

Alcohol and Drugs in New Zealand

An Asian Perspective: A Background Paper

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FOREWORD

In November 2003 the Alcohol Advisory Council (ALAC) commissioned, from the Asia Pacific Centre for Community Health Research at the Auckland University of Technology (AUT), a background paper on an Asian perspective on alcohol use and misuse in New Zealand. Valuable contributions were also made by the Asian project team of Community Alcohol and Drugs Services Auckland and, consequently, the brief was extended to include other drugs.

In the Auckland region, discussions had previously been held with agencies that have an interest in the health and welfare of Asians. They indicated that before any plans were made to introduce any particular programmes aimed at reducing alcohol-related harm, background information should be collected on the current knowledge and from that, recommendations should be made for action.

Although papers have recently been written on mental health and general public health issues among the Asian population, this paper is the first attempt to bring together alcohol and drug specific information in regard to Asians living in New Zealand.

I would like to acknowledge the work of the authors and the support of the Faculty of Health at the AUT, Community Alcohol and Drugs Services, Auckland who contributed their expertise and experience.

My belief is that this paper will provide a valuable contribution to the knowledge on this topic, as well as provide a very useful resource for agencies that work with Asians to reduce alcohol and drug-related harm.



Dr Mike MacAvoy
Chief Executive
Alcohol Advisory Council of New Zealand

INTRODUCTION

In December 2003, the Alcohol Advisory Council of New Zealand (ALAC) commissioned a literature review of the current knowledge on alcohol use among Asians, along with recommendations for future action within New Zealand. The initiative reflects the need for a comprehensive strategy on reducing alcohol-related harm for this specific sector of New Zealand society, with its diverse communities, characteristics and cultural beliefs.

After consultation with Community Alcohol and Drug Services in Auckland, the project was extended to include other drugs, with the aim of informing ALAC and other agencies on strategies and policy.

Asians in New Zealand

Recent increases in Asian immigration to New Zealand have had a major impact on the population's size, growth rate, age-sex structure and ethnic composition. According to the 2001 Census, Asians are expected to make up 9 percent of the population by 2016 and comprise 20 percent of the Auckland region's total.

Asians are not a homogeneous group; they come from at least 28 different countries¹ in the Far East and Southeast Asia (Dhooper, 2003) and each community group has its own cultural beliefs, habits and attitudes. These can be very different from those of New Zealand's mainstream society.

Research to Date

Since 1990, research on Asian immigrants in New Zealand has focused on issues such as adaptation problems and difficulties, mental health status, the use of mainstream health services and alternative healing practices (Ho et al, 2002). Little research has been undertaken on alcohol and drug (A&D) use and misuse.

However, while international epidemiological data indicates lower rates of alcohol and drug (A&D) misuse among Asians compared with other ethnic populations (Amodeo et al, 1996; Dhooper, 2003; Zane and Sasao, 1992), anecdotal evidence suggests these figures are rising. New Zealand studies (Adamson, 2000; ALAC, 2000, 2002,) have not specifically identified Asians, which means there is no substantial evidence on A&D use and misuse among this population.

Overall the general well-being of Asians living in New Zealand has received very little attention. This may be because of the perceived low demand for existing services and the (mis)conception of Asians being a 'model minority' (overachieving, having high economic status, good discipline and perfect family

¹ Bangladesh, Borneo, Burma, Cambodia, China, Guam, India, Indonesia, Japan, Korea, Laos, Malaysia, Micronesia, Nepal, Pakistan, Philippines, Singapore, Sri Lanka, Thailand, Tibet, Vietnam.

relationships). There may also be a limited understanding of the prevalence, patterns, perception and impact of A&D use among Asians.

Purpose of the Research

This paper reviews New Zealand and international literature with the aim of identifying factors associated with an increased risk of A&D misuse among New Zealand's Asian population – and any concerns that may not have been recognised, or responded to, in current A&D services.

International material was found via the Expanded Academic and Web of Science, while local research came from INDEX New Zealand, New Zealand government and non-government websites and local published and unpublished materials available from university libraries or through personal communications.

Limitations of the Research

This background paper is the first to address A&D misuse among Asians within New Zealand, and aims to shed some light on, and enhance our, understanding of the situation. However, it recognises that a number of research issues make it challenging to obtain a substantial picture.

For example, most research on drug misuse does not appear to examine links between the substance and ethnicity, whether in use or involvement in the drug market (Reid et al, 2001). This means not much is known about the levels of drug use among different ethnic groups in most countries (Pearson and Patel, 1998; Smith and Citta, 1994). Larger multi-racial studies involving Asian people appear unable to distinguish between Asian ethnic groups and rely on easily available studies that have found substance use among Asians to be less than that of other ethnic/racial groups (Kandel et al, 1976; Maddahian et al, 1985; Newcomb et al, 1987). In addition to representing Asians as a single homogeneous group, earlier findings appear to be based on samples of more acculturated Asian groups (i.e. Japanese and Chinese Americans) without the inclusion of recent migrant groups.

Another limitation of this paper is that most of the literature is derived from the United States, Australia and the United Kingdom, which means it largely relates to ethnic communities living among mainly English-speaking populations (Reid et al, 2001). Reports on substance use in Asian countries are also limited, possibly because research has been conducted and published in their own languages. This review located two studies conducted in Malaysia and Hong Kong (Abdullah and Fielding, 2002; Peters et al, 1997) that may provide some useful information on substance misuse among Asians from their countries of origin.

EXECUTIVE SUMMARY

While New Zealand's Asian population has increased dramatically in the past decade, there has been very limited research into issues relating to their use (and misuse) of alcohol and drugs (A&D). ALAC has funded this background paper to examine the current and existing literature on Asian and A&D issues and provide an indicator for future directions. There is a large diversity in the different Asian cultures in New Zealand and the authors have not made any assumptions that all Asian groups are the same.

Asian People in New Zealand

The increase in the Asian population is mainly due to an increased migration to New Zealand. The latest national Census (Statistics New Zealand, 2001) shows Asians are the third largest ethnic group in New Zealand, with a majority (78 percent) born overseas.

It is important to note that the Asian population encompasses various ethnicities, the largest being Chinese (44 percent), followed by Indian (26 percent) and Korean (8 percent). The Asian population is also relatively youthful compared with the New Zealand population. In 2001, 21 percent of New Zealand Asians were in the 15-24 year age group compared with 14 percent of the total population. About two-thirds of Asians live in the Auckland region while 11 percent live in Wellington followed by 7 percent in Christchurch.

Asian People and A&D Issues

The literature review indicates that many different factors influence A&D use among New Zealand's Asian population:

- Asian people have a different physiological response to alcohol from Europeans. However, this does not appear to affect alcohol consumption; it has been suggested that socio-cultural factors play a more significant role in alcohol use.
- Traditional perceptions of A&D use are important. For example, alcohol and some drugs have historically been considered therapeutic.
- Alcohol is used in important social rituals in many Asian cultures.

These traditional perceptions affect A&D use among the Asian population in contemporary society.

A&D Use Among Asian People Overseas

The review indicates wide cultural variations in attitudes to A&D consumption and the prevalence of A&D-related disorders, which can be affected by significant differences in migration patterns and subsequent post-migration experiences. This is confirmed by the results of A&D research in Asian home countries.

In addition, the rates of A&D misuse among Asians are not consistent, suggesting that it varies across cultures and countries.

A&D Issues for Asian People in New Zealand

Literature on A&D use among New Zealand's Asian population is very limited. However, research on migrant Asians reveals common post-migration issues that include language barriers, acculturation, difficulties in adjusting to the host society, and changes in the family structure and dynamics. However, there have been no investigations into how these issues affect A&D use, despite international literature suggesting a link between post-migration issues and A&D consumption.

Asian People and A&D Services' Use in New Zealand

Data on Asian people and A&D services' use is limited, partially because of research methodology issues such as Asian people being categorised as 'Others' in ethnicity data collection systems.

Available data indicates that Asian people do not use A&D services to any great extent (reflecting the findings of overseas literature). New Zealand research strongly suggests this is due to Asian migrants lacking knowledge about the available services, the services not being culturally responsive to Asian people, and language barriers. Limited knowledge of New Zealand's healthcare system has also been found to impede Asian people accessing appropriate healthcare services.

Health Promotion in the New Zealand Asian Community

The literature clearly shows that Asian people tend to seek professional help as a last resort, partly due to strong family values and a wish to avoid family shame. Health promotion could be a key pathway to educating and promoting available services to Asian communities and helping to prevent the consequences of A&D misuse. New Zealand literature shows that Asian communities are cohesive and keen to be involved and collaborate with service providers to make positive changes.

Conclusion and Recommendations

Despite the scarce literature on A&D issues for Asian people, the picture for the New Zealand community is clear. Key recommendations cover three areas:

- Undertake more research on A&D issues in the New Zealand Asian community and develop a consistent collection system for up-to-date ethnicity data.
- Improve Asians' A&D treatment service use by:
 - removing language barriers
 - providing more culturally appropriate services through cultural competency skills training and developing policies in A&D service organisations that reflect different cultural needs.
- Raise awareness of A&D issues in the Asian communities through health promotion.

The review also suggests encouraging and adopting community participation and inter-agency approaches to ensure the community can easily access education and health promotion programmes.

ASIAN PEOPLE IN NEW ZEALAND

Defining 'Asian'

In this paper the term 'Asian' includes people from the Far East to Southeast Asia. However, the literature does not define 'Asian' clearly, and few researchers have collected data that allows a comprehensive description of ethnic groups (Chang, 2000).

