

Culture and offender rehabilitation in New Zealand: Implications for programme delivery and development

Armon Tamatea & Tansy Brown

Cultural differences and lack of awareness of the impact of differences between the practitioner and an offender can be major barriers to the process of service delivery. Indeed, consideration of cultural factors can greatly inform an offender's engagement in rehabilitation, from building rapport in the therapeutic working relationship to designing, implementing and evaluating appropriate intervention programmes¹ and executing therapeutic strategies.² This chapter explores issues about incorporating cultural factors into forensic and correctional rehabilitation. It also offers practical guidelines to help practitioners to negotiate cultural difference into their work, with particular emphasis on Maori and Pacific peoples.

The responsivity principle of offender rehabilitation requires that treatment programmes are delivered in a manner that is compatible with the abilities and learning styles of offenders.³ Historically, the emphasis of correctional resources was guided by *risk* (who to treat) and *need* (what to target in treatment) principles; however, the *responsivity* (how to deliver treatment) principle has become increasingly prominent as a heuristic to inform treatment suitability and effectiveness with a range of offender variables, such as gender, age, level of intellectual ability and religious and cultural identity. Given, however, the demographic composition of offenders in New Zealand, culture has emerged as a

1 Serin & Preston 2001.

2 Evans & Paewai 1999.

3 Andrews & Bonta 2010.

pressing concern for correctional and forensic agencies, and as a major social issue.⁴

Furthermore, when working with Maori and Pacific offenders, it is important to consider the environment in which treatment takes place, who delivers the messages and how they are delivered. For example, Pacific languages, of which there are thirteen distinct languages identified, connect the participant to a 'cultural space', give special meaning and can provide for a sense of belonging. Sharing food and having spiritual, musical and other cultural content may all help reduce barriers and increase opportunities for engagement to facilitate positive change.

A brief note on historical context

Although the history of Maori and Pacific peoples in New Zealand has been well-documented, selected points will help establish a historical context.

Foreign powers increased their interest in the country following a lengthy period of contact (approximately 1640 to 1830s) between European explorers, sailors and settlers and the Maori inhabitants. This resulted in political attempts to establish Maori sovereign independence with the *Declaration of the Independence of New Zealand* in 1835, followed by British colonial rule with the signing of the *Treaty of Waitangi* in 1840. The treaty gave Maori sovereignty over their lands and possessions and all the rights British citizens had. However, the English version of the treaty is considered to give the British Crown sovereignty over New Zealand, whereas in the Maori version the Crown receives *kawanatanga* (governorship). Dispute over the true meaning and the intent of each party is a long-standing issue.

Despite efforts by crown officials to recognise Maori customary rights in law, rapid cultural assimilation resulted in reduced land ownership, influence and rights of Maori, which in turn contributed to a legacy

4 As of December 2009 there were approximately 8,200 offenders in New Zealand prisons, of which 50.6% identified as Maori, 33.7% were of New Zealand European descent, and various Pacific peoples collectively constituted 12.1%. These proportions have remained more or less stable since 1999 despite broader demographic changes in wider New Zealand and an increased number of prisoners over the last decade (Department of Corrections 2000; 2003; 2009).

of conflict, marginalisation and dislocation of Maori resources and political autonomy.

The urbanisation of Maori proceeded rapidly in the second half of the 20th century — a majority now live in cities and towns — and many have become estranged from tribal roots and customs. Despite significant social and economic advances in the previous century, Maori are now over-represented in the lower percentiles in most health and education statistics and in labour force participation. They also feature disproportionately highly in criminal and imprisonment statistics. Like many indigenous cultures, Maori have suffered both institutional and direct racism.

However, a resurgence of things Maori in the latter half of the 20th century saw an increase in the conservation of traditional customs and practices (particularly in educational institutions such as Kohanga reo). What became apparent through this period was an emerging contemporary Maori culture, which in turn affected commerce, arts and sports. During this period a Maori force in national politics was also developing.

This history has important implications for the design and delivery of assessment and treatment programmes for Maori offenders. Maori culture has endured transition from a collectivist and economically viable community to marginalisation and assimilation. It is now a culture of diversity, increased political presence and with a growing positive identity.

Following the signing of the Treaty of Waitangi, the colonial governor sought but did not get approval from the London Home Office to 'take over' Samoa. In 1878 a second request to London was also denied, as Britain and Germany were negotiating for control of Samoa. In 1888, the Cook Islands were declared a British protectorate and Tokelau and Niue followed suit. Tonga also became a British protectorate.

