

ASIAN PACIFIC ALCOHOL PEER
CONSULTATION AND TRAINING
PROJECT

NEEDS ASSESSMENT

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ACKNOWLEDGEMENTS

The Asian Pacific Alcohol Peer Consultation and Training Project was made possible because of the active involvement of various institutions and individuals. For their invaluable support and assistance, the Project Staff acknowledges the following:

- STATE of CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS, HEALTH AND WELFARE AGENCY, for providing the funds.
- SPECIAL SERVICE FOR GROUPS, for administrative and fiscal support

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I. PROBLEM STATEMENT

There is little information regarding the Asian and Pacific Islanders who are at-risk of having alcohol problems. The information regarding the drinking patterns and recovery issues of Asian and Pacific Islanders is sparse and does not show the different patterns between the ethnic groups. The information also shows little about Asian Pacific individuals who are at-risk. There is also a lack of data on the social, cultural and psychological factors needed to make up profiles of at-risk persons. These lead to the conclusion that there is a low occurrence of alcohol problems.

To better understand this at-risk population, the target population of the Needs Assessment for the Asian Pacific Alcohol Peer Consultation and training Project included those who are at-risk for alcohol problems from six Asian Pacific groups (Chinese, Japanese, Korean, Pacific Islander, Pilipino and Southeast Asian). Sociodemographic characteristics and associated psycho social factors were assessed for this at-risk group.

Descriptive research in this area indicates heavy alcohol use among four groups: Japanese, Chinese, Korean and Pilipino. However, this finding is a decade old and only implies the existence of alcohol problems. Clearly more research on alcohol problems and its social and psychological causes is needed in order to determine service needs.

The Asian Pacific population of approximately seven million people is the fastest growing ethnic group in the United States. There is a great diversity among "Asian/Pacific Islanders" - - at least 32 different nations and ethnic groups (Trimble, Padilla and Bell, 1987). Nearly half of the Asian Pacific population are foreign born. Southeast Asians are the newest

and fastest growing Asian population on the West Coast. In California the Asian Pacific population is the third largest ethnic group, behind Caucasians and Latinos, comprising almost 10% of the population (Chi, Lubben and Kitano, 1989; 1980 Census data). The 1990 Census data shows the increasing numbers of Asian Pacifics in California and nationwide.

There is little data about the Asian Pacific population and substance abuse. Further, most of the data available deals with Asians as a single ethnic entity, with the assumption that drinking patterns for all Asian groups are the same. This tendency to lump such diverse groups into a single "Asian American" category "tends to confuse the already lamentable state of research on this topic" (Yu and Liu, 1987).

From 1973 to 1983, the National Institute on Drug Abuse did not fund any research programs focusing on the Asian Pacific population (Trimble, Padilla and Bell, 1987). One possible reason for the lack of information on alcohol and other drug abuse among Asians is due to the stereotype held by researchers and service providers that Asians do not have drug problems and therefore are not in need of in-depth study - the "model minority stereotype. This does not show the differences between the various subgroups. Substance related problems that do exist within the subgroups need to be recognized in order to develop successful programs.

Another barrier to research on alcohol problems in the Asian Pacifics is the belief that there are certain physiological states that prevent excessive drinking. The "flushing reaction "which is characterized by flushing, rapid heartbeat, a generalized feeling of being ill and other feelings of discomfort, is exhibited by some Asians after the consumption of alcohol. This reaction is due to the lack of a liver enzyme called

ALDH-1 which is involved in the metabolism of alcohol. It has been noted that “in effect, the absence of ALDH-1 acts as a natural equivalent to the administration of the drug disulfiram (Antabuse) by creating a physical reaction to alcohol that is so unpleasant that it discourages many Asians from drinking excessively. (Stoil, 1987).

However, the “flushing reaction” is not a good predictor in the discouragement of alcohol consumption. Not all Asians experience the “flushing reaction”, and the occurrence of flushing differs from one Asian group to another. It has been noted that other groups, such as Native American Indians, who flush, still have high rates of drinking and alcohol problems (Sue, 1987). Further, not all Asians who flush stop drinking once flushing occurs (Sue, Zane and Ito, 1979; Chu, Fertig et al., 1978). The evidence from research to date indicates that flushing response within and between-groups of Asian Pacifics differ greatly. Therefore, based on these differences, it is not possible to predict drinking patterns regardless of generational status or cultural values (Sue, 1987).

In addition to academic research, community-based studies show extremely small numbers of Asian Pacifics enrolled in traditional health care programs. Asian Pacific groups tend to underutilize health and mental health services provided by state hospitals (Kitano, 1969; Okano, 1978), general hospitals (Yamamoto, James & Palley, 1968), community health centers (Brown, Stein, Huang & Harris, 1973; Sue, 1977), and university clinics (Sue & Sue, 1974; Sue & Kirk, 1975). At the same time, the evidence strongly suggests that, contrary to previous belief, many Asian Americans have significant alcohol-

related problems (Kitano, 1988, Chi, Lubben & Kitano, 1988). The underutilization of alcohol and other health services reflects problems in service delivery and treatment, but not a lower need for such services. Most mainstream health care services are not well equipped to respond effectively to the unique and cultural needs of Asian Pacific clients.