For example, United States researchers tend to classify ethnic groups into five main racial groups (white, African-American, American Indian/Alaskan Native, Asian/Pacific Islander and Hispanic) despite the existence of hundreds of ethnically distinct groups in that country (National Institute on Drug Abuse, 1997). In culturally diverse New Zealand, Asians have been categorised as 'Others' in major studies. This means there is a lack of information pertinent to the A&D use among these ethnic groups. (Hatty, 1990; Romios and Ross, 1993).

Statistics New Zealand (2001) defines Asians as 'people who identify with an Asian ethnicity (e.g. Chinese, Indian and Korean) with or without other ethnicities. This does not equate to a birthplace description'. It also states that 'because ethnicity is self-perceived, people can identify with an Asian ethnicity even though they may not be descended from Asian ancestors. Conversely, people may choose not to identify with an Asian ethnicity, even though they are descended from Asian ancestors.'

Similarly, Nguyen (1999) defines an Asian as 'someone who was born and/or raised in an environment where Asian cultural beliefs, values and practices are introduced and shared by family members, having experience of the Asian extended family system and the Asian patriarchal system; and culturally identifies herself or himself as Asian' (p.23).

Asians Defining Asians

Despite their similarities, most Asians recognise significant differences between themselves (Vasil and Yoon, 1996). The needs and views of Asian people from different ethnic backgrounds also vary with their backgrounds and their time spent in New Zealand.

Challenges for Research

The distinct differences among Asian populations lead to inherent complexities in assessing and treating those with A&D misuse. The term 'Asian' therefore appears to be multifaceted, encompassing significant aspects of the individual's situation and important differences in customs, values and beliefs. Both Statistics New Zealand's (2001) and Nguyen's (1999) definitions are used in this paper.

Demographic Details

In the 2001 Census approximately 6.6 percent of the population identified with one or more of the Asian ethnic groups. Seventy percent identified as European, 14 percent as Maori, 5.4 percent as Pacific peoples and 4.6 percent as 'Others' who did not specify their ethnicity (Statistics New Zealand, 2001).

Within the broad category of 'Asian', there are many ethnic groups with distinct characteristics. The largest is Chinese, accounting for 44 percent of the Asian population, followed by Indian (26 percent), Korean (8 percent), Filipino (5 percent), Japanese (4 percent), Sri Lankan (3 percent), Cambodian (2 percent), Thai (2 percent) and Vietnamese (1 percent).

In 2001, 1,172,997 people usually lived in the Auckland region. Sixty percent of them were European, followed by Asian (12.5 percent), Pacific peoples (12 percent) and Maori (11 percent). Both Asian and Pacific peoples made up greater percentages of the Auckland region's population than the national figures, while people from European or Maori backgrounds comprised a smaller percentage than the national figures.

One-fifth of the Asian population was in the 15-24 year age group (compared with 14 percent of the total New Zealand population). Over three-quarters (78 percent) of the New Zealand-resident Asian population were born overseas, an increase from 71 percent in 1991. Of the 183,615 Asian people who were born overseas, nearly three-quarters had lived in New Zealand for less than 10 years. This shows that nearly four in five New Zealand-resident Asians were born overseas and they were relatively young.

Nearly one-third of Asian people in New Zealand had a tertiary education. Overall, Asian people had higher than average unemployment rates (7.4 percent) and significantly lower than average income levels (only 17 percent earned more than \$30,000). Across ethnic groups, unemployment among Chinese, Cambodian and Vietnamese recent immigrants was higher (between 20 percent and 24 percent) than among Indians and Koreans (between 13 percent and 18 percent).

Post-Migration Issues

For Older People

The rising population of older Asian immigrants faces the most difficulties in integrating with New Zealand society. Their main obstacles are an inability to communicate effectively in English and dependence for transport on family members (Cheung, 2002). For example, among Chinese recent immigrants aged 65 years and over in 2001, 77 percent of men and 85 percent of women could not speak English or Maori.

For Women

Asian immigrant women have unique and diverse socio-economic experiences:

- Some are in 'astronaut' family structures, where their husbands have returned to their country of origin to work.
- Some had professional jobs before moving to New Zealand and may have experienced occupational shifts upon immigration.
- Some are from traditional religious backgrounds and speak limited English, so have to cope with considerable social and cultural isolation in their new country.

These experiences have implications for women's and their families' mental health (Ho et al, 2002).

Acculturation

Migration involves losses, disrupted life patterns and exposure to multiple stressors. Although many immigrants have high levels of formal education and business or professional backgrounds, they may be forced to compromise to adapt to their new country – sometimes resulting in the loss of traditional cultural values and norms, especially when the new cultural system is significantly different from the old (Collins, 1992; Oetting and Beauvais, 1990-1991).

Post-migration psychological, social and cultural stressors may lead immigrants to take drugs to reduce their feelings of isolation and depression shortly after immigration (Nemoto et al, 1999; Reid et al, 2001). Feelings of personal failure, a role reversal between parents and children, and economic stress are also considered precursors for A&D abuse among Asian immigrants (Kim et al, 1995). Thus, immigrant status among Asians is considered a risk factor for A&D misuse (Ja and Aoki, 1993).

While all immigrants experience the acculturation process to some degree, not all experience it in the same way or over a similar period of time (Trimble, 1990-1991). The level of adjustment to mainstream culture varies greatly among Asian ethnic groups and may influence drinking behaviour among Asians (Chang, 2000; Makimoto, 1998).

Inter-generational Conflict and Peer Pressure

For young Asian people, increased cultural dislocation and confusion with new environments can lead them to gravitate into peer groups with markedly different social and moral codes (Bhattacharya, 1998; Cheung, 2002).

Peer bonding has been found to explain behaviour leading to A&D use, especially when there is weak bonding to the family and school (Elliott and Voss, 1974; Jessor and Jessor, 1977; Kandel, 1982). Also well documented is immersion into a 'street culture' coupled with peer pressure to experiment with alcohol and other drugs (Bankston, 1995; Gillmore et al, 1990; Kim et al, 1992; Le, 1996; Mellor and Richetson, 1991). Many studies have established that the second generation of immigrants - Asian children born and raised in Western countries - is at greater risk of developing A&D issues (Clarke et al, 1990; James et al, 1997; Li and Rosenblood, 1994).

Intergeneration conflicts also occur when patterns of traditional behaviour are no longer appropriate or relevant in addressing the contemporary problems of immigrant youth (Kim et al, 1992; Nguyen, 1995; Van and Holton, 1991; Westermeyer, 1987). Drug use has been identified as a coping strategy for adolescents to deal with their conflicts with parents (Rogler et al, 1991; Szapocznik and Kurtines, 1980). Relationships between disruptive family relationships, deviant behaviour and A&D use among adolescents are well recognised (Brook, 1993; Castro et al, 1994; Recio Adrados, 1993), but studies also show family links and support help to mediate the negative influence of acculturative stressors and protect against initiation into substance use (Vega et al, 1993).

Language Barriers

Research (Ngai et al, 2001; Walker et al, 1998) indicates that language difficulties are a significant barrier to ethnic communities' use of A&D treatment services.

The inability to communicate effectively in the language of the majority appears to be a major social and economic disadvantage, possibly preventing the use of much-needed services (Jackson and Flaherty, 1994) and restricting opportunities for employment and therefore economic advancement (Jacubowicz, 1975).

Asians in Auckland appear to:

- lack adequate information on the healthcare system (Cheung, Chen and MacDonald, 2003)
- not understand the role of community-based health providers (Ngai et al., 2001)
- not understand their entitlements to publicly funded healthcare (Asian Public health project, 2003; Ngai et al, 2001).

As substance misuse is seen as a complex health issue, people with limited language abilities may have difficulty accessing treatment and other forms of help – and the fact that some substance use is illegal may discourage them from seeking help. In addition, there may be no written material on A&D treatment services in ethnic languages and translation may either be difficult to obtain or unavailable (Success Works, 1998a, 1998b).

Interpreters

As noted by Amodeo et al (1997), a lack of interpreters deters potential clients from using or returning to A&D treatment services. Although there are increasing numbers of interpreters available, there are issues in working with them (Baker, 1981; Freed, 1988), such as interpreters misinterpreting information and fearing clients' or their own loss of face if they accurately describe clients' behaviours. Clients too may feel reluctant to share sensitive information with an interpreter if they are a neighbour or acquaintance; this is likely given the relatively small size of Asian communities (Amodeo et al, 1997).

Education

The relationships between education and A&D use are not clearly defined.

Some studies suggest that educational attainment and school leaving age are inversely related to substance misuse (Alcibes et al, 1992; Bray et al, 2000; Obot et al, 1999). Additionally, overseas research has shown the rates of lifetime substance use are much higher among school dropouts (Office of Applied Studies, 1998; Swaim et al, 1997). Nonetheless, ethnic youth seem to have some difficulty in gaining educational qualifications owing to language barriers, poverty and other factors.

A 2001 study by Ngai et al found that non-English-speaking immigrant students faced stress and frustration in the first few years at local schools owing to language barriers and social isolation. They could become frustrated and withdrawn, which could affect their academic performance and social

integration (Cheung, 2001). In another study, Mohan (1989, cited in Bhattacharya, 1998) looked at the association of Asian-Indian parents' expectations with substance misuse. It found that Asian-Indian adolescents faced tremendous pressure to keep up the image of 'whiz kids' and meet the expectations of their parents (p.176). This could create anxiety and frustration and dispose adolescents to use drugs as a palliative coping strategy to relieve tension or reduce stress (Juon et al, 1995).

Employment

The employment disadvantages that ethnic community members face stem from language problems, unfamiliarity with systems and services, lower levels of education, and other factors (Reid et al, 2001).

Even if they overcome the language barrier, many new Asian immigrants and refugees face serious problems finding a job because their country of origin qualifications are not accepted in New Zealand (Asian Public Health Project, 2003). Additional barriers include a lack of local work experience and the older age of many immigrants and refugees (Ho et al, 2002).

