Alcohol Community Interventions and Services for Pacific Peoples

Literature Review

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LE ALA

Community Action Research

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LITERATURE REVIEW

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ACKNOWLEDGEMENTS

This literature review is part of 'Le Ala', a community action research project led by Pacific peoples. Its findings and recommendations are intended to guide the development of a community intervention(s) aimed at reducing alcohol-related harm among Pacific peoples in New Zealand.

The literature search was developed and undertaken by Susan Bidwell of New Zealand Health Technology Assessment, literature search specialists and Dr Ieti Lima.

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DISCLAIMER

ABOUT LE ALA

Le Ala is a Pacific led group of researchers, clinicians and academics who are multi-ethnic, multi-lingual with an in-depth understanding of Pacific cultures and protocols. They are managed by Fresh, a Wellington based social change company. They have worked together in the past and bring complementary skills and experiences from tertiary, government and non-government sectors. The Le Ala members are located in Auckland, Wellington and Christchurch and have nation-wide networks with Pacific communities. Above all, Le Ala has a strong philosophical belief that peoples' cultural uniqueness must be respected and retained. They involve community leaders and influencers in activities so that they are able to take ownership of issues and pass the knowledge on to their communities. Le Ala endorses the notion that Pacific people should be active drivers of and participants in research that affects them leaving them empowered to determine their own realities.

EXECUTIVE SUMMARY

This literature review is part of 'Le Ala', a community action research project led by Pacific peoples. Its findings and recommendations are intended to guide the development of a community intervention(s) aimed at reducing alcohol-related harm among Pacific peoples in New Zealand.

The review involved a systematic and critical analysis of international and local, published and unpublished literature relevant and/or transferable to Pacific peoples – specifically interventions related to alcohol, alcohol-associated behaviours and other related risk-taking behaviours. It covered the effectiveness of different interventions and services among high-risk populations.

KEY RESULTS

The purpose of Le Ala is to find a practical, community-based approach to intervening on alcohol problems among New Zealand's Pacific peoples.

This literature search aimed to identify current alcohol-related interventions (in both Pacific and other communities), identify any gaps and place the Le Ala intervention project in the context of a credible field of study. Overseas literature was chosen for its relevance to ethnic and indigenous communities, covering strategies from primary prevention in schools to whole-community involvement.

The search began by reviewing historical information, to understand the relationship between Pacific peoples and alcohol before Pacific settlement in New Zealand. It then identified key information that could be considered in developing a solution-focused intervention. For example, a search of the latest epidemiological data found that alcohol consumption is now endemic in Pacific communities in New Zealand. What was once the domain of older men is rapidly being usurped by young people (including women).

The most common of a wide range of New Zealand based interventions (past and present) fell into the broad category of 'mainstream' – that is, they were unmodified or adapted programmes from District Health Board (DHB) providers. These interventions operated at the 'treatment' end of the intervention spectrum for people already identified as having problems. Unfortunately, much of this literature was descriptive rather than evidence-based.

The search revealed pockets of local innovation e.g. performance (such as dance, theatre, drama, public speaking and music) as a health-promotion strategy, and school- and church-based interventions. However, these did not focus specifically on alcohol.

The literature review also aimed to canvass potential methods for developing an innovative solution to actual and potential alcohol-related problems in the Pacific community in New Zealand.

It recognised that any intervention has to be meaningful to the people with whom it is being used – and, out of the many qualitative methodologies available, identified that 'narrative' approaches best achieve this (for more detail, see page 40). Narrative approaches enable communities to be involved in developing and 'owning' interventions designed specifically for them (rather than taking a 'one size fits all' approach). Examples include the Te Whanau Cadillac programme for Maori youth (see page 37) and the Northern Territory of Australia's 'Strengthening and Supporting Community Action' project (see page 45). Key features of successful 'narrative' programmes include:

- indigenous community control, good governance, social accountability and commitment from community leaders
- a clear set of principles and a plan and strategy, including a realistic timeframe
- clearly defined management structures and strong managerial leadership and support
- appropriate staff (including native language speakers where relevant) and staff development and support
- holistic, multi-strategy, flexible interventions
- intra - and inter-agency collaboration
- effective reporting , monitoring and evaluation procedures
- adequate resources.

CONCLUSIONS

The literature review identified the need for prevention strategies to address the growing problem of alcohol misuse (and its concomitant problems) among some Pacific communities in New Zealand. The theses, scoping and discussion papers, keynote addresses, conference presentations and other material reviewed show that alcohol has secured a firm place in the lives of many Pacific peoples, and its misuse has become a major challenge for Pacific communities.

The New Zealand Government, non-government organisations and agencies such as ALAC have undertaken research and established health services and preventive strategies to address alcohol misuse among some Pacific groups. However, more work is needed to strengthen the resources of individuals and communities being harmed by patterns of excessive consumption.

Most studies identified the need for education programmes and health-promotion initiatives to raise awareness among drinkers and the general public of alcohol's adverse effects on health and wellbeing. However, providing general information on the consequences of excessive consumption is not enough to overcome the negative impacts on the health and wellbeing of New Zealand's Pacific communities.

A solid body of national and international literature supports an alternative, innovative, community-based intervention that, through a 'narrative', story-telling approach, can successfully address issues that are culturally important to both young and old. Two 'narrative threads' – religious beliefs and commitments (identified in a Ministry of Health document [2004] as limiting the amount of alcohol drunk by Pacific peoples) – need to be explored through further qualitative investigations.

These investigations can take place through 'participatory action research– a scientifically rigorous yet reflexive method that accommodates the diverse requirements of the unique Pacific 'learning communities'.

RECOMMENDATIONS

This report recommends that a Pacific community-based intervention(s) that aims to minimise harm from alcohol misuse be designed, implemented and evaluated using participatory action research to ensure practical solutions to 'real life' problems.

The intervention(s) should:

- be culturally effective, holistic and flexible in design for diverse Pacific population groups
- be controlled by Pacific communities with good governance and social accountability
- have built-in effectiveness evaluations
- be based on the stories and 'narratives' that are integral to the life and survival of each Pacific community
- consider the range of 'harms' created by alcohol misuse in the Pacific community
- involve consultation with all sectors of the Pacific community, including church and community leaders and youth
- produce a range of strategies, from primary prevention to treatment, that successfully minimise harm from alcohol misuse.
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INTRODUCTION

OBJECTIVE

This literature review focuses on informing the Le Ala (Pacific Solutions) project and guiding the development of a community intervention(s) aimed at reducing alcohol-related harm among Pacific peoples in New Zealand.

REVIEW SCOPE

The literature review covers four key areas:

- Clinical and other treatment (with a best practice focus)
- Health promotion and illness prevention
- Community development and evaluation
- Community interventions

Its core themes include Pacific demographics and inter-generational and trans-generational diversity.

This review also critically analyses the published literature on alcohol and drug education, encompassing prior research studies, literature reviews, government policies and theoretical articles. The information focuses on education approaches designed to affect people's health attitudes, help-seeking behaviours, and knowledge of and behaviours on alcohol and drug education.

REVIEW FOCUS

While focusing on illness prevention and care for the well, the review also captures information on health care and health promotion. It includes a discussion on interventions and a brief discussion on more intensive, acute treatments. However, it does not cover clinical research on medication applications, particularly in relation to alcoholism and addiction.

'Alcohol and other drug-related harm' covers a wide range of physical, social, psychological and spiritual domains, with three levels of treatment or intervention – mild, moderate and severe. As a result, there is a large amount of literature on treatment as well as the promotion of health and the prevention of harm caused by alcohol and other drugs.

Owing to the diverse range of interventions, outcomes, settings and theories revealed, this report presents the results and key findings in a narrative, systematic review style. It includes research showing positive intervention results and programme effectiveness, and in the main excludes ineffective research results.

The general approach was to assess literature on prevention, harm reduction and treatment as it relates to Pacific peoples in New Zealand. The literature reviewed included relevant books, journals and articles, with subjects covering cross-cultural interventions, community-based interventions, relevant policy and relevant epidemiology.

Le Ala takes a 'community participatory action research approach, with the aim of increasing Pacific communities' understanding of alcohol and drug-related harm and encouraging behaviours that reduce the likelihood of harm. This approach encompasses four dimensions of wellbeing: physical, psychological, social and spiritual.

Howard (1998 p.86) notes that the four purposes of prevention interventions are usually to:

- prevent use, even if experimental
- reduce use
- encourage safer use
- provide for harm/risk minimisation

It is this continuum of intervention strategies that form the basis of the search strategy.

DATA EXTRACTION AND SYNTHESIS

This report was prepared using a systematic method of literature searching, selection and appraisal. See Appendix 1 for more detail.

CULTURALLY APPROPRIATE RESEARCH

A common theme of the literature review was the need for research to use culturally appropriate methods.

'Cultural appropriateness' and 'cultural competencies' are terms used in most Government-developed Pacific research guidelines and development strategies (Ministry of Health, 1997[a]; National Health Committee, 1998; Anae et al, 2001; ALAC, 2001; HRC, 2004; Agnew et al, 2004; Social Policy Evaluation and Research, 2005).

Cultural appropriateness is also covered in a number of publications such as Bell (1998), who refers to a study on diabetes mellitus and coronary heart disease carried out with three Samoan church communities in Otara, Glen Innes and Glen Eden in Auckland. He states that one of the most effective ways to ensure that future community-based prevention programmes will empower Samoan communities is to provide culturally appropriate programmes. Bell argues that such programmes are likely to enable Samoan people to adapt better to the modernising environment.

Other studies with different Pacific ethnic groups also highlight the importance of using culturally appropriate research methods that recognise Pacific cultures and protocols. These include Aiolupotea (1994), Gray (2005a) and Nosa (2005).

REVIEW LIMITATIONS

Although this review has used a structured approach, it has some limitations – primarily the lack of available published (and more importantly unpublished) evidence-based literature.

The reviewers made every effort to use a wide network of contacts to identify material that does not exist in the public domain. Inevitably, individual works may have been missed and others may have been embargoed at the time and therefore could not be included. In addition, some local initiatives (e.g. ALAC's host responsibility programme for Pacific peoples and its performance as a health-promotion strategy) are only described as they have not been formally evaluated. The same problem applies to international examples, with ample descriptions of intervention strategies but very little information on outcomes.

Another limitation is that only using literature written in English may have led to an indeterminable bias. Another apparent bias is created by the prevalence of literature by and about the Samoan community. This may be due, in part, to the number of Samoan people living in New Zealand – the 2001 Census (Statistics

New Zealand, 2001) reveals that they represent nearly 50% of the Pacific peoples living in New Zealand, compared with 22% from the Cook Islands, Tonga 17%, Niue 8%, Fiji 3%, Tokelau 2% and Tuvalu 0.85%.

Finally, there is a scarcity of literature on:

- alcohol-related injuries among Pacific people
- the identification and definition of Pacific populations 'at risk' for problem drinking
- Pacific peoples and alcohol-related harm
- problem drinking as it relates to intra-familial, intercultural and trans-generational family relationships.

Articles were initially selected by examining the abstracts, but to minimise the possibility of inappropriately excluding material, full text articles were retrieved where detail was ambiguous or lacking.

It is important to note that a literature review is always a work in progress; this document is a snapshot of the most comprehensive material available at the time.

BACKGROUND

PACIFIC APPROACHES TO INTERVENTION WITH ALCOHOL AND DRUG PROBLEMS

There have been a number of concepts and models developed to try and help Pacific and mainstream services offer a more culturally appropriate response to people presenting with alcohol and drug related problems:

The Fa'afaletui concept (Tamasese et al, 1997), which relates to the weaving together of knowledge from within the houses of relational arrangements

The Samoan Fonofale model, which takes a holistic view of health and recognises that Samoan people's health is best nurtured within the social context. Based on Pacific perspectives, it proposes that "the mental health of Pacific people is intrinsically bound to the holistic view of health… and… greater application of Pacific health models is required including establishing and maintaining links between mental health primary health and social services" (Mental Health Commission, 2001 p.6). The model has been used and accepted in the mental health sector for almost 20 years (Bathgate and Pulotu-Endemann, 1997; Annandale and Instone, 2004).

Although these models do not substantially differ in their generic ethical considerations, they do emphasise the value of Pacific communication nuances, cultural engagement processes and core values.

Some believe that a cross-sectoral, multidisciplinary approach is helpful for understanding the complexity of human behaviour in relation to alcohol and for effective interventions. It is also thought that the evidence of harm-causing behaviour involving alcohol and drugs, and other high-risk behaviours associated with Pacific peoples in the New Zealand context is symptomatic integration in mainstream culture. However, there is little knowledge evidenced by robust research among Pacific communities (MacEwan, 1999; Siataga, 2001). In general populations, a large amount of research is oriented towards genetic, environmental and learned behaviours in relation to alcohol dependence and related harm (Stewart, 1997).

IDENTIFYING AT-RISK PACIFIC POPULATIONS

There are significant research gaps in the identification and definition of 'at-risk' Pacific populations and the extent of problem drinking in the wider socio-economic context.

PROBLEM DRINKING AMONG PACIFIC PEOPLES

Problem drinking has been broadly defined as "any use of alcoholic beverages that causes damage to the individual, or to society or to both" (Heather and Robertson, 1997). Thorley (1985) suggests that drinking problems arise from three types of consumption:

- Regular excessive consumption.
- Dependence.
- Intoxication.

This, by implication, suggests that everyone who consumes alcohol, including Pacific peoples, is potentially at risk from alcohol-related harm. It can be concluded that it is important to determine what constitutes 'most at risk' in developing effective, targeted interventions.

Little is known about Pacific peoples' vulnerability to alcohol, but in general populations being male, young and from low socio-economic communities puts people at a high risk of alcohol misuse and consequent harm. ALAC (2000), and Casswell and Gordon (1984) suggest that resiliency also needs to be explored to understand the impacts of adverse circumstances on at-risk behaviours and alcohol.

Two pieces of doctoral work (Lima, 2000; Nosa, 2005) try to explain alcohol misuse and its consequent harms in identified communities. However, as qualitative pieces the validity of their claims rests on the 'density' of the data gathered rather than statistical significance. When in-depth information from a fewer number of people is the goal, sampling continues until a point of 'data saturation' is reached i.e. "no new information is forthcoming" (Patton, 1990). According to Patton, under these circumstances, "the validity, meaningfulness and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected… than with the sample size."

Heather and Robertson (1997) present a comprehensive discussion on the socio-historical politics of alcohol production, consumption and treatment. They analyse the disease model versus social learning models, with consumption elimination as part of a harm-minimisation continuum rather than as the underlying ideology. They compare a 'civil liberty' argument on the rights of choice and social demand with the disease model of alcoholism, which redirects responsibility to a deterministic physical element believed to exist in an 'unknown' proportion of the population. They also comment on a belief that much of the harm related to alcohol consumption can be ameliorated through proper education programmes.

SAMOANS' AWARENESS OF ALCOHOL'S ADVERSE EFFECTS

A pilot study of Samoan people's awareness of the effects of alcohol on health and wellbeing finds that many have very little knowledge (Lima, 2000). Opinions of both participants and key informants are divided across generational and, to a lesser degree, gender lines. While older participants, mostly born and socialised in Samoa, express concerns that younger people are not adequately informed of the effects of excessive alcohol consumption, younger participants argue they are more aware and, indeed, better informed than older people.

The contention that older Pacific people are more likely to drink irresponsibly is promoted mainly by younger participants, but also supported by three older Samoans. An older man, who drinks, demonstrates an acute awareness of the detrimental effects of alcohol on Samoans and other people. He cites the example of Pacific people, mainly men, who end up in court for a range of charges as a consequence of alcohol abuse:

> When the husband goes to drink he would come home drunk and invariably, would bring up a family issue that may have been bothering him for some time. Often that would result in domestic violence, beating up the wife and quite often, the children cop the brunt of the beatings and violence. Samoan people seem to be more susceptible to domestic violence than other Pacific ethnic groups. Some get into fights or beat people up and consequently, end up in prison, even death (Lima, 2000 p.23).