During World War I, New Zealand was instructed to take Samoa under military rule; all civil rights were suspended. The 1940s saw many Pacific people recruited for the war effort. The resistance movement, Samoa Mo Samoa, grew and called for independence;⁵ self-government was realised in 1957. In 1962 the Treaty of Friendship was signed between New Zealand and Samoa, enabling more immigration

5 Field 1991.

to support New Zealand's growing economy. Between 1967 and 1970, the country's resources came under pressure, with more than 70,000 immigrants arriving from the Commonwealth — and only 3000 from the Pacific. Pacific immigrants experienced the 'dawn raids', and newspaper headlines began to feature youth gangs, often modeled on black American culture. Dawn raids were a response by the New Zealand Government at the time to catch 'overstayers' by raiding houses early in the morning on the assumption that people would be asleep and at home.

In 1945 the total population of Pacific people in New Zealand was just over 2,000; this had grown to 256,329 by 2006. At the current growth rate the projected numbers of Pacific people in this country will be 599,000 by 2051. Samoa is the island nation making up the largest Pacific group in New Zealand, followed by Cook Islands and Tonga. Fijian is the fastest growing nationality, followed by Tongan. The median age for Pacific peoples in 2006 was 21.1 years, compared to 35.9 for the general population, and most live in the North Island. New Zealand-born Pacific peoples have a younger profile with a median age of 13 years, and 39.3 percent of the total Pacific population is under 15 years of age.

The turbulent and rapid emergence in New Zealand of Pacific peoples has important implications for the design and delivery of assessment and treatment programmes for Pasifika communities. A Pacific person has a rich and diverse history — from their own, their parents' and their grandparents' journeys in and across the Pacific. Across families, villages, districts and countries there are many stories. Understanding these journeys helps Pacific individuals construct a sense of identity and a stronger platform from which to launch into the future. It also helps programme designers ensure that these people, as minority cultures, cannot be marginalised and discriminated against because of a lack of understanding or acknowledgement of their cultural values and behaviours.

What do we mean by 'culture'?

Broadly speaking, 'culture' is a system of shared attitudes, values, goals and practices that characterises an institution, organisation or group. Although culture is often equated with demographic features such as

race or ethnicity, the scope of the word as used in this chapter implies broader understandings, such as values, norms, language (including symbols) and knowledge derived from communal traditions. A focus on traditional Maori and Pacific cultural expressions⁶ is of interest because these cultural traditions are likely to be encountered in correctional programme settings in New Zealand.

What does culture have to do with offender rehabilitation?

When developing (or refining) treatment programmes for offenders, the issue of *effectiveness* becomes a central concern, and the methods for determining the degree of efficacy need to be built into any long-range design agenda. The Department of Corrections' special treatment units,⁷ for example, have adopted a systematic evaluation approach, a framework that has determined the functioning and performance of treatment programmes and in most cases has aligned programme content and delivery with international best practice. The value of systematic evaluation lies in the sequence of steps facilitators and psychologists follow to address issues of change in a methodologically sound way. These steps, as outlined by Kazdin, include:

1. specifying and assessing treatment goals specific to the individual's needs (then prioritising identified goals)
2. specifying and assessing procedures and mechanisms (i.e. the treatment process, programme content, etc.) that are expected to lead to therapeutic change
3. selection of appropriate measures that can assess progress of *relevant* treatment targets over time

6 For instance, Pacific communities themselves are made up of diverse cultures, each island nation with different physical features, language, clothes and practices. Within Pacific communities there are Pacific and island-born, and now second- and third-generations of New Zealand-born, each adding a layer of understandings and developing new cultural meanings. Consideration also needs to be given to the many children of intermarriage and their sense of place and identity where cultural worlds combine or collide.

7 At the time of writing, six prison-based special treatment units were in operation; they include the Kia Marama (Rolleston) and Te Piriti (Auckland) programmes for child sex offenders; the Karaka (Waikeria), Puna Tatari (Spring Hill) and Matapuna (Christchurch) programmes for mixed, high risk offenders with complex needs (including the adult sex offender treatment programme), and Te Whare Manaakitanga (formerly the violence prevention unit, Rimutaka), which specialises in non-sexual violence with high risk offenders.