Unemployment or underemployment also seems to create distress 'not only because of personal economic deprivation but also because of a failed sense of duty' (Johnson and Turner, 1993, p.738, cited in Reid et al, 2001). In a recent survey of 1,338 Asian families in New Zealand, 42% regarded issues relating to employment as having a negative impact on the family (Ngai et al, 2001). A similar study in Auckland found 'deskilling' was a major negative factor, as professional immigrants had to settle for lesser skilled or manual work such as cleaning or driving (Pakuranga Chinese Baptist Church Employment Action Group, 1998).

Overseas research (Reid et al, 2001) shows that high unemployment among ethnic minority groups and a concentration of the employed in low-status and low-paid jobs produces an economic and social disadvantage - both predisposing factors for involvement with substance misuse. Unemployment is also known to affect self-esteem and confidence adversely, cause boredom and depression (Ho et al, 2002), and may influence the probability of drug use (Health Department of Victoria, 1988; Parker et al, 1995). Likewise, Alcorso (1990) reports general practitioners' beliefs that unemployment and an inflexible job market put ethnic minority groups at social risk, including the risk of substance misuse.

Young people finding it difficult to get gainful employment may find the substance use market an attractive alternative. Selling drugs is seen as lucrative yet requiring little or no formal education, so could be particularly attractive to socially disadvantaged young people with little to lose (Ethnic Youth Issues Network, 1998; Westermeyer, 1987).

Economic and Social Disadvantage

Researchers (Lee et al, 2002; Reid et al, 2001) have concluded that social and environmental conditions (e.g. poverty, unemployment, low education levels and limited job opportunities) are related to family relationship satisfaction. Structural factors (e.g. overcrowding, less time for child supervision) often appear to contribute to increased family stress, which in turn may lead to substance misuse

(Jones and DeMaree, 1975). Reid et al (2001) argue that these associated factors, not ethnicity per se, make immigrants vulnerable to involvement with substance misuse.

An involvement with illicit drugs (either using or supplying) may correspond to the low socio-economic status of individuals, communities or regions. Several studies (Madden, 1994; White, 1999) have measured higher concentrations of illicit drug use in areas that seem to have high unemployment and social deprivation. Substance misuse has been evident and more widespread in deprived neighbourhoods where housing is poor, unemployment is high and educational opportunities are few. These conditions appear to be common for ethnic communities (Almog et al, 1993; Van De Wijngaart, 1997; Weatherburn and Lind, 1998). Ethnic community members who experience discrimination and exclusion from the mainstream economy may find a convenient niche in the alternative economy (Cheung, 1989), of which the substance use market is usually seen as the most profitable and accessible.

ALCOHOL AND DRUG USE IN NEW ZEALAND

Alcohol and Drug Use According to DSM-IV

In New Zealand, substance use has been formally classified using the criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). This system diagnoses alcohol and substance 'abuse' and 'dependence' (mild, moderate or severe).

The essential features of the 'abuse' syndrome are:

- a maladaptive pattern of substance use, leading to clinically significant impairment or distress of social or occupational functioning. It includes high daily consumption, regular heavy weekend drinking and binge drinking
- as a result of recurrent substance use within a 12-month period, a failure to fulfil major role obligations, exposure to physical hazards, legal problems and social or interpersonal problems.

The key features of the 'dependence' syndrome are:

- a maladaptive pattern of alcohol use leading to clinically significant impairment or distress as manifested by tolerance, withdrawal, large amounts of substance taken over a longer period of time, unsuccessful efforts to cut down or control substance use, a great deal of time spent to obtain the substance, given up other activities for substance use, and recurrent physical or psychological problems caused by the substance (pp.197-198).

The DSM-IV may be able to provide some guidelines and framework for the Asian population. However, relying solely on a Western classification could undermine the complexities of Asian characteristics - so when assessing alcohol and substance use and dependence, health professionals might like to consider using a more heterogeneous perspective (Freeman, 1991).

A multivariate view like this emphasises a continuum of misuse besides which the causes, course and consequences are often intertwined with co-occurring health, mental health and other psychosocial problems. Such an assessment model is suitable when considering the problems of Asian clients who, for example, may not consume alcohol at the levels of other mainstream groups but nevertheless encounter a range of co-occurring psychosocial difficulties affected by the use of alcohol or other drugs (O'Hare and Van Tran, 1998). Helping professions may also consider bringing cultural context and meaning to clients' issues, which often include grieving multiple losses and struggling with the stresses of acculturation and adaptation (Eisenbruch, 1991).

Alcohol and Drug Health Promotion in New Zealand

The Ottawa Charter

'Public health' has been identified as a major component in health promotion in New Zealand and is about promoting well-being and preventing ill health before it occurs (Ministry of Health, 2002a). The country's public health planning is based on an international model called the 'Ottawa Charter' (Ottawa

Charter, 1986), which has been adopted as a working document for health promotion by the Ministry of Health and many health authorities. (see Appendix One).

Community Action

The Sale of Liquor Act 1989 requires and encourages a cross-sectoral community approach and suggests that local government, police and health promoters all have responsibility for liquor licensing.

ALAC has promoted a collaborative inter-agency and wider community liaison approach to licensing issues, in managing public events where alcohol is available and in other activities aimed at reducing alcohol-related harm. Several communities in New Zealand have been involved in the Youth Access to Alcohol Project (YATA), co-ordinated by ALAC, since YATA's inception in 1999. The YATA project works with broad based community teams aimed at reducing the alcohol-related harm experienced by young people in New Zealand through reducing the supply of alcohol by adults to young people.

Several community action projects relate to alcohol and other drug use, such as the SHORE centre at Massey University for community action research; the Waipareira project involving anti-drink-drive health promotion for young Māori males; and Community Action on Youth and Drugs (CAYAD), a partnership between Pākehā and Māori to reduce cannabis and other drug-related harm among young people (Ministry of Youth Development, 2003).

Social Marketing

ALAC and the Land Transport Safety Authority (LTSA) have undertaken mass media campaigns on drinking and drink-driving targeted at young people. The LTSA's anti-drink-drive advertising campaigns are run in conjunction with a significant increase in high-profile compulsory breath testing by police. Young people, including under-age drinkers, feature disproportionately in drink-drive and alcohol-related road fatality data. These campaigns aim to be realistic without lecturing or threatening, and to use shock tactics to appeal to core emotions, without focusing on gore (LTSA, 2003).

In 1989, changes to the Sale of Liquor Act led to a significant increase in the number and range of places selling and supplying alcohol. Looking for a way to harness the significant community energy around alcohol issues at this time, ALAC launched *Host Responsibility* in 1991, following the development of the *National Guidelines on Host Responsibility*.

The campaign moved away from focusing on the drinker as the key problem and emphasised the role of the drinking environment as a contributor to alcohol-related harm. In the past decade, ALAC has delivered numerous initiatives under the *Host Responsibility* banner, including mass media campaigns, resource development and training programmes. It has also developed programmes for sports clubs and workplaces and to meet the needs of Māori and Pacific peoples. Today, *Host Responsibility* operates under a multitude of guises, with many different organisations taking ownership of the concept (ALAC, 2003).

Community participation is also essential when developing effective health promotion and prevention programmes for Asian communities. For example, many Asians, especially refugees who have lived in war-torn areas and experienced poverty and a lack of education, may not be familiar with the notion of alcoholism and drug dependence as a health risk issue. Preventing health problems could also be a new concept for them because of their previous life/transition experiences, so efforts to enlist the community in A&D problem prevention programmes may be relatively slow.

Drug Education in New Zealand

Education plays a major role in information sharing and awareness. In New Zealand, drug education is included in the Health and Physical Education Curriculum (Ministry of Education, 2000a).

The Ministry of Education's *Drug Education: A Guide for Principals and Boards of Trustees* (Ministry of Education, 2000b) expects drug education to extend beyond the classroom, and includes guidance on aspects of school-policy setting and managing drug-related incidents. This is seen as part of a 'whole-school approach' to the problem of drugs and is explicitly related to the World Health Organisation's concept of the 'Health-Promoting School'.

The Ministry of Youth Development (2003) recommends that effective school-based drug education should include the following features:

- Relevance to the needs of young people
- Interactive and activity-oriented design
- Peer-led education
- Follow-up and ongoing education
- Provision of factual information
- Social influence approaches.

Drug education should also be combined with adequate enforcement, education for families and communities, mass media campaigns and legislation.

Family-Based Approach

As well as school-based programmes, New Zealand operates a number of family-based approaches to health promotion. For example, GAIN New Zealand is designed for families with 12 to 16-year-old children. Professionals recruit participants through a general invitation to participate in a family communication and conflict resolution course, and from specific referrals as an early intervention with specific teenagers.

The programmes are delivered by training facilitators working in pairs, usually a school-based person with a community service person. They work through a manual of family life skills activities, adapting the programme to the group's needs. Between 1990 and 1998 over 500 courses were run throughout New Zealand involving some 7,000 participants. Close to 500 people have received training to deliver the programme (Ministry of Youth Development, 2003).

Early Intervention

Although risk factors have a cumulative effect over time, some early in life can strongly affect later life (ANCD, 2001). There is growing evidence that early drug use is a predictor of later drug misuse (Ministry of Youth Affairs, 2003).

The most recent longitudinal studies in New Zealand, Australia and the United States confirm that young people who are exposed to drugs at an early age run a higher risk of later harmful drug use (Toumbourou, 2003). This suggests that A&D interventions need to happen early in a person's using-life so that more pronounced social health problems are less likely to develop (Toumbourou, 2003).