Two older New Zealand-born women also suggest that older Samoan drinkers are more inclined to drink irresponsibly. One says that there are:

> …heaps of women who at some stage in their lives had drunk irresponsibly, or who will go out and drink with the idea of having a good time which really means going out and really drinking (Lima, 2000 p.36).

A New Zealand-born, abstaining Samoan mother of six young children says she is not a great believer in alcohol, and argues that it is not good for children to be around alcohol. She says she has tried alcohol and doesn't like it. She adds that she doesn't like her husband drinking, and that his drinking isn't helped by the fact that all his brothers drink at home "from morning to night nearly every single day" (Lima, 2000 p.27).

A younger, New Zealand-born participant with Samoa-born parents who came to New Zealand more than 30 years ago demonstrates a clear awareness of the detrimental effects of alcohol abuse on his family and his father's health. Of his father he says that drinking:

> …has affected his health four or five times and still he hasn't changed his attitude towards drinking (Lima, 2000 p.21).

He adds that his father:

> …has got liver problems, kidney problems, everything. I've seen my father do bad things to my mother, I've seen my uncles do the same to their wives and stuff like that (Lima, 2000 p.21).

He also says that he has seen his father in situations where he would almost sacrifice the family mortgage just to ensure that money was available to drink.

The contradictory perceptions of older and younger people of the adverse effects of alcohol is reflected in the findings of a needs assessment of alcohol resources for Pacific peoples (Pacific Islands Drugs & Alcohol Services [PIDAS], 1998). The participants in the study, all over 30 years of age, profess that Pacific peoples have negligible awareness of alcohol.

The PIDAS report suggests that before encouraging and promoting concepts such as host responsibility, the Pacific community "needs to be informed not only about the role that alcohol plays in creating social and familial problems, but more particularly its effects on their bodies and their health" (PIDAS, 1998 p.29).

NIUEANS AND ALCOHOL

Nosa (2005) conducted a study of Niuean drinking patterns and notes that when Niuean men get together to consume alcohol:

> …groups are usually made up of male family members or close male friends. Sometimes men from other ethnic groups are also invited to attend, but women and young children are usually excluded (Nosa, 2005 p.86).

Nosa adds that:

> Niuean men drink with those they trust. When drinking with other Niuean men there are certain rules or codes of practice enforced within a drinking group. Drinking groups usually consist of male friends or male family members. Looking after one another is a paramount factor as is the issue of safety. Strong friendship ties are also formed and maintained if there is a sense of loyalty (Nosa, 2005 p.87).

Nosa notes that Niuean men have distinct styles and places of drinking:

'Boot drinking', happens when men drink outside, beside or inside their cars. They usually drink at a slow and casual pace, and becoming drunk is not necessarily the aim. In this environment, violent or aggressive behaviour rarely occurs

'Garage drinking' happens when men gather to consume alcohol in a garage or shed. It is referred to as a 'piss up' or 'drink up' and the main purpose is to consume alcohol.

In these contexts:

> …drinking continues for long periods of time and sometimes fights occur fostered as the result of heavy drinking (Nosa, 2005 p.88).

Women do not take part in boot or garage drinking, a gender demarcation also mentioned by Gray (2005b), who highlights the important role of supportive friends within women's drinking circles compared with the cultural and gender restrictions of male drinking. Gray finds that Niuean women prefer drinking socially with other women, arguing that this ensures safety within the drinking environment. Gray also notes that older women face limitations surrounding drunken, disorderly behaviour and that women tend to be more aware of cultural boundaries (Gray, 2005b).

These two studies and the national survey of Pacific peoples' alcohol and other drug and gambling consumption (Ministry of Health, 2004a) show that Niueans are one of the Pacific groups most at risk from drinking and alcohol-related harm. As such, they should be considered for inclusion in Le Ala as an ethnic group.

Nosa (2005) and Gray (2005b) both find Niueans to be reluctant study participants. Nosa notes that "Niuean people are often reluctant to help other Niueans, even family members". He believes this may relate to

Niuean people's reluctance to share knowledge because of 'fulukovi' (selfishness), which he suggests may be a cultural trait or have an established history within the Niuean community (Nosa, 2005 p.59). Gray says that as a younger Niuean woman researcher, she found it difficult to recruit older Niuean-born women for her study. This insight points to two paradoxes:

- While Niueans may be at most risk from alcohol-related harm, there is less information that might be used to construct culturally informed and sensitive interventions
- While the Niueans may benefit most from interventions, they may be less inclined to participate in their design and implementation.

THE IMPORTANCE OF LANGUAGE

There is much international literature on the importance of language in expressing and shaping societies. Darder states that:

> Language constitutes one of the most powerful media in transmitting our histories and social realities as well as for thinking and for shaping the world (Darder, cited in Hunkin-Tuiletufuga, 2001 p.10).

Hunkin-Tuiletufuga (2001) highlights the importance of Pacific languages "in the formation and maintenance of Pacific identities within New Zealand" (p.196) – and in an examination of Pacific languages and identities in New Zealand, argues that maintaining Pacific languages is critical for the retention of Pacific cultural identities in New Zealand.

> The way we perceive the world, and our place in the sun, is determined very much by the linguistic values placed upon our cultures by our languages (Hunkin-Tuiletufuga, 2001 p.200).

Hunkin-Tuiletufuga also notes that bilingual education, together with the influence of the Samoan language on identity and self-esteem, has positively affected Samoan students, especially those born in New Zealand.

In the area of health, the Public Health Commission (1995 p.11) believes there has been an "identified failure or inability… to access health services due to language problems". In an effort to improve health service delivery to Pacific peoples in New Zealand, the Ministry of Health developed a "package of health strategies that belong to Pacific people and reflect their needs and their initiatives" (Ministry of Health, 1997a p.iii). The related document, titled Making a Pacific Difference: Strategic Initiatives for the Health of Pacific People in New Zealand, was:

> …developed by Pacific people to enable policy makers, the funders and providers to respond appropriately, effectively and efficiently to health needs of Pacific people (Ministry of Health, 1997a p.1).

The Pacific Health Strategy's principles for action in developing and delivering health services for Pacific peoples includes the need for "community involvement" and the importance of "workforce development" that reflects Pacific consumers' linguistic and cultural backgrounds. To that end, it says:

> …the health sector needs to openly value the linguistic and cultural skills of its workforce and to acknowledge this during the recruitment and training of staff at all levels of the health system (Ministry of Health, 1997a p.22).

While the use of Pacific languages when researching Pacific communities, and the possession of linguistic skills, have been advocated as necessary attributes for Pacific health workforce development, a recent study indicates that a person's inability to speak or understand a Pacific language can lead to discrimination and condemnation. Poutasi's (1999) study, which explores the impact of the inability to speak Samoan on Samoan women's identity, shows that all of the six Samoan participants had experienced discrimination and insecurities owing to their inability to speak the language. Poutasi notes that because some of the women were unable to speak the language they:

> …were subjected to ridicule and condemnation, not only from friends and acquaintances but especially from within the family (Poutasi, 1999 p.19).

Poutasi adds that the women, all of whom were born and raised in New Zealand and had varying degrees of Samoan language ability, felt "less" Samoan because of the belief that "to be a Samoan, means knowing the language" (Poutasi, 1999 p.25).

These observations on the increasing differences in Pacific language fluency within Pacific populations points to the importance of establishing interventions that address them. For example, fluency is declining in New Zealand-born populations, a loss that seems to have happened more quickly in some groups than others (Hunkin-Tuiletufuga, 2001). This has obvious implications for intervention design; while Pacific language-based programmes may be appropriate, and indeed essential, for migrant sectors of the Pacific population, mixed-language or English programmes may be more effective in others.

ALCOHOL AND YOUTH

Although New Zealand has a normative culture of alcohol consumption, young people between the ages of 15 and 20 years consume, on average, 70% more than the general population (ALAC, 2005).

According to ALAC Chief Executive Dr Mike MacAvoy (ALAC, 2005) 50,000 12 to 17 year olds are uncontrolled binge drinkers, with a further 75,000 binge drinking at social events.

As the years of adolescence are a time of change, understanding youth development is vital to working with youth and working in the youth health sector. For this reason, information on adolescence is included below.

HUMAN DEVELOPMENT AND ADOLESCENCE

Adolescence is a period characterised by risk taking and the increasing importance of peers in influencing life decisions. However, it is important to note that physical changes, including pubertal, cognitive and psychosocial developments, may not happen in a particular order (Juszczak and Sadler, 1999).

Much research has been undertaken on human development and adolescence. In New Zealand, it focuses on achieving identity status and understanding the ages and stages of developmental changes.

Tupuola's (2004) research questions master narratives in developmental theory, which tend to dominate Western perspectives of personal development. She suggests that Samoan women experience heterogeneity and multiple subjectivities, which raises critical questions for development theorists. In short, she argues for more complexity in understanding human psychological development and in avoiding the tendency to tag development to fixed age-stage theories. She also suggests that some criteria for addressing age-appropriate approaches are essential for targeted prevention.

PEER PRESSURE

According to Lima (2000), peer pressure is a critical component of drinking behaviour, particularly among young people. A pilot study of Auckland Samoan people's awareness of the effects of alcohol on health and wellbeing found that some young participants reverted to drinking alcohol (and smoking) as a way of coping with the stresses of student life and peer pressure. Participants also stated that pressure from parents and adults to perform well added to the pressures of student life.

Matatumua's early study of Pacific peoples' alcohol use in New Zealand (1969), examines the acculturation process and attitudes of migrant Samoans living in Dunedin. Matatumua suggests that on arrival in New Zealand, Samoans were more likely to consume alcohol because it was the custom of their associates. Nosa (2005) suggests that peer pressure may have prompted migrants to drink in order to be accepted as "one of them".

The apparent importance of peer groups in encouraging drinking behaviour also suggests the possibility of using the same social phenomenon to discourage certain forms of drinking. Larson (1998), commenting on UNICEF's presentation at the 1998 Pacific Spirit Conference in Auckland, suggests it is important to consider ways to use peer pressure to have a positive influence when designing health-promoting strategies. He says that providing peer support to help young people drink less or slow down could be a valuable start and gives "friends don't let drunk friends drive" as an example of a campaign building on the notion of positive peer support (Larson, 1998).

THE HISTORICAL CONTEXT

Alcohol is not a traditional part of the Pacific islands' culture. It was introduced to the Pacific by Western visitors such as whalers, traders and sailors, and rapidly adopted by Pacific men (ALAC and Ministry of Health 1997a). Migration provided a second channel for introducing alcohol to Pacific peoples (Ministry of Health, 1997a), with migrants adopting the customs and practices of their host society. Their patterns of alcohol use paralleled those they observed in their new environment.

Research is limited on the underlying reasons for these patterns in Pacific communities. In studying Polynesia's cross-cultural drinking pathology, Lemert (1979) studies drinking patterns in the Society Islands, Cook Islands and Western Samoa and finds them to be 'integrative' or 'disintegrative' This former includes drinking as a pivotal mechanism of social integration, and the latter a symptomatic response to conflict-producing situations of extraneous origins. Lemert notes the lack of alcoholism in the sense of 'addictive drinking', with personality changes and serious organic pathology among full-blooded Polynesians' traditional (ceremonial) drinking patterns across cultures (ALAC and Ministry of Health, 1997b).

A study of alcohol consumption among Tokelauan migrants to New Zealand in the 1970s (Stanhope and Prior, 1979) reports modest consumption among men compared with the New Zealand national average. The authors note that while drinking is uncommon among women, there is a trend of increasing prevalence and quantity. Overall however, they are hopeful that such alcohol consumption in migrant populations "may provide the basis for encouraging continuing prudence regarding alcohol and ready acceptance and provision for the non-drinker of alcohol" (Stanhope and Prior, 1979).

In a more recent survey of Pacific peoples' drinking patterns, Siataga (2001) suggests a complex range of factors behind some Pacific people drinking to a degree that is detrimental to their physical, mental, social, economic and spiritual wellbeing. These include lack of awareness of alternative lifestyle choices and of strategies that include abstinence, moderation and host responsibility. Other factors include sub-cultural and generational drinking patterns, poor communication in families, and interpersonal stressors.

The degree to which marginalisation experiences are different for New Zealand and overseas-born Pacific peoples is unknown. Compared with migrants, the locally born have different social networks and are connected in different ways with the 'hegemonic' mainstream Palagi society. Given that significant numbers of people are now locally born, it is reasonable to expect their life stories in relation to alcohol to also be significantly different.

Until recently, there has been limited data on hazardous drinking among Pacific peoples in New Zealand. The Ministry of Health survey Taking the Pulse: The 1996/97 New Zealand Health Survey (1999) sampled 645 Pacific peoples using an Alcohol Use Disorders Identification Test (AUDIT) questionnaire as part of a national survey of 7862 adult New Zealanders. The findings from the Pacific sample were summarised as:

> Pacific people... were most likely to report not drinking any alcohol in the previous year; however, Pacific drinkers also tended to drink more on a typical day when drinking than European/Pakeha drinkers.

Lima (2004) identifies a paucity of research on the effect of alcohol on the health of Pacific peoples living in New Zealand. The existing literature includes Gray's (2005) exploration of the place of alcohol in the lives of Niuean women living in Auckland, Neiche and Park's (1988) study of some Auckland Samoan women's perceptions of the effects of alcohol on their lives, and Graves et al. (1979) examination of the ethnic differences in alcohol consumption patterns among Maori, Palagi and Pacific islanders at public bars in Auckland.

Another more recent study is a qualitative exploration of the place of alcohol in the lives of Pacific peoples (ALAC and Ministry of Health, 1997b). Two smaller pilot studies, commissioned by ALAC in 2000, examine Samoan and other young Pacific peoples' behaviours and attitudes towards alcohol, and their awareness of the effect of alcohol on health and wellbeing (Lima, 2000; Siataga, 2000).

THE PICTURE TODAY

More recent data on Pacific peoples' drinking can be found in the Pacific Drugs and Alcohol Consumption Survey 2003, conducted for the Ministry of Health by Pacific Health Research and Development Services Ltd and SHORE/Whariki (Ministry of Health, 2004). On the positive side, the report states that Pacific people are:

- more likely to be non-drinkers (46% of Pacific peoples compared with 19% of all New Zealand adults)
- less likely to have been early starters (32% of Pacific people did not start drinking more than the occasional sip until they were 20 years old compared with 28% of all adult New Zealanders)
- less likely to be regular drinkers (33% of Pacific people drink at least once a week compared with 56% of all adult New Zealanders).

However, when Pacific people do drink, they drink more heavily. They are more likely than Pakeha to have drunk more than 10 glasses on the last drinking occasion (six standard drinks is the upper limit of responsible drinking for men on any one occasion, and four for women). Annual consumption is reported at 6.9 litres of absolute alcohol for the general population, while the Pacific sample averages 20 litres. Broken down by gender, Pacific men drink 27 litres of absolute alcohol per annum while women drink 13 litres. As with the general population, most drinking takes place in the home or at someone else's home.

Although men are more likely to drink alcohol (61%), drinking among women is increasing rapidly, with 51% reporting drinking alcohol. A breakdown by island group shows that Cook Islands Maori youth (13-29 years) and women in each age bracket and Niuean women in the 30 to 65-year range are more likely to be drinkers than they were previously. Samoan women drink less in all age categories. Given the increasing prevalence of alcohol consumption among Cook Islands and Niuean women, they could possibly be singled out for targeted interventions.

