A Stocktake of Pacific Alcohol and Drug Services and Interventions

Stocktake Report

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LE ALA
Community Action Research

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STOCKTAKE REPORT

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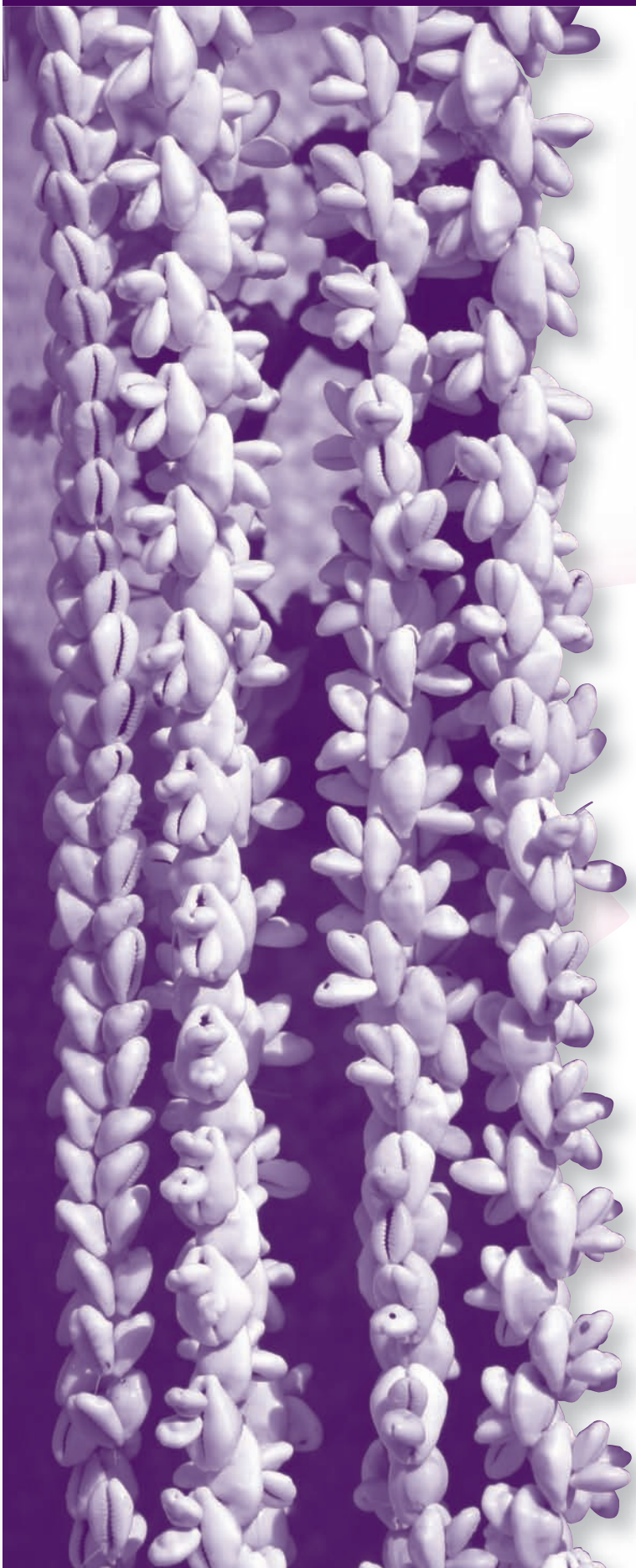

This report was prepared by Magila Annandale, Professor Cluny Macpherson, Vainetutai (Ta'i) Richard and Moana Solomona. A short initial literature search was undertaken by Susan Bidwell of New Zealand Health Technology Assessment (NZHTA). The authors then collected and reviewed additional information on current Pacific alcohol and drug services and interventions to provide critical appraisal.

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FOREWORD

Le Ala is a community action research project led by Pacific people from a range of academic and clinical disciplines. It aims to increase Pacific peoples' understanding of alcohol- and drug-related harm and encourage activities that reduce its likelihood.

This study takes stock of Pacific alcohol and drug (A&D) services and interventions targeted at Pacific communities in New Zealand. It includes a comprehensive literature review that provides insights into relevant A&D services provided, and interventions carried out, nationally and internationally with 'cultural communities'.

The stocktake focused initially on existing services and served a useful research purpose in identifying existing programmes and approaches to delivering A&D interventions. It also contributed added value, providing insights into, and raising issues about, the significance of socio-demographic shifts within the Pacific population.

These insights led the team to consider the implications of these changes for future A&D education and treatment programmes, and to extend the stocktake exercise to consider the issues that will influence the delivery of education and treatment to a rapidly diversifying Pacific population.

As a result, the report is more than a stocktake. As well as looking at the situation today, it takes a look into the future – and to the actions we need to take to ensure we provide relevant, timely and targeted inventions to help those at risk of A&D-related harm.

EXECUTIVE SUMMARY

The health disparities of Pacific communities are well documented. The Ministry of Health's A National Strategic Framework for Alcohol and Drug Services (Ministry of Health, 2001) identifies Pacific peoples as at-risk populations.

Le Ala is a research project that aims to help address this by building a strong information base to improve community-based alcohol and other drug (A&D) prevention interventions and services for Pacific people.

The purposes of this stocktake were to:

- inform Le Ala's work by providing evidence of relevant interventions and services that are effective in helping to prevent alcohol misuse and related risk-taking behaviours within Pacific populations, and that seek to reduce alcohol-related harm
- provide a resource for the communities of interest in this field
- identify issues that will confront funders, researchers and communities of interest in providing A&D services for a rapidly changing and increasingly diverse Pacific population.

METHODOLOGY

Information was collected mainly through dialogue with a diverse range of A&D and other social service providers (managers and staff), District Health Board (DHB) funders and planners, A&D clinicians and practitioners, service users and others. More than 100 people participated in fono, face-to-face meetings, interviews and a survey.

Participants were asked to answer questions such as:

1. How do you identify those at-risk of developing alcohol-related harm?
2. What interventions are working well with Pacific people? How do you know? Why?
3. What interventions are not working with Pacific people? How do you know? Why?
4. What interventions do you think work better with Pacific people? Why?

The study also included a short literature review, with a key source of information being the Le Ala Alcohol Community Interventions and Services for Pacific Peoples Literature Review (Warren et al 2006), which provides important insights into A&D interventions with cultural minorities in New Zealand and overseas. The review also included publications obtained through bibliographic searches of databases such as Medline, Embase, Cinahl and Psychinfo, the Cochrane Database of Systematic Reviews and other internet sources.

The researchers initially intended to develop a guide for evaluating evidence of the effectiveness (including cost effectiveness and cost benefits if possible) of service delivery related to A&D and alcohol-associated issues for Pacific peoples. However, this did not eventuate, as feedback from informants highlighted a distinct gap in the availability of evidence-based information. Service providers said that in many cases funding was not available for them to undertake rigorous evaluations of their services, and this included maintaining appropriate data-collection systems to support service evaluations.

This research follows a suite of studies (entitled PADOPTS – the Pacific Alcohol & Drug Outcomes Project) commissioned in recent years by the Alcohol Advisory Council of New Zealand (ALAC), which concentrated on Pacific providers' delivery of treatment services. While this stocktake provides some information on services' treatment and care, its prime focus is on issues pertaining to prevention and health-promotion interventions targeted at Pacific populations. In addition, it explores service capacity and capability matters relevant to Le Ala's aims and objectives.

KEY FINDINGS

A significant finding of this review was the apparent lack of available national and international information on evidence-based Pacific A&D interventions.

This is understandable in the New Zealand context given the relatively recent development and establishment of Pacific providers and Pacific-targeted interventions. It's also important to emphasise that specific research on Pacific A&D prevention is largely under-developed – again, not surprising given that providers deliver treatment-based interventions with a limited focus on prevention strategies.

This stocktake shows that A&D service delivery is inextricably linked to the Government's existing funding arrangements, which target the 3% of the population with 'substantial to severe' alcohol-related problems. This continues to create a significant gap in the provision of prevention services and interventions.

(Further research is required to determine those who are 'at risk' in Pacific communities. According to A&D practitioners, a range of variables may define them, with some providers mentioning that at-risk service users are mostly captured through referrals from government agencies such as the Ministry of Justice and Department of Corrections).

Pacific A&D services provide a variety of interventions, including counselling, psycho-educational sessions, music therapy (pese) and psychodrama. Some offer spiritual and traditional healing services. They use a combination of Pacific and mainstream models of care, and while many interventions are provided in English, some services are provided in Pacific languages.

According to interviewees, the programmes delivered by Pacific A&D services are generally effective. It was unclear, however, whether structured evaluations had been carried out to support this view. Although many of the service providers recognised the importance of evaluation, a lack of resources prevented them doing so. Programme evaluation is critical to ascertain whether programmes are addressing the needs of Pacific peoples effectively.

The characteristics of effective interventions are accessibility, cultural appropriateness, alignment with Pacific health belief models and acknowledgement of the increasingly diverse Pacific peoples, particularly the increasing number of New Zealand-born Pacific youth who have dual/multiple ethnicities. Including alcohol users' families in interventions and using inclusive approaches are thought to be important, and fono participants favoured church- and school-based approaches.

Identified service gaps have been attributed to a lack of funding and inadequate skills. This includes insufficient staff trained in A&D programme delivery together with shortfalls in the number of staff required to provide more programmes. This lack of resources prevents most service providers developing, implementing and evaluating prevention strategies to reduce alcohol-related harm among Pacific communities.

The stocktake also revealed insights into the rapidly changing socio-demographic characteristics of the Pacific population – and went a step further to take a closer look at their potential impacts in the future. The changes will become more obvious as a large, young, New Zealand-born-and-raised cohort with different social characteristics and experiences from the first generation comes of age. Services designed to meet the needs of, and respond to, the consumption patterns of the earlier Pacific migrant cohort will have to be expanded and or modified.

RECOMMENDATIONS

Based on the study findings, 10 recommendations have been developed.

1. Prevention strategies need to be culturally appropriate and take into account holistic approaches to health and wellbeing. They must recognise and acknowledge diversity within Pacific communities, particularly the growing New Zealand-born Pacific population.
2. Dedicated funding is recommended for developing and implementing Pacific A&D prevention initiatives, such as educational activities aimed at preventing Pacific peoples engaging in risky drinking. Current funding approaches focus on the substantial-to-severe end of the A&D use spectrum and do not include prevention initiatives.
3. An evaluation tool is needed to gauge the effectiveness of prevention programmes for Pacific people. An agreed flexible evaluation template would probably ensure a greater degree of consistency and comparability in intervention evaluations.
4. The notion of dual/multiple ethnicities and their impact on Pacific prevention strategies requires further investigation. It would be prudent to determine the critical factors that influence positive attitudes and behavioural changes relating to A&D use for this segment of the Pacific population.
5. Peers, or those of similar age and ethnicity to the target population, should administer prevention intervention approaches involving face-to-face contact where possible. The use of role models with whom Pacific youth can identify is recommended for both delivering alcohol education messages and promoting intervention programmes.
6. Service providers commonly believe that the church is an effective setting for implementing A&D prevention initiatives. However, evidence of a declining commitment to formal religion among New Zealand-born Pacific youth raises questions about this role for Pacific churches in future. Further exploratory work is needed to determine the role of churches and the approaches that would be effective there.
7. According to the study participants, community-based strategies for intervention/prevention are likely to be more effective if they begin early. This suggests that investing in alcohol education programmes targeted at those entering adolescence (for whom alcohol use is becoming a real behavioural option) may have greater long-term benefits for more people than investments in treating older adult populations with established drinking patterns.
8. Further research is needed to identify clearly those at greatest risk of alcohol-related harm within Pacific communities. A recent national study of Pacific A&D consumption suggests a correlation between high levels of alcohol consumption and the peoples of the Cook Islands and Niue. Interventions and prevention strategies that are ethnic specific rather than pan-Pacific may be needed to address these disparities.
9. A database of Pacific services and prevention programmes is needed – and its value would be greater if key comparative data were collected, e.g. numbers of participants, funding levels, number of interventions per annum and completion rates.
10. A working party comprising demographers, researchers, providers and funders needs to be convened to consider the significance of socio-demographic shifts in the Pacific population and the timing of proactive moves to anticipate and prepare for the steadily increasing numbers of New Zealand-raised Pacific young people who will start consuming alcohol in the next decade.

GLOSSARY

Client-Centred Therapy

Client centred therapy (CCT) was developed by Carl Rogers in the 1940s and 50s. It is known as Rogerian Therapy. It is a non- directive approach to therapy. This appeals to many clients because they control the content and speed of the therapy and the therapist does not evaluate them in any way. The foundational belief of CCT is that people tend to move toward growth and healing and have the capacity to find their own solutions. Therapists:

- listen and try to understand things from the clients perspective
- check this understanding with the client if they are unsure
- treat the client with the utmost respect and regard
- be self-aware, self-accepting and open with the client.

Cognitive- Behavioural Therapy

A way of talking about how you think about yourself, the world and other people, and how what you do affects your thoughts and feelings. This therapy can help people to change how they think (cognitive) and what they do (behaviour). It focuses on 'here and now' problems by breaking them down into smaller parts. From this can follow thoughts, emotions, physical feelings and actions. Each area can affect the others and the way that a person thinks about a problem affects how they feel physically and emotionally. It can also change what they might do about the problem.

Community-Based Strategies

Strategies designed and implemented by community groups for their own use. They may involve educating youth and families through running church or sports events or promoting health and using community nurses to help with health promotion.

Culturally Appropriate

Understanding how to deliver a programme using cultural approaches that work best for the particular community. For example, ethnic-specific language approaches may be used to run health programmes.

Culturally Specific

Culturally specific programmes are specific to a particular culture or ethnic group e.g. Pacific, Samoan, Cook Islands, Niue.

Culture

A dynamic and constantly evolving term used to describe values, beliefs, customs and practices based on ethnicity and heritage.