A significant body of literature supports this 'developmental pathway of substance abuse', which shows that very few individuals who use drugs at one stage of development have not also used drugs in the preceding stages. This suggests that drug use in later adolescence can be reduced by delaying or reducing use in early adolescence (Fisher et al, 2002).

This approach has been popular in Australia, where it is emphasised in the Australia National Mental Health Strategy and the Crime Prevention Strategy. In New Zealand it is a key component of ALAC's business.

ASIAN PEOPLE AND ALCOHOL AND DRUG USE

General Health Beliefs and Values

Asian people in New Zealand have biological, religious, cultural, language, education and socio-economic experiences that inevitably affect their sense of health and well-being. Health professionals need to consider these experiences – along with pre-migration and post-migration risk factors such as language difficulties, cultural stigma, the disruption of support networks and acculturation issues – if they are to provide comprehensive assessments and effective interventions (Cheung, 2002; Ho et al., 2002; Ngai et al., 2001).

Biological Factors

Much research has been done on understanding how genetic and metabolic differences between Caucasians and Mongoloids contribute to a lower rate of alcohol abuse among Mongoloids. These studies (Chan, 1986; Lee, 1987; Nagoshi et al, 1988; Suddendorf, 1989; Suwaki and Ohara, 1985) attribute an apparent lower rate of alcohol abuse among Mongoloids to a missing liver enzyme (ALDH-I isozyme) that metabolises alcohol.

Other studies have examined some Asians' physiological response to alcohol, characterised by facial flushing and other uncomfortable sensations (Newlin, 1989; Wolf, 1973). However, these reactions have no impact on their alcohol consumption level (Johnson and Nagoshi, 1990; Sue et al, 1979). Other studies (Johnson and Nagoshi, 1990; Newlin, 1989) have suggested that socio-cultural factors play a greater role in alcohol use.

Traditional Values

In traditional Asian cultures, the family is the fundamental production unit (Shon and Ja, 1982). Western conceptions of 'individuality' and the many related notions of self, autonomy, choice and privacy seem rarely condoned. Each person occupies a position within a system of interpersonal and inter-group relations (in the family and community) and is not encouraged to behave in a totally individualised way (Chung, 1992). The family, not the individual, is the primary social unit (Chu et al, 2001).

The traditional endorsement of social order and responsibility to the 'collective' appears strong among Asians. In New Zealand, Asians live with more people than the national average (Walker et al, 1998) and appear to operate to strict hierarchical rules. Respect for elders is central to most Asian cultures (Zodgekar, 1993).

An individual's sense of self and social status is reflected largely in how well they uphold their family obligations, especially through bringing honour to the family. The concept of 'face' embodies such values, and people strive always to acquire or maintain face rather than lose it. Saving face is to feel honourable, virtuous and respectable, while losing face brings profound shame and dishonour to the individual as well as to the family (Norbeck and DeVos, 1972).

Given this centrality of the family in most Asian cultures, it seems essential to assess the family's role when working with Asian clients with A&D-related problems. The relationship between parents and child is vertical, with power and status determined hierarchically (Chu et al, 2001). The child is expected to maintain family traditions and fulfil family obligations. In contrast, Western culture tends to be more individual-centred.

While individuation has been described as a part of the normal developmental transition from adolescence to adulthood (Jessor and Jessor, 1977), Asian cultures emphasise 'de-individuation' and value family/kin responsibilities, a hierarchical power structure, obligations and filial piety (Ross-Sheriff, 1992). The cultural distance between mainstream society and the country of origin further intensifies the stress of acculturation and adaptation. This could lead to family conflict and communication deficits and on to alienation between parents and children, which in turn may manifest into delinquency and drug use (Catalano et al, 1992; Kandel, 1982).

In mainstream society, individuals are held responsible for their actions, but in Asian families the family accepts and takes blame for trouble caused by family members, whether they are children, adolescents, adults or elders (Bond, 1991). Mental illness, for example, is viewed as familial and heritable as it may relate to past family transgressions and is therefore damaging to the reputation of the family as a whole (Gong-Guy et al, 1991). Within the family and the immediate community, substance misuse is considered a taboo issue, particularly if it affects the functioning of the family.

Once the family's name is damaged, the stigma continues for generations.

When seeking help, Asian families tend initially to go to relatives, friends and traditional health/medicine, implying a significant role of culture in healthcare (Ngai et al, 2001). If all else fails and the misuse behaviours become unbearable, they may move beyond the boundaries of traditional problem-solving processes. This could imply that mainstream A&D treatment services are a last resort for assistance. People with A&D misuse problems referred by their families to mainstream treatment services often show a great deal of resistance.

Asian people with A&D misuse issues may take advantage of the culture of family interdependence. It is not unusual to find them continuing to live at home or receiving financial support from their family even after their parents have used all their problem-solving options. These values and beliefs may contribute to families' tendency to cover up A&D-related problems, tolerate the destructive behaviour of the alcoholic or drug-dependent individual (Amodeo and Liptik, 1990) and postpone help-seeking until the problem becomes severe and dysfunctional (Amodeo et al, 1996). However, Amodeo et al also argue that using such values and beliefs could be a culturally appropriate and effective method for convincing people with misuse issues that behaviour change is necessary (i.e. protecting the honour of the family and community). Having families see the positive results of being actively involved in recovery may help to change help-seeking attitudes, prevent frequent relapses and sustain longer periods of quality of life.

Perceptions of A&D Use

Historically, the most common forms of Asian substance use have been nicotine, alcohol and opium because of the widespread acceptance of their use. For example, alcohol and opium have long been valued for social and medicinal properties (Booth, 1998; Westermeyer, 1991) and in Asian history, drug use was a significant part of culture and trade.

Asian groups seem to vary in their attitudes towards alcohol and do not necessarily consider a drinking pattern as risky or hazardous and requiring external help (Chang, 2000). Similarly, opium use is either accepted or stigmatised, depending on its social context. For example, some Asian cultures view opium use as a privilege of the aged, to ease their physical distress and prepare them for transition to an afterlife (Booth, 1998, cited in Chang, 2000, p.207). However, issues of substance misuse are seldom discussed and adolescents in Asian families often lack information. Family prestige and pride shroud the harmful consequences of substance misuse (Mohan, 1989), putting Asian adolescents at increased risk (Connor, 1977; Ishisaka and Takagi, 1982).

Southeast Asia

Many Southeast Asian cultures do not consider alcohol a harmful drug and some have a traditional belief that it is a health-promoting substance unless an individual using it behaves in a way that disgraces the family (Amodeo et al, 1996; Makimoto, 1998).

Alcohol is commonly consumed during important social rituals such as celebrations and funerals; sometimes in large quantities, particularly by the men (Wang et al, 1992). This practice is most common in modern urban Japan and Korea (Chung, 1992), where public intoxication is viewed without stigma and is accepted as normal social group behaviour. Solitary drinking, however, is rarely condoned, and solitary intoxication is viewed with great suspicion and disdain. Peer pressure to drink is always strong in those cultures (Amodeo et al, 1997).

Alcohol is also used in Southeast Asian cultures as self-medication to provide temporary relief from feelings of sadness, loneliness and grief (Amodeo et al, 1996; Chang, 2000; Nemoto et al, 1999; Reid et al, 2001; Selvaraj, 2001). In the Philippines, beer is popular among men in Manila and 'tuba', an alcoholic beverage made from nipa palm, is popular in the surrounding rural Luzon province. Men in the Philippines consider that the higher their level of alcohol consumption, the higher their level of 'man's maleness' (Selvaraj, 2001).

South Asia

Similar to those in East Asia, many South Asians, except practising Muslims, use alcohol for socialisation purposes; excessive consumption is considered unacceptable. In his comparison of Chinese and American drinking styles, Hsu (1970) suggests that differences between Chinese and American cultural values can account for differences in drinking styles. He says the Chinese are 'situation-centred', which requires the individual to seek harmony with the social environment. Responsibility to others discourages them from getting drunk and exhibiting abnormal behaviour. In contrast, the Americans are 'individual-centred' which emphasises self, independence and assertiveness, values that are conducive to unrestrained individual freedom in drinking.

India

Drinking in India is believed to take place in prescribed social situations, which may limit the likelihood of alcohol misuse. Marijuana use is also widespread and culturally acceptable (Dornbush and Fink, 1977). Drinking is seen as a serious problem only when an individual's use affects their functioning, such as not being able to go to work, developing an illness or not fulfilling their obligations to the family (Bhattacharya, 1998). Substance use is considered a moral problem when contributing to family shame and dishonour (Kim et al, 1995).

Gender-Specific Roles

While gender-specific role expectancies prevail across all cultures, research shows they might be particularly strong in the Asian-Indian culture (Bhattacharya, 1998). For example, females in Asian-Indian families are expected to maintain a subordinate role and not assume decision-making power (Kakar, 1982), while Western culture encourages the development of personal identity and social independence. Asian-Indian adolescents practising Western-style behaviour within the family may generate intergenerational and between-gender conflict (Jain, 1990). Socialising with, or dating, peers from other ethnic groups is not considered acceptable (Sikri, 1989) and parents are more likely to overprotect their female children (Bhattacharya, 1998).

Cultural conflict may also lead to family conflict, especially when female children challenge their parents' different treatment of male siblings. Studies (Felix-Ortiz and Newcomb, 1995) show that disagreement between parents' and female children's socialising norms alienates children from parents and leads to their seeking peer approval and support. This may lead to substance misuse owing to negative reinforcement from peers.