According to the same survey, Pacific people tend to have extreme drinking patterns. On the basis of their beliefs, attitudes and behaviours towards alcohol, New Zealand's adult Pacific population (18-plus years) can be divided into four groups:

1. Don't drink at all ('non-drinkers').
2. Are aware of how much they are drinking ('conscious moderators').
3. Are unable to drink as much as they would like to for a variety of reasons ('constrained binge drinkers').
4. Have no restrictions on their drinking ('uninhibited binge drinkers').

The two key reasons given for abstaining or for limiting the amount of alcohol they drink are "religious beliefs" and "commitments".

Pacific peoples in New Zealand drink in a social environment where alcohol consumption is the norm (only 19% of the general adult population in New Zealand are currently non-drinkers) – 74% partake in heavy

and risky drinking at least once in their lives and 36% within the past two weeks. This 'binge style' drinking pattern "results in more harms and social costs than those incurred by dependent drinkers" (ALAC, 2005). The 'harms' include:

- Injuries resulting from accidents or fights
- Problems with relationships because of alcohol
- Problems at work
- Neglect of family responsibilities
- Embarrassment from indulging in non-usual behaviours.

These harms are all associated with excessive per-occasion consumption (ALAC, 2005).

ALAC is developing a long-term strategy to help Pacific communities work with their families to reduce harm. It is based on three key objectives:

1. Enabling New Zealanders to make the connection between risky per-occasion consumption and the resulting social and physical harms.
2. Showing New Zealanders that they might be at risk of contributing to that harm and that there is something they can do about it.
3. Persuading New Zealanders to drink differently so that harm does not occur.

On an individual level, ALAC aims to "sell to the New Zealand drinker the notion that we have to reduce the amount of alcohol we drink on a single occasion" (ALAC, 2005). However, ALAC acknowledges that advertising alone will not work, so has developed an integrated programme of complementary strategies that includes:

- achieving better compliance with, and enforcement of, the Sale of Liquor Act
- controlled purchase operations to identify breaches of the Act
- parents' programmes
- policy measures relating to issues such as tax/price, outlet density, advertising and purchase age
- community programmes and strategies that focus on dependent and hazardous drinkers.

KAVA

A 1980s' study of 'Kava, alcohol and tobacco consumption among Tongans with urbanization' (Finau et al, 1982) found different consumption rates between urban and rural Tongans. Kava consumption was an almost exclusively male activity and was significantly higher among rural males (48%) than urban males; only 1% of women reporting drinking kava. At the same time, alcohol consumption was almost exclusive to the urban male population, with only 1% of rural men consuming it. The authors noted that "kava, a traditional Pacific beverage may have lost ground to alcohol as urban Tongans adopt a more cosmopolitan life style" (Finau et al, 1982). At that stage it was suggested that if kava proved relatively harmless, it might be promoted as a "less unhealthy" alternative to tobacco and alcohol.

Nearly 20 years later, in a 2003 survey of drug and alcohol consumption among Pacific peoples in New Zealand (Ministry of Health, 2004), just under a quarter of Pacific respondents reported ever having tried kava., with 8% of that sample having drunk kava in the previous 12 months. Although overall kava consumption had reduced from the 1980s' study, it was still predominantly a male activity and more prevalent in the Tongan community.

Cook Islands Maori and Niuean men were less likely to have ever tried kava and less likely to have drunk kava in the previous 12 months. Pacific respondents who did drink kava did so more than twice a week, with the most common location being the 'kava club' (followed by 'home' and ceremonial festivals).

ETHNIC DRINKING BEHAVIOURS

A recent study by Nosa (2005) on Niuean people's drinking and the use of alcohol among Niuean men in Auckland, and a study by Gray (2005b) on the drinking behaviours and attitudes of Niuean women in Auckland, highlight growing concerns about alcohol use among Niuean people in New Zealand.

Gray states that while some Niuean women experience negative behaviour around alcohol consumption, particularly when their safety is threatened, it is seen as a way of socialising, having fun, being happy and feeling safe, primarily when drinking with other women. Similarly, the Niuean men in Nosa's study indicated that consuming large amounts of alcohol and drinking "to get drunk" were the "Niuean way" of drinking. For most men, drinking to "get drunk" was the main reason for consuming alcohol (Nosa, 2005 p.83).

A Ministry of Health (2004) report identifies a pressing need to address Niuean alcohol use in New Zealand. Comparing ethnic subgroup differences within the total Pacific sample in a national survey on the use of alcohol and other drugs and gambling, it finds that "Niuean respondents aged 30-65 years, and in particular, Niuean women, were more likely to be drinkers" (Ministry of Health, 2004 p.20). The report also finds that Niuean women are more likely to drink at their workplaces. However, compared with their peers in the Pacific sample, Niuean women are less likely to be involved in an accident causing injury or major damage (Ministry of Health, 2004 p.22).

ALCOHOL AND MOTOR VEHICLE CRASHES

According to Holder (2003), drink/drive crashes are those in which at least one driver involved in the crash has been drinking. They have three categories: non-injury crashes, injury crashes and fatal crashes (in which at least one person is killed).

As the likelihood of being involved in a traffic crash is greater when a driver has been drinking and the cost (economic and social) of such crashes is high, this is an important indicator of alcohol-related harm (Holder, 2003). Although there is a dearth of information on drink/drive crashes in the Pacific community specifically, it is worth considering the available peripheral material.

APPROACHES TO ENGAGING THE PACIFIC COMMUNITY

Any community-based intervention that aims to minimise harm from alcohol misuse in the Pacific population living in New Zealand has to connect with these communities in ways that are meaningful to them.

This happens on several levels, beginning with the method of engagement. It is also important to consider forms (e.g. narrative inquiry) and sites (schools and churches) of communication. Literature on these is considered below.

PARTICIPATORY ACTION RESEARCH

According to Glaser (1998 p.45), "the choice of an appropriate method is in the eye of the researcher. Until recently, the Western scientific method has been viewed as the major and only valid and reliable way to approach knowledge and understand people." It focuses on the empirical, systematic and objective analysis of selected variables using an 'a priori' theoretical scheme (Leininger, 1985 p.2).

Participatory action research, (an increasingly common method used in social science research) is popular because it provides practical solutions to routine, real-life problems. It "sets out to explicitly study something in order to change and improve it" (Wadsworth, 1998).

This approach espouses the principles of:

- democratising knowledge production and use
- ethical fairness in the benefits of the knowledge-generation process
- an ecological stance towards society and nature
- an appreciation of humans' capacity to reflect, learn and change
- a commitment to non-violent social change.

Participatory action research is 'learning by doing'. It aims to both contribute to people's practical concerns in an immediate problematic situation and further the goals of social science. According to Reason (2001), it focuses on:

- producing knowledge and action that are directly useful to a group of people
- empowering people at a deeper level through constructing and using their own knowledge for the benefit of their own community.

This means participatory action research has a dual commitment to study a system and, at the same time, collaborate with the system's members in moving it in a mutually agreed desirable direction. Accomplishing this requires active collaboration by all the participants – the researcher studies the problem systematically and ensures the intervention is informed by theoretical considerations. There are two main tasks to:

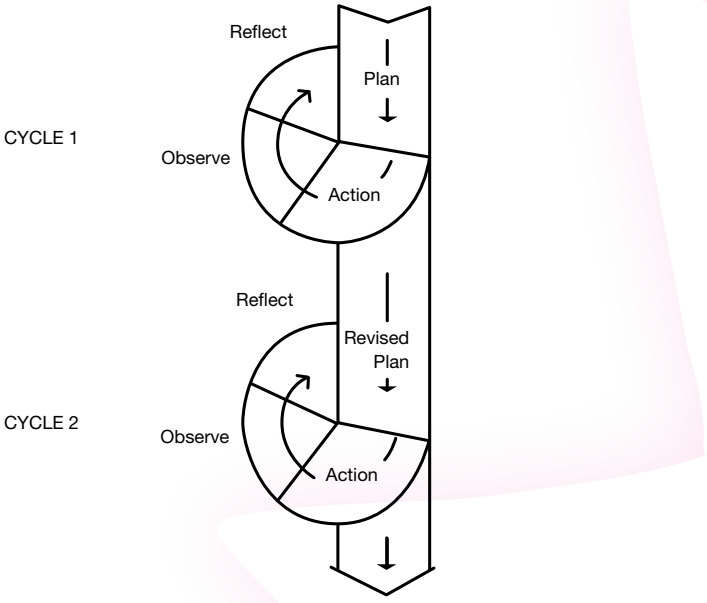
- produce information and knowledge that are directly useful to participants in their cultural environment
- enlighten and empower the average person within the participant group by motivating them to take up and use the information.

The participatory action research method is inextricably linked to the intervention developed out of it.

McTaggart and Kemmis (1995) developed a simple model of the typical participatory action research cycle.

(Figure 1). Each cycle has four steps: plan, act, observe and reflect.

Figure 1: Simple Participatory Action Research Model



Participatory action research is used in real situations rather than in contrived, experimental studies. It is suitable when circumstances require flexibility, or when the people in the research, or change, must be involved quickly or holistically. Collaborative input is negotiated with the participants who will benefit directly from the research. The result is some type of social action.

In New Zealand, an example of participatory action research and community action programmes can be found in the Te Whanau Cadillac project (Conway at al, 2000). It was set up by the Ministry of Education to reduce drug-related suspensions in schools and to help young people to not use, delay the use of or reduce their current misuse of drugs.

The project was a partnership between the project workers, their communities and the research team (Conway et al, 2000). The investigators brought their "research knowledge and formative evaluation skills to help set objectives and plan initial and ongoing development", and the communities brought their "local knowledge and experience to determine appropriate strategies and activities" (Conway et al., 2000). The result was an intervention that helped to reduce drug and alcohol problems in the identified communities and ensured 'ownership' of the strategy by the communities for which it was developed. Features of this approach that might apply to Le Ala include:

- the development of a formal relationship with six key community organisations
- the appointment of 'project' workers from each community who understood their community dynamics, needs and aspirations. For this particular project the research team relied on the 'bro' factor – the appointment of role models who had credibility with the target audience (young males)
- strengthening community action through a kaupapa Maori (Maori worldview and philosophy) approach that was grounded in tikanga (custom) and te reo (language) the provision of a facilitation role to organise project workers' planning and support meetings and liaise regularly with the workers through

visits, phone calls and electronic networking the establishment of a closed-forum website that provided training and link-ups for the project workers the facilitation of a national meeting aimed at: increasing informed discussion and debate; promoting positive policies and practices and best practice approaches for schools and youth; developing alliances between key community organisations and sectors; and resource development to increase youth voice and involvement.

One of the keys to Te Whanau Cadillac's success was its move away from the previous 'one size fits all', or 'inoculation' approach. The participatory action research approach fostered participation, representation and leadership based on the Maori holistic approach to wellness, using traditional activities and resources.

PARTICIPATORY ACTION RESEARCH WITH PACIFIC PEOPLES

A recent study used participatory action research to examine community empowerment in New Zealand (Williams et al., 2003). The purpose of the research, which involved Pacific women, was to understand how communities strengthen their ability to take collective action and make positive changes in their environments. It was developed in collaboration with a community outreach programme initiated by a religious order in Hilltown.

The study found that while marginalised communities may be relatively powerless in relation to social and economic structures, they have considerable scope for exercising power and agency. It also showed that story-telling is an important tool that enables the conscious reconnection to and reconstitution of people's identities (Williams et al, 2003 p.39).

COMMUNICATION METHODS

PIDAS commissioned a project on Pacific peoples' drinking that evaluated resources developed specifically to promote moderation and reduce alcohol-related problems. The evaluation focused on the effectiveness of six posters and a pamphlet produced in English and translated into Samoan, Cook Island Maori, Niuean, Fijian and Tongan (Wilson, 2000). It found that a key feature of such a campaign was increasing Pacific peoples' access to accurate information on current health issues and "… consulting with Pacific Islands people on health issues, and providing educational materials suited to their needs" (Wilson, 2000 p.5).

Wilson notes that the findings indicate that group-specific interventions are more effective than non-specific ones.

In the PIDAS study, culturally appropriate resources for Pacific peoples were seen as essential for raising awareness of alcohol. Participants thought they should be appropriate for the community for which they were intended, be understandable, relate to the target audience and catch their attention (Wilson, 2000 p.4).

Although the resources were well accepted, preparing translations was identified as a difficulty in their production that required urgent attention (Wilson, 2000 p.4). However, ALAC has since developed several alcohol-related resources for Pacific communities, including host responsibility information that has been translated into the four main Pacific languages. Other research projects, such as the first nationally representative survey of alcohol consumption patterns in Pacific peoples living in New Zealand (Ministry of Health, 2004), used computer-assisted telephone interviews and computer-assisted cellphone interviews in English and four other Pacific languages.

Similarly, an HRC-funded study examining the roles and responsibilities of Samoan men in reproduction (Anae et al, 2000) conducted qualitative interviews with older Samoan men and women mainly in the Samoan language. The older participants' narratives were translated into English before the data was analysed. The study was unusual in that the report was produced in English but featured quotes in Samoan.

This allowed the Samoan text to remain 'true' to its spoken and cultural context. The research team believed this strategy would provide non-Samoan-speaking Samoans with the opportunity to see and read the original Samoan text alongside the English analysis (Anae et al, 2000 p.vi).

Aiolupotea (1994) emphasises that the Samoan language needs to be the language of instruction when working with Samoan clients. He argues that using English when communicating with Samoans who may not be fluent in that language:

> …poses a great problem in their ability to communicate and interact with the counsellor. He added that the language barrier 'can often be an obstacle to their being diagnosed correctly and ultimately treated successfully' (Aiolupotea, 1994 p.80).

NARRATIVE INQUIRY AS AN APPROACH TO RESEARCH

Narrative inquiry is part of a growing school of methodologies broadly referred to as 'qualitative' research – implying "an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured… in terms of quantity, amount, intensity or frequency" (Denzin and Lincoln, 2005).

Narrative inquiry is cited here as a possible research method because of its potential to explore community-based solutions to minimising alcohol-related harm in Pacific communities in New Zealand. According to Denzin and Lincoln (2005) "narrative is a way of understanding one's own and others' actions, of organizing events and objects into a meaningful whole, and of connecting and seeing the consequences of actions and events over time."

Narrative inquiry has the potential not only to describe and report "oppressive social processes" but to "disrupt" them (Chase, 2005). The act of narrating a significant life event itself "facilitates positive change" (Chase, 2005). A central tenet of the approach is that "speakers construct events through narrative rather than simply refer to events" (Chase, 2005).

In recent years, qualitative theorists have advocated the study of life stories or narratives to understand how individuals make sense of themselves in the world (Gergen and Gergen, 1998; Mishler, 1995; McAdams, 1993; Riessman, 1993). Using this narrative approach, Paris and Bradley (2001) tracked the "developmental gains" of three women during recovery, "using Erik Erikson's theory of psychosocial development". Despite similar personal problems and turning points that moved them to stop drinking, "each woman followed a different path to self-reconstruction and psychological growth". The narrative method allowed the researchers to identify the similarities and differences in recovery from alcoholism that are "often lost in larger aggregate accounts of personal change" (Paris and Bradley, 2001).

Earlier researchers (Arminen, 1991; Preston, 1996; Hanninen and Koski-Jannes, 1999) also used a narrative approach to understand recovery from addictive behaviours. Preston (1996) postulates that her subjects (and possibly others) do not seek help:

> …because they fear that their own stories will be denied as untrue and that in this process their own identities and personal accounts will be lost.

Hanninen and Koski-Jannes (1999) and Arminen (1991) examine recovery stories as a way out of addictive behaviours and interpreting change. According to Hanninen and Koski-Jannes (1999):

> …self-narrative structures the conception of the past by focusing on events considered to be essential in shaping the life course.