Fonofale Model

A model consisting of a Samoan house (fale) with four posts holding up the roof. Each of the four posts represents an important aspect of health and wellbeing – physical, spiritual, mental and other. The roof represents cultural values and beliefs, such as traditional methods of healing as well as Western methods.

Holistic Approach

An approach that acknowledges all important dimensions of health and wellbeing for a Pacific person.

Many Pacific peoples believe that spiritual wellbeing is equally essential to good health as physical and social wellbeing. A holistic approach can be defined as ensuring a state of physical, mental, social and spiritual wellbeing.

Intervention

An action undertaken to change what is happening or might happen in another's affairs, especially to prevent something undesirable.

Le Ala

A Samoan term that means 'the way'. For the Le Ala project, it embodies the notion of pathways to wellbeing.

Matalafi Matrix

A tool used by clinicians to assess Pacific clients. It takes a 'snapshot' of a person's life around A&D use. The matalafi is a Samoan healing plant. Legend has it that once used for fofo (traditional Samoan massage) it moves and fully replenishes itself for use at another time. As with a client whose situation constantly changes, it dictates the need for the clinician to capture those changes (ALAC, 2006, p 6).

Motivational Interviewing

A multi-staged model developed to move people through a series of stages of change (Miller and Rollnick, 1991).

Palagi

A Samoan term for a non-Pacific person, usually of European descent.

Pesepesega (Pese)

Samoan term for singing or song.

Prevention Intervention

Programmes or approaches used to address potentially high-risk behaviours, e.g. education awareness programmes on the effects of alcohol abuse, life-skills building, community-based initiatives, Pacific values and beliefs' awareness. All of these approaches are ways to educate and encourage youth, elderly and other populations on healthy decision-making before behaviours become high risk and/or uncontrolled.

Talatalaga Aiga Model

A model designed by Samoa workers in the Samoan language, but which can be used across all Pacific groups. It uses the concepts and processes of talatala (untangle), toelalaga (reweaving), uluulumatafolau (re-mending) and fa'aleleiga (reconciliation).

Traditional Healing

Traditional practices used for treating internal and external ailments in the Pacific. Traditional healing varies with each Pacific group and ranges from consulting a matai (chief) to using herbal medicines extracted from plants by traditional Pacific health practitioners.

INTRODUCTION

This report aims to provide insights into existing alcohol and drug (A&D) prevention interventions and services provided by Pacific providers for Pacific people in New Zealand. It has been designed to inform Le Ala, a community action research project that seeks to increase Pacific peoples' understanding of alcohol- and drug-related harm and encourage behaviours that reduce the likelihood of harm.

It is preceded by and complements an extensive national and international literature review, Alcohol Community Interventions and Services for Pacific Peoples, and a suite of recent studies on Pacific services (entitled PADOPT – the Pacific Alcohol & Drug Outcomes Project) commissioned by the Alcohol Advisory Council of New Zealand (ALAC) which focuses on providers' delivery of treatment services (as opposed to prevention and health-promotion interventions).

The Le Ala literature review was a key source of information for this report. Additional information has been collected through dialogue with a diverse range of A&D and other social service providers (managers and staff), district health board (DHB) funders and planners, A&D clinicians and practitioners, service users and others.

RESEARCH PURPOSE

The main purpose of the research was to inform the Le Ala project by undertaking a stocktake of Pacific A&D interventions and services that are considered effective in addressing alcohol use and related risk-taking behaviours within Pacific populations. It also aimed to identifies approaches to intervention that may not be widely used and which, on the basis of information from settings with similar combinations of economic and socio-cultural factors, may have potential applications for service delivery to Pacific populations.

Once the stocktake was underway, it became apparent that there are a number of issues relating to the future development and delivery of services for Pacific peoples – particularly given significant changes in their socio-demographic make-up, education and living standards and lifestyle choices. The authors chose to explore this further, and provide additional recommendations for New Zealand programme planners and developers. You can read more in 'Looking to the Future' on page 36.

SCOPE

Currently 10 Pacific A&D services in New Zealand are directed by Pacific people and target primarily Pacific communities. They either are based within DHBs or operate as non-government organisations (NGOs). There are also mainstream organisations that provide A&D services to a range of clients, including Pacific people.

Recent ALAC-commissioned studies provide useful insights into the models of care and cultural underpinnings that influence Pacific service design and delivery. However, while this stocktake captures some information on service treatment and care, it primarily focuses on issues relating to prevention and health-promotion interventions. It also discusses aspects of service capacity and capability relevant to Le Ala's aims and objectives.

DEFINING 'PREVENTION'

Le Ala aims to identify and improve the effectiveness of Pacific A&D-related prevention strategies. These strategies can be called interventions, even though they may occur before any risky behaviour takes place.

ALAC (2002, p 29) defines prevention strategies at three levels:

Primary prevention – interventions that prevent a health problem occurring, e.g. school-based education

Secondary prevention – approaches that capture health problems at early stages, e.g. work with at-risk youth

Tertiary prevention – often treatment based, these strategies aim to prevent a reoccurrence or relapse of an illness.

A health-promotion focus defines and underpins the approaches of this study.

CONTEXTUAL BACKGROUND

This section describes key characteristics of the Pacific population – as well as issues that will need considering for the future design and development of A&T services and interventions.

THE PACIFIC POPULATION

Pacific populations are not homogenous. Comprising seven main ethnic groups from origin nations in the Pacific, they share some broad similarities but have their own cultures, languages and histories. Table 1 illustrates this using figures for 2001-2002 from Statistics New Zealand (Instone, Annandale and Gilbertson, 2004).

Table 1: Pacific Populations in New Zealand 2001-2002

Country	New Zealand Population	% of Pacific Population	Population Born in NZ	% Born in NZ	% Speak Own Pacific Language
Samoa	115,000	47%	66,700	58%	67%
Cook Islands	52,500	22.5%	36,750	70%	18%
Tonga	40,700	17%	20,757	51%	60%
Niue	20,100	8%	12,395	62%	28%
Fiji	7,000	3%	3,150	45%	28%
Tokelau	6,200	2.5%	2,714	44%	44%
Tuvalu	1,965	.007%	1,179	60%	72%
Total	243,465	100%	143,645	59%	50%

Source: Statistics New Zealand; Table – 'Pacific Populations in New Zealand' (cited in Instone, Annandale & Gilbertson, 2004, p MCH).

Pacific populations in New Zealand total 265,974 (6.9% of the total population). Samoans form the largest ethnic group (131,103) followed by Cook Islanders (58,008), Tongans (50,481), Niueans (22,476), Fijians (9,864), Tokelauans (6,819) and Tuvaluans (2,628). Importantly, there are considerable numbers who speak their own language (Census of New Zealand Population, 2006).

Samoans, Tuvaluans and Tongans have the highest numbers of native language speakers. In most cases, Pacific A&D providers can deliver services in more than one Pacific language in conjunction with English. However, English language speaking among Pacific populations is rising at the same time as Pacific language speaking is declining, using assumptions based on information in Table 1. This shows that almost 60% (this figure had increased from previous years) of Pacific people were born in New Zealand, so are highly likely to speak English.

When compared with the total population, Pacific peoples also have a much younger age structure. The median age for the total New Zealand population is 35 years compared with 21 years for Pacific peoples. Within Pacific populations, the average age for a Pacific-born is 37 years compared with 12 years for those born in New Zealand.

PACIFIC PEOPLES - CHARACTERISTICS AND TRENDS

Pacific populations in New Zealand are largely urbanised, with 98% (238,595) living in cities – mostly in Auckland, followed by Wellington. There are also significant numbers living in Christchurch and steadily increasing numbers in Waikato (Annandale and Instone, 2004, p 23).

Le Ala's research concentrates on urban areas where Pacific people are present in large numbers. However, increasing numbers of Pacific people are living in regional centres – so research may be needed on whether they need different forms of intervention than those in the main centres.

In addition, the youthfulness and increasing number of New Zealand born and educated Pacific people highlight important population characteristics that could affect the design and tactics for A&D interventions. This includes determining the priority target audiences and their language requirements. It is possible that the demand for 'ethnic language-based' Pacific services will decline in the future.

INTERMARRIAGE

The increasing rates of ethnic intermarriage in Pacific populations, revealed in successive national censuses, mean that significant numbers of people of Pacific descent do not identify primarily with only one ethnic group or language.

Over time, a more generic 'Pacific' identity and lifestyle may replace multiple distinctive ones, with implications for intervention strategies. Health-promotion interventions will need to respond to a multiplicity of cultures through communication channels that appeal to younger audiences. However, this development should not, in the medium term, exclude approaches that appeal to 'traditional', more mature Pacific people who are embedded in their culture.

FAMILY

Table 2 illustrates the high proportion of Pacific people who live in a family situation.

Table 2: Pacific Family Statistics

Family Occupancy	Pacific Population	Total Population
Living in a family situation	82%	77%
Living in an extended family	29%	8%
Average number of occupants for all households	5.4	3.5
One-parent families (Pacific one-parent families are more likely to be living with extended family)	21%	17%

Source: Statistics New Zealand; Table – 'Pacific Family Statistics' (cited in Annandale and Instone, 2004, p 23).

Family members often act as key influences, particularly in important decisions. For example, research on Samoan populations shows that families influence individual members' health-seeking behaviours (Macpherson and Macpherson, 1991) by discussing the likely cause of a complaint or condition and reviewing various management alternatives. These family 'consultations' often precede, and become crucial in, decisions on appropriate treatment-seeking strategies and decisions to modify or abandon them.

According to the Mental Health Commission (2001, p 1), family plays a key role in Pacific consumers' healing and recovery. There is also an increasing amount of qualitative data that supports families' major role in Pacific communities, of which some has been collected through government consultation processes with Pacific communities. As a result, the government is recognising the importance of family and communities in designing strategies to reduce economic and social disparities for Pacific communities.

Evidence suggests that the design and positioning of key messages for A&D prevention need to consider the influential role of families. For example, where heavy abusive drinking is common in several generations, it is in effect a normative behaviour and drinking sessions may be a form of family activity. In this case, treating individual members in isolation may be difficult, because the prospect of altering the behaviour of an individual member may be related to the prospect of altering the alcohol consumption patterns of other family members.

It may also be important to establish whether the significance of family influences are the same in different generations. For instance, it's possible that the importance of gerontocracy in distributing power and authority within families is declining among Pacific people raised in New Zealand. Certainly the family's role in influencing young Pacific people's behaviour may be declining, and peer influences may be increasing (Macpherson, 2002). Messages based on the premise that all Pacific people value family, respect older people and will respond to the same message will fail if younger people are more readily influenced by their peers.

It's possible that respected older family members with religious credentials will be the most effective agents of behavioural change in some sectors of the Pacific population, and that non-family members with professional credentials will be more effective in others. Research could productively focus on who influences opinion and conduct, and how, in different sectors of the Pacific population. Flexible interventions are needed that can incorporate these different influences.

PACIFIC PEOPLE AND ALCOHOL

A survey commissioned by ALAC and reported in the Globe (2005, 1:9) found that Pacific adults and young people who drink, consumed more than the general population on their last drinking occasion. Pacific adults consumed on average 6.3 standard drinks compared with 3.8 for the overall population. For Pacific youth, the average standard drink consumption was 6.9 compared with 4.7 in youth overall.

However, the survey also indicated that compared with other ethnicities, Pacific adults and young people are also more likely to be non-drinkers. Evidence shows a great difference between Pacific adults who are heavy drinkers and those who are non-drinkers. This re-confirms that Pacific peoples consist of several sub-groups with different patterns of alcohol use. This is likely to impact on the way interventions are carried out.

Warren, Kirk and Lima (2006, p 22) refer to a Ministry of Health national Pacific survey undertaken in 2003, which gave a breakdown of drinking patterns by Pacific island group. Cook Islands Maori youth (13-29 years), women in each age bracket, and Niuean women in the 30-65 year range were more likely to be drinkers than others in the same category. In all age categories Samoan women drank less than the other people in the same age category. While the significance of these differences in this context relates to identifying and managing high-risk groups, there may be good reasons for exploring the characteristics and conduct of the non-drinkers in the Pacific population for clues to variables connected with low-risk behaviour.

The same survey concludes that while Pacific men are more likely to drink alcohol (61%), drinking among Pacific women is increasing rapidly, with a reported 51% drinking alcohol.

PROBLEM DRINKING

Surveys in recent years show that intoxication is tolerated in New Zealand. They also show that some Pacific people tend towards extreme drinking patterns. Heavy and risky drinking, sometimes referred to as 'binge' drinking, is practised by many New Zealanders – and 'results in more harms and social costs than those incurred by dependent drinkers' (ALAC, cited in Warren et al, 2006, p 23).

Excessive and harmful drinking for Pacific adults can result in self-harm and harm to others. This includes incidents of violence, accidents, personal relationship and work problems and neglect of family responsibilities (Globe, 2005). The most significant types of alcohol-related harm include (Ministry of Health, 2001):

- deaths and physical health problems from alcohol-related conditions
- alcohol dependence and other mental health problems
- effects on unborn children
- drink-driving fatalities and injuries
- drownings
- violence, both within and beyond the home
- workplace injuries and lost productivity.

IDENTIFYING THOSE AT-RISK

The ability to define those in greatest need enables policy-makers, programme designers and researchers to intervene where the risk of harm is greatest and target resources more effectively. Pacific people at risk have a higher probability of alcohol misuse than others, so may experience alcohol related harm. Warren et al (2006, p 12) highlight the paucity of literature on the identification of at-risk Pacific populations, and conclude that in New Zealand's general population, those with a greater probability of being at risk of alcohol misuse and exposure to harmful behaviours are young males from low socio-economic communities.

Participants at the Auckland and Wellington fono were invited to describe Pacific people whom they consider to be at risk of experiencing alcohol-related harm. Their responses were varied and did not specifically identify any population segment. They did, however, describe the causal factors that influence at-risk behaviour, as well as the symptoms associated with those who are or may be prone to being at risk.