4. assessing on multiple occasions (e.g. pre-, post-, follow-up)
5. evaluation of the data.⁸

Such an approach informs whether change actually occurs, the extent of the change and whether treatment was responsible (or not) for the change. All are critical issues to consider when evaluating the therapeutic effectiveness of any treatment programme. In the field of correctional programmes, there is consistent evidence that certain models of intervention (e.g. those that address risk and need principles) and certain characteristics of staff are related to improved outcomes.⁹ It is argued that characteristics of site, programme, staff/therapist(s) and offender all influence treatment efficacy, and to maximize responsivity as many characteristics as possible should match.¹⁰

As noted earlier, ethnic minorities, especially Maori and Pacific peoples, are over-represented in New Zealand prisons. Furthermore, the proportion of Maori prisoners appears to grow in relation to high risk categories.¹¹ Hence treatment programmes should be adapted to accommodate the cultural needs of those who participate, as culture is an important responsivity issue for offender rehabilitation efforts.

For instance, offenders who have retained strong affiliations to traditional Maori and Pacific values present with unique characteristics that, if unrecognised, may result in missed opportunities to engage, and if not responded to, risk alienation of the offender. Beyond commonly recognised variables (such as the use of non-English first language and integration using key members of the community — *kaumatua* and church elders), the use of prayer groups and fasting and the practice of making amends through restorative justice are commonplace in Maori and Pacific communities. Healing through massage with *mirimiri* (Maori), *milimili* (Samoa) and *fotofota* (Tonga), and *rongoa* (traditional Maori medicines) can also contribute to a treatment programme. As with any therapeutic relationship, a primary objective for practitioners is to be respectful and do no harm — to recognise similarities and to be aware of difference. Practitioners who assume authority and

⁸ Kazdin 2006.

⁹ Andrews & Bonta 2010.

¹⁰ Serin & Prescon 2001.

¹¹ Wilson's 2004 study of 150 prisoners revealed that Maori constituted 83% of high risk offenders (compared with approximately 50% in the general prison population), whereas only 4% were of Pacific Island descent.

influence by virtue of their role in correctional systems may be less aware of difference and miss opportunities for open dialogue and to communicate important messages.

Culturally-informed or enhanced programmes attempt to combine traditional (e.g. *tikanga*) and mainstream therapeutic approaches.¹² Fundamental characteristics include recognition of an individual's relationship with family (*whanau/fanau*) and communities (e.g. *iwi*) and reintegration possibilities with these groups, inclusion of traditional activities as part of the therapy experience (e.g. *whakatau*, *poroporoaki*, *hui*) and an emphasis on developing cultural identity as a basis for a non-offending lifestyle.¹³ All of these factors acknowledge a wider context for an individual's reality than is captured by Western-based treatment philosophies that tend to promote an individualist outlook, which may be at variance with some offenders' core social understandings.

As with Maori, Pacific people are also over-represented in the criminal justice system and there is rapid population growth, resulting in a youthful population. The development, training and implementation of programmes targeted at Pacific communities needs to address a range of contributing factors, including social and economic disadvantage, social and cultural dynamics and treatment approaches that focus on the 'whole person'. Preliminary data for a preventative focus suggests best outcomes for youth are achieved using group-centred practices, such as restorative justice, where cultural responses to offending sit alongside the legal requirements.¹⁴ An offender may be punished by being required to make restitution, or face ostracism from family or community while court action is in progress. When many people live closely together it is important that the protocols and ways of behaving are understood to maintain harmony in daily life. Treatment from one's own community for breaching protocol, such as raised voices during evening prayer, can often be swift and severe — stoning for certain transgressions is still practised in Samoa.¹⁵ Culture defines the relationship as we work towards a common understanding.

12 e.g. Cognitive Behavioural Therapy; see Tseng 2001 & 2003.

13 Nathan, Wilson & Hillman 2003.

14 Tuala-Warren 2002; Tamasailau 2006.

15 The authors know of no such practices in New Zealand.

Culture-informed therapy

To simplify and illustrate ways culture can be integrated into treatment, we use a clinical process to emphasise typical decision points and action phases in the course of an offender's engagement in intervention programmes:

Pre-therapy intervention

Because many offenders are unlikely to be familiar with Western-based therapy approaches, one helpful process is to engage with participants before intervention to explore and discuss understandings, expectations and concerns about embarking on treatment.¹⁶ For example, Pacific offenders may have experienced, directly or indirectly through immediate or extended family, a therapeutic relationship of pastoral care. They may need some prior information about becoming a 'client' of a service.