They argue that this self-narrative also provides future orientations.

McAdams (2006) offers a critique of the meaning we create through the individual and social construction of coherent life stories. He acknowledges that:

> …the idea that a human life resembles, or can be made to resemble a coherent story, holds a great deal of intuitive appeal.

He critiques the idea that 'coherent life stories':

1. provide coherence by convincing causal explanations for the self
2. reflect the richness of lived experience
3. advance socially-valued living action.

McAdams (2006) argues that "most criteria for coherence… reflect the culture within which the story is told and the life is lived". If the first principle of stories is that they exist to be told, any consideration of narrative coherence must eventually come to terms with characteristic assumptions on the kinds of story that can and should be told in a given culture and the stories that are understandable and valued among people who live in and through a given culture. McAdams (2006) concludes that:

> …living action, like narrative identity, can never hide from the interpretive cultural eye. At the end of the day, culture will judge whether a life is worth living, and whether a story is worth telling.

Macaulay et al. (1999) argue for participatory action research as a health-promoting activity in itself for enhancing resilience in all communities. As a methodology, it increases the results' cultural and internal validity, minimises harm and maximises the benefits of the outcomes (Macaulay et al, 1999). The authors outline the issues that the researcher(s) and the participating community need to negotiate, such as the terms of the partnership, confidentiality, data interpretation and methods for resolving disagreements. However, despite their enthusiasm for the method, the authors are not uncritical apologists. Macaulay et al (1999) say that in participatory action research (like all research):

> …researchers may inadvertently collaborate with a minority section of the population that does not represent the interests of the entire community.

Other potential difficulties centre on the length of time these collaborative projects take, unrealistic community expectations and funding agencies' recognition that costs outweigh potential benefits (Macaulay et al, 1999).

CULTURALLY RESPONSIVE MODELS

A number of studies describe and examine culturally based interventions at a range of treatment- and community-based sites. Boyd-Ball (2003) examines a family-based intervention programme adapted from mainstream treatment for American Indian youth. The mainstream programme built support around the young people to attain abstinence, engaging family and community as motivating influences and focusing on six tasks:

- Relationship-building.
- Positive reinforcement.
- Limit-setting.
- Monitoring.
- Problem-solving.
- Communication as a family unit.

Cultural adaptation was undertaken for relationship-building and communication. It used two legends (myths) to assess the families' skills in relationship-building, problem-solving and communication as a family unit. The young people were followed up for three years. The stories were linked to child pro-social behaviour and the percentage of days abstinent from individual drug use.

Marshall (2003), a medical anthropologist, reviews four studies on the "interaction of social and personal constructions of illness meaning". He uses narrative to understand a wide range of illness experiences and healing practices in cultural communities, including the way a marginalised group of men in a poor Mexico City neighbourhood construct and cope with their drinking problems. Other studies (Marshall, 2003) link community healing and cultural revitalisation as a pathway to self-government. Marshall argues for "the talk, stories, and narratives" as a way of clinicians and patients "explaining who they are, how they feel, and how they might heal physical, psychic, and spiritual maladies". He concludes there is a place for "narrative theory" as a way to approach the "healing arts".

Gray (2005a) contends there are "a large number of papers describing interventions targeting individual, family and community levels" but a "paucity of studies that formally evaluate" the effectiveness of such interventions. He compares studies in Australia aimed at preventing substance misuse among indigenous peoples, but is concerned more with the broad lessons that might benefit policy and practice

in Australia than with specific intervention strategies. He finds that, in spite of substance misuse problems being socially determined, a disproportionate number of interventions are targeted at the individual and family in indigenous communities, with mainstream programmes being adapted to local cultural situations. In spite of this, he finds indications of success in broader strategies aimed at reducing supply (including dry community declarations, liquor licensing restrictions and strengthening social cohesion).

In another project, Gray (2005a) identifies eight key elements in ventures widely recognised as successful:

Indigenous community control, good governance, social accountability and commitment from the chief and council.

- A clear set of principles and a plan and strategy, including a realistic timeframe.
- Clearly defined management structures and strong managerial leadership and support.
- Appropriate staff (including native language speakers where relevant) and staff development and support.
- Holistic, multi-strategy, flexible interventions.
- Intra- and inter-agency collaboration.
- Effective reporting, monitoring and evaluation procedures.
- Adequate resources.

Gray (2005a) concludes that "without good processes in place and without adequate funding it is unrealistic to expect optimal outcomes."

In addition to identifying elements of "effective intervention", Gray (2005a) maps their geographical distribution and concludes there are imbalances:

> between regional population size and resource allocation in the type of intervention funded, with a disproportionately small allocation going to community-based projects in the domain of indigenous employees' workforce development.

Gray argues that these 'imbalances' combine to create a situation where services do not reach a significant proportion of the indigenous population, and those services that are available are "barely adequate for their needs" (Gray, 2005a). Gray proposes four redress approaches:

- Extending primary health care interventions to complement residential treatment, including adequately resourcing indigenous community-controlled health services.
- Ensuring that these new developments go beyond calls to use brief interventions and provide a full range of preventive and therapeutic services in primary health care settings.
- Ensuring adequate resourcing and support for existing intervention projects. The imbalance between treatment and other intervention strategies should not be redressed simply by re-allocating existing resources.

Making a greater, concerted, whole-of-government effort to address the structural factors underlying the high rates of substance misuse and other health and social problems in indigenous Australian communities.

The Government of Australia's Northern Territory has developed a project called Strengthening and Supporting Community Action and has encouraged and funded a comprehensive range of activities to reduce alcohol and drug related harm in its indigenous communities. Its strategy includes:

1. Community education – feeding back statistical information to the community about the number of people who use alcohol, tobacco and other drugs, the number of related illnesses and accidents, the financial costs and the crime-related statistics. Part of this strategy encourages families to talk about "sorry business", the long history of alcohol-related problems, and to think past the "last event" and see the bigger picture.
2. Health Weeks, where the community can focus on health-promoting activities.
3. Quit Week, which has traditionally been linked with 'World No Tobacco Day' but may be extended to include alcohol and other drugs. The programme suggest a range of activities including poster and song competitions, community-designed T-shirts, health-message murals on buildings' walls and encouraging people to give up smoking (or drinking) for the day.
4. Sharing success stories about how other communities have approached alcohol and other drug issues.
5. Working with others e.g. supporting schools to run health education sessions, offering information and responding to requests from other community groups.
6. Providing alternatives, such as recreational and sporting activities.
7. Outstations – taking 'at-risk' children out of their drinking and drug-using environments to an 'outstation' and giving them experiences in working with cattle and camels, fencing, schooling and hunting.
8. The Aboriginal Living with Alcohol Strategy, through which a team of people responds to requests from communities that have identified alcohol as a local issue in need of attention and action. The team visits communities for up to two weeks to help local leaders to determine what needs to be done and how to take action.

A number of other interventions target the individual, beginning with legitimising the role of service providers in raising the issue and offering a brief intervention with alcohol, tobacco and other drugs (even when it is not their core business). Health providers are encouraged to make alcohol and drug issues part of routine health checks and offer advice about alcohol (especially when not to drink), strategies for cutting down and strategies to support people wanting to stop drinking.

New Zealand's cultural, indigenous solutions to alcohol misuse among Māori are best articulated by Durie (2001), who outlines four broad approaches focused on:

1. the individual who has an alcohol misuse 'disorder' and leading to treatment (which includes traditional healing, kaupapa Māori service and workforce development)
2. health promotional messages targeted at 'at-risk' segments of the population (usually young adults). This perspective argues that individuals are responsible for their drinking behaviour and untoward effects should not be used to interfere with others' freedom to drink. This includes the use of Māori wardens, advertising, information campaigns, community action and Manaaki Tangata
3. community-based approaches leading to local initiatives and leadership (including hapu and community development)
4. a national strategy linked to public policies and law.

As with other researchers on cultural approaches, Durie (2001) contends that:

> …strategies to contain alcohol misuse need to be seen alongside other socio-cultural-economic programmes and within the broader parameters of positive Maori development.

COMMUNITY DEVELOPMENT AND EVALUATION

Community development projects address local influences that are detrimental to the community's health (National Health Committee, 1998). The National Health Committee identifies community control by members as a key feature of community development because communities "are able to mobilize a large resource in support of projects in which they have a sense of ownership" (National Health Committee, 1998 p.66).

THE IMPORTANCE OF COMMUNITY RELATIONSHIPS

Many researchers and research funders promote the need for Pacific communities to be involved in research. In a study of the impact of health research on Pacific peoples in New Zealand, Lima (1999b) notes that many health research professionals, including some Pacific health providers:

> …support in one form or another, the need for involvement and participation of communities, like Pacific people, in research and initiatives that target their health (Lima, 1999b p.118).

Lima argues that research that examines Pacific peoples' health should consider the population's diversity in ethnic groupings, geographical locations, mobility, educational achievement and socio-economic factors that influence their health. More importantly, says Lima, research on this population should explicate Pacific peoples' "defined" needs in terms of health care preferences and other socio-economic requirements. Lima also argues that disseminating research findings and relevant information to Pacific communities is an important part of the research process (Lima, 1999b p.23)

CULTURALLY APPROPRIATE METHODS

Brown's (2000) examination of culturally appropriate research methods for Samoan communities in the Waikato region finds that Pacific peoples:

> …need culturally appropriate services that acknowledge relationships between men and women, youth and older people, church, family and community roles and obligations (Brown, 2000 p.88).

Brown's insistence on acknowledging Pacific cultural values and familial relationships when working with Pacific communities is reflected in other literature (Aiolupotea, 1994; PIDAS, 1998; Anae et al. 2000; Lima, 1999 a, 2004; Nosa, 2005). Brown concludes that assessment and intervention services need to: consider translating words and concepts; follow cultural and spiritual protocols; and consult widely and appropriately with Pacific communities.

FAMILY-BASED RESEARCH

McGoldrick et al. (1982) suggest that family theory and therapy systems are not well developed within mainstream health and social services, and international research by EUROCARE (1998) shows that most alcohol research does not focus on families.

The Ministry of Health (1997a) says:

> For Pacific people, the family is the main unit in which children learn, grow and are enabled to survive the vulnerable years of early childhood (Ministry of Health, 1997a p.7).

Hayes (2001) identifies the centrality of "family" in Pacific young people's lives, and notes that family is the main source of knowledge about nutrition and food and other lifestyle behaviours. Hayes also argues that instead of young Pacific people "seeking health, and consciously making choices", they are more likely "to base their behavioural decisions on the actions of their peers and family members" (Hayes, 2001 p.175).

While it may be possible to promote parents as positive role models, Lima (2004) suggests it may be difficult to get families to participate in such research. This, he says, is due to Pacific families' diverse composition, size, denominational affiliations, length of residency in New Zealand and other socio-economic and cultural factors, and various dynamics in terms of family. These require a variety of strategies for any intervention to be successful. Lima suggests that mass media strategies targeting the home environment may be successful, as this strategy has worked in the past.

TRANS-GENERATIONAL COMMUNITIES

Although Pacific peoples' trans-generational issues have been raised in health policy research, most New Zealand literature is predominantly sociological and educational and does not consider in-depth psychological treatment processes or analysis. Adult and youth intervention models are distinguished by the kinds of service involved and the legal or statutory environment in which the services are delivered. There is very little treatment-outcome research focused on Pacific young people and alcohol-related harm.

Analyses in education, sociology and public health have highlighted Pacific peoples' heterogeneity and the multiple subjectivities (the world of the individual as 'real' or 'true') they experience (Anae, 2001; Lima, 1999a; Macpherson, 2001; Enosi et al, 2005; Taule'ale'ausumai, 2001; Tiatia, 1998; Tupuola, 2004). Consistent themes emerging from this research include the social realities and philosophical tensions between traditional and modern cultural influences that shape the concepts of 'belonging' and 'wellbeing'. These are sometimes framed as the differences between Western and non-Western views and between holistic and biomedically focused views.

All Pacific populations have raised concerns on how to address the health needs of Pacific youth and/or Pacific peoples born and raised in New Zealand (Agnew et al, 2004; Suaalii-Sauni et al, 2005). This socio-cultural dynamic is an important consideration in designing prevention programmes where ethnicity, gender, age and class are variables affecting health and wellbeing for a heterogeneous 'client/consumer' population group. The Ministry of Health (1997a) states:

> There will be a growing division between New Zealand-born and Pacific-born people about the needs of Pacific people and the best methods for meeting those needs. The position of the church in New Zealand cultures is likely to be weakened. The extended family structure will be weakened by economic forces and the second generation of New Zealand-born Pacific people is likely to grow up in relative poverty, with a weakened cultural base. All these factors represent a risk to the mental health of Pacific people (Ministry of Health, 1997a).

BEST PRACTICE INTERVENTIONS

This section reviews a number of current interventions as well as those that might apply to a Le Ala community intervention(s).

Reviewing and using 'best practices' can help decision-makers, practitioners and funders to select and apply effective strategies to address complex and challenging problems. There is no 'one size fits all' programme for all communities; each has its own cultural, economic and environmental circumstances that affect behaviour and outcome.

This section begins with an exploration of 'best practice' as a concept before discussing participatory action research as a way into a 'problem' and a solution to it. It also explores other interventions developed out of narrative inquiry that have proven effective in intervening with alcohol misuse problems in cultural and indigenous communities.

EVIDENCE-BASED BEST PRACTICE

Fawcett et al (2000) develop a "community tool box: an internet based-resource for building healthier communities" that includes six action points:

1. understanding the community context (e.g. assessing community assets and needs)
2. collaborative planning (e.g. developing a vision, mission, objectives, strategies and action plans)
3. developing leadership and enhancing participation (e.g. building relationships and recruiting participants)
4. community action and intervention (e.g. designing interventions and advocacy)
5. evaluating community initiatives (e.g. evaluating programmes and documenting community and systems changes)
6. promoting and sustaining the initiative (e.g. social marketing and obtaining grants).

The community tool box is not prescriptive, but it does provide a basis for self-determination in diverse communities. It may provide Le Ala with a framework for considering alcohol-problem interventions in Pacific communities.

OVERVIEW OF BEST PRACTICE

There is very little literature on Pacific peoples and alcohol-related harm. In 1999, ALAC published an Overview of Specialist Alcohol and Drug Assessment, Treatment and Interventions in the New Zealand Context (MacEwan, 1999). This discussed Pacific peoples as a special population and reviewed best practice treatment interventions derived from international studies. It noted that in New Zealand most treatment purchasers and providers operate within a medical model, which emphasises internal problem-solving.

MacEwan says that increasing evidence from international outcome research suggests that:

> …while cognitive/affective/motivational/solution focussed approaches will work for some, for others, perhaps most, external processing involving environmental/community/peer relationships will be of greater importance in terms of effectiveness (MacEwan, 1999).

MacEwan notes that socio-environmental approaches show more significant promise for better outcomes than medical model approaches, which emphasise bio-psychological causes and treatment processes. Essentially, he argues for the use of bio-psycho-social approaches. The report notes the positive potential of the community reinforcement approach, which involves care in the community or participation in a community-based rehabilitation process. In New Zealand, motivational enhancement therapy is more common.

MacEwan ranks best practice alcoholism-treatment models from the most effective to the least effective based on Miller's (1993) ranking of 67 treatments in 302 published clinical research trials. The four highest rated interventions were:

1. brief interventions
2. motivational enhancement
3. social skills training
4. community reinforcement.

According to MacEwan, there is no clinical evidence that specific services for special populations are superior to general services. The underlying assumption is that matching clients to providers and ranking their age, gender and ethnicity help with client motivation and encourages the adoption of behaviours and attitudes that promote positive change. The report acknowledges that Pacific peoples are heterogeneous and treatment services should address this. MacEwan notes that it is not clear how ethnicity and 'Pacific islandness' should be weighted in relation to other individualistic characteristics.