CAUSAL FACTORS

- A range of issues impact on why Pacific people may be placed at risk including:
  - exposure to family violence
  - youth engaging in binge drinking
  - technology and media influences impacting on a person's decision-making on whether or not they'll engage in risky behaviour
  - issues to do with cultural identity
  - dissonance between the cultural ideologies and practices of New Zealand-born and Pacific-born people.
- low socioeconomic status
- disconnection from the church, which can sometimes lead youth, in particular, to engage in harmful alcohol drinking behaviour
- the culture of drinking that's associated with sporting activities
- kava misuse, sometimes owing to some people's difficulty in recognising the differences between ceremonial use and misuse
- peer pressure
- youth being unsupervised.

SYMPTOMS

- Changed/erratic behaviour, including lack of motivation and harmful drinking habits.
- People who have mental illness sometimes use alcohol/drugs to self-medicate when they're feeling depressed or angry.

SUMMARY

Pacific populations can be characterised as young and fast growing (Pantin et al, 2005), with significant heterogeneity in a multicultural and multiethnic population.

In designing and delivering relevant, effective Pacific A&D services and targeted interventions, it is critical to recognise the growing proportion of Pacific peoples born or raised in New Zealand compared with the declining number of older, Pacific-born people. The different experiences, worldviews and lifestyles of these sub-populations mean that each of these 'ethnic groups' may require a distinctively different approach.

This is increasingly likely to affect A&D-related interventions – in determining whether messages need to be conveyed in different Pacific languages, which communication channels will most likely reach target populations and the sorts of messages that will trigger behaviour changes in the target audiences.

In addition, demographic factors such as household size and composition shape lifestyles and the ways that alcohol becomes embedded in daily life. It is worth exploring the role of families and extended families in influencing the attitudes and behaviours of Pacific people in relation to A&D use; it may help to ensure that health promotion and education messages are appropriately positioned, targeted and relevant to those to whom they are directed.

The 'Looking to the Future' section of this report considers the consequences of these socio-demographic trends for the design of effective educational and treatment programmes for a rapidly changing population. It attempts to overcome a defect of stocktakes, which focus on the programmes existing at a given time and are almost invariably dated by the time they are published.

The Le Ala research team (endorsed by the steering group) believes that value can be added to this stocktake exercise by identifying trends that emerged from discussions with fono participants and treatment providers and a review of social science literature – and using them to anticipate some of the requirements of future programmes for the increasingly diverse Pacific population.

RESEARCH DESIGN AND METHODOLOGY

The stocktake comprised a document review, fono of small group discussions, in-depth interviews and a survey of Pacific service providers. Approximately 100 people from a range of organisations (see Appendices 2-4) participated in discussions and interviews on Pacific A&D services and interventions.

DOCUMENT REVIEW

The Le Ala literature review, Alcohol Community Interventions and Services for Pacific Peoples, was the primary information source for this stocktake.

Other documents and information relevant to the stocktake included:

- ALAC-commissioned draft research reports on Pacific treatment services
- evidence-based literature on A&D prevention interventions targeted at Hispanic communities in North America with similar socio-cultural-economic characteristics to Pacific peoples in New Zealand. This information was sought to fill the gaps in New Zealand owing to a lack of evidence-based interventions targeting Pacific communities
- information on approaches for evaluating health-related community interventions.

The major bibliographic databases searched included Medline, Embase, Cinahl and Psychinfo, while electronic and library catalogues included the Cochrane Database of Systematic Reviews. Websites perused were hosted by:

- the United States National Institute on Drug Abuse www.nida.gov
- The Health Communication Unit, University of Toronto www.thcu.ca/infoandresources/evaluation_resources.htm
- the Drug Info Clearing House (Australia) www.druginfo.adf.org.au
- the United Nations Office of Drugs and Crime www.unodc.org/unodc/index.html.

The search also covered relevant government reports and literature from personal collections.

LIMITATIONS

It's important to emphasise that research on Pacific A&D prevention and harm reduction is largely under-developed.

The Le Ala literature review highlighted the scarcity of information available on evidence-based Pacific A&D interventions in New Zealand and abroad. There were also no written reports available on evaluations of New Zealand Pacific A&D interventions, a fact thought to be due to the relative youthfulness of providers and interventions.

Pacific A&D services in New Zealand primarily focus on treatment interventions, rather than programmes such as health promotion and prevention. This reflects the '3%' funding formula and criteria used by the government and DHBs to buy A&D services – in which services are provided to the estimated 3% of the population with 'substantial to severe alcohol and drug related problems' requiring intensive treatment (Ministry of Health, 2001, p 3).

As a result, Pacific services and interventions favour clinical interventions. Pacific service providers report that the funding approach does not sufficiently cover holistic and cultural approaches, which they believe are necessary for effectively delivering A&D prevention programmes to Pacific populations.

ALAC has recently commissioned in-depth studies of Pacific A&D treatment services and interventions. Although these reports are not yet ready for dissemination, the drafts indicate they may address some of these issues and help in developing more appropriate programmes and refining existing ones.

GUIDE FOR EVALUATING SERVICE DELIVERY EFFECTIVENESS

The stocktake researchers initially intended developing a guide to evaluating evidence of the effectiveness (including cost effectiveness and cost benefits if possible) of service delivery related to alcohol and alcohol-associated issues for Pacific peoples.

However, feedback from informants revealed this would be difficult, as the guide's parameters required high-quality data that was not available for all the programmes surveyed.

Many service providers explained that a lack of resources already hampers treatment delivery – and that, while they recognise the importance of evaluation, they are reluctant to divert resources that might reduce the reach and effectiveness of their treatment programmes. They also don't have the specific skills and time required to instigate and administer these monitoring programmes, so would have to secure the services of those who can. In the current funding environment, there is no incentive to increase programme costs by adding evaluation components that effectively increase the cost per treatment and appear to reduce the effectiveness.

Not surprisingly, providers choose to focus on their areas of competence and depend on fairly general measures to assess the effectiveness of their work.

However, even if providers were willing to monitor their activity more systemically, improvements would be required to produce data of the quality required for effective evaluation.

There also appears to be a lack of adequate systems for storing and disseminating information. A report by Matangi-Karsten et al (2003, p 33) revealed that most Pacific NGO A&D services lacked centralised filing systems. It also noted the importance of a well developed database system for Pacific A&D services to store quantitative clinical information (e.g. demographics) and qualitative information (e.g. Pacific processes and interventions).

FONO AND INTERVIEWS

The stocktake gathered evidence from those carrying out and funding community interventions targeted at Pacific populations through:

- stakeholder dialogue at fono
- in-depth face-to-face interviews with Pacific A&D service providers
- a survey of A&D service providers.

STAKEHOLDER DIALOGUE

The 10 providers of Pacific-targeted A&D services in New Zealand known to the researchers also offer other social services in areas such as gambling and mental health. The larger services are located in Auckland, with others operating in Wellington, Hamilton and Christchurch. Most Pacific A&D services are provided by NGOs, while others are part of DHBs.

All participants in the stakeholder dialogue were asked to sign a consent form (see Appendix 8) allowing information gained from discussions to be used in this report. The responses were then tabulated to identify themes.

FONO

A preliminary meeting with two key Pacific A&D service managers in Auckland discussed the Le Ala research project and, in particular, the planned fono with key stakeholders. This approach was used to enlist the support of key sector leaders, who in turn helped with recruiting appropriate fono participants.

A preliminary meeting in Wellington was not considered necessary as there are fewer providers of A&D services there. As researchers had established relationships with most of the Pacific A&D services in the regions where fono were hosted, they were able to define and refine the fono planning informally.

After identifying appropriate target audiences to attend fono, databases from Fresh (the Le Ala project manager) and ALAC were used to compile extensive invitation lists.

Most of those targeted were close to the fono locations, although some invitations were extended to stakeholders outside these areas, including a well known Pacific A&D service in Hamilton. About 60 attended in Auckland and 20 in Wellington; all participants were split into groups with one person in each group assigned to take notes.

The fono aimed to gain information about:

- identifying Pacific people at risk of experiencing alcohol-related harm
- the effectiveness of different kinds of interventions for Pacific people.

Fono attendees were asked:

1. How do you identify those at risk of suffering alcohol-related harm?
2. What interventions are working well with Pacific people? How do you know? Why?
3. What interventions are not working with Pacific people? How do you know? Why?
4. What interventions do you think work better with Pacific people? Why?

CHRISTCHURCH MEETINGS

Comparable information (using the same questions as above) was gathered in Christchurch. Owing to it being a smaller community with fewer treatment-providing organisations, a series of face-to-face meetings/ interviews was held with providers and key informants.

IN-DEPTH INTERVIEWS

To elicit more detailed information, in-depth, face-to-face interviews were conducted with seven established and newer providers (see Appendix 4) representing a range of approaches, from throughout New Zealand. All the major providers were represented.

This approach enabled the researchers to provide explanations where required, clarify questions and explore topics in depth.

Participants came from two services in Auckland, one in Hamilton, two in Wellington and two in Christchurch (of which one had recently lost its A&D contract and the other had just started providing these services).

At least three days before the interview, interviewees were sent (by email or post according to their preferences):

- an information sheet on the Le Ala Community Action Research (see Appendix 7)
- a questionnaire (see Appendix 6), with the expectation that it would be given to the interviewer at the interview (some were emailed). Where this didn't happen, the interviewer offered to help the interviewee to complete it on the spot
- a consent form giving permission for information gained from the interview to be used in this report (see Appendix 8).

The face-to-face interviews covered the questions detailed in Appendix 5, which covered:

- the services provided
- the types of people using the service
- the methods of service delivery that work and those that don't
- any improvements the interviewee would like put in place
- the effectiveness, or otherwise, of interventions trialled or used. This included service providers' subjective impressions and objective evidence where available.

Interviewees were given the opportunity to correct any inconsistencies or omissions in the interview notes. The interview and questionnaire results were analysed to identify themes and issues. The findings are reported in the next section.

Most of the Pacific-targeted A&D service providers interviewed offer other services as well, ranging from family counselling and prison programmes to spiritual and traditional healing services. Only one Pacific service (in Auckland) provides solely A&D services. Other organisations in the stocktake provide 'mainstream' programmes/interventions for a range of clients, including Pacific people. Appendix 10 has a summary of the providers and their services.

Providers most commonly target Pacific people in their local geographical areas, including clients referred from agencies such as the Department for Courts and mental health services. The high costs of servicing larger populations effectively limit the size of most agencies' geographical coverage.

INTERVENTIONS

Defining Interventions

In its broadest sense, an intervention is 'a set of sequenced and planned actions or events intended to help individuals or groups to achieve a desired outcome' (Designing Interventions, 2006). For example, one Pacific A&D service conducts weekly counselling sessions that involve self-reflection and motivational interviewing. This aims to help clients to change their attitudes and reduce harmful drinking behaviour (outcomes).

The large gaps in knowledge of Pacific peoples and alcohol has probably influenced the approaches for minimising alcohol-related harm among Pacific communities, as they tend to be based on mainstream interventions or adaptations of mainstream interventions. These models are largely based on Western medical understandings of alcohol consumption and use, rather than on ethnic and culturally specific knowledge and experience.

The stocktake revealed varying interpretations of what interventions are and what they entail. Pacific A&D workers readily understood 'treatment intervention' from a palagi perspective, describing it as another stage of 'helping' clients and their families. However, the challenge for most lay in translating palagi treatment models and practices into a Pacific context within their work (Matangi-Karsten et al, 2003, p 14).

Types of Intervention

Generally speaking, A&D interventions (whether mainstream or Pacific) involve a combination of approaches – from detoxification-type programmes to pharmacological interventions (methadone) and counselling, psychotherapy and abstinence, for example through the Alcoholics Anonymous 12 Step programme (CADS, 2005).

They include a combination of individual, group/family and community initiatives implemented in school-based (particularly for young people) or community settings. Intervention prevention has two main approaches (Foxcroft et al, 2006, p 4):

- psychosocial interventions, which aim to develop psychological and social skills. For example, young people may be taught skills such as peer resistance to help them misuse alcohol less; or counselling may be part of a client's treatment programme. Clients experiencing psychological and physiological withdrawal symptoms may also receive pharmacotherapy
- educational interventions, which aim to raise awareness of the potential dangers of alcohol misuse so that people think twice before engaging in excessive drinking. The current ALAC harm-minimisation television advertising campaign (It's not the drinking. It's how we're drinking) is a good example of this approach.

Some researchers argue that interventions must begin with a recognition of the impacts of the socio-political

context and ethnic and cultural aspects on the community – that efforts targeting individual risk factors should be secondary, as long-term effectiveness will come from programmes focusing on community-wide needs (Beatty, 1994, p 179).

Range of Pacific Interventions

The limited information available suggests that 'an eclectic mix of palagi and Pacific treatment models' and interventions is being used for Pacific peoples using Pacific A&D services. These include individual and family approaches using a combination of Pacific and mainstream models of care.

The intervention programmes may consist of counselling sessions, music therapy (pesepesega), psychodrama, motivational interviewing, anger and violence management programmes and cognitive-behavioural therapy (Matangi-Karsten et al, 2003, p 14-20).

Pacific A&D services cater mostly for Pacific clients, although most mention working with Maori and other non-Pacific clients as well. Although no specific information was provided on clients' ethnicity, gender or age, some services delivered programmes in Samoan and Tongan. There was no detail on whether this reflected the client base or that other Pacific groups did not require language-specific programmes.

Service providers indicated that most clients using Pacific A&D services are Pacific youth and adults. The A&D-related services they use range from counselling and psychotherapy to anger management programmes. While providers did not reveal the diagnoses of those who use their services, they did comment that clients' problems had involved the misuse of alcohol and other drugs. Most Pacific A&D services provide treatment interventions, although some also implement preventive interventions.