Knowledge of and Access to A&D Treatment Services

Research (Beyer and Reid, 2000; Van de Wijngaart, 1997) shows that people from ethnic minority groups have lower admission rates to drug treatment services than their mainstream counterparts. It has been suggested that this reflects more the under-use of services by ethnic communities than a lesser need (D'Avanzo, 1997; Legge, 1993; Sasao, 1991; Zane and Kim, 1994). Le (1996) found that around 67percent of heroin users smoking and injecting in Cabramatta (a suburb of Sydney, Australia) were from non-English backgrounds; 25 percent of them were Vietnamese and most had never used drug treatment services. Their knowledge of drugs appeared poor and many adolescent heroin users did not understand the health risks associated with using drugs - possibly a result of cultural and language barriers (Le, 1996).

Many ethnic communities regard substance misuse as a taboo subject. Combined with traditions of self-sufficiency and community-based solutions, this could be a significant explanation for the low use of treatment services. In addition, there may be no written material on drug treatment services in preferred languages and a lack of understanding of the Western healthcare system (Ngai et al, 2001).

Alcohol and Drug Use Among Asians Overseas

Internationally, there are wide cultural differences in:

- attitudes to substance consumption
- physiological reactions to substances
- the prevalence of substance-related disorders.

There are also important regional, national and ethnic distinctions among Asians, all affected by significant differences in migration patterns and subsequent post-migration experiences (Bhattacharya, 1998; Nemoto et al, 1999; Selvaraj, 2001).

Despite some knowledge and understanding of A&D misuse and its treatment, there is little data specific to the Asian population. This could be interpreted as Asians having minimal requirements for treatment services, despite concerns about increasing A&D misuse and sales, particularly among Asian youth (Ja and Aoki, 1993). However, overseas studies suggest Asians have a fairly high prevalence of alcoholism, with health professionals often ignoring the issue due to inaccurate perceptions and stereotypes of Asians as a 'model minority' – overachieving, having high economic status, good discipline and perfect family relationships (Fong, 1992; Ja, 1991; Kitano and Chi, 1987), with high rates of abstention and low rates of A&D misuse (Caetano et al, 1998; Chang, 2000; Nemoto et al, 1999; Varma and Siris, 1996).

Caetano et al (1998) state this image is likely to result from:

- the fact that few Asians enter A&D treatment
- the lack of research among refugees from Cambodia and Vietnam.

In contradiction to earlier findings of lower incidences of alcohol and drug-related harm among Asian ethnic groups, two American studies (Morales, 1991; Wong, 1985) show that certain Asian groups demonstrate the same or higher levels of specific A&D abuse as other ethnic groups. In addition, Kitano and Chi's (1987) measurements of alcohol use in Los Angeles revealed strong evidence of diverse substance abuse among different Asian groups.

These community-based surveys provide a broad glimpse of the patterns of substance use and chemical dependency among Asian ethnic groups. They also begin to confirm observations from ethnic communities and the few Asian ethnic-specific treatment settings. A more concrete illustration was found in a newly developed residential programme in San Francisco for Asian drug abusers, which within a few months had established a six-month waiting list for its 15-bed capacity (Asian American Recovery Services, 1996).

Issues relating to the under-use of non-Asian treatment programmes in the US are similar to the issues of cultural insensitivity raised by Sue and colleagues (Sue, 1976; Sue and McKinney, 1975) leading to under-use of mental health treatment services by Asians. Sue and others (Wu and Windle, 1980) called for:

- a particular emphasis on, and increased use of, ethnic paraprofessionals
- the development of ethnic-specific services somewhat reflective of mainstream and traditional agencies

-
- new forms of treatment that reflected relevance.

Studies distinguishing Asian ethnic groups have found different patterns of use and misuse between each other and from other non-Asian groups (Chi et al, 1988, 1989; D'Avanzo et al, 1994; Kitano and Chi, 1985; McLaughlin et al, 1987; Sasao, 1991; Westermeyer et al, 1989). For example, McLaughlin et al examined ethnic differences between Asian and Pacific islanders (APIs) in a statewide sample of 2,503 households in Hawaii. While the APIs reported lower use across most drugs than Caucasians, there were important differences between the non-Caucasian groups. In particular, native Hawaiians reported higher alcohol, cocaine, amphetamine and marijuana use, while Japanese and Chinese reported higher levels of tranquilliser use than other Asian groups.

Meanwhile, a study of 1,578 Asian drug users' admission records in publicly funded drug treatment programmes in San Francisco (Nemoto et al, 1993) revealed ethnic group differences in primary drug use, the drug administration route and the types of drug treatment programmes used. The same study found Chinese Americans were more likely to take sedatives orally and less likely to inject drugs than other Asian ethnic groups. Japanese Americans were more likely to inject heroin than other Asian ethnic groups.

Asian A&D-related problems have not been addressed in the United Kingdom, and a national survey showed Asians do not use drugs. However, the latest research indicates the widespread use of cannabis and heroin among South Asians. In response to this, the United Kingdom government established a special project to tackle the issue (Bhatia, 2000).

In Victoria, Australia, Asian communities are also experiencing an epidemic of illicit drug use, particularly heroin. Key informants and community consultations in one study (Reid et al, 2001) agreed that the ethnic communities' use of drug treatment services did not match the size of the problems experienced. Alcohol and drug information system data on drug treatment services in Victoria for 1997/1998 shows that few people from non-English-speaking backgrounds were receiving treatment for heroin (6 percent of the total treated, while they represented 17 percent of the state's population). However, cautious interpretation is required owing to the restricted ethnicity variables used in the database (Beyer and Reid, 2000). In fact, inadequate ethnicity identification is a significant problem for investigators in this field, as relying on country of birth excludes second and third generation migrant descendants.

Alcohol and Drug Use among Asians in Asian Countries

In Malaysia, a study of urban secondary school students aged 11 to 20 years indicated that more than 10 percent had taken illicit drugs (Hanjeet et al, 1997). Substance use rates among Chinese outside China are lower than among the non-Chinese population in the West (Chen et al, 1999; Isralowitz and Hong, 1988; Everingham and Flaherty, 1995; Sue et al, 1985). Alcohol consumption among Singaporean Chinese university students was 72 percent for males and 52 percent for females (Isralowitz and Hong, 1988), while among Chinese households in the US the prevalence was only 52 percent and 26 percent for males and females respectively (Sue et al, 1985).

Rates of illicit drug use (5 percent) among young Chinese aged 15 or older in Sydney, Australia, were lower than that of the general population (27 percent) (Everingham and Flaherty, 1995). However, substance use in university students is reported to be generally very high in other countries (Heras-Teber et al, 1997; Metintas et al, 1998; Shiota et al, 1997; Webb et al, 1996). Few studies have examined substance use in Chinese university students in Hong Kong.

Abdullah et al (2002) found that the use of A&Ds (e.g. tobacco, alcohol, marijuana and other illicit drugs) among university students in Hong Kong was not as high as in Europe or the US, with the substances most commonly being tobacco and alcohol. It also found that the proportion of reported over-drinkers is lower in Hong Kong than among US and UK students. These differences suggest that substance use among Chinese university students is not as high as in university students in Western countries.

This may indicate the effect of cultural norms and social environment on substance use behaviour, as discussed in *Social Learning Theory* (Bandura, 1986) and elsewhere (Li et al, 1996; Peters et al, 1997). Generally, young people in Chinese societies are not encouraged to smoke tobacco or use illicit drugs. Moderate levels of alcohol use are acceptable at social events, but drunkenness is frowned upon by Chinese society (Hong and Isralowitz, 1989).

Family influence in substance use is important among Hong Kong Chinese (Peters et al, 1997) as it is in other countries (Blackford et al, 1994). However, low substance use rates among Chinese youth may be affected by:

- under-reporting
- controls on advertising alcohol beverages and tobacco products
- the legal age limit of 18 years for purchasing alcohol or tobacco products
- the relatively high price of tobacco in Hong Kong.

The serious penalty (a fine of US\$650,000 and life imprisonment) for drug trafficking into Hong Kong (mainly through Cambodia, Nepal, the Golden Triangle on the borders of Thailand, Myanmar and Laos and via Mainland China) and the relatively high prices (US\$838-2,322 per kilogram of cannabis or US\$129-182 per kilogram of cocaine) may have contributed to the low rate of illicit drug use among students in Hong Kong (Census and Statistics Department, Hong Kong Government, 1996; Department of Community Medicine, 1998).

People's perceptions of risk are influenced by knowledge about, attitudes towards and the consequences of certain activities. Abdullah et al (2002) argue that a low perception of the risks of substance use in their study may explain students' behaviour. In the study, a substantial proportion who thought that regularly smoking cigarettes and using alcohol or drugs posed 'no risk to slight risk' to their health were not likely to hesitate before using these substances. Students had different attitudes to alcohol from other drugs including marijuana, which has been stigmatised as highly dangerous in Hong Kong. Alcohol is also more socially acceptable than other substances and is readily available. Furthermore, reports on the beneficial effects of moderate alcohol consumption may have encouraged students to consume alcohol more than other beverages.

It is obvious that several substance types are used within the community, and Abdullah et al (2002) argue that younger Chinese are potentially at greater risk of using them. In addition, the emphasis on Western lifestyles encourages drinking and smoking, particularly among teenagers and young adults in Asian countries (Lee et al, 2002).

However, it is uncertain if those with higher educational attainment, including university students, are also at greater risk for different types of substance use, and if so, what their use patterns are. Information on cigarette smoking, alcohol use and illicit drug use among young adults, particularly among university students, is important in effective anti-substance use intervention programmes. These young adults could be future community leaders influencing social policies (Lee et al., 2002).

Alcohol and Drug Use Among Specific Asian Groups

Asian Youth and Alcohol and Drug Use

Overseas epidemiological surveys that include Asian-American youth populations have provided valuable information about their drug and alcohol use. These studies include:

- the California Student Substance Use Survey (Austin, 1999; Skager and Austin, 1993)
- the 1983 and 1990 New York State surveys of secondary students (Barnes and Welte, 1986; Barnes et al, 1993)
- the Minority Youth Health Project in Seattle (Harachi et al, 2001)
- Sasao's study of high-school Vietnamese and Chinese students (1994; 1999)
- the Seattle Social Development Project (Gilmore et al, 1990).