ENTRY

MacEwan's analysis has been affirmed in recent Pacific-led social science research that explored clinical and cultural competency in Pacific peoples' mental health and wellbeing (Suaalii-Sauni et al, 2005; Agnew et al, 2004; Matangi-Karsten et al., 2003).

DEFINING CULTURAL COMPETENCY

The ethical impetus for exploring cultural competency is intimated in the following statement:

> Understanding patients' diverse cultures – their values, traditions, history and institutions – is not simply political correctness. It is integral to eliminating health care disparities and providing high quality patient care. Culture shapes individuals' experiences, perceptions, decisions and how they relate to others. It influences the way patients respond to medical services and preventive interventions and impacts the way physicians deliver those services (Sutton, 2000 cited in Suaalii-Sauni et al, 2005)

According to Chaput and Claussen (2004):

> Cultural competency, rather than the generalisation of cultural attitudes and beliefs, or attempts to become versed in every individual's cultural group, is the most useful and realistic goal an organisation can have with respect to understanding cultural factors and their influence on service provision (Chaput and Claussen, 2004, p.1).

This seems especially relevant for services/organisations that work with several Pacific sub-populations. Ethnically 'matching' the workforce is only one of several strategies for organisations responding to staff cultural competency skills. In general, says Van Ngo (cited in Chaput and Claussen, 2004):

> Cultural competency refers to a set of congruent behaviours, attitudes and policies that enables human service organizations to work effectively with various racial, ethnic and linguistic groups" (Van Ngo, 2000 cited in Chaput and Claussen, 2004 p.2).

COMMUNITY INTERVENTIONS

Some have recognised the cultural differences between distinct Pacific population groups in New Zealand and incorporated them into strategies and development plans. For example, the need to be aware of the diversity within and between Pacific cultures is a performance indicator for a competent alcohol and drug worker working with Pacific peoples (cited in Practitioner Competencies for Alcohol and Drug Workers in Aotearoa – New Zealand) (ALAC, 2001).

Research suggests alcohol misuse and dependence start mainly in people's late teens and early 20s. The Public Health Commission recommended to the Minister of Health (1993-1994) that:

> …primary prevention strategies should be focused on young drinkers as this is where the best health gains are likely to be achieved (Public Health Commission, 1994 p.20).

The literature on 'community interventions' is organised according to the definition and identification of people within a 'community'. One body focuses on the community of 'youth' (DeJong and Langford, 2002; Miller-Day and Dodd, 2004; Foxcroft et al., 2005a), another on targeting specific issues such as high-risk drinking and alcohol-related injuries (Holder et al, 2000), while a third is divided along ethnic lines (Marshall, 2003; Gray, 2005a; Brady, 1998; Durie, 1998, 2001). Each has something to contribute to this review and will be discussed in turn.

All the 'youth'-focused studies are aimed at the 'risky' binge drinking typical of this age group. DeJong and Langford (2002) develop a typology of programmes and policies for both preventing and treating campus-based, alcohol-related problems. They adopt an 'ecological' framework, which recognises that strategic interventions work best when pursued at several levels. The typology matrix is targeted at the individual, groups, the institution and the community, with interventions at each of these sites including:

- knowledge – attitudes and behavioural intentions
- environmental change, such as alcohol-free options, changing the normative environment from one of heavy alcohol consumption to health promoting, alcohol availability, alcohol promotion and policy/law enforcement
- health protection using risk-reduction and harm-minimisation strategies
- intervention and treatment for those identified as having a problem.

Miller-Day and Dodd (2004) hypothesise that "parent-offspring interaction is an important predictor of offspring's negative drug attitudes, and that conservative drug use norms may protect youth against future risk of negative outcomes". They study the narratives of 75 parent-offspring pairs who were asked to relate their shared drug-prevention conversations. Three narrative themes, identified as useful but not tested for their efficacy, include:

- framing drugs and drug use as a problem
- evidence narratives supporting the idea of harms
- pro-prescriptive information as a way of reinforcing 'tools' and 'rules' for healthy living.

Foxcroft et al., (2005a) review 56 studies to identify and summarise rigorous evaluations of psychosocial and educational interventions aimed at the primary prevention of alcohol misuse by young people up to the age of 25 years. They acknowledge that intervention for this age group is challenging and scrutinise three types of intervention:

1. The 'strengthening families' programme, where parents and children are taught to clarify expectations, manage strong emotions, communicate effectively and have appropriate discipline. This shows promise, but needs to be evaluated on a larger scale and in different settings.
2. 'Culturally focused' interventions incorporating problem-solving, personal coping and interpersonal communication skills' development using myths, legends and stories. This also requires further development and rigorous evaluation, including for cost effectiveness.
3. Life skills' training, which includes cognitive-behavioural skills to raise self-esteem as well as resistance, assertiveness, relationship, anxiety management and communication skills. However, given there are no clear indicators or predictors of alcohol misuse and its consequences, more work is needed on

outcome measures.

It appears that each of these three strategies had some measure of success, but of the 56 studies examined, only 20 show evidence of ineffectiveness. According to Foxcroft et al., (2005a) it is difficult to draw firm conclusions on the lack of effectiveness of prevention interventions because of many studies' methodological shortcomings. The often high attrition levels and a lack of 'intention to treat' analysis threaten the results' validity.

Holder et al (2000) evaluate the effect of community-based interventions on high-risk drinking and alcohol-related injuries. The interventions were implemented in six stages across five 'sites' over three years the:

- first site involved 'community mobilisation' and included media engagement to draw attention to the problem
- second focused on the risk of drinking and driving and engaged the support of councils and police
- third intervention site aimed at restricting access to alcohol and included planning and zoning restrictions, limiting alcohol at special events and a review of current licensing practices
- fourth intervention site targeted responsible beverage service and included on-site training programmes for people serving alcohol
- final intervention site focused on youth drinking.

The study concluded that "a coordinated, comprehensive, community-based intervention can reduce high-risk alcohol consumption and alcohol-related injuries resulting from motor vehicle crashes and assaults" (Holder et al, 2000).

PACIFIC ALCOHOL AND DRUG SERVICE DELIVERY IN NEW ZEALAND

In a recent overview of interventions with Pacific clients with alcohol and drug issues in New Zealand, Robinson et al (2006) attempted to define best practices by Pacific workers for Pacific clients in a treatment setting. They collected data on assessment techniques, intervention strategies and outcome measures and concluded that the most effective assessments were those conducted by skilled Pacific staff with sound knowledge of alcohol and drugs, Pacific cultures and processes.

The findings imply the need for clearly defined performance and outcome measures that accurately reflect Pacific processes and interventions. For example, assessment needs to be recognised as the first phase of 'helping' in the treatment intervention – and establishing rapport is vital to developing ongoing engagement with the client, making the initial stage more than merely completing an assessment form.

Client progress is measured at different stages of the client's journey, especially at the beginning (the assessment stage) and the end of treatment (after the follow-up period). As with other interventions recommended for Pacific peoples, it is important that they not only focus on the individual but be intensive and longer and incorporate families and significant others. There is clearly an identifiable 'Pacific' way of working with Pacific clients. All participants applied elements of both Pacific and Palagi understandings of alcohol and drug issues to their practice. The degree to which this happened depended on the worker's and client's age, gender, birthplace and preferred language.

THE NEED FOR EFFECTIVE COMMUNICATION

Communicating health information to the general population can seem a simple matter of developing,

designing and broadcasting health information over the airwaves or via print media and other communication channels. Effective health-promotion messages can change people's health attitudes and behaviours – but messages that are ineffective, ambiguous or inappropriate can be overwhelming and futile. As Kephart (1997) argues, "inadequate communication between members of a minority and a majority culture can often cause poor health for the former." Kephart states that communication is vital to maintaining and improving Pacific peoples' health within Pacific communities (Kephart, 1997 p.21).

Educational programmes that raise awareness among Pacific peoples of the harmful effects of alcohol misuse should be promoted extensively among Pacific communities using mass media as well as Pacific-specific media and communication networks. Nosa (2005) argues that the mass media could be used "as an avenue to communicate the health impacts of alcohol consumption" and proposes the use of mass media, in particular Pacific television programmes such as Tangata Pasefika, Pasifika Beat and Triangle television and radio stations such as 531PI, Niu FM and Access radio that specifically target Pacific peoples.

According to Nosa, Niuean men may also benefit from understanding how alcohol is metabolised by the body and from culturally appropriate and easily accessible information about how alcohol affects the body (Nosa, 2005 p.179). Gray (2005b) says that Niuean women need support services in education and health to reduce the negative effects of alcohol use for the next generation.

Some health issues, especially those of a sensitive nature (Macpherson and Macpherson, 1990), are not frankly and openly discussed in some Pacific cultures. For example, a study of the roles and responsibilities of Samoan men in reproduction (Anae et al, 2000) finds that talking about sex and contraception is strictly taboo. Some older men comment that "the only place you could talk about sex was in church sermons in the context of stories about Biblical eunuchs" (Anae et al, 2000 p.228). Most of the informants in the study are unsure of the church's role in sex education. In another example, Peteru's 1997 study of the sexuality and STD/HIV risk-related sexual behaviours of single, unskilled, young adult Samoan males finds that:

> Finding the most appropriate medium to impart information to high risk behavior groups and the general public, and breaking the many cultural and religious barriers that prevent the discussion of sexuality related issues in an open manner, are issues that need to be addressed (Peteru, 1997 p.217).

These examples provide insights into how sensitive issues such as sex and sexuality are framed and understood within fa'asamoa (the Samoan way of life) and Samoan people's social and cultural contexts.

Alcohol and the consequences of its abuse create a similar degree of sensitivity, especially where alcohol abuse may have resulted in violence or sexual abuse or brought shame on the family. Alcohol abuse by some Samoan men may be problematic and out of control, but any harm caused to family members as a consequence often remains within the family. The collective obligation to preserve the social unit's public prestige may, and often does, outweigh the need to seek help for a member if that involves a public expression of deviance or an admission of weakness.

Paradoxically, this often results in the greatest level of 'denial' where the victim of misuse is a publicly significant figure, which results in fewer role models admitting to alcohol abuse. This also means that opinion leaders, whose public admission might lead to changed behaviour, are less likely to admit to the need to modify alcohol use patterns.

Interestingly, Brown (2000) notes that there appears to be a disproportionate number of Samoan men and women with patterns of harmful or hazardous drinking. The level of problem drinking behaviour in Samoan communities may be concealed, but individuals in need of intervention such as education can be identified if approached appropriately (Brown, 2000 p.89).

Some recent, and extremely popular, attempts at confronting these issues in Samoan society have come from Samoan writers, comedians and performers, who have found new ways to communicate messages about alcohol. Early writers such as Albert Wendt, and later writers such as Sia Figiel, wrote only in English – and although alcohol and alcohol-related harm featured in their writing, their works communicated largely with an English-speaking audience. More recently, writers have satirised and parodied the behaviour of Samoan drunks and explored the consequences of their conduct in popular television series such as bro Town, stage performances by the Naked Samoans, stand-up comic performances by Tofiga Fepulea'i and Eteuati Ete, and most recently in the feature film Sione's Wedding. All have shown, in different ways, drunks as somewhat pathetic figures of fun, and drunkenness as having both sad and tragic consequences for drunks and those around them.

YOUTH AND PREVENTION

Howard (1998 pp.83-105) argues that effective youth interventions require the increased involvement of target populations(s) as well as attention to non-school variables such as family and community. He suggests that experimentation and variable patterns of use and cessation are common among adolescents as they develop. He notes that many young people's substance use is functional rather than pathological or mindless, and argues that many young people use substances:

- to relieve boredom
- out of curiosity
- because they want to feel good (or better)
- to keep awake or get to sleep

- for peer/social acceptance
- to adopt a rebellious stance.

Howard says that individuals may not perceive youth drinking as a problem, and that the risk factors for developing serious substance abuse or misuse appear to include:

- poor social relations
- family difficulties
- values associated with masculinity or rites of passage
- poverty
- environmental stressors.

Howard suggests that young women are often introduced to substance use by male partners and cites Wheeler:

> The history of drug education has not been one of spectacular success. This history of failure can be traced to the inability of earlier drug educators to comprehend why people take drugs. Perceiving drug taking to be a totally negative experience, they were forced (Howard, 1998 p.140).

According to Howard, effective prevention involves the target population in all stages of the intervention. He lists the stages of intervention as assessment, planning, delivery, monitoring and evaluation, and suggests local needs' assessments to inform planning. Methods can include focus groups and the use of narrative research, surveys, key informant interviews and case studies. Needs' assessments should be comprehensive, culturally sensitive and based on local/target audience need.

Feeney (2002) reviews 20 years of alcohol and drug education programmes in New Zealand. Most had been delivered in schools, although Feeney notes that alcohol and drug education is not just a school issue. Successful programmes require family and community involvement, with common success factors including:

- integrated school and community interventions
- interactive ongoing approaches
- innovative teaching methods
- school, community and family involvement.

Citing research by Lloyd et al. (2002), Feeney states that alcohol and drug education programmes are likely to:

- be intensive, ongoing, started in primary school and continued at secondary school
- focus on schools, communities and families/parents
- be based on life skills
- use interactive teaching styles and peer educators
- focus on delaying the onset of drug use and misuse rather than on prevention.

Tobler (in Feeney, 2002) argues that youth alcohol and drug programmes should involve youth, community agencies and schools.

> …programme participation: most researchers support an integrated, co-ordinated approach to alcohol and drug education programmes that involves students, schools, families and communities (Feeney, 2002 p.9).

Feeney (2002) includes an analysis by Wheller that describes three generations of drug education, in chronological order:

1. The first generation assumes that people will not take drugs if they have enough information and understand the dangers of doing so.
2. The second generation assumes that strengthening personal skills will help a person to resist misusing substances.
3. The third generation is drug education based on the assumption that the target population wants to change its drinking behaviour. It aims to minimise the risks associated with alcohol use and provide client-centred strategies and skills that work in the real world.

Feeney (2002) compares Wheller's analysis with Brovold's (1990) analysis of four models underpinning a school-based programme in California. She asserts that they are relevant to the New Zealand context and summarises the models as follows:

1. Rational Model. This model supposes that providing individuals with enough information about the harms of misuse of alcohol and drugs will result in a rational choice to avoid use.
2. Social Learning Model. This model uses teaching and role modelling based on desirable behaviours, on the assumption that human behaviour learned through modelling will positively affect individuals' behavior.
3. Developmental Model. The developmental model caters for a range of young people's ages and experiences throughout adolescence. Programmes combine age-appropriate information with attitudinal and behavioural concepts.
4. Social Norms Model. The social norms model promotes the idea that a large percentage of young people do not misuse alcohol and drugs. It addresses a popular perception among young people that 'everyone does it'.

Howard (1998 p.91) suggests that peer education using trained peers appears to be effective for 'out of school' programmes, including planned interventions such as street theatre and drama. He says that peer educators must have high status, be supervised and receive adequate training and support. Howard also comments that the 'halo effect' of new programmes that are not sustained over time needs to considered.

The Iowa Strengthening Families Programme (ISFP) was based on a bio-psycho-social model. Parents and children were taught appropriate discipline, how to clarify expectations, how to manage strong emotions and to communicate effectively. Children were also taught peer skills through seven family sessions held once a week for an average of two hours (Spoth et al, 2001).

Spoth et al describe relevant drinking variables for primary interventions as whether the participant has ever:

- used alcohol
- used alcohol without permission
- been drunk.