Establish a therapeutic alliance

Rapport is often a necessary prerequisite for change to occur. A lack of rapport can increase the likelihood that clients in the criminal justice system will miss scheduled appointments, not follow through on referrals or self-terminate from treatment. An effective therapeutic alliance is a collaborative effort against self-defeating behaviour, and comprises:

1. *Goals* — mutually endorsed aims of the intervention or a valued outcome that is a target, such as reducing reoffending or developing a positive pro-social identity
2. *Tasks* — the 'substance' of the therapeutic process, the means or specific activities that will facilitate change (e.g. cognitive restructuring or behavioural rehearsal of alternative coping responses)
3. *Bond* — a complex network of positive personal attachments between the offender and therapist that includes mutual trust, acceptance and confidence in the practitioner's ability to facilitate change.¹⁷

¹⁶ Sue 2006.

¹⁷ Bordin 1994.

Rapport is assisted if there are common understandings between the offender and therapist. Use of appropriate language in greeting, the offer of prayer and the sharing of food are ways to increase trust and enable communication. Meeting people at ‘their place’ may mean ‘navigating without a paddle’ on occasions and being open to ask questions about their level of cultural competence in order to work in a respectful partnership. Some Pacific people are shy and may need a third party to initially negotiate the process, with different levels of acculturation.

Assess readiness and foster treatment-promoting factors/recognise and resolve resistance and ambivalence

Much of this phase involves the practitioner exercising ‘dynamic sizing’. Dynamic sizing refers to the attitude and skill that guide the practitioner’s responses of when to be inclusive and to recognise

Mr A, a Maori in his late 50s, was eligible to enter a mainstream, prison-based treatment programme to address his sexual offending rehabilitative needs. One of the assessing therapists discovered he had been eligible for programme participation for some years but that he had waived all previous opportunities to attend because of his belief that the programme would not apply to him and that he would struggle with the content — an issue that had caused him much anxiety and avoidance. After a number of individual sessions, designed to gradually socialise Mr A into treatment, the therapist recognised that Mr A would be more likely to engage openly if his whanau was involved in the decision-making process. The therapist therefore proposed holding a whanau hui (family meeting) at the prison to help Mr A make an informed decision about whether or not this form of treatment would be appropriate for him. Mr A agreed, and the later meeting with his wife, sister and adult children provided the opportunity for him and his whanau to express their concerns and misgivings, and to discuss how the treatment programme would help him develop a better supported reintegration plan than if he had continued to relinquish further opportunities. With his whanau’s blessing, Mr A made a commitment at the hui to attend and complete the programme.

characteristics typical of a given culture (e.g. avoidance of direct gaze), and when to be exclusive and to recognise idiosyncratic behaviours that are not necessarily culture-specific (e.g. intrafamilial sexual abuse) when interacting with a person of a different culture.¹⁸ Working with Maori and Pacific people requires understanding of practical steps for effective engagement and interaction. Meeting face-to-face (kanohi ki te kanohi) is essential to establish rapport. Treatment in isolation from one's family or spiritual community may not be as effective as working with significant others. Being flexible with timeframes for introduction and assessment is helpful. Indirect questioning, use of humour and hospitality are also important variables for consideration.¹⁹

Recognise and resolve resistance, ambivalence, transference and countertransference

Culture affects not only the process and outcome of therapy but also how offenders perceive their therapists. For instance, if a practitioner is afforded matua status (venerated older male) by an offender, culturally-specific modes of conduct may occur as a result (e.g. deference, not speaking until invited). On the other hand, the same practitioner may present an image of authority that has associations of punishment and rejection for the offender. In this way, working alliances can be compromised by unrecognised cultural attitudes towards authority. In a communal society, responsibility and accountability for a crime may be shared, and the shame (whakamaa) may have a wider impact than just on the individual. The social and family environment will influence the outcome. Unfamiliar or jargonistic language may result in a Pacific person deferring to the person they consider has greater knowledge and expertise — in the interests of maintaining the relationship — possibly harming the maintenance of open and informed consent. Guidance and supervision on cultural and clinical variables, and the way they may interweave is useful from a person familiar with these nuances.²⁰ This is especially useful for the offender who believes their offending is culturally acceptable. For example, they may believe their offence is in keeping with their cultural beliefs about child discipline or gender roles. One of the greatest challenges of working with culture in offender