The frequency of heavy drinking among adult Japanese, Koreans and Pilipinos as shown in several studies (Kitano et al., 1988; Chi et al., 1988) indicate the need to understand the differences between the Asian Pacific subgroups and to determine how best to serve them. It is crucial that we learn more about the Asian Pacifics who are at-risk for alcohol problems, as well as, those with alcohol-related health problems.

III. LITERATURE REVIEW

Almost two-thirds of Asian Pacifics living in the U.S. are in three states:

California	35%
Hawaii	16%
New York	9%

In California, their numbers grew so fast during the 1980's that they are now the state's third largest ethnic group at 9% of the population, behind the Caucasians and Latinos (Chi, et al., 1989). The 1990 Census shows that the population of Pacific Asians in California is 12%.

Research in the area of alcohol and other substance abuse of Asian Pacifics is scarce, particularly for populations other than Chinese and Japanese. With the expanding number of refugees and immigrants currently living in the U.S., particularly from Southeast Asia, previous findings on alcohol problems must be viewed with circumspection. There are variations in how particular communities maintain their cohesiveness in terms of traditional customs, values, language and social organization. It must not be assumed that there is homogeneity in substance use among all Asian Pacific groups in the U.S.

Foreign born Chinese and Japanese populations, as well as, Chinese Americans and Japanese Americans, are less likely to seek treatment for alcoholism or alcohol problems than White Americans, according to data from a variety of courses. Low rates of alcohol-related hospital admissions for Asian Americans have been reported

(Chu, 1971; Rosenthal, 1970. Kitano and colleagues (1985) reported that few Japanese Americans are in alcoholism treatment programs. Although research on alcoholism in Asian Pacific populations is scarce, the data that exists support the view that members of this group are less likely to seek treatment for alcohol abuse or addiction.

Researchers at the University of California, Los Angeles, (Chi, Lubben and Kitano, 1989; Kitano and Chi, 1986; Lubben, Chi and Kitano, 1988; Chi and Kitano, 1989) have studied drinking among Chinese, Japanese, Korean and Pilipinos in Los Angeles. The combined studies showed that abstinence among these groups was high:

Abstaining	<u>Men</u>	<u>Women</u>
Japanese	17%	27%
Pilipinos	19%	55%
Chinese	21%	51%
Koreans	45%	75%
Heavy Drinking		
Chinese	14%	1%
Koreans	26%	1%
Pilipinos	29%	3.5%
Japanese	29%	11/7%

The researchers concluded that while the results confirmed the traditional view of Asian women as abstainers or light drinkers, they also revealed a considerable amount of

heavy drinking among men, particularly Japanese and Koreans, possibly as high as the general U.S. population. There is lack of similar data available for other Asian Pacific groups.

The Chinese, Japanese, Korean and Pilipino studied differed significantly in their drinking behavior. However, the men who drank heavily had similar characteristics: they were under age 45, of relatively high social status and educational background, in professional or white collar occupations, with permissive personal attitudes toward use, and with friends tolerant of drinking. There was little evidence of alcohol-related problems (e.g., arrest for drinking, loss of personal impairment, drastic changes in lifestyle).

Overall, previous studies indicated that Asians are less likely to be treated for alcoholism than are other ethnic/racial groups and that a large percentage abstain entirely from the use of alcohol. This low rate of Asian Pacifics receiving treatment and recovery services has been attributed to a lack of culturally sensitive treatment and recovery programs geared to the genetic/physiological factors and historical/cultural values of Asian Pacifics.

GENETIC AND PHYSIOLOGICAL FACTORS: There have been conflicting reports of the importance of the genetic/physiological determinant in the Asian Pacific drinking patterns. Various researchers have reported flushing of the neck and face after drinking small amounts of alcoholic beverages (Kitano et al., 1985; Seto et al., 1978;

Wilson et al., Ewing et al., 1974; Wolf, 1972). These researchers have hypothesized that flushing is due to a genetic predisposition and may indicate an intolerance to alcohol.

The high blood acetaldehyde levels of Asian subjects, was compared to the effects of Antabuse (disulfiram) which is used to treat alcoholism by making the individual intolerant to alcohol. The physiological basis has been traced to the lack of a liver enzyme, ALDH-I, involved in the metabolism of alcohol. Zeiner et al., (1979) hypothesized that the physiological reactions (flushing, increase in blood pressure, rapid heart beat) were associated with high acetaldehyde levels. Contrary to Zeiner et al., Set et al., (1978) found that there was no relationship between acetaldehyde level and severity of flushing and the other unpleasant symptoms.

The relationship between acetaldehyde levels and alcohol consumption is still unclear. Teed et al., (1976) reported that American Indians had approximately 50% higher acetaldehyde levels after ingesting alcohol than did Chinese and White subjects. Further, the American Indian group reported higher levels of alcohol consumption.