Programme frequency and length vary – more often than not, the client and the service provider determine a programme's required length and regularity. Some counselling sessions consist of an hour per week for up to eight weeks, while others last as long as six months. Programme duration is largely determined by contract specifications and are mostly short term with some follow-up intervention. In some circumstances, ongoing treatments extend beyond the specified contracted period, but it is unclear whether the contract specifications or clients' needs determine the treatment approach.

The Effectiveness of Interventions

From the information provided for this stocktake, it is difficult to determine the effectiveness of Pacific programmes. In general, respondents commented that their programmes were effective but struggled to articulate the basis for this view. Some explained that, while they understood the benefits of systematic evaluation, it had not been done (for reasons covered in 'Limitations' on page 19.

Pacific services are unique, and have the ability to provide interventions in some Pacific languages. Pacific providers also use spiritual and traditional healing as well as counselling and psycho-educational programmes as intervention approaches. However, it is not known whether these culturally specific programmes are more effective, and why. Comprehensive evaluations of these prevention programmes are needed to establish the effectiveness more effectively.

The following sections discuss a sample of interventions employed by Pacific A&D services.

1. Interventions Provided in some Pacific Languages

Some providers deliver interventions in Pacific languages. Pesepesega – a new type of music therapy delivered in Samoan and Tongan – is run by Pacific people for Pacific people, and involves singing mostly in Samoan and Tongan in response to participants' language needs. The time spent on the programme is determined by each client's needs, with the matalafi matrix used to assess their changing needs throughout.

Pesepesega aims to improve client's wellbeing and build rapport between clients and staff, and is either mandatory or self-referred. There was no indication of the circumstances in which the programme is mandatory, but programmes are usually mandatory when a person is referred from the community probation services or by court order or directive.

The programme includes clients/staff from the Isa Lei Mental Health Service. It is funded by a DHB, but acquiring enough staff with the skills and experience to deliver it is problematic.

Approximately 40 people have started the programme and about 30 have completed it. Its newness made it difficult to determine its effectiveness, but according to the interviewee the feedback has been mixed. The interviewee rated the programme 8 out 10, where 10 is most effective. It was mentioned that the supervision part of the programme was being evaluated, but no further details were provided.

2. Psycho-educational Sessions

Psycho-educational sessions cover life skills such as communication, problem-solving, relationships, parenting skills, anger regulation, self-esteem building, violence prevention and budgeting.

Treatment involves a number of approaches, with spiritual healing and traditional approaches included as part of the healing process. Matua (cultural experts or church ministers) may be involved but treatment is normally prescribed by competent Pacific clinicians/counsellors who are familiar with and respect Pacific values and protocols.

The focus is on one-to-one sessions, with treatment lasting for the time required for the client to be able to manage life on their own. Clients are referred on to appropriate support services such as WINZ, budgeting services and career advisors as and when needed. A lack of Pacific clinicians and the inability to source Pacific-specific funding for dual diagnosis or forensic clients, or clients with co-existing disorders, has, according to stocktake participants, resulted in an inability to provide full ethnic-specific services.

These services are funded by DHBs and delivered by most Pacific providers participating in the stocktake. In a typical year, they are provided to about 200 clients, of whom half complete the programme. Most feedback has been positive.

The respondent ranked the programme at 8, with the proviso that not all treatment works for everyone and it's a two-way process. They noted that the timing of the service provision and the client's willingness/motivation are vital to recovery; if the client no longer wishes to participate, they won't gain anything from remaining in the programme.

Systematic evaluations are needed to gain feedback from those who complete the programme and gain insights into why half do not. Having such a system will also enable interventions to be adjusted to best meet clients' changing needs.

Programme providers embrace continuous improvement. This includes an internal evaluation every three months, but as is the case with most feedback in this stocktake, this information on the evaluation was not available.

3. Counselling Programme

Most provider participants deliver intensive counselling services, often focused and structured on the needs of the individual. This is different from the psycho-educational sessions described above, which are tailored to a general need.

The frequency and length of counselling sessions varied. Table 3 outlines one Pacific service's description of its eight-day counselling programme:

Table 3: Counselling Programme Example

Day	Duration of Session	Topics/Activities
1	2 hours	Introduction, Screening, Assessment
2	1 hour	Presentation, Counselling
3	1 hour	Family, Dynamics, Relationships
4	1 hour	Personal Development, Behavioural Changes
5	1 hour	Legal/Forensic History, Mental State, Evaluation
6	1 hour	Social, Relationships, Family
7	1 hour	Finance, Personal Development, Friends, Environment
8	1 hour	Summary, Conclusion, Evaluation, Outcomes

Clients are required to specify their goals (for example to be alcohol and/or drug free) and be honest to themselves and others. They also have to state the way in which they expect to achieve their goals. A form completed by the service's staff tracks progress/outcomes.

This programme is funded by the Ministry of Health and run by Pacific for Pacific, although others are welcome to participate. It has been running for 15 years, and although the exact number of Pacific people who have participated is unknown, they may number in the hundreds. Progress tracking includes a review timeframe and follow-up. Other organisations involved in the programme include:

- Alcoholics Anonymous Service
- Odyssey House
- Vincentian Centre
- City Mission
- Salvation Army.

Client feedback has been positive, and the stocktake participant rated the service 9 out of 10. They said that the Ministry of Health had evaluated the service and the outcome was positive, but this evaluation was not available to the authors of this report.

4. Alcohol and Drug Programme Together with Violence Cessation

Experience has shown the provider of this programme that alcohol and drugs are usually involved in violent episodes in some way. To address this, clients being assessed for violence problems are first assessed for A&D problems. An A&D practitioner is contracted to provide the assessment service.

The programme is not mandatory, as it's provided in addition to stopping violence programmes for which clients are referred. The entry criterion is that the client has undergone an A&D assessment that indicates alcohol and/or drug issues are present.

Pacific people who are qualified and experienced in A&D assessment and counselling run the programme. It takes 10 weeks to complete, with each client's time commitment agreed at a case planning meeting and recorded in an intervention plan. The programme was available for about three months, and a strategy is now in place to continue it, as the interviewee believed it essential for addressing Pacific peoples' violence issues.

The programme was funded by fees. Three people started it but none completed because, according to the interviewee, it wasn't mandatory. He added that some clients didn't want to commit to changing their behaviour, so stopped coming when the programme started to look at their responsibility for their behaviours and habits. No feedback was obtained because no-one completed the programme.

According to the interviewee, the programme was not cost effective in an accounting sense, but from an organisational perspective it provided a lot of information for developing the service further. The interviewee rated the programme 8 out of 10 because it challenged clients about their behaviours and whether they wanted to change. It was not formally evaluated.

This insight suggests there may be difficulties ensuring treatment completion when clients are not committed to changing their behaviour.

5. Talatalaga a Aiga Model

The Talatalaga a Aiga model was designed by Samoan workers in the Samoan language, but can be used across all Pacific groups.

Funded by a DHB, it's used for A&D and gambling counselling and is mandatory, with referrals made by a Department of Corrections probation officer. Clients are directed to the provider by the District Court, with entry criteria including an A&D assessment indicating there are issues, which may include violent behavioural concerns. Clients must be Pacific.

This programme is run by Pacific people for Pacific people. It consists of 12 sessions, held once a week for three months. At the end of the 12th session, the programme is reviewed and the client's future needs assessed. The client is followed up pending the official closing of their file.

Other organisations involved in the programme include the Salvation Army's OASIS problem gambling programme (www.oasiscentre.org.nz), the Problem Gambling Foundation (www.cgs.co.nz) and Tapa Employment Services, which is involved in helping clients to return to the workforce.

Completion rates are high. One couple with A&D issues said it was culturally appropriate and unique in comparison with mainstream services they had attended in the past. They also said it was satisfying to work with people who were skilful and had the passion to listen to and hear their stories. They had found the session empowering.

No systematic evaluation of the programme was available, which again reflects agencies' difficulties when resourcing treatment and evaluation processes. Given a choice, most practitioners and clinicians prefer to deliver services for which they are trained, rather than attempting programme evaluations for which they are not.

Stocktake participants rated the programme 8 out of 10 owing to its appropriateness and sensitivity towards Pacific people. One participant commented that the model may not work with non-Pacific people, but did not provide reasons.

INTERVENTIONS – WHAT WORKS AND WHAT DOESN'T WORK?

Many mainstreams interventions take a 'one-size-fits-all' approach that may not be suitable for ethnic groups. Their design is also often based on risk and protective factors for a generalised group of individuals. Interventions for ethnic communities need to be flexible and long term (Pantin et al, 2005 p 94).

Participants were asked to provide information about A&D interventions that work (or don't) work well with Pacific people. However, most responses were more about intervention approaches than specific interventions or programmes, and there appeared to be as many different views as there were interviewees.

Most responses were straightforward, with comments about the importance of ensuring that interventions have meaning and are easy for clients to access. This includes networking with other appropriate agencies. Participants highlighted that interventions are not effective when intervention providers are judgemental and/or disregard client confidentiality. They also emphasised that hard-line approaches, such as promoting abstinence, do not work for many people and are likely to result in their doing the opposite.

Other interventions or strategies that participants had commonly found not to work included:

- approaches that don't address family dynamics and behaviour
- models that don't consider traditional and contemporary views of Pacific cultures
- approaches that are not holistic
- interventions that don't incorporate Pacific cultural values and perspectives
- some Western models that are clinically/medically and individually focused – they do not work as well for Pacific people.

Some common themes emerged on intervention approaches likely to draw effective outcomes for Pacific communities. Most are also described and confirmed in the study conducted by Matangi-Karsten et al (2003, p 21). They include:

- family-focused approaches
- programmes that are accessible and flexible
- school-based programmes
- church-based initiatives
- approaches that integrate culture and diversity
- holistic approaches
- peer-matched programmes
- the use of media and role models.

According to participants, the following approaches would work best for Pacific people.

FAMILY APPROACHES

According to participants, A&D interventions for Pacific peoples should include families – and most Pacific A&D services incorporate family therapy in their treatment intervention programmes. Examples include parenting skills and family relationship programmes.

There is strong evidence from overseas studies involving similar ethnic communities that families act as a protective factor against A&D misuse for youth. For example, A&D use-prevention strategies for Hispanic youth stress the importance of including family because of its importance as a protective factor within Hispanic communities. Measures included in these studies included family relationships, including family connectedness, family supervision and parental attitudes toward children's alcohol use (Sale et al, 2005).

Hispanic youth (especially females) who scored highly on these measures were less likely to engage in A&D use. Family support, parental support and learning problem-solving skills were identified as key protective factors of life stresses for this group (Sale et al, 2005, p 202).

The range of family intervention programmes varied, but one study examined the effectiveness of the Parental Management Training programme among Latino youth. The programme used 'didactic instruction, modelling, role playing, and home practice to teach parenting skills in encouragement, monitoring, discipline, and problem solving'. It was adapted for the Latino community and found to be effective overall in reducing maladaptive behaviours in Latino youth (Martinez and Eddy, 2005, p 841).

ACCESSIBILITY AND FLEXIBILITY

According to stocktake participants, interventions need to be accessible and delivered in languages understood by Pacific peoples. If necessary, an interpreter should be employed. Service providers may also need to modify the formality used when addressing younger adults.

Participants suggested that for most Pacific individuals and families, transportation to and from ongoing service-based interventions could be challenging. Some offer home-based programmes as a compromise, but often these approaches are more costly to run. They suggested that intervention programmes be implemented in areas where large numbers of Pacific peoples congregate, such as schools, churches and community centres.

Participants advocated implementing intervention approaches in community-based settings rather than clinical environments. They also stated that intervention initiatives need to be flexible and delivered in small increments.

SCHOOL-BASED INTERVENTIONS

Stocktake participants stated that interventions need to begin in schools and that Pacific youth should be captured at an early age.

A recent youth study by Leger (2005, p 15) suggested that Pacific young people in the West Auckland area are in favour of school-based health interventions, for reasons such as problems at home and being among peers. They reported that, in contrast to church- or community-based programmes where confidentiality could be breached, schools offer neutrality and anonymity, particularly in relation to sensitive health issues.

However, it must be noted that interventions in this setting require parental, school and student permission. While school-based programmes appear favourable, some youth in the West Auckland study acknowledged

that a large proportion of Pacific youth drop out of school at an early age. There was general agreement that these particular people need to be targeted and involved in health intervention strategies. The Social Workers in Schools programme might provide a platform from which to develop the sorts of programme these young people advocate.

A review of school-based interventions for illicit drug use by Faggiano et al (2005, p 14) provided some evidence that those that developed individual social skills were effective. In this review, participants (students) were generally classified into a control group, which undertook the usual school curriculum, or one of three programmes:

- skills focused – aimed at enhancing students' abilities in generic, refusal and safety skills
- affective focused – aimed at modifying inner qualities (personality traits such as self-esteem and self-efficacy, and motivational aspects)
- knowledge focused – aimed at enhancing knowledge of drugs, and drug effects, and consequences.

The review and subsequent follow-up revealed that individuals within each group experienced mixed results. Although some positive results were seen in the intervention groups, they were not significantly different from the results of control group. According to Faggiano et al, methodological discrepancies rather than the interventions themselves may have been the cause of insignificant results.

CHURCH-BASED INTERVENTIONS

Stocktake participants identified church-based interventions as an approach that would work for some Pacific people. Some argued that intervention providers should use the church as a platform for carrying out the intervention, rather than the church initiating and carrying out the intervention by itself.

Educational programmes may work well for Pacific families as church-based interventions, but care needs to be taken to ensure that Pacific people who do not associate with a church have some way of receiving the information.

Wills, Yaeger and Sandy (2003, p 29) found not only that churches are a useful base for trialling and implementing interventions, but that high church attendance, and religiosity in particular, acts as a buffer for maladaptive A&D misuse. Their study found that religiosity was inversely proportional to A&D misuse among adolescents – that is, that adolescents who were more religious tended to become less involved with A&D misuse. A four-year follow-up of the study revealed the same results.