18 Sue 1998.

19 Further guiding principles are identified in Kingi-Ulu'ave, Faleafa & Brown 2007.

20 Te Pou o te Whakaaro Nui 2010.

Mr D was a 25-year-old of Maori and Tongan ancestry who had served almost ten years in prison for a home invasion that involved sexually aggressive elements. He was three weeks into a long-term, intensive, prison-based group treatment programme for violent offenders. However, Mr D's strong gang affiliation and misogynistic attitude presented as oppositional, and he demonstrated verbally confrontational behaviour towards the female therapist in group sessions. An individual therapy session was arranged to focus on addressing his motivation (task). In the absence of his peers, he became more comfortable with the therapist (bond) and disclosed that he had witnessed one of his parents being ostracised from their marae. He subsequently denounced his connection with all things Maori. This furthered his association with an antisocial group that explicitly rejected traditional societal and cultural values (i.e. Maori and Tongan). The therapist assisted Mr D to work through the emotional impact such an experience had for him (task) and collaborated with him on targets for him to work on throughout the programme. These targets included reducing his tendency to provoke and managing his inappropriately oppositional behaviour. The targets challenged his expectations of rejection and degradation, and his deviant cognitions (goals). Despite his long-standing anxieties with Maori cultural involvement, Mr D was invited by his peers, the therapist and the Maori service provider, to attend group culture therapy, a therapeutic capacity of the programme that provided opportunities for him to develop positive experiences in pro-social contexts (in this case, a Maori cultural setting) and extend his cultural understanding.

rehabilitation is determining what aspects of the offender's culture may be seen to reward antisocial behaviour and what aspects do not.²¹

Conduct an integrated risk assessment

A thorough assessment that integrates static (historic and unchangeable), stable–dynamic (changeable but durable) and acute–dynamic (highly changeable) variables and incorporates protective variables (factors that

21 Andrews & Bonta 2010.

have the potential to buffer or reduce risk) is essential if a practitioner is to measure treatment gains in a meaningful way.²² It is argued that risk factors per se are not culture-specific, and that even the ‘big four’ (antisocial cognitions, antisocial associates, a history of antisocial behaviour, and antisocial personality) occur universally across demographic and international contexts.²³ However, protective factors may be more effective if informed by culture. It is recommended that such assessments occur as a routine aspect of case management.

Develop an effective case conceptualisation and cultural formulation

In brief, a ‘case conceptualisation’ seeks to direct practitioners to formulate hypotheses about an offender’s behaviour that guide treatment (establish goals, inform strategies), anticipate obstacles and prepare for termination (i.e. when goals have been met). This step is essential when focusing on the target behaviours of greatest concern — the offending. A ‘cultural formulation’ supports the clinical formulation²⁴ and risk assessment and can direct the focus of treatment, intervention strategies and the sequential ordering of treatment tactics. A sound cultural formulation seeks an explanation of the cultural factors that impact on the offender’s personality, level of functioning and offending behaviour, and on the practitioner–offender relationship. A cultural formulation involves:

1. identifying the offender’s cultural identity and their level of acculturation. Although this may seem self-evident on meeting the offender, practitioners are encouraged to check this out with the individual, as it is not uncommon for offenders to deprecate their ethnicity of origin and claim an ethnic or cultural status contrary to practitioner experience (e.g. a Maori who has denounced his whakapapa and ‘doesn’t worry about that cultural crap’). For Pacific peoples, it is useful to ask for parents’ place of birth to identify their Pacific connections. Village stories give insight into ancestral heroism or curses that follow families and may require some intervention.

22 Andrews, Bonta & Wormith 2006. The subject of risk assessment is beyond the scope of this chapter. However, the reader is directed to chapters five and eight of the current volume where the topic will be dealt with in detail.

23 Andrews & Bonta 2006.

24 Sperry 2010.

2. exploring the offender's cultural explanation of their offending behaviour and their expectations of treatment and of the practitioner. For instance, over the course of treatment the practitioner may have to negotiate their perceived role as healer, advocate, facilitator, expert/authority, seer or counsellor.
3. identifying the cultural elements in the offender's psychosocial environment; for example, stressors, such as strong influence from pro-criminal peers, against pressure to maintain an offence-free lifestyle from whanau. Guidance and encouragement from key people in the community can help with reintegration. For instance, most Pacific churches have groups for men, women and youth or for all the unmarried parishioners. Many Pacific community agencies work from a holistic perspective and will give support to people with needs outside the confines of their contractual obligations as part of their Christian beliefs.
4. identifying cultural elements likely to be operative in the therapeutic relationship, such as traditional practices that may help with coping. A common example is the use of karakia (prayers) and waiata (songs) to attain mental quiet and set the tone for the session. For Pacific peoples, prayer, often in the form of hymns, serves the same purpose. It is also important to take time and not to move directly into the therapy; to develop skills at 'talking around' or using indirect conversation before engaging in therapy.
5. identifying cultural elements likely to be operative in the treatment process, such as culture-specific ways of communicating with others (e.g. deference to older males).