Another complication is the difference between “slow flushing” which occurs after two or more drinks and “fast flushing” which occurs after one drink or less. Fast flushers tend to report less alcohol use than slow flushers. Fast flushing is less common than slow flushing (Johnson, 1989). Not all Asians who flush stop drinking once flushing occurs (Sue, Zane and Ito, 1979; Fertig et al., 1978).

The research to date shows that the genetic and physiological factors do not adequately explain Asian Pacific drinking behavior. If these factors were determinants, there would be a predictable occurrence of intolerance to alcohol within and between Asian Pacifics regardless of generational status or cultural values.

SOCIOCULTURAL FACTORS: Since the genetic and physiological factors alone do not seem to account for ethnic differences in drinking behavior, many researchers have sought an explanation in the values, customs and traditions of the various Asian Pacific groups. Several researchers have noted that Americans value assertiveness, individual achievement, individualism and spontaneity, while the Chinese and Japanese value responsibility to others, interdependence, restraint, moderation and group achievement. Thus, it would seem that alcohol more likely would be used by Americans than people with Asian Pacific cultural traditions (Sue, 1987).

Researchers have observed that in accordance with Asian Pacific cultural values, drinking is social rather than solitary, occurs in prescribed situations, is usually accompanied by food, is used to enhance social interaction and occurs within a context of moderate drinking norms. Women are expected to drink little or no alcohol. In Chinese and Japanese cultures, aggressive, disorderly and noisy behavior when intoxicated are condemned. Thus, even when they do become intoxicated, Chinese and Japanese drinkers seldom get arrested for public drunkenness or other disorderly behaviors in public. Although cultural traditions tend to curtail heavy drinking, they also may hide problems that do exist (Chu, 1972; Kitano, Hatanaka et al., 1985; Chu,

Fertig et al., 1978; Singer, 1972; Wang, 1968; Chi Lubben and Kitano, 1989; Sue, 1987).

While alcohol is an essential part of religious ceremonies and festive occasions, excessive use is condemned as one of the four vices that men should seek to avoid (the others being womanizing, gambling, and opiate use)(Yu and Liu 1987). Wang (1968) believed that the importance of intellectual control within the Chinese culture made alcohol an unlikely drug of choice.

In both Chinese and Japanese cultures, there are strong sanctions against drunkenness, especially when associated with aggressive or violent behaviors (Kitano et al, 1985; Chu et al., 1979; Singer 1974; Wang 1966). According to Wang, when the Chinese are intoxicated, they are much more apt to display expansive speech and behaviors than aggression. Social prohibitions such as these account for the finding by Kitano and colleagues that drinking by the Japanese is not associated with problem behaviors or crimes in either the U.S. or Japan. Singer (1972) also indicated that when the Chinese are intoxicated, they refrain from disorderly behaviors in public. As a comparison, he indicated that crimes associated with drunkenness in 1968 and 1969 accounted for 1.75 percent of all arrests in Hong Kong versus 45 percent of all arrests in the U.S. Indochinese youths in the U.S. have also been found to be less likely than White, Hispanic and Black youths to report vocational, medical and legal problems as a result of drinking (Morgan, Wingard & Felice 1984).

Cultural background and drinking styles in other Asian groups differ tremendously. However, researchers hypothesize that the various Asian Pacific cultures are similar in their encouragement of moderate drinking.

ACCULTURATION: As has been found for Native Americans and Latinos, the level of alcohol use among Asian Pacifics is influenced by their degree of acculturation (Austin, 1989; Austin and Gilbert, 1989). According to the acculturation theory, Asian Pacifics who are recent immigrants should drink in a manner similar to drinking in their country of origin; as Asian Pacifics become more assimilated into American culture, their alcohol consumption should become more like that occurring in the American culture, their alcohol (Chi, Lubben and Kitano, 1989). It has also been hypothesized that alcohol consumption increases as Asian Pacifics try to cope with the stress that accompanies changes in social norms, family relationships and upward mobility (Yu and Liu, 1987). The evidence for the influence of acculturation on Asian Pacific drinking has been mixed.

In support of acculturation factors positively correlating with increased alcohol consumption, the drinking patterns of Japanese appear to be changing as a result of acculturation and exposure to the American value systems. Kitano et al (1985) found that younger males and females report heavier drinking and a lower percentage of

abstention than older Japanese individuals. In a survey of college students, Sue et al. (1979) found support for the hypothesis that highly assimilated Asian students drank more than did less assimilated students. Similar results were reported by Kitano, Hatanaka et al., (1985) for Japanese American adults. Yuen and Johnson (1986) found that daughters of Chinese and Japanese ancestry in Hawaii drank significantly more than their mothers did.

Other studies, however, have negated the acculturation theory. A survey of college students by Akutsu, Sue et al., (1989) concluded that acculturation was not a significant predictor of increased drinking among Asians. In a survey of Pilipinos in Los Angeles, women retaining Pilipino drinking patterns while men drank similarly to Western patterns, suggesting that other factors besides acculturation were operating (Lubben, Chi and Kitano, 1988).

