destigmatised] language terminology (sic) around mental illness.
5	**Family**	Samoan workshop	We can't separate mental health from family health because it does affect the mentality of the family. Unlike other countries and cultures that only look at one part, we look at the holistic perspective…*o le tagata ma lona aiga* (the person and their family), for example, when we look at the person, we also look at other members of the family such as the mother, father, sister or brother and how they are affected by their mentally sick family member.
6	**Tapu considerations**	Fijian workshop	Relationships are formed around tribal structures. These structures are based on three elements: land, kinship and spirituality. In Fiji all three elements underpin a person's birthright. It is believed that within these three elements are many sacred relational bonds. When one of these bonds is broken, Fijians believed [that] in traditional times… [when] people can become fragmented and vulnerable…mental illness occurs.

Table 4: A snapshot of some of the progression of cultural competencies in health in New Zealand

Year	Cultural competency work	Description
1996	New Zealand Nursing Council cultural safety guidelines	In 1996 with the public release of the work on cultural safety in nursing and midwifery education. The impact of the health reforms of the provision and delivery of services during this time was significant.
1997	Ministry of Health Pacific peoples charter	In 1997 the MOH's Pacific peoples health Charter in the Pacific Health and Disability action plan addressed culturally appropriate health service provisions. These provisions were aimed at providing cultural appropriate and relevant services to Pacific people and that it included the recruiting of Pacific staff at training and clinical level.
2001	Alcohol Advisory Council (ALAC) Alcohol & Drugs Practitioner competencies	In 2001, the A&D practitioner's competencies were released and demonstrated a commitment to the Pacific people's health charter.
	Cultural competency work for Child and Adolescent in Mental Health by Mua'autofie Tueipilesi'ufofogaosamoa Leavea-Clarke	The work by Mua'autofie Tueipilesi'ufofogaosamoa Leavea-Clarke was a 6 month programme aimed to provide training for clinicians on language and protocols.
2005	DHB Pacific cultural competencies framework by Jemaima Tiatia and Lita Foliaki	Work commissioned by WDHB and is aimed to address cultural competencies at a policy level.
	DHB Pacific cultural competency programmes/workshops	DHBs (e.g. CMDHB, WDHB) provide programmes aimed to inform and train clinicians/health workers on Pacific cultural competencies.
2007	Seitapu cultural competency frameworks by Fuimaono Karl Pulotu-Endemann, Tamasailau Suaalii-Saunid, David Lui, Tina Mcnicholas, Moe Milne and Tony Gibbs	Work commissioned by Te Pou O Te Whakaaro Nui in association with Pava. It provides a framework designed for use by all mental health workers in New Zealand. It espouses four competency areas that involve a three-level stair-casing continuum.
2008	Cultural competency literature review by Jemaima Tiatia	A comprehensive review of the literature on cultural competencies.
2008	Pacific cultural competency training by David Lui	A two-day training workshop that introduces participants to the foundation knowledge and principles to assist in understanding and working with pacific peoples. The programme will assist the participants with their work in mental health both in terms of cultural and clinical practice. It could also assist people working in other sectors like, Police, Justice, Corrections, Social Services, Housing, Primary Health and Addictions. It will also assist participants in carrying out assessments for pacific clients using a culturally appropriate Assessment Tool.