The epidemiological data suggested that Asian Americans are at a relatively lower risk from A&D use than youth from most other ethnic groups (Bachman et al, 1991; Barnes and Welte, 1986; Barnes et al, 1993; Harachi et al, 2001; Skager and Austin, 1993).

However, data from the California Student Substance Survey indicates that substance use by Asian-American youth may not be as low as generally assumed, and that there are variations among different Asian ethnic groups (Austin, 1999). Data from the Minority Youth Health Project also indicates that Asian middle-school students have a higher rate of crack or cocaine use compared with white or African-American students. Reports on Vietnamese-Americans also indicate a fairly high rate of problems with tobacco, alcohol and other drugs (Yee and Thu, 1987), with participants suggesting that substance use is acceptable for alleviating personal problems.

Based on the limited information, Asian-American youth may have a lower rate of alcohol use but be relatively heavy drinkers if they do drink (Austin, 1999; Chi et al, 1988). Reports also suggest that Asian-American youth have a higher rate of cocaine and crack use than the comparison group, despite an overall lower rate of drug use (Harachi et al, 2001).

Cultural Factors

Nemoto et al (1999) state that a number of immigrants, particularly Chinese and Vietnamese, say a fear of addiction and needles are reasons for not injecting heroin. Younger drug users choose smoking crack or snorting cocaine. In contrast, older groups inject heroin, cocaine or speed-ball.

All ethnic groups mentioned the stigma associated with injection drug use and the shame about drug use. In general, shame and loss of face of the family and stigma in the community are strong psychological concerns among Asians who use illicit drugs (Ja and Aoki, 1993; Nemoto et al, 1999). This is because drug misuse is interpreted as a disruption to the harmonious, interdependent relationships among family and community members and is considered an individual as well as a family failure (Asian American Recovery Services, 1996).

These common cultural factors should be considered in programmes aiming to prevent hard or injection drug use among Asians. Outreach as well as education programmes at the individual, family and community levels are necessary for drug abuse prevention programmes targeting Asians (Lee et al., 2002).

Gender and Alcohol and Drug Use

Gender differences in substance use are common among the Asian population - for example, Japanese men and women are generally reported to be the heaviest drinkers (Chi et al, 1989), with excessive drinking by Japanese and Korean men as prevalent as it is for American men.

In the Asian group as a whole:

- male college graduates aged under 45, in professional or white-collar occupations and living in cities, appear to have higher drinking rates than the general population (Kitano and Chi, 1985)
- women drink less than men across all ethnic groups, a gender gap that may be even wider in Asian groups (Kim et al, 1992)
- educated young or middle-aged Asian women are more likely to drink (Chi et al, 1989; Towle, 1988)
- Asian women's use of cigarettes, alcohol and tranquilisers appears to be increasing, even though they are expected to drink little or no alcohol and infrequently use tobacco (Kim et al, 1992). This could be caused by social attitudes and greater acculturation to more alcohol consumption.

Refugee and immigrant women are also at risk of substance misuse, with reported high rates of emotional disturbance as a result of the stress of migration and adjustment to a new country (Krupinski, 1967). Research has found that Cambodians have endured the most psychological stress of any Southeast Asian group before migration (Kinzie and Fleck, 1987). Post-migration to the United States, Cambodian refugee women also experience a loss of tradition, urbanisation, poverty, cultural conflict and role change, which increase their substance use (Kim et al, 1992). In another study of substance use in Cambodian refugee women, D'Avanzo et al (1994) state that the most striking finding was that these women appear to use prescription drugs, such as sleeping pills, to reduce stress.

Asian People and Alcohol and Drug-related Harm in New Zealand

Knowledge of A&D harms among New Zealand's Asian population is also limited, with contemporary research concentrating on migrants' adaptation problems and difficulties (Abbott et al, 2002; Abbott et

al, 1999; Abbott et al, 2000; Acumen, 2001; Friesen and Ip, 1997; Henderson et al, 2001; Ho, 1995, 2002; Jones and Ainsworth, 2001; Kudos Organization Dynamics, 2000; Ngai et al, 2001; Pakuranga Chinese Baptist Church Employment Action Group, 1998; Pernice et al, 2000; Walker et al, 1998). However, a survey conducted among general practitioners in Auckland noted that alcohol-related problems are commonly reported among Asian patients (Walker et al, 1998).

In early 1999, Regional Alcohol and Drug Services (ALAC, 2000) initiated a standardised brief screening package that enabled providers and policy-makers to understand the needs of people showing A&D misuse. However, Asian people were categorised into 'Other NZ' in this report. Likewise, the *Youth Drinking Monitor* report (ALAC, 2002) adopted 'other ethnic' groups.

The *Youth Health Status Report* (Ministry of Health, 2002b) provides extensive information on drug use among young people in New Zealand, while the 2001 National Drug Survey (APHRU, 2002) provides a good picture of A&D issues. However, despite there being population-specific information on A&D-related issues in New Zealand, there is very little information on A&D issues for the Asian population, despite Asians being the country's third largest population group.

An Auckland telephone survey revealed an absence of Asian clients in Regional Alcohol and Drug Services (Adamson, 2000). Meanwhile, Community Alcohol and Drug Services, Auckland statistics reveal only 68 Asian clients out of 5,420 accessed the service between March 2000 and April 2001 (Community Alcohol and Drug Services, 2004). And out of the 3,904 calls received during 2003 by the Alcohol and Drug Association's Alcohol and Drug Helpline, only 35 callers identified themselves as Asian (less than 1 percent of the total calls). Likewise, between 1999 and 2003, only 169 out of the 7,849 people who used A&D treatment services were Asians (2.2 percent) (personal communication from CADS, Auckland, 2004).

In spite of the inadequate empirical data, media reports (North Shore Times, 2003a; North Shore Times, 2003b) suggest Asian people have some problems with A&D issues, especially Asian youth and foreign students. A recent Auckland campaign (Bell, 2002) found that South Asian drink-drivers are only a small percentage of all drink-drivers in the region, but numbers are increasing relative to the mainstream population. A&D agencies in the Auckland region have also anecdotally reported an increase in the number of South Asian clients with alcohol-related drinking charges seeking appropriate treatment. A 2001 Auckland-wide drink-drive survey by Alcohol Healthwatch listed 133 Indian-origin drivers caught above the legal breath alcohol limit (Slade, 2002).

The number of Asians picked up by police for drug-related crimes has also risen gradually since 1990. Almost all significant heroin seizures since 1987 have involved Asians from criminal networks. In 1996, 6.4 percent of all apprehended offenders were Asians, making them the second most likely offenders on a per capita basis behind Maori (Samson, 1997). A high-quality ecstasy flood into New Zealand from Asia (McLoughlin, 2001) and New Zealand's largest ecstasy haul, in which three Asians were arrested in January 2001, are more indications of drug-related offences by Asians (*The Dominion*, 19 January 2001).

The dramatic growth of Asian students in New Zealand has been accompanied by increasing concern over their being used to import methamphetamine ingredients. Such action is alarming the New

Zealand Customs Service (Booker, 2004). Students are increasingly offering their New Zealand addresses as 'clearing houses' for the transit of precursor substances such as ephedrine and pseudoephedrine, needed to make the highly dangerous drug.

Loneliness has been cited as a common problem by student sojourners (Cheung, 2001; Cheung, 2003a; Ho et al, 2002). For many it is the first time they have left their families and they can easily become 'prey' for organised crime groups for drug trafficking. In response to this, the Ministry of Youth Development organised focus groups in 2003, with international/overseas students reporting that drug education initiatives need to reflect their particular cultural realities and concerns. However, there has been little substantive research addressing A&D misuse concerns among this group.

Instead of dismissing Asians in New Zealand as not having problems with alcohol and drugs, it may be more appropriate to consider that they have different views and are less likely to acknowledge and approach treatment services (Cheung, 2002). It is important to acknowledge that low demand does not necessarily reflect low service need. Health professionals need to investigate the perceived barriers and their significant predictive factors of A&D service use to ensure we address patterns of under-representation and under-use among Asians in New Zealand (Chen et al., 2003).

Current A&D Health Promotion in the Asian Community

According to the March 2004 Asian Youth Forum, two challenges face Asian communities in New Zealand:

- low levels of knowledge about drugs among parents and young people
- a lack of drug-related information in different Asian languages (Cheung 2003a; Chen et al, 2003).

According to Cheung, New Zealand's Asian communities have a number of perspectives on A&Ds that differ from the New Zealand norm. Likewise, studies of Asian women, students, older people and refugees in New Zealand are limited, with an evident absence of these groups in mental health and substance misuse data (Ho et al, 2002). These seems to be a need for culturally appropriate, drug-focused health promotions among the country's Asian communities as well as further research into A&D issues among Asian people here (Chen et al., 2003; Cheung, 2003a).

Despite the limited A&D health promotion programmes in the Asian community, a recent project (the Asian Public Health Project) has identified that Asian communities are keen to be involved in, to plan and implement public health initiatives (Asian Public Health Project, 2003; Cheung et al, 2003). The Project report introduces the concept of 3Cs: Consultation, Collaboration and Co-operation. Asian communities have advocated for more involvement and seek collaboration with different agencies to achieve better health outcomes for their communities. Their interest has provided a good avenue for service providers to consult and facilitate stronger community action in developing A&D education in the community (Cheung, Chen and MacDonald, 2003).