The evidence regarding the relative influence of sociocultural factors (including acculturation) and physiological factors on Asian Pacific drinking patterns remains inconclusive, although it seems reasonable to assume that both operate and interact in ways not yet fully discerned. Sue and Nakamura (1984) have proposed the reciprocity model, in which alcohol consumption, the physiological dimension and the social/psychological dimension interact with one another. Within the social/psychological dimension, one's drinking behavior is presumed to be influenced

by cultural background as well as the mainstream American culture. They also suggest that researchers would benefit by considering successive generations of three groups: Asian Pacific Islander Americans, recently arrived Asian Pacific Islanders, and Caucasian Americans.

The physiological theory shows indices demonstrating that physiological factors can play a role in alcohol consumption levels. Other studies have shown that drinking tends to be greater among Asian Pacifics who are more assimilated into the American Culture, which could indicate that physiological factors don't automatically protect against higher levels of use. It also suggests that as young adults of Asian Pacific ancestry gradually loosen their adherence to traditional values and behaviors and adopt mainstream values, their use of alcohol and other drugs will increase, as will their risk of developing problems.

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August 1991

IV. METHODS

The Needs Assessment Survey of the Asian Pacific Alcohol Peer Consultation and Training Project was designed to identify the alcohol problems and needs of Asian Pacific population groups in order to identify gaps in services and to design strategies for improving and initiating services to the targeted Asian Pacific communities (i.e., Chinese, Japanese, Korean, Pilipino, Southeast Asian and Pacific Islander).

The project used a two-pronged approach to complete the Needs Assessment. This included 1) Key Informant Surveys (community perspective); and 2) Interview Survey with 204 Asian Pacific clients from Drinking Driver Programs (i.e. DUI clients and ex-clients). The Project expanded activities to include in-depth interviews with selected “high-risk” Asian Pacific individuals. The following are the methods employed by the Project:

A. KEY INFORMANT SURVEYS: For the Key Informant Surveys, the Project utilized existing community-based networks to draw together knowledgeable members with each community. Community consultants were selected by the Project to assist in this endeavor. These consultants nominated other community members to be invited to participate in the process. The selection of community leaders (as consultants as well as participants) was crucial as the results of the survey directly depended on the selected participants. Special Service for Groups and the Project have the demonstrated ability to network effectively with the various Asian Pacific

communities utilizing this methodology.

Every effort was made to select a cross-section of each community, including community leaders, service providers, and current/former clients, etc. Each meeting assessed the community's perspective on alcohol usage and related issues of treatment.

Ten (10) Key Informant Surveys were completed, representing the six targeted Asian Pacific communities. There were a total of eighty (80) participants. At least one Key Informant Survey meeting was held for each targeted community. All meetings were held in Los Angeles or San Diego counties. A copy of the meeting agenda is included in the appendix.

B. DUI CLIENT SURVEYS: Asian Pacific individuals who are significantly at-risk for alcohol problems were the target population for the DUI Client Interview Surveys. We focused on individuals who had been cited for "driving under the influence" (DUI) and were participating in court-mandated programs. This population provided a unique opportunity to assess alcohol related needs from the standpoint of Asian Pacific individuals and/or those who have exhibited problematic behavior. This is the first time this population has been studied, and it is one of the few attempts to extend the analysis beyond the largest Asian Pacific groups (i.e. Chinese, Japanese, Korean and Filipino).

The Project used a survey to gather data from these clients of Drinking Driver Programs (DUI Programs). The "hidden" population of at-risk subgroups within the

Asian Pacific population was more easily targeted by the Project because DUI Programs are court-mandated. Participants completed a variant of the Pacific Asian Alcohol Use Survey Form developed by Kitano and his colleagues (Kitano, Lubben & Chi, 1988). Interview questions were based on a study by Cahalan et al., (1969), and drinking patterns were measured on a variation of Cahalan's quantity, frequency and variability (QFV) scale. The QFV scale has five categories: heavy, moderate, light, infrequent drinkers and abstainers. The quantity of alcohol consumed per occasion, the frequency of occasions and the variability of time and amount were used as measures of alcohol consumption. The survey form includes sociodemographic information, reasons for drinking (e.g. boredom, anxiety, etc.), other substance abuse, and history with alcohol service providers as well as recommendations for service delivery.

The procedure for acquiring survey participants first was to identify counties in the state with the highest population concentrations of the six targeted Asian Pacific ethnic groups (Chinese, Japanese, Korean, Pacific Islander, Pilipino and Southeast Asian). These counties, it was assumed, would have the highest number of Asian Pacific DUI participants compared with other counties in the State. The five counties selected to represent Northern and Southern California were Los Angeles, Orange, San Diego, Santa Clara and San Francisco.

DUI service providers in each selected county were contacted by mail and followed-up by phone. Each provider was surveyed regarding the participation of Asian Pacific DUI clients in their programs and solicited to participate in the survey if their Asian Pacific clients

were willing. Bilingual Project staff who had been trained in the administration of the survey instrument conducted interviews.