This may be an important feature when considering interventions for Pacific peoples in light of their traditionally strong association with churches and religion. Although there were no further details given, one can speculate that Pacific peoples' high attendance at church, and their involvement in church life, could be a locus for intervention implementation, as long as services were also provided for those not associated with a church.

Census data reveals evidence of a declining commitment to formal religious affiliation among Pacific peoples, as well as an increasing range of religious affiliations among Pacific youth, including non-traditional denominations. If this signals an alienation from either cultural roots or religious belief, it is unlikely that programmes delivered in traditional churches would reach these people.

CULTURE AND DIVERSITY

Interventions must be culturally appropriate – underpinned by values and norms that clients, and usually practitioners/clinicians, accept as central elements of their worldview and lifestyle.

For example, the notion of reciprocity, which features in many Pacific cultures, needs to be recognised. This means the participation and input of those involved in the intervention process must be acknowledged to gain support and make participants receptive to the intervention. Other, more simple elements for building rapport and relationships include sharing food and using humour to make serious points without injuring the parties involved.

Some participants stated it was important to acknowledge minority groups, such as gay/lesbian and fa'afafine/transgender people. These populations may be at greatest risk because they tend to be marginalised and discriminated against by the dominant society and to a lesser extent by their own communities. In response to discrimination, some become isolated and turn to drugs and alcohol.

Stocktake participants also indicated a need to focus on and engage with youth.

Effective intervention strategies must be relevant to Pacific people. Stocktake participants reported that models such as Fonofale, Te Whare Tapa Wha and Te Whaka Tua Rua (a Maori behavioural change model) are familiar and effective for Pacific people. They indicated that these models have been largely used for treatment interventions and could be transferable to other types of intervention.

Martinez and Eddy (2005, p 841) found that 'when ethnic minority students recognize themselves in the programme content, such as when their teachers or the program models a member of their ethnic group, they appear to relate more readily to the embedded messages and act to support them'.

The efficacy of intervention programmes targeting ethnic groups similar to Pacific ethnic groups is difficult to determine (Beatty, 1994, p 173). In research, ethnic communities are often 'lumped' under a blanket category that fails to recognise their diversity, including dual or multiple ethnicities. It's not clear how these groups respond to culturally specific prevention intervention studies or initiatives . However, Beatty (1994, p 176) points out that researchers have to recognise these differences and consider those caused by factors such as 'national origin, citizenship status, racial identification, cultural identification, language and self-identification'. Others say that serious gaps in the area of culture and their impacts on intervention efficacy are a concern that needs to be addressed urgently (Forehand and Kotchick, 1996, cited in Martinez and Eddy, 2005, p 841).

HOLISTIC APPROACHES

According to interviewees, inter-agency holistic approaches work best.

Intervention initiatives should integrate a range of approaches, with spiritual interventions and traditional healing included as part of the healing process. Interventions need to be applied in all areas that are significant to Pacific people. A broad, multi-systemic approach to finding new ways of coping with alcohol dependency appears to work well.

PEER/SUPPORT MATCHING

According to stocktake participants, health workers/educators should be matched where possible by gender, ethnicity and age to their clients. They also proposed Pacific peer support groups, particularly for young people, to provide safe and culturally appropriate support. According to the West Auckland youth study, young people related better to health workers of their ethnicity and age (Leger, 2005 p. 15).

In their review, Foggiano et al (2006, p 12) found that programmes about drug knowledge and attitudes administered by peers were more effective than those administered by teachers and external educators. They indicated that this difference did not arise with other youth-targeted programmes involving decision-making, self-esteem and self-efficacy. Dorr (1982) and Eigen & Siegel (1991, cited in Kulis et al, 2005, p 134) also found that when youth recognise themselves (by ethnic identity and age) in those who deliver health messages, they appear to relate more readily to the messages being conveyed.

USING MEDIA AND ROLE MODELS

Stocktake participants suggested that it was useful to use the mass media, namely television and radio, for health promotion and education programmes. This could include using Pacific languages to convey appropriate messages to the wider community. Well known Pacific role models in sports, music, the fashion industry, film and television could also be used to raise awareness of alcohol-related harm.

Story-telling via various media is another way to send targeted messages to young people.

ALAC – Suggested Intervention Strategies for Pacific Peoples

ALAC (2002, p 141) suggests a number of other strategies for reducing alcohol-related harm among Pacific peoples. These include:

- developing information resources in different Pacific languages
- ensuring all age-related alcohol health promotion initiatives (especially those targeting young people) also address the needs of Pacific peoples
- using existing cultural structures and mechanisms to promote safer use of alcohol among Pacific peoples
- ensuring Pacific peoples are fully involved in developing policies on alcohol, including control and regulation, education, treatment and research
- improving links between Pacific communities and statutory and non-statutory agencies (including churches) to ensure co-ordinated and integrated planning.

THEMES AND ISSUES

A number of key themes and issues emerged from the findings of this stocktake. They included:

- identified gaps in research and knowledge
- the inadequacy of many mainstream models for use with Pacific peoples
- Pacific youth having needs that are not currently being met
- some workforce needs not being met
- funding being generally inadequate to provide the services that Pacific people need.

GAPS IN RESEARCH AND KNOWLEDGE

Owing to the significant lack of information available about Pacific peoples' A&D use/misuse, this stocktake relies mostly on findings from key informant interviews and group discussions with Pacific A&D service providers, clinicians, practitioners and associated stakeholders. However, much of their work is treatment focused and still in its infancy.

Some aspects of international A&D prevention studies conducted in ethnic communities, such as Hispanic communities (which share similar socio-cultural characteristics to Pacific communities), are useful but not always applicable in the New Zealand context.

EVALUATION OF CURRENT INTERVENTIONS

As a number of service providers acknowledged, programme evaluation can determine the impacts of A&D interventions. However, difficulties can arise in resourcing programme implementation and evaluation. The stocktake findings indicate that it's unclear whether intervention programmes delivered by Pacific A&D services are being adequately resourced financially and with adequate expertise to undertake systematic evaluations.

However, most stocktake participants reported most interventions are evaluated in some way, even if through client satisfaction surveys. As specific details, including the outcomes of these evaluations on programme development, were not available, some caution is required when describing the efficacy of current Pacific A&D interventions.

INADEQUACY OF MAINSTREAM MODELS

In most cases, current Pacific intervention strategies are adapted from mainstream approaches. This is probably due to the lack of robust information and research on Pacific A&D programmes, which is necessary to grow innovation and inform their development. In addition, the service specifications defined by funders and planners can limit holistic and culturally diverse approaches.

The adaptation of mainstream models for use with Pacific peoples raises the question of their validity and reliability for Pacific communities. A&D prevention researchers abroad strongly advocate the presence of a substantive body of knowledge specific to the ethnic community of interest. The Le Ala literature review (2006, in press) will go some way to improving this knowledge base.

Reports from stocktake participants suggest that most providers are culturally competent. They deliver a range of A&D services using mainstream and Pacific models of care. Overall, participants claim that most programmes they deliver work well for Pacific peoples.

COMMON PRINCIPLES FOR DELIVERING EFFECTIVE INTERVENTIONS

According to Clouds (2006), a United Kingdom-based addictions treatment service provider, some common delivery principles apply to all types of treatment intervention.

However, these principles are treatment rather than prevention focused, so while some are useful as a guide, others may not apply to prevention strategies aimed at broad segments of Pacific communities. Using the data gathered and Clouds' suggestions, general principles could include:

- goal(s) – it's important that the goal(s) or purpose of the prevention strategy or intervention is stipulated from the onset. The goal(s) helps to identify the desired outcomes
- families – involving families is critical for Pacific peoples, as many belong to large, extended family units
- resources – it's essential to have adequate and appropriate resources, such as funding and staff
- culture and language – interventions need to be culturally appropriate and available in various Pacific languages
- supportive evidence – although there is a general lack of research information on Pacific peoples, it's important that as much appropriate information as possible is collected and used to guide the intervention development and implementation.

PACIFIC YOUTH

During this stocktake, it became apparent that many stakeholders consider Pacific youth a priority audience. With New Zealand-born Pacific youth comprising a significant portion of the Pacific population, participants agreed that A&D issues involving them require immediate attention.

As Pacific populations continue to grow, an increasing number of Pacific young people have two or more ethnicities. This may lead to problems with cultural identity, which may also include sexual orientation and youth culture. The need to conform with the dominant culture, together with peer pressure, can often lead Pacific young people to engage in A&D misuse and other risky behaviours. A&D interventions need to respond to the Pacific sub-population groups and strategies need to empower Pacific youth to make positive choices about A&D use.

Nothing is known about the impact of intervention strategies targeting Pacific people with dual or multiple ethnicities – or the impact of acculturation on the effectiveness of targeted intervention programmes. Other important questions that remain unanswered relate to the effectiveness of current Pacific interventions for Pacific young people and the applicability of mainstream approaches for this group. It's also important to know the factors that are most critical when developing strategies for Pacific young people.

WORKFORCE NEEDS

The lack of capacity within the Pacific mental health and addictions workforce has been well documented.

Finding suitably skilled and qualified staff trained in A&D programme delivery is challenging. Providers say that insufficient funding prevents them offering competitive pay rates – a matter of particular concern for smaller NGOs that operate on limited funding. DHB-funded Pacific services have access to the established DHB infrastructures and, in general, have consistent revenue streams.

FUNDING

Stocktake participants suggested that current funding mechanisms hinder the provision of quality interventions. Providers continually emphasised the need for more revenue to support their initiatives; additional resources could help them to design and improve their intervention evaluations, to ensure that programmes are responsive to needs and of a high standard. Focusing funding on the 3% of people with A&D issues who are the most critical makes it extremely difficult to provide interventions for the majority whose conditions are not as severe. Prevention strategies would reduce the number of those in the 3% category and could go a long way to preventing Pacific communities engaging in risky A&D-related behaviours. Present funding mechanisms do not consider the higher costs of incorporating cultural recognition into intervention programmes.

LOOKING TO THE FUTURE

One of the problems inherent in stocktaking exercises is that they are snapshots of an activity at a particular time. While they're important for both researchers scoping fields and funders seeking to monitor activity, by the time reports have been filed the reality they sought to capture has often altered and their value limited.

In addition, stocktaking exercises are so focused on the activities at the centre of their frame of reference that they can overlook important shifts occurring beyond this centre.

However, stocktakes often produce valuable insights not typically incorporated into reports because, strictly speaking, they are not part of the programme or activity they seek to capture and review. This focus on what is happening, rather than the context in which it is happening, means that the importance of the context is often overlooked.

This particular stocktake reviewed the programmes currently delivering A&D treatment and intervention to New Zealand's Pacific community, but in the process highlighted rapid changes in the Pacific community. As this has implications for the future of treatment and intervention provision, it may be as important to consider these socio-demographic shifts and their implications for both patterns of alcohol use among 'Pacific peoples' and the interventions necessary to mitigate them.

POPULATIONS WITHIN POPULATIONS

Much Pacific population health data used in public policy is not disaggregated. As a result, the population is treated as a singular entity for which singular 'Pacific' solutions may be available.

In fact, a number of studies suggest there are a number of sub-populations within the 'Pacific population' that are increasingly distinctive. The socio-demographic characteristics of Pacific populations born and/or raised in New Zealand are starting to diverge markedly from those of the older, overseas-born population – and have been for some time.

Some of these differences were highlighted early by demographers such as Richard Bedford (Bedford, 1985) and more recently by statisticians such as Cook et al in an address to the Pacific Vision Conference (Cook, Didham and Kharwaja, 2001). Entitled 'The Shape of the Future: On the Demography of Pacific People', the address identified some of the emerging differences in patterns of educational attainment, income and labour market distribution, spatial distribution and reproductive trends within these sub-populations. More importantly, the demographers pointed to the fact that these differences between the sub-populations will grow rapidly as the currently young population cohorts come of age.

These differences are not simply demographic. They are reflected in shifting patterns of ethnic identification, particularly within the New Zealand-raised population (Bedford and Didham, 2001). This increasingly diverse pattern of ethnic identification and cultural orientation reflects the increasingly disparate ethnic backgrounds of the Pacific-descent population, which are the consequences of:

- a sustained period of ethnic intermarriage between Pacific and non-Pacific people (Callister and Didham, 2007)
- the diverging cultural orientations of Pacific migrant parents (Macpherson and MacPherson, 1991)
- the changing composition of New Zealand-born Pacific peoples' personal social networks (Maingay, 1995)
- the growing number of Pacific people born, raised and educated outside Pacific enclaves (Statistics New Zealand, 2006).

All of these suggest an increasingly variegated New Zealand-born population that is on the edge of even more significant diversity.

This clearly has implications for the design and delivery of services to Pacific adults, which have in the past been designed around the needs of a population largely born and raised abroad. A series of social and demographic processes is steadily transforming central elements of what it has been to be 'Pacific' in New Zealand.

This is not to suggest that an inevitable assimilation process is occurring and that a distinctive Pacific culture will cease to exist in this country. Rather, it suggests that there will be a range of Pacific cultures and these will differ in significant ways from those of today. These shifts will have implications for the design and delivery of services currently provided to the 'Pacific community'.

The following sections identify some of the key trends and consider some of their implications.

EDUCATIONAL EXPERIENCE

The first, and arguably most obvious, difference is that the New Zealand-educated Pacific populations have been exposed to a different educational curriculum from that of migrants educated abroad and earlier.

The New Zealand-educated Pacific population has been exposed to the same public health and alcohol messages in the curriculum as other New Zealanders –earlier and in a more structured way, and under the optimum conditions for their adoption.

Since they are also fluent in the language of instruction, they might be expected to have received and interpreted these messages in much the same ways as their non-Pacific classmates – with the impact of these messages possibly greater because of:

- Pacific-born parents' widely expressed belief that formal education is the most significant vehicle for social mobility for New Zealand-born children
- the explicit support Pacific parents typically show for formal education.

As a consequence, these people's attitudes to alcohol would be significantly different from those of their parents and grandparents, and from those of earlier migrants who arrived later in their schooling and were exposed only to parts of the secondary curriculum (and in a second language).