In summary, effective cultural formulations seek to derive culturally-relevant interventions informed by functional links between the offender's cultural behaviour and their risk and desistance behaviour.

Plan and implement treatment and anticipate obstacles

Practitioners need to consider how the offender's culture influences the process and outcome of therapy. For example, typical therapeutic processes such as self-affirmation may be seen as a type of aggrandisement considered inappropriate in some cultural settings. Furthermore, disclosure of offending (particularly sexual offending) may encompass

whakamaa (shame) by the offender, and they may subsequently engage in passive-aggressive behaviours intended to sabotage their ability to engage with the task, or withdraw from treatment. Such treatment-interfering behaviours need to be identified and resolved. Consultation with an appropriate cultural expert or supervisor is a recommended ‘first step’ to explore what behaviours are thought normative or abnormal in situations where the offender may perceive therapy to be challenging and confrontational.

At 34 years of age, Mr K had served five years of an eight-year sentence for multiple sexual offences against children, and was participating in a prison-based group treatment programme for child sexual offenders. His static risk was seen as ‘low’, but other factors such as an overt emotional identification with children, poor problem-solving and deviant sexual interests were considered to have elevated this estimation. Throughout his imprisonment, Mr K had kept a low profile and had incurred no institutional charges. His psychologist assessed his IQ to be ‘borderline’, and he presented in an awkward and demure manner, so much so that he was often considered ‘invisible’ by his therapist and other group members. Mr K had poor living skills, a meagre work ethic and minimal communication with others. He confirmed to his therapist that he identified as Maori and expressed respect for tikanga Maori (things Maori) but was ambivalent in engaging in social activities where he felt he would be harshly judged by others. Other members of the therapy group — at the suggestion of the therapist — invited Mr K to get involved with the runanga, a group of older Maori prisoners doing a number of activities, including organising recreational activities for staff and prisoners in the unit. Despite some apprehension, Mr K accepted the challenge and became involved in increasingly more socially demanding tasks, such as canvassing opinion from the wider prisoner body. Over time, Mr K’s engagement with these tasks helped him manage his social anxiety, addressed his tendency to isolate himself and created accomplishments — in other words, desistance-parallel behaviours — designed to address a range of rehabilitative needs.

Termination

Termination of treatment is a process of ending a relationship predicated on support and change.²⁵ Inevitably, participants in group programmes, or any intensive intervention effort, develop meaningful relationships with therapists and each other. Such relationships are even more evident with individuals who value whanaungatanga (sense of kinship) through shared experiences and working together, and who invest in social relationships, a factor often in contrast to Western-based psychological approaches where individualism is prized over interdependence.²⁶ For Pacific communities, the end of a programme is a time to celebrate and share with those close to the person. The programme has not been completed alone, and the celebration represents a journey undertaken with others and a new beginning. Being prepared to accept responsibility in a community forum for offending behaviour and asking for forgiveness may be part of this process. Establishing supportive networks are vital for ongoing success and maintenance of treatment gains.

Practice issues with culture and offender rehabilitation*Service delivery*

Given that culture acts as a perceptual lens through which the world is viewed by offenders, practitioners and the organisation, care should be given to considering the role of culture in service delivery. Practitioners tend to perceive cultural competence as a distinct set of skills rather than an integrated part of routine clinical care and offender management.²⁷ As such, cultural issues risk becoming relegated to the domain of specialist providers with cultural expertise (and who may not share the same outlook or degree of clinical competence), whose involvement may be intermittent or disconnected from the rest of the service, thus perpetuating a disjointed process of care. Two suggestions for enhanced service delivery include:

1. engaging the offender's family or whanau as the focus of service delivery.²⁸ Developing a therapeutic relationship with the offender's

25 Sperry 2010.

26 Ridley & Kelly 2007.

27 Yamada & Brekke 2008.

28 Simpson & Tapsell 2002.

family will help the offender feel understood and supported, and increase the likelihood of successful rehabilitation and reintegration.