The Project completed 204 survey questionnaires from Asian Pacific clients in California DUI programs. Clients were recruited from first offender and multiple offender adult drinking driver programs, although the Project obtained no multiple offender clients. Patterns of alcohol consumption were studied. A copy of the instrument is included in the appendix.

C. IN-DEPTH CLINICAL INTERVIEWS: The Project had ongoing evaluation of the Key Informant Surveys and the DUI Surveys. It became apparent that there is a sub-group within the Asian Pacific population which is often unrecognized within the community as well as in the alcohol literature. This subgroup includes admitted alcohol offenders (most of these also admitted to other substance abuse) with exhibited problematic behavior. The Project expanded its activities to include in-depth interviews with thirteen (13) Asian Pacific alcohol offenders. This group is apparently at the extreme end of the alcohol consumption spectrum. The thirteen (13) clients were recruited from Asian American Drug Abuse Program (AADAP) in Los Angeles, the Haight-Ashbury Clinic and Asian American Recovery Services (AARS) in San Francisco. All clients were current or former clients of residential treatment programs for substance abuse. All interviews were taped in cooperation with the client. A copy of the interview instrument is included in the appendix.

Limitations of the Sampling Methodology (DUI Client Surveys):

We chose the nonprobability, availability sampling methodology because of the prohibitive costs associated with drawing an exhaustive sampling frame. There are obvious limitations in our ability to generalize findings to the general Asian Pacific population as well as to the entire Asian Pacific DUI client population in California. Given that the purpose of the study was to directly assess alcohol related problems in an ethnically diverse sample where each member has been identified as at-risk, first time service

The utility of our findings is also increased by the fact that we successfully obtained a sufficient sample size ($N = 204$) that included all the targeted Asian Pacific groups which allowed us to carry out a reasonable analysis plan.

TABLE 1: KEY INFORMANT SURVEYS

RISK GROUPS AS IDENTIFIED THROUGH KEY INFORMANT SURVEYS

<u>CHINESE</u>	<u>JAPANESE</u>	<u>KOREAN</u>	<u>PACIFIC ISLANDER</u>	<u>PILIPINO</u>	<u>SOUTHEAST ASIAN</u>
<p>1. Businessmen (male) - alcohol an intrinsic part of business transactions.</p> <p>2. Youth - teens and college-age Youth, both male and female. Specific Subgroups new immigrants (Taiwan) & 2nd generation and later.</p> <p>3. Females - generally agreed there is less a problem than with males. cases a problem</p>	<p>1. American born males - pack drinking, keeping up with peers</p> <p>1. Youth/young adults - socially expected. Often, the only drug of choice Although poly-drug use is also significant. Males at greater risk than females</p> <p>3. Japan-born businessmen (“shosha”): Japanese Nationals temporarily Hidden Business obligations</p> <p>4. Isolated elderly - widowers, monolingual individuals without a strong social support network</p>	<p>1. Males (both) American-born and foreign-Born) - high alcohol consumption Rates. Pack drinking.</p> <p>2. College age males and females - increasing trend among young men and women. Social expectations high.</p> <p>3. Females in General - increasing Trend, but significantly less than men. living in the US. group: waitresses/ hostesses in Korean bars, Encouraged to drink with clients</p>	<p>1. Youth - Main target group. Excessive drinking noted. Significant problems with drugs and gangs. Mostly males, but increasing problems with Females due to erosion of clear-cut familiar and sexual roles.</p> <p>2. High incidence of low-income and poverty level persons. Alcohol and related problems High risk sub-although there</p>	<p>1. 1st generation Seniors - often male</p> <p>2. Immigrant youth - exacerbated by other drugs and gang activity.</p> <p>3. American Born youth and young adults - social pressures, acculturation.</p> <p>4. Males in general- pack drinking, peer pressures. females in general engage in alcohol less exacerbated. is an increasing trend of substance abuse.</p>	<p>1. Recent immigrants - exacerbated by problems of acculturation and Post Traumatic Stress Syndrome</p> <p>2. Males in general - peer and social pressures.</p> <p>3. Women in general significantly less than males, although there is a custom to drink alcohol after giving birth of a child, to restore than men, the mother’s health.</p>

TABLE 2: KEY INFORMANT SURVEYS

**BARRIERS TO ALCOHOL RECOVERY SERVICES
AS IDENTIFIED THROUGH KEY INFORMANT SURVEYS**

<u>CHINESE</u>	<u>JAPANESE</u>	<u>KOREAN</u>	<u>PACIFIC ISLANDER</u>	<u>PILIPINO</u>	<u>SOUTHEAST ASIAN</u>
1. Denial - the single most important factor contributing to barriers	1. Denial - especially as drinking is culturally accepted, and due to being such a close-knit community, a sense of shame is heightened.	1. Denial - embarrassment is probably the key factor motivating the denial response.	1. Denial - especially as there is a lack of culturally relevant substance abuse education.	1. Denial - unwillingness to admit to any type of problem of this type	1. Denial - and lack of knowledge about substance abuse, especially so for recent immigrants. Also shame - to the individual as well as the family.
2. Lack of Chinese-American counselors and bilingual outreach programs.	2. Korean media (probably watched by 90% + of the community tends to glamorize drinking.	2. Only few Japanese American counselors and bilingual outreach programs.	2. Lack of Pacific Islander (e.g. Tongan, Samoan) professionals in all fields.	2. Lack of Pilipino counselors and bilingual outreach programs.	2. Lack of Southeast Asian counselors and bilingual outreach programs.
	3. Only a few Korean American counselors and bilingual outreach programs.				