As an increasing proportion of the Pacific population has this level and type of exposure to alcohol messages through education, their views and use of alcohol might be reasonably expected to converge on those of their non-Pacific peers rather than the current 'Pacific' patterns.

EDUCATIONAL ATTAINMENT

Levels of alcohol use and abuse rise when minority populations are excluded from or marginalised within a society. A sustained lack of educational attainment contributes to this – it's evidence of a population's exclusion or failure within the system.

In response to Pacific populations experiencing unacceptably high failure levels within the formal education system, Pacific communities, educators and the government have been working to turn the situation around.

Comprehensive educational initiatives have included the Pasifika Education Plan, which was launched in 2001 (and refined since) to provide direction for policies aiming to improve education outcomes for Pasifika peoples. The Plan's success depends on Pasifika families and communities, education services and Government working together.

Trends suggest that New Zealand-educated populations are, as a consequence of rising levels of formal educational attainment, increasingly socially mobile. The proportion of New Zealand-born Pacific students remaining longer in school has risen steadily: Pacific retention rates at 16 years of age now exceed those of the general population for both males and females and have been stable at these levels for some years, despite a buoyant labour market that typically reduces the premium associated with educational 'investment'. This translates into larger numbers entering post-school education (see Table 5) (Ministry of Education, cited in Callister and Didham, 2007).

Table 5: Proportions of Various New Zealand Population Groups in Tertiary Education (2001-2004)

		2001	2002	2003	2004
European	18 - 24	35.9	36.7	37.6	38.2
	25 - 39	12.0	13.4	14.2	15.2
	40+	3.8	4.5	5.1	5.7
Maori	18 - 24	30.8	33.9	34.2	34.3
	25 - 39	20.3	26.6	27.3	27.7
	40+	10.1	15.8	17.0	17.6
Pacifica	18 - 24	26.5	28.4	30.1	31
	25 - 39	12.0	14.2	15.7	18.0
	40+	4.9	6.3	7.0	9.4

Source: Ministry of Education

While Pacific peoples have not attained the same rates as other populations, the rates are rising steadily, particularly in older age groups. They are expected to rise both further and faster as the early generations master the system's requirements and help their children to enter and succeed in tertiary education.

An analysis by the New Zealand Institute of Economic Research (de Raad and Walton, 2007) explored the possibility that the combined effects of demographic transitions and increases in the human capital available to the Pacific population would lead to convergence with the norms for the general population. It concluded that:

> 'average incomes of Pacific people will converge toward those of non-Pacific people. But the continued influence of lower-skilled and lower-earning migrants means that real per capita incomes will remain well below real per capita incomes of the total population by 2021' de Raad and Walton, 2007: i)

However, if migrants are removed from the population, the convergence occurs much earlier owing to the greater social capital and income available to the New Zealand-born and -educated component of the population.

To the extent that heavy alcohol use reflects the stresses of marginalisation by a society or exclusion from that society, evidence of social mobility might suggest this effect will be temporary. As New Zealand-educated Pacific people attain more social and cultural capital and gain access to higher-status occupations (and the associated incomes) they might be less marginalised, with their mobility having positive impacts on the aspirations of their children and the community more directly.

The steady recent growth of a New Zealand-educated Pacific 'middle class' that no longer comprises primarily and musicians and sports people has the potential to transform the aspirations and goals of the large cohort identified earlier, because it shows that inclusion is possible. Where declining exclusion and marginalisation is associated with shifts in alcohol use, it would be expected to lead to shifts in the pattern of 'Pacific' alcohol use and a convergence with New Zealand norms.

SPATIAL DISPERSAL

People's distinctive beliefs and practices are most likely to be maintained when they live in ethnic enclaves in which these are 'normative'. A spatially concentrated population typically has the critical mass necessary to ensure that core cultural values and practices are widely and routinely performed and that these appear to be the 'normal' way of thinking and acting.

Early Pacific migration to New Zealand, widely referred to as 'chain migration', concentrated the Pacific population in a small number of such enclaves in the areas of economic growth at the time. Chain migration continues to concentrate migrants in enclaves where the first migrants established themselves until labour market conditions change. Within three such enclaves, which at various times contained as much as 97% of the total Pacific population, Pacific values, institutions and practices became established. In these 'plural' communities, values and institutions were re-established and thrived. Studies of the Samoan community point to parallel sets of values, institutions and practices supported by migrants (Pitt and Macpherson, 1974).

When populations become dispersed and form smaller entities in a larger number of centres, it becomes increasingly difficult to maintain the critical mass necessary to maintain social institutions and practices. There are fewer people to support and maintain the institutions and to enact the key social transactions that give the community its distinctive character and serve to introduce the community's children to these practices.

In these 'satellite communities', the opportunities to use language and see and engage with a full range of cultural practices decline, at the same time as opportunities to use another language and engage with other populations' cultural practices increase. For children whose parents choose, or are required, to live in these satellite communities, opportunities are likely to be constrained at an important part in their ethnic-socialisation process. This process is described in detail by a number of Pacific authors who contributed to Making Our Place Growing up PI in New Zealand (Fairbairn-Dunlop and Makisi, 2003).

This spatial dispersal is increasingly evident for Pacific populations in New Zealand. The 2006 Census reveals a concentration in the main centres, but a steadily growing number of smaller populations in regional centres. These small sub-populations may continue to regard themselves as distinctly Pacific, but may, in reality, become steadily less familiar with the patterns evident in the enclaves.

As they spend more and more time in multi-ethnic communities, their values, norms and practices (including those relating to alcohol consumption) may steadily converge with those of their non-Pacific neighbours with whom they increasingly work, worship and spend discretionary time.

LANGUAGE USE

One of the consequences of the above processes is a steady decline in the number of Pacific people using Pacific languages as first languages. This has been charted by linguists such as Hunkin-Tuiletufuga (2001) and is captured periodically in the New Zealand Census.

In the most recent Census, the number of Pacific peoples who could engage in everyday conversation in a Pacific language ranged from 71% for the most recently settled group (the Tuvaluans) to 16% for the longest-settled group, the Cook Islanders. There is a clear correlation between the proportion of a Pacific population born in New Zealand and the level of ancestral language competence (see Table 4).

Table 4: Relationship Between Proportion of Pacific Populations born in New Zealand and Pacific Language Competence. (Source: New Zealand Census of Population 2006)

Source Island	Proportion of Population Born in NZ	Proportion of Population Able to Use Ancestral Language
Niue	74%	25%
Cook Islands	73%	16%
Tokelau	69%	40%
Samoa	60%	63%
Tonga	56%	61%
Fiji	44%	29% (1)
Tuvalu	37%	71%

Note 1: this is probably because many Fijian-born migrants speak Hindi rather than another Pacific language.

If, as linguists argue, this loss rate is often exponential because parents who can't speak a language can't transmit it, it's likely that all of the Pacific languages will follow the trajectory of Cook Islands Maori unless strenuous and well designed initiatives are created to arrest the decline in the number of speakers. If this trend continues unchecked, the need to design and deliver Pacific A&D programmes in Pacific languages may decline over time.

RELIGIOUS AFFILIATION

Pacific populations in New Zealand have long had a widespread and intense commitment to Christian religion and church membership and attendance. This is said to have been important for migrants because of their longstanding commitment to Christian values and religious practices and because the congregation has replaced the island 'village' as the centre of social and political activity. Pastors are said to have become surrogate leaders, filling political leadership vacuums where other models were not available.

This centrality of Christianity and church communities has been important for social and health service delivery: many initiatives have been designed for and delivered to Pacific congregations in 'traditional' denominations. A variety of programmes, from weight management to budget services, have worked in these services for migrants and they remain valuable centres, but there are reasons to believe this situation has begun to change.

Early censuses of Pacific population revealed religious affiliation levels of around 99%. These have begun to drop as New Zealand-raised Pacific people apparently re-evaluate the personal significance of religious affiliation. Religious affiliation has dropped to 96% for Tuvaluans, 90% for Tongans, 86% for Samoans and Tokelauans, 82% for Fijians, and 70% for Cook Islanders and Niueans.

The numbers are greater for New Zealand-born and, for reasons outlined in Macpherson (2002), this number may well increase rapidly as more of New Zealand-born people come of age and make their own religious declarations in Censuses.

If this trend were to continue unchecked, the 'traditional' church could become less significant as a venue for programme delivery, and the delivery of services to church communities may be confined to older, island-born populations. This is not to suggest that young Pacific people are vacating the religious beliefs with which they were raised, but that they may be expressing these in ways that are reflected in the re-distribution of the Pacific population across a number of 'non-traditional' forms of religious community.

ETHNIC INTERMARRIAGE

Cultural beliefs and practices of all types are more likely to persist for as long as they are protected from challenges. To the extent that Pacific alcohol consumption patterns are 'cultural', they are more likely to persist while they are protected from questioning and criticism. Conversely, they are more likely to decline as they are exposed to critique and contested.

While formal education can help to change patterns in the public sphere, ethnic intermarriage can play a similar role in the private sphere. As people marry others who do not share their cultural beliefs and practices, these practices are increasingly subjected to scrutiny and may not enjoy the uncontested status possible in a marriage where both partners share them.

Pacific populations have, in the absence of any religious or cultural barriers to out-marriage, been marrying into non-Pacific populations in significant numbers since their arrival in large numbers in the 1950s. While these rates have been relatively high, they have increased rapidly in the recent past, leading researchers to state:

> the data indicate that intermarriage is much more common amongst young people suggesting that as this group ages overall rates will become higher over time. For example, among the 45 and older age group 78% of Pacific men had a Pacific partner, while for women this was 75%. But in the 15-24 age group, within group marriage rates are just over half for men (52%) and 68% for women (Callister and Didham, 2007).

Given Pacific peoples' marriages with non-Pacific peoples in New Zealand, certain distinctively 'Pacific' cultural patterns, including alcohol use practices, could shift to resemble those of the population into which Pacific people are marrying.

As New Zealand-born, educated Pacific people grow up in multi-ethnic households and multicultural communities (where they associate with more non-Pacific people and are exposed to a growing number of intermarriages), the probability of ethnic intermarriage increases. As Callister and Didham (2007) in a review of Pacific intermarriage patterns note:

> Country of birth, which can be linked to education and attitudes, but also potentially to where the partnership was formed, has a strong association with rates of intermarriage … marriage outside of the Pacific group is much stronger for those born in New Zealand.

Their data (Callister and Didham, 2007 [tables 14 and 15]) show that out-marriage rates for New Zealand-born Pacific females and males are significantly higher than for overseas-born Pacific populations, in all age groups, and that the differences were greatest in the younger age groups. This suggests, as one would expect, an increasing tendency to ethnic intermarriage among New Zealand-born Pacific populations.

With the relatively high (and increasing) ethnic intermarriage rates for Pacific populations, a number of Pacific cultural practices, including alcohol consumption patterns, would be expected to shift. And since

both Pacific men and women are marrying large numbers of Europeans, the patterns might be expected over time to converge with 'European' norms.

DRIVERS FOR CHANGE

Given all of the above social trends, the cultural patterns and practices (including those relating to A&D use) evident in the Pacific population will certainly change with time. However, they may not be noticed because, for the most part, those designing and delivering social services focus on the areas of the Pacific population in which there is most evidence of Pacific disadvantage, and the clearest need to intervene to offset this disadvantage.

Yet these changes will gain momentum as the steadily increasing New Zealand-born and -educated population comes to dominate the New Zealand Pacific population. This balance has been rising steadily since the early 1980s; by 2001, 58% of the Pacific population had been born in New Zealand and an even more significant proportion of the population had been educated here. This figure increased still further by 2006 to 68%, although this covered a range from the Niueans, of whom 74% had been born in New Zealand, to Tuvaluans, for whom the comparable figure was 37%.

This trend is apparently inevitable: immigration from the Pacific source countries has declined to around 3000 per annum over the past decade (de Raad and Walton, 2007). For both demographic and structural reasons, it's unlikely that levels of permanent migration from the region will increase. In many small island states the populations are so small that the high rates of replacement migration that would reverse this trend are demographically unsustainable; for example, the population of the Tokelau Islands hovers at around 1500 and that of Niue at around 1200. Since both of these populations are New Zealand citizens and free to migrate, we must assume that the population that remains does so because it wishes to live in the islands.

Even if a 'new' population were available in the source countries, as it is in several, the New Zealand economy is unlikely to require the skill mix available there on a permanent basis.

This means that growth in the New Zealand Pacific population will come largely from internal growth, comprising a group born and educated in this country and whose social experiences, qualifications and aspirations are increasingly likely to resemble those of the general population with whom they will increasingly marry and identify.

CONCLUSION

In general, this stocktake confirms a lack of information in most areas of Pacific A&D services and interventions.

Of particular significance is the paucity of information on A&D prevention intervention strategies for Pacific communities. Although the stocktake identified some prevention approaches being used by Pacific A&D services, most focused on treatment interventions. However, international research shows that while individual approaches are important, prevention strategies that involve communities appear to be more effective in reducing A&D use among similar ethnic groups to Pacific peoples.

Pacific A&D services deliver a variety of intervention programmes with seemingly varying degrees of success. According to A&D practitioners, a range of variables could define, and research is needed to determine, those at risk within Pacific populations.

A range of tailored intervention approaches is likely to create positive outcomes for Pacific populations – a finding that's supported by overseas studies involving other minority ethnic groups. To be effective, interventions must take into consideration holistic approaches to health and encompass culturally diverse views. Family and parental support featured strongly in literature on effective approaches for cultural communities. Although abstinence approaches may work for some, using inclusive approaches is more desirable. Some service providers say that current approaches are inadequate to meet clients' needs and this issue needs to be addressed for effective prevention interventions to be designed and implemented.

Workforce capacity and capability has a major impact on the viability and sustainability of Pacific A&D services. The lack of suitably qualified and experienced staff and the issue of insufficient financial resources are key concerns in the sector.