In follow-ups undertaken after one, two and four years, the ISFP's effectiveness was found to increase. Compared with the control group, the intervention group showed significantly lower percentages for each variable. Spoth et al comment that:

> …community interventions also need to be considered by policy makers as the potential benefit goes beyond youth. If community interventions can have a significant impact on important youth alcohol misuses as impacting on other groups within a community then there may ultimately be an economy of scale. Instead of different interventions for different groups, a single community intervention that covers all these groups may be more cost effective (Spoth et al, 2001).

SCHOOL-BASED INTERVENTIONS

Schools have been successfully used for interventions. A study by Lima (1999b) examines the impact of neo-liberal reforms and health research on Pacific peoples in New Zealand, using the school-based 'Rheumatic Fever Prevention Project'. This health-promotion initiative addressed the high prevalence of rheumatic fever among Pacific young people. Lima finds a general consensus among participants "that schools are the best places for health primary prevention projects because all children go to school" (Lima, 1999b, p.112).

Some participants in the study noted other positive aspects of locating research projects within schools. These included a decrease in absenteeism and the availability of project personnel (such as nurses who visit schools to medicate) to identify children with problems needing attention (Lima, 1999b).

Edwards and Chapman (2000) argue that adolescent health promotions should aim to reach people "while they are still undergoing a process of identity development in order to assist them with adopting lifestyles associated with lasting health benefits and avoiding harmful short-term decisions" (Edwards and Chapman, 2000 p.206).

Munro (1996) points out that:

> …schools are the one 'social agency' with the professional capacity to educate young people about drug use issues (Munro, 1996 p.220, cited in ALAC, 1999c p.45).

Barwick (2000) suggests that multifaceted community programmes offer "the most hope for reducing drug-related harm" (Barwick, 2000 p.3, ALAC, 1999c p.57). An Education Review Office report, Students at Risk: Barriers to Learning, states that:

> The delivery of a comprehensive health education programme is one way a school can actively promote behaviour and values that contribute to a safe physical and emotional environment (Education Review Office, 1997 p.29).

According to Hayes (2001), that same report conflictingly states that in New Zealand schools:

> …health education is generally not taken seriously as an area of learning (Hayes, 2001 p 177).

Hayes contends that:

> Along with educating young people about behaviours which affect their health, the school is responsible for providing a place where young people can adopt healthful lifestyle and nutritional behaviours, and engage in regular physical exercise (Hayes, 2001, p.177).

PERFORMANCE AS A HEALTH-PROMOTION STRATEGY

Another creative approach to health promotion involves preventing substance abuse among Pacific young people through performance.

> 'Performance' used broadly covers a wide range of expressive forms such as dance, theatre, drama, public speaking and music. Started by the United Nations Office for Drug Control and Crime Prevention (UNODCCP, 2003) in 1998, the Global Youth Network project allow young people to have a say in designing and implementing drug abuse prevention projects so that their legitimate knowledge of issues surrounding youth culture could be effectively used to prevent substance abuse (UNODCCP, 2003).

> Performance is very captivating and beneficial to both participants and audiences… It usually involves interpersonal skills such as working cooperatively in a group to reach a common goal, accepting others and communicating effectively. The development and practice of these characteristics along with others make for resilient youth, better able to withstand problems that can lead to substance abuse (UNODCCP, 2003 p.7).

At the one-day Canterbury Pacific Youth and Alcohol Fono in Christchurch in mid-2004, performances by members of the Christchurch-based Pacific Island Underground group were one of the most popular presentations. The skits were based on the performers' perceptions and experiences of 'risky situations' with alcohol use and misuse in which young people sometimes find themselves (Lima and Borovnik, 2004).

In their evaluation of the fono, young people reported that the skits were "very real" as they re-enacted scenarios at night clubs and public places. They were also enthusiastic about other workshops facilitated by younger presenters, who shared some of their own potentially risky life experiences around alcohol that were later portrayed in the skits and performances (Lima and Borovnik, 2004b).

ENTERTAINMENT-EDUCATION

Entertainment-education is another approach that uses performing arts and media as a health-promotion communication tool. Singhal and Rogers (1999) define it as:

> The process of purposely designing and implementing a media message both to entertain and educate in order to increase audience members' knowledge about an educational issue, create favourable attitudes, and change overt behaviour (Singhal and Rogers, 1999 p.10).

Entertainment-education approaches use appropriate performing arts and broadcast media to convey information about social and peer group norms. Glik et al (2002) also cover their use in promoting protective health behaviours, noting that unlike pure entertainment, entertainment-education efforts:

> …seek to positively change audience members' knowledge, attitudes, intentions, and/or

> behaviours with respect to an issue (Glik et al, 2002).

In the case of health, they argue that:

> Performances are designed to promote lifestyle choices or provide guidance on avoiding or preventing diseases (Glik et al, 2002 p.40).

While the study by Glik et al used entertainment-education primarily to educate and influence young people about sexuality and HIV/AIDS, the authors note that almost all groups in the study addressed a range of youth issues (Glik et al, 2002 p.45), including "date rape, violence, gang issues, stereotyping, homelessness, teen pregnancy, eating disorders, drug and alcohol abuse, suicide prevention, and the prevention of STDs" (Glik et al, 2002 p.46).

PERFORMING ARTS AND PACIFIC PEOPLES

During the past two decades a growing number of Pacific peoples have succeeded in establishing careers in New Zealand's performing arts and music industry, through live stage performances, hip hop music and other performing arts media. This was highlighted and reinforced by the popular drama, film and music presentation of Imperishable Seeds, a Metaphor for Youth Development by an alliance of Pacific providers at the Pacific Spirit '04 Conference in Auckland in 2004. The presentation portrayed stories of alcohol abuse, domestic violence, suicide and other social issues that confront young people, including Pacific youth, in contemporary New Zealand society.

> The performance by the group confirmed once again the enormous talent of Pacific people in drama, music and the arts and how it (performance) can be used effectively in communicating messages to target audiences (ALAC, 2004)

CHURCH-BASED INTERVENTIONS

Researchers have promoted Pacific churches as 'excellent settings' for research with Pacific peoples. For example, Bell (1998) comments on this in an investigation of lifestyle and other risk factors for non-insulin-dependent diabetes mellitus and coronary heart disease in three Samoan church communities in Auckland.

Similarly, Hayes' (2001) study of Christchurch Pacific secondary school students' health, which examined the effects of their dietary and lifestyle behaviours on long-term health, finds that:

> The best avenue for providing health information to Pacific Island adults and young people is the church (Hayes, 2001 p.181).

In his review of the literature on Pacific peoples and alcohol, Nosa (2001) states that the:

> Hub of many Pacific Islands communities is represented within the church and that many Pacific Island migrants have a strong link with the church (Nosa, 2001).

However, Nosa also notes that "there may be a conflicting issue in the church regarding alcohol, since some members enjoy drinking alcohol while others may feel guilty and uncomfortable". This can create "a sense of having to choose between church values and alcohol consumption" (Nosa, 2001).

Brown (2000) agrees, suggesting that "the church remains central in Pacific communities and is a potential ally for community consultation and for individual interventions" (Brown, 2000 p.90).

Brown also notes that church ministers and community leaders "openly disapproved of drinking alcohol and preached abstinence", suggesting that the leaders' disapproval may have resulted in the research attracting predominantly problem drinkers (Brown, 2000 p.82). Brown reports that she received mix support in completing her study from the Samoan community and church leaders.

A pilot study with Samoan people in Auckland examined drinking behaviours and awareness levels on the effects of alcohol. Several participants and key informants suggested that Samoan church leaders, who have been accorded status and are highly respected within Samoan society, should be more involved in promoting educational programmes that highlight the detrimental effects of alcohol on health and wellbeing (Lima, 2000 p.44). This was supported by a Samoan pastor, who argued that church leaders should work more closely with church members "to ensure that young people were given all the help regarding consumption of alcohol". The pastor also said:

> Too many of us are complacent and have shown lack of courage and conviction in addressing the problem of alcohol. Sure there are those who are working tirelessly to ensure that our young people have the support services available when they get into trouble. But some seem unperturbed by the young people's dilemma. We seem to think that the extent of our job is the pulpit and the spiritual sustenance of people. We forget that it is part of the faifeau's role to look after the physical, mental as well as the spiritual needs of our flocks (Pastor key informant, cited in Lima, 2000 p.44).

In a discussion paper titled The Church and Alcohol Related Harm, delivered at a Pacific Alcohol Issues Workshop organised by ALAC and the Health Funding Authority in February 2000, Siataga contends that:

> Pacific churches and church leaders have an important role to play in developing holistic models of care for people identified with drinking problems (Siataga, 2000, p.8).

Siataga states that Pacific churches are important support institutions within Pacific communities, and that churches and church ministers have unique positions and enjoy significant authority within Pacific cultures. He argues that this could be used to ensure that Pacific problem drinkers are not isolated from community support.

Other commentators are not convinced that Pacific churches are the best venues for research projects with Pacific communities. Samoan educationalist and theologian Taule'ale'ausumai notes that while many Pacific churches continue to be the:

> …gathering and worshipping places for many Pacific families, some New Zealand-born people have begun exploring other forms of worship within the Christian faith, outside the Pacific churches (Taule'ale'ausumai, 2001 p.185).

Macpherson (2004) notes, there is evidence of: a declining level of commitment to Christian churches within Pacific populations; an increasingly critical approach to the ways Pacific churches are organised; and a scepticism about the objectives of some church activity. The Census shows declining levels of affiliation with the main-line Pacific churches and movements to either evangelical congregations or away from any form of religious affiliation.

CLINICAL AND OTHER TREATMENT (BEST PRACTICE FOCUS)

The review of unpublished literature revealed very little information on clinical and other treatment.

One study (Brown, 2000) discusses culturally appropriate treatment models for problem drinkers with a focus on providing information on a "culturally appropriate methodology for research for and with Samoan communities". It includes useful information about "Samoan beliefs about the effects of drinking" (Brown, 2000 p.40).

Using both qualitative and quantitative processes, Brown combines feedback from community consultation, key informants and individual and group interviews to explore common issues and themes. She also examines the appropriateness of the Alcohol Use Disorders Investigation Test (AUDIT) and the Alcohol Effects Questionnaire (AEQ) for identifying people who may have an alcohol problem. Brown's analysis shows that the qualitative results, which included an examination of the AUDIT and AEQ design and content, should consider:

> …issues of language used in questionnaires and the meaning of items and concepts which would provide useful information when doing research with Pacific communities (Brown, 2000 p.89).

The study finds that while there were "no significant differences in drinking behaviour across age ranges, birthplaces or gender", there was a "disproportionate number of Samoan men and women who have patterns of harmful or hazardous drinking" (Brown, 2000 p.89).

Aiolupotea (1994) examines the attitudes of Samoan drinkers in Auckland, and how they may differ from those in mainstream New Zealand society. Using individual face-to-face interviews and focus groups with Samoan counsellors working for the Samoan Substance Abuse Programme at Lavea'i Trust, the study examines the place of alcohol within the Samoan community. It scrutinises population- and individual-based intervention strategies implemented in New Zealand and evaluates the effectiveness of both mainstream intervention strategies and those used in the Samoan treatment programme (Aiolupotea, 1994).

Aiolupotea finds that Samoan men's drinking patterns are influenced by factors such as the desire to be accepted into mainstream New Zealand society and to be considered equal to their Palagi peers. In

Matatumua's (1969) Dunedin-based study, alcohol was also perceived as a great 'barrier breaker' that provided its consumers with "a common bond shared by all, regardless of other differences" (Aiolupotea, 1994, p.53).

Aiolupotea's study also finds that "any decision not to conform to the group drinking pattern was often perceived by his drinking partners as an expression of weakness". In some instances, "refusal to drink was regarded by drinkers as a blatant sign of disrespect" (Aiolupotea, 1994 pp.53-54).

Aiolupotea identifies the language of instruction as a barrier for Samoan clients requiring alcohol addiction counselling. He says that using English in health education makes it difficult for Samoans not fluent in English to communicate and interact with Palagi counsellors. Often it fell upon the client to:

> …make efforts to adjust his preferred language and communication so that it fits in with that used by the counsellor (Aiolupotea, 1994 p.81).

Aiolupotea's preference for interviewing Samoan counsellors was, in part, an attempt to explore the cultural appropriateness of counselling methods being taught to counsellors and whether mainstream counselling programmes addressed, and were culturally sensitive to, Samoan clients' needs. This included cultural protocols, Samoan values and programmes' responsiveness to the diverse needs of Pacific clients seeking treatment for their alcohol problems. Aiolupotea argues that the Lavea'i Trust and the Samoan Association for Substance Abuse were formed in 1987 in response to the lack of culturally appropriate services for Samoan people.

Aiolupotea notes that, initially, the Lavea'i Trust's Samoan Substance Abuse Programme did not gain a high profile among the Samoan community, partly because of some people's perceptions that it was inferior to other programmes and partly because some Samoan church leaders were unwilling to promote the programme in their churches. In trying to understand the lack of support from church communities, especially church leaders, Aiolupotea surmises that:

> Perhaps this stems from an unwillingness to confront the possibility that there could be a problem with alcohol amongst some of their church members and the scandal that may arise within the Samoan community. Indeed, it has been suggested that perhaps, in the eyes of some Samoan ministers, it seems if a parishioner turns up to Sunday service, and appears sober and happy, then he does not have an alcohol problem (Aiolupotea, 1994 p.90).

PACIFIC 'TREATMENT' MODELS:

Clinical and Cultural Competency/Integration

Three important research studies specifically address the nature of Pacific-targeted services. They include Enosi et al's (2005) Exploring 'Cultural Competency' in Pacific Mental Health, Agnew et al's (2004) Pacific Models of Mental Health Service Delivery in New Zealand Project Report and Matangi-Karsten et al's (2003) An Overview of Pacific Workers' Treatment Interventions with Pacific Clients with Alcohol and Drug Issues in Aotearoa – New Zealand.

Matangi-Karsten et al's research aimed to:

- initiate the process of evaluating and improving the effectiveness of alcohol and drug treatment services for Pacific peoples by reporting on current treatment interventions for Pacific clients with alcohol and drug issues across alcohol and drug services in Auckland, Hamilton, Wellington and Christchurch
- provide information on clinicians' opinions of current treatment models, outcome tools and processes used by clinicians for Pacific peoples with drug and alcohol related problems

- make initial recommendations on ways to improve drug and alcohol treatment for Pacific clients with the long-term aim of reducing drug- and alcohol-related problems among Pacific peoples.

The research involved qualitative interviews with 31 Pacific staff members from 13 services registered with ALAC.

There was a clearly identifiable 'Pacific' way of working with Pacific clients but this was mediated to some extent by the funding arrangements and reporting requirements of the services. All participants applied elements of both Pacific and Palangi (Western) understandings of alcohol and drug issues to their practice. The degree to which this occurred depended on the age, gender, birthplace and preferred language of the worker and the client (Matangi-Karsten et al, 2003 p.2).

Matangi-Karsten et al report that while there appeared to be no significant differences between Pacific interventions offered by non-government organisations (NGOs) and district health board (DHB) providers, there were differences in available resources and service structures. Reporting and record-keeping requirements in DHBs were seen to take time away from 'Pacific processes' (in particular 'rapport building') and including families in treatment.

Agnew et al's (2004) research involved fono and qualitative interviews to inform an analysis of the perceptions of New Zealand Pacific mental health consumers, families and service providers of what makes a Pacific mental health service 'uniquely Pacific'. Key findings affirmed the need for further research in articulating what a Pacific service model entails, as distinguished from Pacific models of health belief. The authors concur with Matangi-Karsten et al's (2003) findings that the differences between specific NGO Pacific mental health services and DHB-based Pacific mental health services are not as marked as they were a number of years ago.