V. RESULTS

A. KEY INFORMANT SURVEYS

Tables 1, 2 and 3 present data from the Key Informant Surveys. Community leaders, Experts in alcohol/other substance use and other knowledgeable community members participated in meetings to provide insight and perspectives on the problems of alcohol consumption and related treatment issues within their respective Asian Pacific communities.

1. RISK GROUPS: Table 1 presents the at-risk groups identified through the Key Informant Surveys from the targeted communities (Chinese, Japanese, Korean, Pacific Islander, Pilipino, and Southeast Asian). Consistent with the research literature in this area, males in general were prioritized as a high at-risk sub-group. The Japanese, Korean, Pacific Islander and Pilipino groups noted a trend of increasing alcohol consumption by women, especially young adults/youth. The trend conforms with Western-style social norms. Also noted is a significant amount of shame attached to females with substance abuse. Families would hide/ignore the problem even more so than with male family members.

Recent immigrants from each of the Asian Pacific groups were at-risk for alcohol-related problems according to the surveys. Notably, the Southeast Asian groups

emphasized the large number of refugees who have been witness to or even part of a war-

torn, violent homeland. Since the end of the Vietnam War in 1975, there have been increasing numbers of Vietnamese and other Southeast Asian groups (e.g. Hmong, Cambodian, Lao, etc.) Who have settled in California.

Besides Post Traumatic Stress Syndrome (PTSS) and other mental health concerns, Southeast Asians are considered to be at-risk for substance abuse. However, there has been no research to date of alcohol consumption patterns or related issues within the Southeast Asian community. Because of the stigma attached to substance abuse and problematic behaviors, alcohol abuse within the Southeast Asian community remains well-hidden.

The Chinese, Japanese and Korean groups noted that male businessmen, both foreign-born and U.S. -born were more likely to engage in frequent alcohol consumption, as alcohol is often regarded as an intrinsic part of business transactions. Japanese businessmen from Japan (“shosha”) are Japanese Nationals temporarily living in the U.S. These shosha drink heavily with their peers (other shosha), frequent bars that cater to Japanese-speaking clients, and are often loud and boisterous. Because they cluster at their Japanese bars/nightclubs, they are often hidden from the general public. The Chinese and Japanese groups noted that all U.S. born businessmen also drink, often heavily, as an accepted part of business transactions.

Males, especially young adults were noted by all six Asian Pacific groups, as at-risk. Groups cited acculturation (more Western-style drinking), less adherence to

traditional customs and norms, and decreasing parental authority as factors that could exacerbate alcohol consumption. Japanese, Korean and Pilipino groups noted so-called “park drinking” (drinking with peers) as a common occurrence.

2. BARRIER TO ALCOHOL RECOVERY SERVICES: Overwhelmingly, all of the Asian Pacific Key Informant Surveys reported denial as the single most important factor contributing to barriers to alcohol recovery services (see Table 2). The Chinese, Japanese, Korean and Pilipino groups noted an unwillingness to admit any problem relating to “taboo” subjects, including, alcohol/drug abuse, sexual matters and mental health concerns. There is frequently denial by individuals with a problem, as well as, their entire family or significant others because of the traditional stigma attached to problems of this type. The embarrassment and shame connected with these types of problems appear to continue into the second, third and fourth generations.

There is often a strong sense of community in the Asian Pacific groups studied. For example, the Korean community in Los Angeles is very close-knit, with a strong sense of community. Because of this, when there are alcohol/drug abuse problems, the sense of shame is heightened considerably. One participant observed, “... a Korean would be upset if the thought other community members knew of his problem... he would feel that he disgraced his family, since the community now looked down on them.

Pacific Islander and Southeast Asian groups also believed that part of the denial response was due to lack of knowledge about substance abuse. This is because there is

minimal bilingual/bicultural educational materials or outreach efforts in their communities.

This lack of knowledge is especially harmful for recent immigrants, e.g. Southeast Asians, Chinese (many from Taiwan) and Koreans. Not only is there a lack of bilingual/bicultural educational materials, but also a lack of bilingual/bicultural counselors and other professionals in the field of alcohol and other substance abuse. The Pacific Islander group noted the lack of Pacific Islander professionals in all fields as a major problem for their communities.

They reported a critical need for training programs to educate community residents and to train appropriate community resource persons who will then educate/outreach their community.