Further research in the area of Pacific A&D is critical. Overseas research indicates that a credible, substantive body of knowledge is necessary in order to effectively address A&D issues facing ethnic communities. This stocktake aims to contribute to building this body of knowledge.

RECOMMENDATIONS

Based on the study findings, 10 recommendations have been developed.

1. Prevention strategies need to be culturally appropriate and take into account holistic approaches to health and wellbeing. They must recognise and acknowledge diversity within Pacific communities, particularly the growing New Zealand-born Pacific population.
2. Dedicated funding is recommended for developing and implementing Pacific A&D prevention initiatives, such as educational activities aimed at preventing Pacific peoples engaging in risky drinking. Current funding approaches focus on the substantial-to-severe end of the A&D use spectrum and do not include prevention initiatives.
3. An evaluation tool is needed to gauge the effectiveness of prevention programmes for Pacific people. An agreed flexible evaluation template would probably ensure more consistency and comparability in evaluating interventions.
4. The notion of dual/multiple ethnicities and their impact on Pacific prevention strategies requires further investigation. It would be prudent to determine the critical factors that influence positive attitudes and behavioural changes relating to A&D use for this segment of the Pacific population.
5. Peers, or those of similar age and ethnicity to the target population, should administer prevention intervention approaches involving face-to-face contact where possible. The use of role models with whom Pacific youth can identify is recommended for both delivering alcohol education messages and promoting intervention programmes.
6. Service providers commonly believe that the church is an effective setting for implementing A&D prevention initiatives. However, evidence of a declining commitment to formal religion among New Zealand-born Pacific youth raises questions about this role for Pacific churches in future. Further exploratory work is needed to determine the role of churches and the approaches that would be effective there.
7. According to the study participants, community-based strategies for intervention/prevention are likely to be more effective if they begin early. This suggests that investing in alcohol education programmes targeted at those entering adolescence (for whom alcohol use is becoming a real behavioural option) may have greater long-term benefits for more people than investments in treating older adult populations with established drinking patterns.
8. Further research is needed to identify clearly those at greatest risk of alcohol related-harm within Pacific communities. A recent national study of Pacific A&D consumption suggests a correlation between high levels of alcohol consumption and the peoples of the Cook Islands and Niue. Interventions and prevention strategies that are ethnic specific rather than pan-Pacific may be needed to address these disparities.
9. A database of Pacific services and prevention programmes is needed – and its value would be greater if key comparative data were collected, e.g. numbers of participants, funding levels, number of interventions per annum and completion rates.
10. A working party comprising demographers, researchers, providers and funders needs to be convened to consider the significance of socio-demographic shifts in the Pacific population and the timing of proactive moves to anticipate and prepare for the steadily increasing numbers of New Zealand-raised Pacific young people who will start consuming alcohol in the next decade.

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APPENDIX 1 - AUCKLAND FONO PARTICIPANTS

These are the organisations that attended the fono on 8 December 2005 at Auckland's Waipuna Conference Centre. Most of the mental health and addiction services that participated brought along groups of staff. About 60 people attended.

- Accident Compensation Corporation
- Auckland Cook Islands Support Services Trust
- Auckland University of Technology
- Auckland Regional Public Health Services
- Challenge Trust
- Cook Islands Health Network
- Health Star Pacific
- Isalei, Pacific Mental Health & Other Drugs Services
- Lavea'i Trust
- Lotofale Auckland District Health Board
- Man Alive
- Massey University
- New Zealand Council for Educational Research
- Ole Lafetaga Trust
- Pacific Island Women's Health Project
- Pacific Islands Drug and Alcohol Services (PIDAS)
- Pacific Islands Family Support Unit, Starship Children's Hospital
- Pacific Peoples Addiction Services Inc.
- Pacificare Trust
- Pasifika Healthcare (West Fono)
- Radio NZ
- TaPasefika
- Tupu Pacific Mental Health & Other Drugs Services (Waitemata District Health Board)
- Waitemata District Health Board
- Whariki Family Whanau Services
- Youth Horizons Trust.

APPENDIX 2 - WELLINGTON FONO PARTICIPANTS

These are the Wellington-based organisations that participated in the Le Ala fono held on 7 December 2005 at Whitireia Community Polytechnic. Approximately 20 people attended, and some were members of the same organisations.

- Alcohol Advisory Council of New Zealand
- Cannons Creek Fanau Centre
- Capital and Coast District Health Board
- Care NZ
- Congregational Christian Church, Hutt Valley
- Child Youth and Family
- Hutt Valley DHB Community Mental Health & Addictions
- Hoe Mua
- Maninoa Trust
- Mid Central District Health Board
- Ministry of Health
- Pacific Cooperation Foundation
- Pacific Health Care
- Pacific Health Services
- Pacific Island Cultural Social Services Trust
- Radio NZ
- Taeaomanino Trust Alcohol and Drug Service
- Vakaola, Pacific Community Health Inc.
- Whitireia Community Polytechnic.

APPENDIX 3 - PACIFIC ALCOHOL AND DRUG INTERVIEWEES

PIDAS – Pacific Islands Drugs and Alcohol Services Contact: Edward Tanoi	Level 1, 11 Albion Road PO Box 22 176 Otahuhu Auckland
Tupu Pacific Island Mental Health Alcohol and Drug Services Contact: Bruce Levi	1st Floor 409 New North Road Kingsland Auckland
Pacific Peoples Addiction Services Inc. Contact: Neti Samson Cook	PO Box 19 358 Hamilton
Folau Alofa Trust Contact: Kuresa Tiumalu-Faleseuga	34 Beach Street Petone Lower Hutt
Taeaomanino Trust Alcohol and Drug Service Contact: Thomas Rima Isa'ako	Western Bay Finance Building 1st Floor, 6 Hagley Street PO Box 504452 Porirua
Pacific Island Evaluation Inc. Contact: Sala Johnson	187 Cashel Street Christchurch
Pacific Trust Canterbury Contact: Manu Sione	163 Worcester Street PO Box 13 285 Christchurch

APPENDIX 4 INTERVIEW SCHEDULE

Le Ala Community Action Research

Review of Pacific Targeted Alcohol and Drug Services

Interview Schedule

Name of Service: _____ _____ Phone: _____ Email: _____	Address: _____ _____ _____ _____
Interviewee: _____	Contact Details: Phone: _____ Email: _____
Date of Interview: _____ Time of Interview: _____	Interviewer: _____

1. Could you briefly describe the alcohol and drug services that your organisation provides?

_____

_____

2. Who are the target audiences for these services (i.e. age, gender, ethnicity, geographical location)?

_____

_____

3. Who uses the services e.g. Pacific, Maori or other, and in what numbers? (Establish whether the service is well utilised by the target audience.)

_____

_____

4. Can you give examples of positive and negative feedback from service users and/or their families about the services or interventions that you provide?

_____

_____

5. What tools or approaches to service delivery have you found work well with your target audiences?

_____

_____

6. Are you aware of any gaps in the service provision? If so, what are they?

_____

_____

7. Are there any improvements that you would like to make to your organisation's service delivery to Pacific people? If so, could you explain what these improvements might be and why you would like to make them?

_____

_____

8. Are there any other comments that you would like to make?

_____

_____

Thank you for taking part in the Le Ala Community Action Research Project. Your participation will help with the design of interventions for the project. If you would like to keep updated about the progress of the project, you can do so by visiting the Le Ala website.

We will also send you a copy of the final project report if you wish. Yes/No. (If he/she would like a copy of the final report ask where it should be sent and record the address below. Remind them that this is a three-year project.)

APPENDIX 5 - QUESTIONNAIRE FOR A&D SERVICES

Le Ala – Pacific Solutions Research Project - Questionnaire

Alcohol and Drug Interventions

One of the purposes of the Pacific Solutions Research project is to find out what interventions are effective for use with Pacific people who participate in high risk-taking behaviours relating to alcohol and drugs. We would appreciate it if you could take time to fill in the questionnaire below. The information that you provide will be very helpful in assisting with the identification of interventions that are effective for Pacific people.

Please fill in the questionnaire below, including your name and contact details so that we can get in touch if we have any questions regarding your responses. If insufficient space is provided for any question, please continue on a separate page, clearly indicating which question is being answered.

Name of Service: _____ _____	Address: _____ _____
Name of person who filled in the questionaire: _____	Contact Details: Phone: _____ Email: _____

1. Could you briefly describe an alcohol and/or drug intervention, which may be prevention or treatment orientated, that your organisation has trialled that was targeted at Pacific people?

   _____

   _____

2. Was this programme mandatory (compulsory), self-referred or self-selected? (Please clearly indicate which option applies.)

   _____

   _____

3. If the programme was mandatory, could you please indicate who the referring organisation was, how and by whom the referral was made.

   _____

   _____

4. Could you please explain the criteria for entry to the programme?

_____

_____

5. Was the programme run by Pacific people for Pacific people? Please explain.

_____

_____

6. How long did it take to complete the programme and what was the time commitment for participants? (For example, two days a week for 20 weeks, every day for two weeks or other.)

_____

_____

7. How long was the programme available for?

_____

8. Were there any other organisations involved in the programme in any way? If so, who were they, and what was their role?

_____

_____

9. Could you describe how the intervention was funded?

_____

10. How many consumers completed the programme and how many, if any, started the programme but did not complete?

_____

_____

11. Can you relay some consumer feedback that you have received about this intervention?

_____

_____

12. Do you consider the intervention to have been cost-effective? Please explain why or why not.

_____

_____

13. Is there any available documentation about the intervention programme that we would be able to see? If so could you please state the nature of the material available and how we might access it?

_____

_____

14. Could you rate the effectiveness of this intervention on a scale of 1 to 10, where 10 is most effective?

1 2 3 4 5 6 7 8 9 10

Please clearly indicate the number that you choose and explain, or make any comment in the space provided if you wish.

_____

_____

15. If an internal evaluation of the project was undertaken could you please describe the outcome?

_____

_____

Thank you for taking the time to complete this questionnaire. Your contribution will be of great benefit to the Le Ala project. Please give the completed questionnaire to the interview at the time of your interview.

APPENDIX 6 - LE ALA INFORMATION SHEET

COMMUNITY ACTION RESEARCH

Le Ala is a community-based research project aimed at reducing alcohol-related harm in Pacific communities. An action research method will be used throughout the project and collaborative relationships with Pacific peoples will be established. Through cycles of action and reflection and storytelling, people's experiences will be captured and will form the basis for developing community-owned intervention strategies.

The research will occur over three years and will include a review of literature and stocktake of current alcohol-related services. The information collected will be used to design innovative interventions aimed at minimizing harm and facilitating the safe use of alcohol among Pacific peoples.

BACKGROUND

According to research, alcohol is the most popular drug of choice for New Zealanders. Drinking and engaging in risky drinking behaviour has become the social norm and while Pacific people are the highest non-drinkers, when they do drink, they drink heavily and tend to exhibit extreme drinking patterns.

There is anecdotal and qualitative evidence suggesting that binge drinking is a preferred drinking style for some Pacific peoples. This trend is becoming more prevalent amongst New Zealanders including Pacific people.

PROJECT APPROACH

Literature Review and Stocktake of Services

A comprehensive review of the literature and stocktake of current services will be undertaken which will inform recommendations for developing interventions for Pacific communities.

Interventions

The ultimate goal of the research is to improve the effectiveness of community- based alcohol interventions or initiatives for Pacific peoples. In conjunction with Pacific communities, intervention approaches will be designed and implemented. These community-owned initiatives will be trialled, reviewed and refined for increased effectiveness.

Community/Stakeholder Dialogue - Stocktake of Services

The researchers acknowledge the diversity amongst Pacific peoples and the importance of community collaboration. Integral to the success of this project is the participation of Pacific communities and Pacific youth at various stages. Informing the community will occur in two parts.

- Part One will involve informing Pacific communities and stakeholders across New Zealand about the project. Participants will be invited to a presentation about the project and participate in discussion groups.
- Part Two will involve participants engaging in story-telling. This input and dialogue from Part One along with findings from the literature review will form the basis for designing the interventions.

Feedback and Findings

A communications strategy has been developed to ensure that information collected at various stages of the project are reported and appropriately disseminated to relevant agencies, Pacific communities and others.

EVALUATION AND ADVISORS

The project is being evaluated throughout the various stages by a team of independent evaluators. A panel of alcohol and drug sector practitioners, policy makers, community and cultural experts, and academics will also advise on the project as required.

PROJECT TEAM

The Le Ala project is led by a multidisciplinary team of Pacific researchers known as the Pacific Knowledge Consortium and managed by Fresh NZ Ltd. The project team includes:

- Dr. Margaret Southwick (Principal Researcher)
- Dr. Ieti Lima
- Dr. Cluny Macpherson (Expert Advisor)
- Magila Annandale.

If you would like more information or have any questions please do not hesitate to contact us.

Magila Annandale

Project Manager

Fresh

Tel: +64 4 472 4062
Mob: +64 27 2722656
Email: magila@freshnz.com
PO Box 25 340, Panama Street,
Wellington, New Zealand

Dr. Margaret Southwick

Principal Researcher

Dean, Faculty Health Education and Social Science, Whitireia Community Polytechnic.

Tel: +64 4 237 3103 ext 3890

Email: m.southwick@whitireia.ac.nz

APPENDIX 7 - CONSENT FORM

TITLE OF THE STUDY:

Developing participatory knowledge communities. Searching for 'Pacific' solutions: a community based intervention project. Commonly known as "Le Ala Community Action Research"

PARTICIPANT CONSENT FORM FOR INTERVIEWING PACIFIC PROVIDERS

(This consent form will be held for a period of five (5) years)

Please circle the box at the end of each statement that best describes your understanding.