Agnew et al. discuss the makeup of quality health services for Pacific peoples. They comment:

> Pacific models of care are informed by Pacific Models of health belief. Pacific Models of service delivery are also informed by these Pacific Models of health belief or health care. Fully developed Pacific Models of service delivery exist in implicit rather than explicit forms. To develop more explicit articulations of Pacific Models of service delivery, services need to develop written expositions of how these models might be framed, taking into equal account cultural, clinical and service Management issues (Agnew et al, 2004).

CULTURAL COMPETENCY

Only recently has specific research emerged on cultural competency development within the health sector with a specific focus on Pacific peoples. It is most evident within the mental health and addictions sector (Enosi et al, 2005). Enosi et al's study on cultural competency, Exploring Cultural Competency in Pacific Mental Health, aimed to record Pacific mental health providers' perceptions and practices of cultural competency. Through five ethnic-specific fono in Auckland, drawing on the experiences of Samoan, Tongan, Cook Islands, Niuean and Fijian groups, its key finding was the consistent opinion on clinical and cultural competencies:

> All five workshops were supportive of incorporating medical terms into local ethnic languages and/or adapting clinical practices to include cultural competencies and vice versa. All five groups also noted the value of utilising a combination of clinical, spiritual and/or traditional healing practices to address Pacific health problems (Enosi et al., 2004)

HOST RESPONSIBILITY

The host responsibility concept has attracted significant attention during the past decade as an alternative and appropriate strategy to minimise alcohol-related harm.

According to ALAC, host responsibility emerged in New Zealand with the introduction of the Sale of Liquor Act 1989, which required bars and bar staff to take responsibility for their guests and follow a set of guidelines. It focuses on places in the community where alcohol is served and aims to reduce alcohol-related harm by creating welcoming and comfortable drinking environments where alcohol is served responsibly. For ALAC, a responsible host:

- prevents intoxication
- does not serve alcohol to minors
- provides and actively promotes low- and non-alcoholic alternatives
- provides and actively promotes substantial food
- serves alcohol responsibly – or not at all
- arranges safe transport options.

During the early 1990s, ALAC initiated strategies to encourage drinking in moderation in order to reduce alcohol-related problems for all New Zealanders. It also implemented a Maori strategy, Manaaki Tangata, to promote moderation in alcohol use by Maori.

In 1999, ALAC commissioned a scoping paper to address host responsibility and drinking in moderation among Pacific peoples (Lima, 1999a). A continuation of ALAC's initiative "to promote safer drinking environments where alcohol is served responsibly" (Lima, 1999a p.8), it provided a detailed step-by-step project overview and commented, among other things:

- on the need for a pilot study to identify and assess the level of Pacific peoples' understanding and awareness of the adverse effects of alcohol and of host responsibility
- that the objectives of the proposal requested by ALAC could best be achieved by promoting alcohol educational programmes and initiatives that target all groups of the Pacific population
- that mass media as well as Pacific traditional media have crucial roles in informing Pacific communities of the harmful effects of alcohol on people's health and wellbeing
- that members of Pacific communities should be proactive and work collaboratively with organisations such as ALAC and other key stakeholders to address drinking in moderation and host responsibility among Pacific peoples (Lima, 1999a p.27).

The scoping paper also identified and raised other issues that needed addressing when developing and implementing a host responsibility project among Pacific peoples:

- The need for more Pacific community participation in the research process.
- The need for a holistic approach that considers Pacific cultural groups' diverse needs.
- The importance of the church's role, particularly that of church leaders in promoting alcohol awareness.

- The value of exploring the use of the successful Pacific Island Heartbeat project as a model for other Pacific health-promotion initiatives, such as the host responsibility project ALAC was looking to develop for Pacific communities at the time (Lima, 1999a pp.9-16).

Since then, ALAC has continued to promote drinking in moderation and alcohol-related harm minimisation among Pacific peoples. In recent years its host responsibility resources have been translated into some of the main Pacific languages.

HOST RESPONSIBILITY AND PACIFIC PEOPLES

The concept of host responsibility can be problematic in some cultural and social contexts. Among Pacific peoples, for example, Lima (2000, 2004) notes that, as a strategy to minimise alcohol-related harm, it:

> …has not gained a lot of ground although constant efforts by organisations such as ALAC, to set in train processes which could promote the concept have gathered momentum over the last few years (Lima, 2004 p 431).

Lima suggests that:

> …concepts such as host responsibility and drinking in moderation are somewhat problematic in the Samoan cultural context wherein hospitality and generosity translates to providing food and drink in abundance (Lima, 2004 p.431).

This is also recognised in earlier research on the place of alcohol in the lives of Pacific peoples, which finds that promoting drinking in moderation within Pacific cultures may be seen as promoting stinginess or meanness (ALAC and Ministry of Health, 1997a p.17).

The following observations from key informants in a recent study (Lima, 2004) – two elderly Samoans, a general practitioner (GP) and a Catholic priest – may help to explain why this strategy appears to be problematic within some Pacific cultures.

> …alcohol was a Western commodity which was introduced by Europeans just as some Europeans brought the Bible to Samoa. And because it [alcohol] was an introduced commodity, Samoan people who perceived the European God as more powerful, and European technology such as 'man-o-wars', firearms, clothes, tools, and even food as superior to traditional Samoan gods and stone-age technology, that Samoans placed more values on European things (GP key informant, cited in Lima, 2004 p.431).

The GP also explained that "Samoans in the past were particularly inclined to offer what wasn't commonly available when they hosted visitors." He said the Samoan mentality of wanting to offer something, such as rarely available food, later included alcohol.

The Catholic priest key informant expressed similar sentiments, noting that "being a host is an important and endearing value and norm of fa'asamoa". However, he also said that over the years alcohol had found its way into and a place within 'taligamalo' (hosting of guests). He said he still practises that Samoan generosity and spirit of hospitality when Samoan visitors he knows and respects visit Auckland. He said he would look for something special that he knew the other person was fond of, such as a favourite food, and take that along when he visited. Likewise, the priest noted that when some people came to visit him they also brought gifts such as "rarely available in Auckland Samoan food" (Lima, 2004 p.432).

PACIFIC ISLAND HEARTBEAT PROJECT

The Pacific Island Heartbeat project has been promoted as an example of a successful Pacific health-related initiative (Kephart, 1997). It is "a heart-health promotion programme that encourages lifestyle changes for Pacific people in New Zealand. The programme assists in the prevention of coronary heart and blood vessel disease" (North Health, 1996, cited in Lima, 1999a pp.14-15). Initiated in 1991, it was devised through a Pacific coordinator and a committee of Pacific peoples representing various groups (Kephart, 1997).

Kephart identifies this and the Oasis Resources Immunisation Promotion project as two effective health initiatives for Pacific peoples that involved Pacific communities. Kephart notes that the services they provided were established, delivered and guided by Pacific peoples for Pacific peoples, and that money and resources are crucial determinants of the success or failure of such projects:

> …without financial capability to employ people and purchase resources, these initiatives would not be able to survive (Kephart, 1997 p.34).

As well as documenting these two projects, Kephart lists more than 50 New Zealand health initiatives directed towards Pacific peoples. Some, including a small number of alcohol and drug services, are still underway.

Aseta Redican, the original coordinator of the Pacific Island Heartbeat project, stated during a discussion that the project started from a community base. It was later used as the springboard for the Pacific Island chapter of the New Zealand Heartbeat Programme. Aseta said that, with a little innovation and flair for creativity, a mainstream community programme that was about to be 'scrapped' in the early 1990s was transformed into a vivacious project to address a specific need of a particular population. This innovative initiative used effective Pacific community networks and partnerships between health professionals and community groups (Lima, 1999a pp.14-15).

CULTURALLY BASED INTERVENTIONS

Culturally based interventions, which incorporate indigenous and ethnic minority groups' cultural values and include traditional cultural practices, have been considered for research in other sectors.

Rapua Te Huarahi Tika – Searching for Pacific Solutions reviews research on effective interventions for reducing offending by indigenous and ethnic minority youth. Undertaken for the Ministry of Youth Development by Singh and White (2000), it notes that successful interventions use culture to help participants identify with and take ownership of programmes that incorporate specific processes for reducing re-offending (Singh and White, 2000 p.38).

Culturally based interventions have been used in other parts of the world, including Polynesia. For example, two interventions in Hawaii involved Native Hawaiian participants in their design and delivery:

- The first, Ho'oponopono, Ho'oponopono (to set right), is a family-focused holistic approach for maintaining and restoring relationships with family members and others and a spiritual realm (Mokuau, 2002). It involves several stages, each focusing on identifying the problem, expressing and discussing thoughts and feelings, rendering an apology for contributing to the problem and granting forgiveness, and releasing the problem.

Facilitated by a respected elder, family member or community leader, Ho'oponopono begins and ends with a prayer invoking guidance from spiritual powers (either traditional Hawaiian sources, such as ancestral spirits called 'Aumakua - the Christian God). In one substance abuse programme, Ho'oponopono is used as a therapeutic intervention to prevent substance use by people released from prison, by helping them

DISCUSSION OF THE LITERATURE AS IT RELATES TO THE PROJECT

This literature review is part of a wider endeavour to develop a community-based intervention project to minimise harm from alcohol misuse in New Zealand's Pacific communities. It aims to identify and collate all the relevant published and unpublished material that might inform the development of such an intervention.

Although areas of Pacific life still require more intensive research, there is enough literature to contribute to this project. Some relates to the lives of Pacific peoples in New Zealand; others take an international perspective.

This section focuses on several areas critical to developing a successful intervention strategy:

- Literature that contributes to an understanding of the problem.
- Literature that contributes to the development of appropriate interventions.
- Engagement methods.
- Narrative as the basis of intervention.

THE PROBLEM

The literature review has established that 'harms' are being caused to Pacific peoples in New Zealand by their drinking practices, and has identified the nature of some of those harms.

People from the Pacific migrated to and settled in a society where drinking was the norm (ALAC, 2005). As a country, we have adopted a 'binge-style' drinking pattern where people consume more than the recommended upper level for responsible drinking on each occasion. Although more Pacific people are reported to be non-drinkers than the general population, those who do drink consume on average three times the annual quantity of their Palagi contemporaries.

Binge-style drinking is also the norm for youth of all cultures in New Zealand, including Pacific youth. However, the young people of this country do not exist in isolation, and interventions developed to reduce harms in this group cannot be considered separately from the social conditions in which they live.

Drinking alcohol in this way leads to a number of identifiable harms, including:

- injuries resulting from accidents or fights
- problems with relationships because of alcohol
- problems at work
- neglect of family responsibilities
- embarrassment from indulging in non-usual behaviours.

Excessive alcohol consumption can also impact negatively on physical health, cultural identity and spiritual practices. There is no doubt that the way Pacific peoples are drinking is contributing to harm, not only for the individuals consuming alcohol, but for the lives and wellbeing of their families and communities.

THE INTERVENTION

There are a number of intervention levels for problems created by drug and alcohol consumption. The first, and most common, is the individual, and programmes have been set up in New Zealand to 'treat' identified patients.

Gray (2005a) finds that Australia, in spite of substance misuse problems being socially determined, has a disproportionate number of interventions targeted at individuals and families in indigenous communities, with mainstream programmes being adapted to local cultural situations. The cultural 'adaptations' often include the unsatisfactory involvement of participants in forums or on advisory boards (Mohatt et al, 2004). Gray (2005a) argues that "deeper levels of inquiry become possible [only] when community representatives with differentiated roles and expertise reciprocally share the responsibility for inquiry with the researchers".

Effective strategies for minimising harm for Pacific peoples must include national strategies addressing alcohol promotion, advertising, marketing, supply and control.

PARTICIPATORY ACTION RESEARCH

The participatory action research approach locates cultural groups as the 'experts' in their own lives and enables the development of interventions that provide real solutions to real problems.

The model fits well with New Zealand's heterogeneous Pacific community, as it allows each community to come up with its own solution. The literature review found a number of projects that had successfully used it for intervening with indigenous and culturally anchored problems.

The model offers research teams a way to engage with communities on their own terms and generate an innovative solution outside the current individual 'therapies'. This solution may benefit the individual even though it is not exclusively directed at them.

Without wishing to predetermine the outcome of Le Ala's next phase, Gray (2005a) identifies the key success factors for ventures that have reduced substance misuse in indigenous communities in Australia: community control, good governance and social accountability; and holistic, multi-strategy and flexible interventions. This literature review identifies a number of strategies that have succeeded to a greater or lesser degree with Pacific communities (e.g. host responsibility, performance, and the use of multi-media). These may form part of an ongoing multi-strategy intervention, but this will only be determined by the outcome of the participatory action research.

NARRATIVE INQUIRY AS THE BASIS OF A SUCCESSFUL INTERVENTION

The study of life stories or narratives as a way of understanding how individuals and communities make sense of their world is becoming increasingly popular in culturally based and addictions literature. Story-telling is gaining traction as the foundation of legitimate and successful interventions in 'cultural communities' with strong oral traditions.

The ideas that inform existing interventions, participatory action research and narrative inquiry are not mutually exclusive. There are points of continuity and intersection that form a solid base from which to springboard interventions of the future.

A synthesis of past and present enables cultural communities to maintain the essence of their stories and traditions and apply them to modern contexts and challenges. The narrative approach is flexible and inclusive and can apply to individuals, families or communities. It allows solutions aimed at minimising harm from alcohol to be gleaned from narrative identity and interpreted through the 'cultural eye'.

CONCLUSIONS

This literature review has identified the need for prevention strategies to address the growing problem of alcohol misuse and the concomitant problems among some Pacific communities in New Zealand.

The theses, scoping and discussion papers, keynote addresses, conference presentations and other material show that alcohol has secured a firm place in the lives of many Pacific peoples, and its misuse (mainly by men) has become a major challenge for Pacific communities. The New Zealand Government, non-government organisations and other agencies such as ALAC have initiated research, health services and preventive strategies to address the onset of alcohol misuse among some Pacific groups. However, more work is needed to ensure those who misuse alcohol are not harming others.

Most studies reviewed identify the need for educational programmes and health-promotion initiatives to raise awareness among drinkers and the general public of alcohol's adverse effects on health and wellbeing. However, general information on the consequences of excessive consumption is not enough to overcome the negative impacts on the health and wellbeing of New Zealand's Pacific communities.

A solid body of local and international literature provides the foundation for an alternative, innovative, community-based intervention that, through a narrative, story-telling approach, can successfully address issues that are culturally important to both young and old. Two 'narrative threads' – religious beliefs and commitments (identified in the Ministry of Health document [2004a] as limiting the amount of alcohol drunk by Pacific peoples) – need to be explored through further qualitative inquiry.

This inquiry can take place through participatory action research – a scientifically rigorous yet adaptable method that accommodates the diverse requirements of the unique Pacific 'learning communities'.

RECOMMENDATIONS

This report recommends that a Pacific community-based intervention(s) that aims to minimise harm from alcohol misuse be designed, implemented and evaluated using participatory action research to ensure practical solutions to 'real life' problems.

The intervention(s) should:

- be culturally effective, holistic and flexible in design for diverse Pacific population groups
- be controlled by Pacific communities with good governance and social accountability
- have built-in effectiveness evaluations
- be based on the stories and 'narratives' that are integral to the life and survival of each Pacific community
- consider the range of 'harms' created by alcohol misuse in the Pacific community
- involve consultation with all sectors of the Pacific community, including church and community leaders and youth
- produce a range of strategies, from primary prevention to treatment, that successfully minimise harm from alcohol misuse.

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United States Indian Health Service www.ihs.gov.

University of Auckland Division of Maori and Pacific Health www.auckland.ac.nz/mpih/pacific.

Werry Centre for Child & Adolescent Mental Health, University of Auckland http://werrycentre.org.nz.

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APPENDIX 1: SYSTEMATIC LITERATURE SEARCH STRATEGIES

SEARCH STRATEGIES

The review involved two separate searches of the bibliographic resource.