Other barriers to alcohol recovery services include the fear of established Western-based programs, including outpatient treatment, residential treatment, hospital inpatient, group/individual counseling, etc. There is a certain amount of fear and intimidation in less established communities, such as the Southeast Asian, Korean and Pacific Islander groups. In addition a communication problem hinders them from seeking help through mainstream agencies and programs. All of the Asian Pacific groups noted a general feeling that mainstream agencies would not understand or would be intolerant of their unique cultural nuances. When an individual or family did attempt to obtain outside help (usually at a crisis, or very advanced stage), they sought help from community-based agencies, community/religious leaders, family friends, etc.

3. SOME SOLUTIONS SUGGESTED THROUGH THE KEY INFORMANT

SURVEYS: All six Asian Pacific Groups agreed there was a need for more and better bilingual outreach and educational services (see Table 3). Educational materials should include general information/referral and technical educational materials (e.g., legal limits, laws, physiological effects, etc.).

To outreach effectively each community, the indigenous, community-based network systems must be involved. Community leaders, churches, temples and schools can be effective conduits to reach each respective community. Individual counseling for at-risk individuals can be effective, as there is less change of “loss of face” and embarrassment that often occurs in group settings. Close family members also should be included in the delivery of services.

All of the Asian Pacific groups mentioned in the family as an important part of any effective alcohol prevention/treatment program.

And the Southeast Asian group noted in particular, that effective inclusion of the immediate family is not only helpful, but a critical part of any treatment effort. Since the family as a whole assumes the shame and guilt of any individual member, the family unit must be the focal point.

Media also was suggested as an effective tool to outreach the various Asian Pacific communities. It is interesting that the Japanese group emphasized the need to use a “health

focus” to effectively catch the attention of a Japanese audience (both U.S. and foreign born). It is hypothesized that the Japanese community is extremely health conscious and interested in health-related issues such as the effects of substance abuse. The Korean group emphasized a “shock value” approach within the media framework. For example, they suggested that true to life scenes of alcohol-induced traffic accidents shown on 30 second public service announcements (PSA’s) would be effective.

All of the suggestions given through the Key Informant Surveys emphasized use of bicultural and bilingual methods.

B. DUI CLIENT SURVEYS

1. Sociodemographic Characteristics: Our sample of respondents (N- 204) reflects a distribution across six of the Asian Pacific ethnic groups. Table 4 shows the relative percentage representation and actual number of each of the groups. It should be recalled that our Southeast Asian classification includes the individuals of Vietnamese, Cambodian and Lao background, and Pacific Islander includes Tongan, Samoan and Native Hawaiian individuals.

Except for the Korean respondents, the representation of ethnic groups is somewhat even. There are more Korean DUI service providers than in other Asian Pacific communities. And the proportion of Korean respondents might reflect a higher number of Koreans mandated by the courts to attend DUI programs.

The age distribution of our sample reflects an equal percentage of respondents who fall into each of the three age categories. Within and between group comparisons indicate that the relative distribution of individuals according to age is highly varied.

Male respondents represented the majority of our sample overall and in each Asian Pacific ethnic group. Within group comparisons, show that Pilipino women were proportionately represented in greater numbers (20.8%) than their counterparts in other groups; however, in actual numbers Korean women were the largest group.

Marital status comparisons across groups present a mixed picture. Most of our respondents were married adults (59.9%), and this pattern was consistent for our Chinese, Korean and Pacific Islander respondents. The pattern was reversed for the Pilipino, Japanese and Southeast Asian groups.

The variables birthplace and years in the U.S. are critical variables and suggest the extent of the acculturation of our respondents, especially as it relates to alcohol usage. As shown by Table 4, our respondents were predominantly foreign born, and that this is true overall and by each of the other groups. All of the Korean respondents, 95.8% of Southeast Asian, 85.2 of Pacific Islander, 81.8% of Chinese, 66.7% of Pilipino and 62.5% of Japanese respondents were foreign born. These were individuals who are recent residents in the U.S., for example, most groups reported living in the U.S. less than five years.

As a group, the respondents were well educated, employed and working in a diversity of occupations that ranged from professional to semi-skilled. At least two-thirds indicated a high school or higher formal educational background, and two-thirds reported working full or part time. More than 10%, and as high as 35% reported working in professional/technical fields. Specific occupations reported by the respondents included: bankers, CPA's, engineers, health care professionals and corporate managers. Individuals of Chinese, Korean, Pilipino and Japanese ancestry reported they worked in small business and sales capacities with similar percentages. This is an important distinction relative to the literature that suggests the role of alcohol as being instrumental to the conduct of business. At the other end of the occupation spectrum our data reflects a significant proportion of all groups who work in semi-skilled occupations that include restaurant workers, auto mechanics, assembly workers and maintenance workers.

2. Consumption Levels: Tables 5 and 6 provide data regarding reported alcohol consumption levels of our respondents. Our survey items and the resulting classification scheme (i.e., Abstainer, Light, Moderate and Heavy) were derived from the Cahalan Scale, which was used in the seminal studies by Kitano et al. We report here on two major issues with respect to consumption, i.e., frequency of consumption and the amount consumed on each occasion.