2. engaging the cultural service provider in the design and implementation of therapeutic plans.²⁹ Such alliances can greatly improve the understanding of an offender and inform the individual's responsivity and treatment strategies. A practitioner who adopts a rigid attitude towards treatment ('it's my treatment or none at all') is likely to damage relationships with the offender and compromise the treatment outcome. Rather than adopt an 'either/or' position, practitioners are advised to consider a 'both/and' philosophy.³⁰

Cultural matching

Cultural matching is the practice of engaging service users with practitioners of the same ethnic and cultural identity, with a view towards improving treatment outcomes.³¹ Benefits of cultural matching include enhancing comfort, communication and empathy by reducing differences,³² resulting in lower stress levels as practitioners and offenders have more in common.³³ However, these aspects are complex and can be difficult to operationalise. Offenders may prefer to be seen by a practitioner from their own ethnicity or cultural group and this may lead to appropriate service utilisation and treatment participation. However, greater engagement may not necessarily translate to improved outcomes in terms of reduced recidivism and may actually impede intervention efforts, particularly if the offender does not want to disclose personal information to their therapist. Cognitive-matching involves establishing practitioner–offender compatibility regarding the individual's perceptions of (and attitudes towards) the problem behaviour. Addressing the offender's coping orientation and conceptualising goals for treatment in this way is emerging as a promising area regarding suitable therapist characteristics that have positive impacts on offender change.³⁴

29 *Ibid.*

30 Bell, Wells & Merritt 2009.

31 Sue 1998.

32 Bell, Wells & Merritt 2009.

33 Brown, George, Sintzel & St Arnault 2009.

34 Zane, Sue, Chang *et al* 2005.

In New Zealand, culture-matching treatment strategies have included the Department of Corrections' Bicultural Therapy Model, where eligible Maori offenders are paired with Maori service providers — individuals who have *mana* (standing) in the Maori community and who have been mandated by their *iwi* to conduct rehabilitative work with offenders. In some cases, entire prison environments have been arranged to facilitate a culture-informed philosophy of rehabilitation, such as the Maori focus units³⁵ and the Pacific focus unit.³⁶

The Pacific focus unit is a holistic programme supported by Pacific elders. Core principles that underpin programme philosophy and content can be loosely translated as follows:

- *feagaiga* — relationship between brother and sister
- *va fealoai* — the 'space between' that governs how we relate with each other
- *va tapuia* — sacred 'space between' that we never cross can impact across individuals and generations
- *faaleleiga* — a form of reconciliation or bringing together.

The programme relies on a collective journey using Pasifika learning paradigms with stories and metaphor to enable change and reduce reoffending.

Cultural competence

Although scholarly conceptualisations of cultural competence vary, a working definition is 'an ability to interact effectively with people of different cultures'. This topic is complex so we provide cursory treatment only. Cultural competence involves: skills, knowledge and awareness that can be developed — an ability;³⁷ interaction and engagement; anticipating and creating opportunities to impact positively and effectively; continued awareness that the interactions are with people (individuals) and *not* stereotypes or constructs; interactions that will inevitably reveal critical differences in outlook that provide information

35 Presently, there are five Maori focus units in the public prisons service. They are in Waikeria, Tongariro/Rangipo, Rimutaka, Wanganui and Hawkes Bay prisons.

36 Also referred to as *Vaka Fa'aola* (the vessel bringing a message of life and growth), and reflecting the people of Tonga, Samoa, Niue, the Cook Islands, Fiji and Tokelau.

37 Sue 1998.

on how best to proceed; and experiencing culture in terms of values, beliefs, norms, symbols, language and knowledge, both regional and local.

Cultural knowledge is essential to understanding values, beliefs and behaviours. A Pacific perspective sees people as an integral part of the family, immediate and extended, not as an isolated entity. Awareness and involvement of the family, consideration of gender and age/status relationships, the impact of the church, verbal and non-verbal communication (especially when English is not the primary language), and connections and responsibilities to a homeland are all significant factors for consideration. Workers' responsibilities may be to the whole group. Examples of respectful behaviour in Samoan communities includes removing footwear when entering a home, sitting when eating and taking a gift, usually food, when visiting. Personal space is important in this culture and people, when passing, lower the body and say excuse me or 'tulou'.

Fā'a Samoa, ulu'ngaanga faka-Tonga or *faka fisi* is about the Samoan or Tongan way of living and behaving. Understanding underlying beliefs and values is needed to interpret and understand behaviour. These include concepts relating to *aiga* (family), genealogy, land, language, responsibility, respect, hospitality, and *alofa* (spirituality). Understanding will help build and maintain respectful and meaningful relationships. For example, in Tonga, respectful behaviour may be shown by the language used, the dress worn or by specific behaviours in the company of others in authority such as a titled person or older family member. *Faka'apa'apa* (respect) can be shown when speaking in any of the three levels of language used — for commoners, for nobles and for the king (when another special dialect is used). When visiting a noble, a *tupenu* (i.e. wrapped garment, a lava-lava) is worn as well as a *ta'ovala*, which is a special fine, small mat wrapped around the waist to cover the top half of the *tupenu*. Also, a specific way of weaving flowers and leaves to indicate a *sisi kakala* is a sign of respect to the noble, and can be offered as some of the gifts taken. A further sign of respect is to sit close by the door and in a lower stance than a person with status.