- Search A covered effective treatment interventions for alcohol-related addictions. It drew from the general literature, concentrating on systematic reviews, meta-analyse, and recent randomised controlled trials. A second stream of search A looked at cross-cultural treatment issues
- Search B identified education, prevention and health promotion for alcohol and drug addictions relevant or transferable to Pacific peoples.

Search A produced a large amount of detailed literature on effective treatments - with many Cochrane reviews, guidelines, health technology assessment reports and other evidence-based resources – so took a broad rather than in-depth approach. However, the cross-cultural literature on treatment was much smaller, so the search extended beyond evidence-based literature to include any items that seemed relevant for the review.

Search B identified that the journal literature on Pacific peoples and other indigenous groups was not extensive, and that the illness prevention/health-promotion literature was smaller still. The search attempted to be as broad and extensive as possible.

Both the cross-cultural and the indigenous literature overlapped at times with accident prevention. References were included in the literature search if they came up in the course of the search, but accident prevention was not specifically included in the strategy.

PUBLICATION TYPE

The review covered studies published from 1990 onwards inclusive in the English language. These included primary (original) research (published as full original reports) and secondary research (systematic reviews and meta-analyses) appearing in the published literature.

CONTEXT

The literature search included studies reporting on:

- clinical and other treatment (with a best practice focus)
- health promotion and illness prevention (including studies analysing effective technologies for communicating key messages and workplace injury prevention research and interventions)
- community development and evaluation
- organisational systems for providing community interventions (leadership, management and quality systems analysis etc).

UNPUBLISHED RESEARCH/GREY LITERATURE

'Unpublished research' refers to papers and workshop presentations relevant to the objectives. It was sourced through personal research networks and searches of major educational research bibliographical databases and printed directories in SCRE and educational libraries.

While there is a voluminous supply of national and international published literature on the review's key

areas, there is a paucity of unpublished literature on alcohol community interventions and services for Pacific peoples, whether in New Zealand or in the Pacific region.

However, this dearth of information did not deter efforts to glean written and even verbal (though informal) information from Pacific colleagues and friends. Informal discussions via face-to-face and telephone conversations helped to confirm the paucity of data on Pacific peoples' alcohol use and abuse; however, there are already some initiatives aiming to improve the information available on alcohol treatment, such as screening for early signs of alcohol problems in primary care services.

For example, a pilot project is underway at a primary health clinic in Auckland to test the onset of alcohol abuse with some patients. Still in its infancy, the pilot requires medical practitioners to screen patients, using a qualitative set of questions, on their alcohol use. The screening questions help to signal whether a patient may be 'at risk' of having more serious alcohol-related problems. However, the pilot is not Pacific-specific, although it includes screening Pacific clients.

This type of anecdotal information, while sparse in detail and requiring further confirmation, is an example of the results of informal conversations on health initiatives in relation to Pacific peoples' alcohol use and abuse. It shows that reviewing unpublished material on a particular issue can inadvertently bring to light rare information that could be quite useful.

Also of note is the way published literature has been interspersed with unpublished material. This signals that while a deliberate effort has been made to determine whether literature is published or unpublished, there can be no guarantees. Unpublished literature has been determined as material not found in books, peer-reviewed journals and any other formal publication mode. The bulk is made up of doctoral and Masters theses, postgraduate papers and literature produced for purposes such as keynote addresses, conference presentations, pilot project reports and discussion and scoping papers.

STUDY DESIGN

There were no limitations on study design.

PRINCIPAL INFORMATION SOURCES

The literature was searched using the bibliographic databases Medline, Embase, Cinahl, Current Contents, the Science/Social Science Citation Index, the Cochrane Central Register of Controlled Trials, Psychinfo, Index New Zealand and the Te Puna-New Zealand Bibliographic Database.

Other electronic and library catalogue sources searched included the Cochrane Database of Systematic Reviews, the Database of Abstracts of Reviews of Effects (DARE), the Health Technology Assessment Database, the ACP Journal Club and Clinical Evidence. The Internet was used to access health departments internationally, professional psychiatry and emergency medicine associations and mental health organisations.

In New Zealand, databases were accessed from the National Bibliographic Database, the Ministry of Health website and library, university and medical library catalogues and the New Zealand Health Technology Assessment unit's in-house collection. The search also identified relevant publications referenced in material obtained during research on the topic. Relevant papers that had cited included papers published from 1990 onwards were also identified using the Science Citation Index.

Searches were limited to English language material dated from January 1990 to August 2005 inclusive.

SEARCH TYPES

The review involved three searches:

- Search A covered effective interventions for treating alcohol-related addictions
- Search B covered effective education, prevention and health promotion initiatives for alcohol and drug addictions that are relevant and transferable to Pacific peoples

This report was prepared using a well tested, systematic searching, selection and appraisal method. The search involved the following databases:

Bibliographic Databases

- Cinahl
- Cochrane Central Register of Controlled Trials
- Current Contents
- Embase
- Index New Zealand
- Medline
- Psychinfo
- Science/Social Science Citation Index
- Te Puna – New Zealand Bibliographic Database

Review Databases

- ACP Journal Club
- Clinical Evidence
- Cochrane Database of Systematic Reviews
- Database of Abstracts of Reviews of Effects (DARE)
- Health Technology Assessment Database

Evidence-Based and Guideline Websites

- TRIP database www.tripdatabase.com
- Scottish Collegiate Guidelines Network www.sign.ac.uk
- National Electronic Library for Health Guidelines Finder http://libraries.nelh.nhs.uk/guidelinesFinder
- Guidelines International Network www.g-i-n.net
- Primary Care Clinical Practice Guidelines (University of California, San Francisco) http://medicine.ucsf.edu/resources/guidelines/index.html
- New Zealand Guidelines Group www.nzgg.org.nz
- United States National Guidelines Clearing House www.guidelines.gov

- ARIF – University of Birmingham www.arif.birmingham.ac.uk
- ATTRACT – NHS Wales www.attract.wales.nhs.uk

University Library Catalogues

- Auckland University of Technology http://aut.lconz.ac.nz
- Lincoln University www.lincoln.ac.nz/libr
- Massey University http://kea.massey.ac.nz/search
- University of Auckland www.library.auckland.ac.nz
- University of Otago www.library.otago.ac.nz
- University of Canterbury www.library.canterbury.ac.nz
- Victoria University www.vuw.ac.nz/library
- Waikato University www.waikato.ac.nz/library

Other Sources

- Mental Health Commission www.mhc.govt.nz
- Werry Centre for Child & Adolescent Mental Health, University of Auckland http://werrycentre.org.nz
- New Zealand Ministry of Health Pacific Health Branch www.moh.govt.nz
- Ministry of Pacific Island Affairs www.minpac.govt.nz
- Counties Manukau District Health Board www.cmdhb.org.nz/Counties
- Capital and Coast District Health Board www.ccdhb.org.nz
- Auckland Regional Public Health Service www.arphs.govt.nz
- Alcohol & Public Health Research Unit, University of Auckland www.aphru.ac.nz
- New Zealand Drug Foundation www.nzdf.org.nz
- University of Auckland Division of Maori and Pacific Health www.auckland.ac.nz/mpih/pacific
- Hawaii State Department of Health www.hawaii.gov/health/mental-health
- United States Substance Abuse and Mental Health Services Administration www.samhsa.gov
- United States Indian Health Service www.ihs.gov
- Information Centre on Aboriginal Health www.icah.ca
- Paktuutit Inuit Women of Canada www.pauktuutit.ca
- Institute for Circumpolar Health Studies Center for Alcohol and Addiction Studies (University of Anchorage) www.ichs.uaa.alaska.edu/caas/default.htm
- Institute of Aboriginal Peoples' Health www.cihr-irsc.gc.ca/e/8668.html

- Hawaii State Department of Health www.hawaii.gov/health/substance-abuse/prevention-treatment/survey/adsurv.htm
- Health Canada www.hc-sc.gc.ca
- Health Canada First Nations and Inuit Branch www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index_e.html
- World Health Organization Regional Office for the Western Pacific www.wpro.who.int

Unpublished research was also identified in this review.

STUDY SELECTION

Studies were selected by:

- scanning (and excluding as appropriate) the titles and abstracts (where available) identified from the search strategy
- retrieving the full text articles for the remaining studies
- appraising the articles against the above study selection criteria.

Full text publications were obtained after excluding studies from the search titles and abstracts.

STUDY APPRAISAL

The evaluation initially classified studies according to the National Health and Medical Research Council's (NHMRC's) (2000) evidence criteria and ranked according to a predetermined quality "evidence hierarchy".

These evidence levels are a broad indicator of research quality, describing groups of research broadly associated with particular methodological limitations. However, they are only a general guide to quality because each study may be designed and/or conducted with particular strengths and weaknesses. High-level evidence is provided by a well conducted randomised-controlled trial. NHMRC checklists of quality issues to consider in appraising research studies were also used when relevant to study design.

The results are presented under six main headings:

1. Epidemiological data – local and international.
2. Trans-cross cultural psychiatry.
3. Trans-cross cultural and social psychology.
4. Social marketing interventions.
5. Action research, community development.
6. Evaluation research.

Community-partnered approaches to research promise to deepen our scientific knowledge base in health promotion, disease prevention and health disparities. They offer the potential to generate better-informed hypotheses, develop more effective interventions and enhance the translation of the research results into

practice. Specifically, involving community and academic partners as research collaborators can improve the quality and impact of research by:

- more effectively focusing the research questions on health issues of greatest relevance to the communities at highest risk
- enhancing recruitment and retention efforts by increasing community buy-in and trust
- enhancing the reliability and validity of measurement instruments (particularly surveys) through in-depth and honest feedback during pre-testing
- improving data collection through increased response rates and decreased social desirability response patterns
- increasing the relevance of intervention approaches and thus the likelihood of success
- targeting interventions to the identified needs of community members
- developing intervention strategies that incorporate community norms and values into scientifically valid approaches
- increasing accurate and culturally sensitive findings' interpretation
- facilitating a more effective dissemination of research findings to impact on public health and policy
- increasing the potential for translating evidence-based research into sustainable community change that can be disseminated more broadly.

For the purpose of this participatory action research (PAR), 'community' refers to populations that may be defined by:

- geography, race, ethnicity, gender, sexual orientation or disability, illness or other health condition
- groups that have a common interest or cause, such as health or service agencies and organisations, health care or public health practitioners or providers and policy makers

or

- lay public groups with public health concerns.
- 'Community-based organisations' refers to organisations that may be involved in the research process as community members or representatives. Potential community partners include tribal governments and colleges, state or local governments, independent living centres, other educational institutions such as junior colleges, advocacy organisations, health delivery organisations (e.g. hospitals), health professional associations, non-governmental organisations and nationally qualified health centres.

APPENDIX 2: SOME USEFUL TERMS AND CONCEPTS

The following terms have been adapted primarily from World Health Organization (1994).

ABSTINENCE

The word 'abstinence' is used when people decide not to use a drug or to stop taking a drug or substance at all times and under all circumstances. People who abstain usually do not intend to use the drug again.

ADDICTION, ADDICTIVE BEHAVIOUR

Addiction to a drug means that the person:

- has a strong desire or compulsion to use the drug (cannot think about anything else)
- finds it difficult to control the drug-using behaviour
- is uncomfortable or distressed if the drug-taking is prevented or stops (withdrawal symptoms)
- keeps using the drug, even when it is causing problems.
- Sometimes this word is used in the same way as drug dependence. The problem with using the word 'addiction' is that people are often labelled as 'junkies' or 'drug addicts'. This term can make us think of them as criminals, dangerous and generally unpleasant people. It also suggests that they are unable to control their lives or change drug-taking patterns.

BINGE DRINKING

Binge drinking refers to the rapid consumption of alcohol over a short period of time to the point of intoxication. There are two forms of binge drinking:

The consumption of five or more drinks in one drinking session

Heavy and continuous drinking over a number of days or weeks.

DRUGS DEFINED

The definition of a drug in the New Zealand National Drug Policy consultation document (Ministry of Health, 2006 p.15) covers a broad base of substances with psychoactive effects. These substances are divided into four categories – tobacco, alcohol, illicit and other drugs.

DRUG ABUSE

This term is often used to describe drug use that causes harm. The problem with using this term is that it can create negative feelings or attitudes toward the user. It is not a recommended term.

DRUG MISUSE

This term is also used to describe harmful or inappropriate use of drugs. It is often used synonymously with the terms 'drug abuse', 'addiction' and 'dependence' but is a preferred term because it does not have the same negative meanings about the user.

DRUG DEPENDENCE

Drug dependence occurs when a drug becomes central to a person's thoughts, emotions and activities. Using the drug takes on a higher priority than many other things in life and the person may neglect other responsibilities.

Being dependent makes it hard for people to stop or even cut down on the drug. They may want to take the drug continually for its effects or to avoid the discomfort and distress of not having it (withdrawal).

DRUG USE

This term means taking drugs. The term does not necessarily mean that the drug taking is harmful or ongoing.

EXPERIMENTAL USE

Sometimes people try out a drug to see what it is like. They might try it once or a couple of times. Many children experiment with different drugs with their friends or family members. While studies on experimental use have not been included in this review, the term has been retained in the appendix because experimentation is usually the way into drug and alcohol use for a young person. Strategies around experimentation may ultimately be incorporated into a community-based intervention for Pacific peoples.

DRUG-RELATED HARM

Drug use can harm virtually every aspect of people's lives. Drug use can result in harm to health, including death, illness, disease, mental health problems and injury. Harms may be chronic, such as depression or heart disease, or acute, such as injuries from falls or car accidents.

Social harms are also associated with drug use. They can include interpersonal violence, family and relationship breakdowns and child neglect.

Economic harms can be the costs of health services, property damage, low productivity and work absenteeism.

As well as affecting the individual user, drug use harms the family and the community in which the individual lives e.g. alcohol may be associated with domestic violence. (Ministry of Health, 2006).

HARM MINIMISATION/HARM REDUCTION

A drug strategy based on a harm minimisation approach has three primary objectives:

- To minimise the harm and the social problems to the individual and the community resulting from the use of drugs
- To reduce the prevalence of hazardous levels and patterns of drug use in the community
- To prevent the initiation into harmful or hazardous drug use, especially by young people (NSW Health Department, 1999 p.A5).

HARM-REDUCTION STRATEGIES

Harm-reduction strategies are designed to reduce the impacts of drug-related harm on individuals and communities. Governments do not condone illegal risk behaviours such as injecting drug use; they acknowledge that these behaviours occur and that they have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause (Ministerial Council on Drug Strategy, 1998 p.46).

HARMFUL USE

This term describes drug use that causes damage to either mental or physical health. It can also refer to the harm caused to the drug user's family or community in general.

INTOXICATION

People are said to be intoxicated when they use an amount of a substance that produces noticeable changes in their behaviour.

RECREATIONAL OR SOCIAL USE

Sometimes people use a drug or drugs on a casual basis to enhance socialising or to increase their enjoyment of leisure and recreational activities.

TOLERANCE

If a person repeatedly takes a drug, their body becomes used to working with a certain level of the drug in the bloodstream. The person's body adapts to the presence of the drug (they develop a tolerance to the drug) and then have to increase their intake to get the desired effect, for example to feel 'high'.

Tolerance can develop to most drugs if they are used regularly. People who regularly use alcohol, tobacco, coffee and tea will develop a tolerance to them and may feel unwell when they stop taking them.

WITHDRAWAL

Dependence, both physical and psychological, results from using some drugs regularly. When a person stops taking a drug, they may experience unpleasant physical and mental effects ('withdrawal symptoms') that are different for each drug. People experiencing these symptoms are said to be 'in withdrawal'.

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