The Asian Public Health Project was initiated by Auckland's Asian community (the Asian Network Inc (TANI)) and is an example of community participation and the success of a 'bottom-up' approach. TANI

has communicated the needs of the Asian community and formed a partnership with government agencies and key stakeholders (Out There, 2002; Public Health Perspectives, 2003).

The project aims not only to conduct a literature review of the public health issues experienced by Asian people overseas (such as in Canada, Australia and the US) but also to stock-take a list of service providers offering Asian-specific services. However, its most important role is to conduct a needs analysis of the Auckland Asian community, identify their perception of any barriers and identify solutions. Based on the results from the Asian Public Health Project, a set of recommendations was developed and overseen by the Asian Public Health Advisory Group (formerly the Asian Public Health Project Team). The Advisory Group comprises people who represent the community and public health professionals and aims to collaborate and implement health promotion strategies in the community.

Feedback on public policy and health promotion strategies is essential in developing an approach appropriate to the community (Ministry of Health, 2002). The Asian community (TANI) not only seeks opportunities to advocate for Asian people to relevant key stakeholders but also responds to government consultative documents. By doing this, the community has the opportunity to learn about new initiatives and ensure policies are culturally sensitive and appropriate (Cheung, Chen and MacDonald, 2003).

Asian Perceptions of and Approaches to Health and Treatment

Similar to those in overseas countries, the treatment services for substance misuse in New Zealand include health service counselling centres, detoxification units, psychiatric hospitals, day centres, residential treatment programmes and individual counsellors working within broader settings (see www.alac.org.nz).

However, the Western belief system of health risk is unfamiliar to many Asians (Amodeo et al, 1996; Bond, 1991; Ho et al, 2002). For example, health risks are categorised differently in Eastern medicine. Tung (1980, cited in Amodeo et al, 1996) points out that Vietnamese patients place illness in three categories:

- naturalistic (caused by spoiled food, poisonous water or germs)
- super-naturalistic (dispensed by gods, demons or spirits as punishment after a violation of religious or ethical codes)
- metaphysical (arising from a philosophical belief that health is the perfect equilibrium of two opposite elements, such as hot and cold, and the current illness is the result of an imbalance between the two) (p.405).

Korean, Chinese and Taiwanese who believe traditional medicine works better than Western medicine still use alternative or traditional treatment methods (Amodeo et al, 1996; Bond, 1991; Mo, 1992). The Chinese in particular stress the balance of yin and yang forces in health, self-control, saving face and the interrelationship between psychological and physiological functions (Chu et al, 2001). With acculturation, however, many new migrants are believed to combine both traditional and Western beliefs about health issues. According to local research (Walker et al, 1998), about one-fifth of Asians in New Zealand try the traditional approach before approaching Western-style treatment.

Individual health among the Asian cultures seems to be part of a wider system, with a frequent blurring of the boundary between personal and family identity (Durie, 1998). Similarly, the divisions between temporal and spiritual, thoughts and feelings, mental and physical may not be as clear-cut as they are in Western thinking. Durie argues that the Western form of medical interest in physical illness greatly outweighs an interest in the person as a whole within a sociological and ecological environment. Heath (1985) argues that 'because the scientific and technical aspects of practice cannot be separated from human concerns and social skills, particular attitudes are required: the readiness to treat people as equals; empathy; willingness to share information two ways; and recognition that patients have a responsibility for their own health' (p.8). Such a distinction of health perspectives reflects the dichotomy of the Western treatment of 'individualism' focusing on empowerment models and the Eastern treatment of 'collectivism' focusing on traditionalism and spirituality in health.

Western culture is seen to foster the concept of independence, while dependence is a key concept in many Asian cultures (Nishio and Bilmes, 1987). The welfare of the family or community often has priority over individual needs (Sue and Sue, 1972). If a Western therapist emphasises independence too much, they may weaken or distort the sources of support and belonging that families uphold. For example, Chinese see external forces as very influential and are more 'cabined, cribbed, confined' than Westerners by family responsibilities, political authority and classroom control (Bond, 1991, p.35).

Eastern approaches to treatment include non-invasive and natural remedies such as herbal medicine, while Western approaches use more invasive or chemically based therapies such as surgery or drugs (Bond, 1991). Historically, Southeast Asians (e.g. Chinese) sought traditional healers to treat illness before considering Western approaches to treatment (Chang, 2000). Those who retain their traditional beliefs about health may be less likely to seek Western medical procedures.

Given this different approach to health and well being, the use of Eastern approaches may act as a barrier to acknowledging the severity of substance use and receiving appropriate treatment. Inefficient or incorrect assessment or treatment can greatly affect the quality of service, and 'may cause prolonged stay in the service or hospital thus increasing the running costs of the health services' (Ngai et al, 2001).

Asian people are sometimes described as 'non-compliant' when they do not follow the Western bio-medical regimens (Hwu et al, 2001). However, it is important to note that non-compliance features have been generated in Western culture and analysed from a Western healthcare perspective. Hwu et al (2001) argue that Asian healthcare practices are quite different, to the extent that compliance may be a concept unknown to either healthcare professionals or patients. For example, in Chinese culture, people expect to make their own decisions on health behaviours, often in conjunction with their family and relatives.

The use of passive coping strategies, such as avoidance, withdrawal, minimising the problem, ancestral worship, wishing the situation would go away, and resignation to and acceptance of fate, has been identified as characteristic of Asian coping styles (Chang, 2000; Chu et al, 2001; Bond, 1991). While researchers are careful to point out that this coping may not be inherently maladaptive, it may lead to a denial of the need for help and thus a delay in seeking treatment (Bui and Takeuchi, 1992; Durvasula and Sue, 1996). Timberlake and Cook, 1984) describe denial as congruent with the Southeast Asian

cultural values of 'self-sacrifice, submission to the common good, harmony, and acceptance of fate' (p.406). With their social structure of hierarchical relationships and subordination of individual needs, many Southeast Asian cultures have seemed to function with some degree of denial as a cultural dynamic, as suggested by Amodeo et al (1996).

Studies have indicated that the Western model of a directive or confession-in-counselling approach tends to induce guilt and shame, thus increasing denial and the use of other defences (Amodeo and Liftik, 1990) and increasing resistance to interventions (Miller, 1992). These studies conclude that when working with Cambodian and Vietnamese people, it is best to avoid a directive or confessional approach that may result in loss of face.

In their study, Amodeo et al (1996) worked with Southeast Asian community leaders to explore supportive methods that could be used to work with Asians with substance misuse issues. They recommended story-telling and using portions of traditional Asian legends – suggesting that through story-telling about fictitious characters and heroes from Asian legends who faced problems similar to the person, they could be given the opportunity to reflect on their current situation without having to acknowledge their problem directly. Other methods suggested by Amodeo et al (1996) included acknowledging the courage Asian people have shown in coming to a new country and reminding them of the potential risk of losing family support, community and society if they continue their substance misuse.

Implications for Alcohol and Drug Treatment

Supporting professionals are advised to avoid 'insight-oriented therapies' (Boehnlein et al, 1985; McQuaide, 1989; Timberlake and Cook, 1984) as well as approaches that pressure people to admit 'alcoholism' and engage in a recovery process based on Western views of spiritual redemption. This strategy may be particularly incongruent with Southeast Asian cultures, as the use of empowerment through challenging oneself or others could be viewed as confrontation. Chang (2000) also indicates that some Asians prefer solutions based on Western medication like 'pills' rather than counselling/psychotherapy/talk therapies when they approach substance misuse treatment services. Including a medical practitioner in a session may help emphasise the importance of treatment.

Ja and Aoki (1993) argue that many Asians with substance misuse are initially sceptical about drug misuse treatment facilities and programmes. They may have considerable fears and anxieties about the process, relating to confronting themselves, recognising their failures, their fears and their lifestyles and being confronted by others on these issues. Embarrassment, shame and loss of face often bring on an enormous reservoir of resistance.

Shon and Ja (1982) claim that family counselling, as opposed to seeing someone outside the family network, could be an important component for Asians because most come from intact nuclear families where family support is crucial. Rather than using an expressive or directive process, an educative and supportive approach allows family members to begin the healing process in their chosen ways and shifts their behaviours of interdependency and possibly co-dependency towards better understanding and communication. Shon and Ja (1982) stress that family approaches emphasising respect and

achieving alliances with the parents will establish stronger therapeutic bonds between the family and the person, so that they feel secure in sharing information.

In using natural support systems and traditional healing methods, religion and spiritual beliefs can be considered as they are an integral part of Southeast Asian cultures (Amodeo et al, 1996). Both Western Christianity and Eastern religions such as Buddhism, Taoism and Confucianism are practised in Southeast Asia. Religious leaders play an important role in many Asian cultures, where Western treatment methods such as hospitals, residential programmes and Alcoholics Anonymous historically did not emerge significantly (Berry et al, 1992). Instead, therapeutic approaches and religious figures such as Buddhist monks appear to be influential in helping people with substance misuse (Bemak, 1989; Canda and Phaobtong, 1992).

Anecdotal reports (Bemak, 1989) , while encouraging adherence to a clinical treatment plan, suggest that using cultural healing practices may be persuasive to Southeast Asians, especially refugees. Gong-Guy et al (1991) describe methods used in some refugee camps in response to mental health problems, including prescribed rituals, incantations, steam baths, massage and herbs and other organic materials. However, Bemak argues that professionals wishing to integrate Eastern and Western healing practices are advised to transcend the boundaries of their own training and try to accept practices that may appear different from a Western viewpoint.

Bemak (1989) maintains that culturally relevant interventions emphasise coping methods and strengths rather than psychopathology, a view that contrasts with mainstream substance misuse treatment approaches that rely on the medical model. According to Amodeo et al (1996), the medical model emphasises that substance use and dependence:

- are chronic, relapsing illnesses likely to worsen without treatment
- require intensive treatment for months and often years
- require vigilance against relapse for the duration of the person's life (p.410).