I have read the Information Sheet explaining this project and have had the opportunity to have my questions about the project explained to me. My questions have been answered to my satisfaction and I know I can ask for more information at any time.	Y	N
I understand that my name, the names of my employees/employers or clients that may be mentioned during the session will not be used. I understand that I may be contacted by an evaluator at a later stage to assess the interview.	Y	N
I understand that the interview may be recorded for the purpose of gathering information for the research and these records will be held by the researchers until the final report for the project has been completed.	Y	N
I understand that the data or information collected during this project is collectively owned by the focus group participants and will agree to abide with the groups collective decision about what will happen to this material at the end of the project.	Y	N
I understand that I may be invited by the research team to participate in the "intervention" stage of this project and I agree that I will consider that request when/ if it is made. I understand that I will be asked to complete another consent form for that particular stage of the project.	Y	N

Signature: _____

Date: _____

Full Name: _____

APPENDIX 8 - SEARCH STRATEGIES

EVIDENCE-BASED ALCOHOL AND DRUG PREVENTION INTERVENTIONS

Search Strategies

Medline

1. exp substance related disorders/ (152197)
2. exp alcohol related disorders/ (71116)
3. alcoholism/ (50813)
4. (alcohol or addict$).ti. (50207)
5. behaviour, addictive/ (1576)
6. or/1-5 (173624)
7. health promotion/ (27290)
8. primary prevention/ (8458)
9. healthy people programs/ (288)
10. preventive health services/ (7630)
11. health fairs/ (342)
12. exp health education/ (92958)
13. school health services/ (9390)
14. (pc or ed).fs. (774138)
15. (prevent$ or educat$).ti. (202812)
16. “early intervention (education)”/ (636)
17. or/7-16 (927263)
18. 6 and 17 (21219)
19. hispanic americans/ or mexican americans/ (10212)
20. (hispanic or latino or latin or latina or mexican or puerto rican).mp. (32806)
21. 19 or 20 (32806)
22. 18 and 21 (298)
23. limit 22 to english (284)
24. program evaluation/ (24284)

25. “Outcome and Process Assessment (Health Care)”/ or “Outcome Assessment (Health Care)”/ (38709)
26. (evaluat$ or effectiv$ or outcome).mp. (2169478)
27. exp evaluation studies/ (575475)
28. or/24-27 (2410604)
29. 23 and 28 (86)
30. from 29 keep (selected references) (38)
31. intervention studies/ (3332)
32. 23 and 31 (5)
33. 23 not 29 (198)
34. from 33 keep (selected references)
35. 30 or 34 (53)

Embase

1. alcoholism/ (25051)
2. substance abuse/ or alcohol abuse/ or addiction/ or drug dependence/ (38780)
3. drug abuse/ (23304)
4. alcohol drinking/ (7674)
5. (alcohol$ or addict$).ti. (44269)
6. or/1-5 (101393)
7. health promotion/ (19016)
8. health education/ (19374)
9. education program/ (17447)
10. preventive medicine/ (7008)
11. primary prevention/ (6852)
12. school health service/ (1336)
13. patient education/ (20565)
14. “prevention and control”/ (154)
15. prevention/ (9882)

16. pc.fs. (298756)
17. or/7-16 (369324)
18. 6 and 17 (8221)
19. hispanic/ (2374)
20. (hispanic or latina or latino or mexican or puerto rican).mp. (12805)
21. 19 or 20 (12805)
22. 18 and 21 (114)
23. limit 22 to english (109)

Cinahl

1. "Substance Use Disorders"/ (1243)
2. Alcohol Abuse/ (1559)
3. Alcoholism/ (3114)
4. Behavior, Addictive/ (596)
5. exp substance abuse/ or exp substance dependence/ (24573)
6. (alcohol$ or addict$).tw. (13677)
7. or/1-6 (31872)
8. health promotion/ (10866)
9. health education/ (6385)
10. patient education/ or health fairs/ or school health education/ (23217)
11. student health education/ (95)
12. Preventive Health Care/ (3409)
13. early intervention/ (911)
14. (prevent$ or promot$ or educat$).tw. (134851)
15. or/8-14 (158160)
16. 7 and 15 (8006)
17. Hispanics/ (6970)
18. (hispanic$ or mexican$ or latino or latina or puerto rican).mp. (8552)

19. 17 or 18 (8552)
20. 16 and 19 (456)
21. limit 20 to english (453)
22. limit 21 to yr=1990-2006 (451)
23. Program Evaluation/ (7732)
24. exp Study Design/ (167473)
25. exp Evaluation Research/ (9411)
26. (evaluat$ or effectiv$).mp. (134606)
27. exp “outcomes (health care)”/ or outcome assessment/ (46789)
28. or/23-27 (273677)
29. 22 and 28 (260)
30. limit 29 to abstracts (255)
31. limit 29 to review (4)
32. limit 29 to research (248)
33. or/30-32 (260)
34. from 33 keep (selected references)

Psychinfo

1. alcoholism/ or alcohol abuse/ (25860)
2. alcohol intoxication/ (1702)
3. drug abuse/ or drug addiction/ (25678)
4. drug dependency/ (6331)
5. exp addiction/ (28239)
6. (alcohol$ or addict$).tw. (72512)
7. health promotion/ (4771)
8. health education/ (5300)
9. prevention/ or primary mental health prevention/ (13368)
10. preventive medicine/ (1033)

11. exp early intervention/ (5016)
12. exp drug education/ (1708)
13. drug abuse prevention/ (2057)
14. (prevent$ or promot$ or educat$).tw. (248976)
15. or/1-6 (89075)
16. or/7-14 (254487)
17. 15 and 16 (16124)
18. exp Hispanics/ (12006)
19. mexican americans/ (3695)
20. (hispanic or mexican or latino or latina or puerto rican).mp. (17605)
21. or/18-20 (19212)
22. 17 and 21 (473)
23. limit 22 to english (429)
24. limit 23 to yr=1990-2006 (372)
25. limit 24 to all journals (254)
26. exp program evaluation/ or exp evaluation/ (46319)
27. (evaluat$ or effectiv$).mp. (297621)
28. outcome$.mp. (100848)
29. or/26-28 (382031)
30. 25 and 29 (71)
31. from 30 keep (selected references)

All other sources of information were searched using simple searches according to the level of complexity supported.

APPENDIX 9 - SUMMARY OF INFORMATION ON PACIFIC SERVICES

Provider Name: TUPU SERVICES (AUCKLAND)

Target audience	Pacific clients (Waitemata city area)
Descriptions of Services/ Programmes	• Clinical services • Early parenting focus programme (P Use) • Counselling programmes (AOD/gambling) (client-practitioner gender match) • Spiritual and Cultural Awareness Programme
Description of Interventions used	• Spiritual (use of church ministers and pastors, awareness of spirituality) • Cultural identity awareness • Early Intervention - education on effects of alcohol and other drug misuse, problematic gambling • Life Skills Education
Tools Used for Interventions	• Clinical tools, e.g. DSM IV brief and comprehensive assessments • Cultural assessments and cultural consultation from cultural advisors • Spiritual models, client centred counselling models, Fonofale model, Matafili Matrix, Psychodrama, • Language interpretation and use of food/humour as part of the healing process
Perceived strengths of using these interventions	• Focus is holistic • Use of Pacific models allows appropriate rapport building with clientele • Cultural Advisors are used for consultation alongside the Psychiatrist (if there is one) or clinical team • Use of cultural assessments makes for more accurate diagnosis and therefore more accurate treatment planning and support needs • Education programmes appropriate to target populations e.g. elderly, youth, male etc
Areas for Improvement	• Need to work more collaboratively with clinical and non clinical staff e.g. care workers/CSW's • CSWs need cultural training and also clarity on their role and what that entails e.g. not just drivers for clients
Programme Evaluation	• Client Feedback (verbal)
Gaps in Service Provision	• The need for more support from DHB, as there is an expectation to do more than mainstream services, with no extra resources • Service need more FTE's as the demand is more than what can be supplied • Staff training needed for general counselling from cultural perspective

Provider Name: PACIFIC PEOPLES ADDICTIONS SERVICES (HAMILTON)

Target audience	Pacific clients (Hamilton city area)
Descriptions of Services/ Programmes	• Clinical and Cultural Assessments • AOD education • Gambling programme • Cultural and spiritual awareness programme • Violence management programme • Community probation programme • Spiritual and traditional healing services • Counselling services (client-practitioner gender match) • Prison programme
Description of Interventions used	• Psycho-education • Spiritual (biblical reference) • Therapeutic Counselling • Traditional healing (using Pacific healers)
Tools Used for Interventions	• Clinical tools, e.g. DSM IV brief and comprehensive assessments including cultural assessments • Cultural consultation from cultural advisors for traditional healing • Spiritual awareness (biblical references) • Counselling models (using mainstream counselling and therapeutic models from a Pacific perspective) e.g. Fonofale
Perceived strengths of using these interventions	• Focus is holistic • Use of cultural assessments and how issues are addressed are more appropriate for assessing needs • Cultural Advisors are used for consultation of use of traditional healing • Education programmes appropriate to target populations e.g. male prisoners, pacific etc
Areas for Improvement	• Would like to make many improvements, but have insufficient resources, including personnel to make them
Programme Evaluation	• Client Feedback (verbal)
Gaps in Service Provision	• There are many gaps but no resources with which to address them • Funding constraints don't allow service to do the work required to work with Pacific clients • Service need more FTE's as the demand is more than what can be supplied • Staff training needed for general counselling from cultural perspective

Provider Name: PACIFIC ISLAND EVALUATION INC. (CHRISTCHURCH)

Target audience	All Pacific Peoples (not excluding those wanting to use the services)
Descriptions of Services/ Programmes	• Cultural assessments • Gambling programme • Traditional healing programme • Anger Management programme • Family counselling services • Budgeting advice • Safe House (for aftercare)
Description of Interventions used	• AOD education and counselling • Gambling counselling • Anger management education • Clinical and cultural assessments • Consultation from traditional healers
Tools Used for Interventions	• Traditional and mainstream models to promote self confidence, cultural values, alofa and sense of belonging (holistic concept) • Interpreting services • Passionate staff/care givers • Pacific models of care (education and application of cultural beliefs and values)
Perceived strengths of using these interventions	• Focus is Holistic • Use of cultural assessments and analytical skills to meet client needs e.g. benefit assistance, housing, clothing • Cultural Advisors are used for consultation of use of traditional healing
Areas for Improvement	• Could do with some more volunteer workers (paid), and staff wages need improvement • More staff training in cultural skills, counselling, listening etc
Programme Evaluation	• Client Feedback (verbal)
Gaps in Service Provision	• There are many gaps due to insufficient funding

Provider Name: FOLAU ALOFA TRUST (WELLINGTON)

Target audience	Pacific peoples Lower Hutt Wellington area
Descriptions of Services/ Programmes	• Anger Management Programme • Violence Prevention Programme • AOD Support Programme • Family Support and Counselling services
Description of Interventions used	• AOD education and counselling • General counselling • Anger Management education • Violence prevention Skills
Tools Used for Interventions	• As the service is run by mostly social workers, a range of more social work type focused models are used e.g. needs analysis for housing, benefits, family assistance, Use of Pacific AOD practitioners from mainstream services etc
Perceived strengths of using these interventions	• Focus is holistic • Great attention give to social needs as well as AOD focus
Areas for Improvement	• Staff training in AOD training
Programme Evaluation	• Client Feedback (verbal)
Gaps in Service Provision	• Would like to add parenting, and family therapy services, and specific alcohol and drug programmes but lack of funding prevents more staff being employed to deliver them

Provider name: TAEAOMANINO COMMUNITY AOD SERVICES. (WELLINGTON)

Target audience	All Pacific peoples (Porirua)
Descriptions of Services/ Programmes	• Alcohol and Drug Programme • Family Support and Counselling Programmes
Description of Interventions used	• AOD Education and Counselling • Language Interpretation
Tools Used for Interventions	• Talatalaga Aiga Model • Ethnic language approaches
Perceived strengths of using these interventions	• Focus is holistic • Use of Pacific cultural assessment, and analytical skills to meet client needs
Areas for Improvement	• Staff training and development in addictions • Working more in collaboration with other AOD services
Programme Evaluation	• Client Feedback (verbal)
Gaps in Service Provision	• There are many gaps due to insufficient funding

Provider name: HINETITAMA COMMUNITY ALCOHOL AND DRUG SERVICES – HUTT VALLEY DHB

Target audience	All Pacific peoples (Hutt Valley)
Descriptions of Services/ Programmes	Mainstream Alcohol and Drug Assessment and Treatment Services (with a Pacific unit, with 1 Pacific AOD trainee worker who works with mainstream team)
Description of Interventions used	• AOD Counselling and Education • Family / significant other Involvement
Tools Used for Interventions	• Client Centred Approaches, Motivational Interviewing, Early Intervention (education and information) • Pacific models e.g. Fonofale
Perceived strengths of using these interventions	• Appropriate for client group, as they mostly are referred from courts and probation, so education and counselling suit this target group
Areas for Improvement	• Staff training in cultural approaches (only 1 pacific trainee AOD worker in the team) • Working more in collaboration with other AOD services
Programme Evaluation	• Team discussions, client feedback (questionnaire)
Gaps in Service Provision	• Lack of Pacific workers qualified in AOD Work

Provider name: PACIFIC ISLAND DRUG, ALCOHOL AND GAMBLING SERVICES (PIDAS)

Target audience	All Pacific peoples (Manukau City Auckland)
Descriptions of Services/ Programmes	• Assessments • Counselling (individual, couples, family) • Day programmes
Description of Interventions used	• Traditional Pacific methods utilised in programmes tailored for the client • Holistic Pacific approach used, and understanding of cultural identity, values, traditions and customs are acknowledged and implemented into therapy • Brief Interventions – minimal and comprehensive interventions
Tools Used for Interventions	• Cultural advice and consultation • Family / significant other Involvement • Psychosocial, cultural assessment, drug and alcohol screening • Advice and Information (harm reduction, medical model, holistic approach)
Perceived strengths of using these interventions	• Appropriate for client group
Areas for Improvement	
Programme Evaluation	
Gaps in Service Provision	

Community Action Research