Respect or *faaloalo* in Samoa is learnt early by example. In a family the child obeys the parent and the youngest obeys the next oldest. The village is an extension of home where each family understands their

position and responsibilities in the hierarchy of chiefly titles and roles. *Ifoga* or showing remorse for a past offence is an example of showing respect. An offender, their family or even a village may show remorse for a misdeed and ask for forgiveness with gifts and a period of penance to prevent disharmony. The act of *ifoga* is a form of respectful public apology, and justice can continue through the legal system.

Fakamolemole means forgiveness, and Tongans have various ways of asking for forgiveness (such as *kole fakamolemole* — pleading or begging) depending on the harm done and in what context. If harm is proven the offender offers something in return of a similar value — often food, traditionally fine woven mats or tapa cloth. Today money may be offered to the victim and family. An offender may take someone, such as an elder, to speak on their behalf, to convey remorse and ask for forgiveness. Prayers are said to mark the significance of the event.

The family is an extended support network in Pacific nations, and obligations and responsibilities are delegated and shared. Family and community demands can also conflict and change over time. Lealailauloto and Taitia discusses the complexities of dual or multiple heritages.³⁸ An example of conflicting and changing values is the gaining of status. In Samoa, status can be inherited or gained by seniority of age or by service to the family and community. In New Zealand, material wealth has now been added to the equation and a Samoan's status may be 'purchased'.

Practice considerations

There are general practice considerations when negotiating cultural difference. The list below is not exhaustive and reflects typical issues encountered in correctional programme contexts.

- Accept intercultural encounters as 'business as usual'. The offender's cultural history and ethnic identity development are important factors in assessing how best to conceptualise presenting problems and facilitate therapeutic goals.³⁹
- Cultural differences are subjective, complex and dynamic. The most salient cultural differences should be addressed first,

³⁸ Lealailauloto 1995; Taitia 1998.

³⁹ Evans & Paewai 1999.

particularly those seen as important by the offender.⁴⁰ Furthermore, the meanings and saliency of cultural differences are influenced by ongoing issues in the psychotherapeutic relationship.⁴¹

- Similarities should be addressed as a prelude to discussion of cultural differences,⁴² and differences should be addressed as assets that can help in the therapeutic process.⁴³
- The therapist's cultural competence will affect the way differences are addressed. Key areas for ongoing development include: *awareness* of one's own assumptions, values and biases; *knowledge* of the worldview of culturally diverse clients; and *skills* to developing appropriate intervention strategies.⁴⁴
- Workforce development — recruit, train and support Pacific clinicians across the range of social service disciplines of social work, counseling and psychology.
- Support existing Pacific and non-Pacific clinicians — offer cultural training and develop organisational competencies.⁴⁵
- Find and support mentors and supervisors who understand and support culturally responsive ways of working.
- Build a body of knowledge with 'practice-based evidence' — a store house for what works — and find a central point to maintain your database of information.
- Be genuine and open to new learning and don't make assumptions.
- Find and use existing resources such the Pacific Peoples Analysis Framework, which details guidelines for consultation and key considerations when working with Pacific communities.⁴⁶ The solution needs to be working 'with' rather than 'for' Pacific people, reflecting the diversity of Pacific populations, utilising those who

40 La Roche & Maxie 2003.

41 Sperry 2010.

42 La Roche & Maxie 2003.

43 Sue 2006.

44 Evans & Paewai 1999.

45 Puluotu-Endemann *et al* 2007; Te Pou o te Whakaaro Nui 2009.

46 Ministry of Pacific Affairs 2006.

have respect in their communities, raising community awareness and increasing capability.

- Treatment programmes are likely to address major responsibility issues if they are designed with input from the consumers (e.g. Maori and Pacific communities) being served.

In summary, it has been argued that developing a culturally informed practice presents: a synthesis of an offender's presenting clinical and cultural 'profile'; the practitioner's ability to competently negotiate a range of salient cultural factors (including access to appropriate supervision); the development of a safe environment and more effective working relationships.

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