Acupuncture, which has been used in several parts of the US for detoxifying mainstream clients from substance misuse and for relapse prevention, might be an important centrepiece in substance misuse treatment for Southeast Asians. It is believed to be culturally familiar, provided on an outpatient basis, and inexpensive (Gong-Guy et al, 1991). It may also be a useful alternative to inpatient medical detoxification, which many Southeast Asians strongly resist because of separation from family members and exposure to an environment where an unfamiliar language is spoken, unfamiliar foods are served and unfamiliar activities take place.

Among mainstream people with substance misuse problems, recovery seems to be conceptualised as achieving abstinence and accomplishing a personal transformation, evident by changes in lifestyle, relationships, identity and self-perception (Amodeo et al, 1996). With Southeast Asians, recovery may not need to involve a personal transformation, given that the culture places relatively little emphasis on self-reflection and insight. Instead, Amodeo et al argue that recovery for Asians may constitute a return to harmony or a return to fulfilling family and community obligations and protecting the honour of the family name. The belief in karma holds that if people do good things in this life, good things will happen in their next life; if they do bad things, they must pay for wrongdoing by suffering in the next life. Their beliefs in karma and maintaining harmony may have contributed to the under-use of treatment services

among Asians, because they believe in letting fate take its course to stabilise family structure and functioning (Chu et al, 2001).

As substance misuse treatment services continue to evolve for the Asian population, an important building block in programme development will be a mechanism whereby Asian clients and their community can help service providers to understand and define recovery in a way that reflects the values and beliefs of their cultures (Amodeo et al, 1996; Bemak, 1989; Brown, 1985).

CONCLUSION AND RECOMMENDATIONS

There is very limited research on alcohol and drug use and misuse by New Zealand's Asian population. This background paper provides only a glimpse of the national and international literature on Asian people's A&D consumption patterns, their help-seeking behaviour and factors influencing these things.

Most of the literature cited in this paper was produced in Western countries with a high number of people of Asian descent and migrants. However, epidemiological data on A&D use in those countries is scarce, partly due to the data collection system not including 'Asians' as an ethnic group until recently.

One of the main themes of this background paper is that cultural factors play a major role in affecting Asian people's A&D use/misuse and their help-seeking patterns. However, the experience of how well culture interplays with contextual factors such as migrants' new experiences in the host society is not well understood. Research into Asian migrants' experiences tends to focus on adaptation issues, accessibility to healthcare services and cultural responsiveness on the delivery of personal healthcare services, but only a small amount has looked at the health promotion in the Asian population.

Despite the fact that literature on Asian A&D issues is scarce in New Zealand, this background paper sheds some light on the subject and has relevance for the local community and service providers.

Based on the findings, recommendations have been developed in four main areas:

- Health promotion in the Asian community.
- A&D treatment services.
- Further research.
- Recommendations for ALAC.

Recommendations for Health Promotion in the Asian Community

Increasing Cultural Responsiveness in Health Promotion and Prevention Programmes

There are few A&D health promotion and prevention programmes targeted specifically at New Zealand's Asian population. The same appears to be true overseas, where studies suggest that Asian youth receive little education on A&D use/misuse.

The lack of such programmes could have a profound impact on the community as young people may not be aware of the potential harms or consequences of misuse. . Educating communities on alcohol and drugs is strongly encouraged, as it would help build knowledge and demystify some myths and perceptions. Culturally appropriate health promotion programmes should also be readily available to different subgroups in their own languages. And given that A&D use is highly stigmatised in the Asian community, outreach programmes are recommended to ensure such programmes are easily accessible for the community.

Community Participation and Health Promotion

Useful and effective resources, community consultation and participation are recommended as essential parts of health promotion.

In accordance with *Achieving Health for All People: A framework for public health action for the New Zealand Health Strategy* (Ministry of Health, 2003), it is important to consult and collaborate with key stakeholders and communities when developing health promotion and prevention programmes. This view was shared by the Asian communities in the recent report recommending the '3Cs' approach (consultation, collaboration and co-operation) as essential to implementing effective strategies and programmes in the community.

Community participation with Asians is particularly important given their limited understanding of health promotion and prevention and the fact that they tend to keep problems within their families. Promoting healthy lifestyle/choice messages to the Asian community needs to first take place at the family/community level, and all initiatives should be evaluated.

Recommendations to Public Health Service Providers

The Ottawa Charter emphasises the importance of community participation in developing and promoting healthy messages to the community. In Auckland, TANI has advocated for the Asian community's public health needs and developed a partnership with government and key stakeholders to conduct the Asian Public Health Project, and an Asian Public Health Advisory Group (APHAG) has been formed. It is recommended that public health service providers liaise and form partnerships with community organisations and interest groups such as these to develop strategies to promote healthy messages to communities.

A&D Treatment Services

Improving Cultural Responsiveness in A&D Services

Much of the literature suggests Asians under-utilise mainstream A&D services. This could be attributed to mainstream services being unresponsive to their treatment options/needs, while differences in cultures and beliefs may result in considerable difficulties in immigrant groups' use of social and health services (Reid et al, 2001).

Involving family and community has been identified as an integral part of the healing and treatment process for the Asian community. This should be taken into account when developing diagnostic assessments, intervention strategies and outcome measurements. A government-funded, designated-Asian A&D service with a support infrastructure is recommended to deliver culturally appropriate treatment services for this population.

Accessibility to A&D Services

A&D services should be made easily accessible to the Asian population. Studies suggest new migrants are not familiar with their host societies' healthcare system and often find it difficult to locate appropriate services. Asian communities should be made aware of the available A&D services and their treatment options by way of material produced in different languages (given that language is one of the barriers to non-English-speaking background people fully integrating into the society, including understanding and accessing the health system). Interpreting services should be made available.

Workforce Development

The literature identifies a multi-lingual and multi-cultural workforce as one of the ways to improve cultural responsiveness in health services. This implies that health services should employ staff who can effectively respond to clients' language and cultural needs.

The existing workforce may need to be made more aware of Asian culture, its heterogeneity, and the implications for service delivery through workforce and professional development pathways. 'Cultural competency' does not only imply extending knowledge of Asian cultures, it also includes building up skills and developing appropriate approaches to addressing clients' needs.

Given that language barriers have been identified as a major hurdle, it is recommended that A&D services use qualified interpreters to ensure accurate health message/assessment and treatment options/intervention. It is also recommended that interpreters working in A&D be specifically trained, as A&D issues are sensitive and stigmatised in the Asian population.

Recommendations to Treatment Service Providers

It is recommended that service providers include Asian people's needs in their service development plans. This will involve a designated person looking at the population's specific language and cultural needs, identifying ways to provide a culturally responsive and sensitive service and developing appropriate policies and procedures.

Recommendations for Further Research

Systematic Data Collection

Because of discrepancies in the international definitions of 'Asian', which makes it difficult to draw conclusions on A&D use/misuse among the Asian population, it is recommended that there is a consistent description of 'Asian' within New Zealand.

Many New Zealand studies on Asian well-being-related issues have adopted Statistics New Zealand's definition, and it is recommended that A&D services adopt the same approach.

Many service providers have also not included 'Asians' in their data collection systems. Given the recent and significant increase in Asian people in New Zealand, it is recommended to include such a

category so that information on A&D use among the Asian population, their A&D use/misuse prevalence and service use rate can be measured accurately.

Understanding Alcohol and Drug Issues in New Zealand

Studies examining A&D issues among New Zealand's Asian population are very limited, so the prevalence of A&D use is not fully understood.

Further research is needed to examine factors relevant to the New Zealand context that influence the consumption and behaviour patterns of alcohol and drugs among the Asian population. This research needs to consider the different subgroups, including Asian ethnicities, gender, age, their length of stay, and their level of Westernisation in the host society.

It is also important to understand the risk and protective factors that affect A&D issues in these subgroups and how they interplay with different contextual factors. Understanding the history, role and conceptions of substance use and its perceived prevalence in different Asian ethnic groups could help to explain and address their use of treatment services and contribute to the development of future health promotion programmes for the Asian community.

Recommendations for Research Groups

Research groups are recommended to seek opportunities to analyse further the data in previous reports or collected from service providers. This is because Asian-specific data in research may not yet have been analysed.

It is also recommended that research groups look at strategies to develop an Asian research workforce. Maintaining a partnership with the Asian community is also essential, not only to identify resources and recruitment opportunities but also to disseminate research results.

Recommendations for ALAC

It is recommended that ALAC:

- Identifies research to be undertaken on drinking patterns and associated harms among Asian populations.
- Develops strategies and policies to address the needs of Asian people.
- Liaises with appropriate and relevant community groups such as TANI and APHAG.
- Develops and maintains a database that includes all resources (both national and international) relevant to the needs of Asian communities.
- Develops resources and health promotion materials to address the needs of Asian populations.
- Advocates with other agencies for a co-ordinated approach to reduce alcohol-related harm among Asian populations.
- Ensures the organisation is continually responsive to the changing needs of the Asian population.

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- Continues strengthening relationships with Asian communities and relevant stakeholders.
 - Adopts a community development approach and continually strengthens relationships with Asian communities to promote and develop a healthy community.

Appendix One

The Ottawa Charter of Health Promotion

The Charter defines health promotion as 'the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environments. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to wellbeing' (see Runanga Whakapiki ake I te Hauroa o Aotearoa, Health Promotion Forum of New Zealand at www.hpforum.org.nz).

Public health and the Ottawa Charter are closely related as the Charter includes the right of individuals and communities to determine the health of themselves and their environments.

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