Table 5 data shows that for a majority of our respondents (82.8%), alcohol consumption was more than occasional (i.e., Moderate or Heavy). Over half (56.3%)

were moderate consumers, which indicates alcohol consumption of a minimum of once weekly to a maximum of multiple times a week. Surprisingly 26.5% of the respondents were classified as “Heavy” consumers, defined as a minimum consumption of 3-4 times a week to an extreme of multiple times daily.

This pattern is consistent in each of the six groups. In five groups, three-quarters or more of all respondents fall into the Moderate or Heavy categories. The Chinese group is less, though still significant, at 63.7% . Interestingly, nearly all of the Pacific Islander respondents (96.4%) are classified in the Moderate and Heavy categories. Of particular interest is the relative number of participants who are in the Heavy classification, about one-quarter of all respondents. Proportionate representation among Japanese (50%) and Pilipino (33.3%) is even higher. Of Pacific Islanders, 14.2% report heavy consumption.

Table 6 provides complementary data to Table 5 regarding the quantity consumed during each drinking occasion. It appears there is a congruence in the proportion of respondents who fall into the Moderate and Heavy classifications if measured by the reported quantity of alcohol consumed during one sitting. This pattern holds overall. Of particular significance is the proportion, one-third of respondents, who fall into the Heavy drinker classification. Between group comparisons reflect a bi-modal distribution that ranges from 11% (Pilipino) to 18.1% (Chinese) at the low end to upwards of 30% at the high end for the other four Asian Pacific groups. Three-quarters (74%) of our Pacific Islander respondents report in the Heavy consumption category. To be included in this category requires the consumption of a minimum of 5-6 drinks to 10+ drinks in one

sitting. The implications are alarming considering that the quantity consumed is coupled to the frequency of occasions of alcohol consumption. Thus, data in Tables 5 & 6 provide substantial evidence that alcohol consumption for this group of Asian Pacific DUI respondents is not occasional, but a highly frequent activity in which a significant amount of alcohol is regularly consumed.

3. Self-perceptions of Drinking: Given the relative seriousness and consequences of a DUI offense, it is interesting to examine the self-perceptions of our respondents regarding their drinking behavior. Table 7 provides a series of valuables that address the issue and also indicates whether the respondent has sought help ever before for a drinking problem.

In response to the question of how respondents characterize their drinking pattern, (Table 7-A), the majority of responses (70%) fall in the middle range of drinking behavior (light and moderate drinkers). This pattern is consistent in all groups, except with the Pacific Islander respondents. Yet, even in this group over half are represented in the middle categories with the rest concentrated in the non-drinking lower end of the scale.

In our sample, there are fewer than 10 individuals (less than five percent) who characterized their drinking as heavy or alcoholic. By group, this is approximately one person in each group, except for three Japanese and three Korean respondents who characterized their drinking as heavy or alcoholic.

The remaining respondents characterized their drinking behavior toward the “non-drinker” end of the scale. The three items that comprise this portion of the scale have the present abstainer quality in common. However, each differed in whether they always abstained, whether they drank in the past or whether they were a problem drinker in the past. In comparing these three items, most tended to admit to drinking in the past. (19.6%), in contrast to those who claimed they were never drinkers (2%), in spite of being DUI clients, or to those who claimed that they were once heavy drinkers and now were non-drinkers (4.9%). This pattern of denying current alcohol use generally held for all groups with some variation with Pacific Islander and Pilipino groups wherein a greater proportion, 24.3% and 11.1%, respectively, reported alcoholic or heavy drinking in the past, but were now abstinent.

When respondents were asked to evaluate whether their drinking behavior was a problem, most responded definitively that it was not a problem (Table 7-B). In this instance, the overall average is roughly two-thirds, while across groups the proportions ranged from slightly over 50 to 70%. There are a significant number of respondents who indicated uncertainty about their drinking behavior (“not sure”). Within the six groups this carried from 20 to 25%, except Pacific Islanders where the proportion was about half. Twenty-five or 12.7% of our respondents answered this question in the affirmative. And these respondents are distributed over five of the six groups with Japanese and Korean having the greatest number (7 and 10 respectively).

The pattern of denial suggested in Table 7-B continues to be evident in the next

question concerning respondents' evaluation of the seriousness of their drinking problem (Table 7-C). Respondent evaluations reflected a strong belief in the lack of seriousness of their drinking behavior. Nearly two-thirds of Pacific Islanders and three-quarters of Southeast Asians reported in this manner. All other groups reflected percentages that were significantly higher. Approximately one-quarter of all respondents did not classify their drinking as problematic.

While a strong tendency to deny the seriousness of their drinking behavior exists for a majority of our respondents, it is important to note that as high as 35% of the Pacific Islanders and 25 of Southeast Asians and less than 5% of Japanese respondents classify their drinking problem as somewhat serious to very serious. Nearly 20% of our sample fall into these categories.

When data in Tables 7-B and 7-C are integrated, it appears that a majority of respondents denied any problematic drinking behavior in their responses to both questions. While most of the remaining respondents may have indicated either some uncertainty or affirmation of a drinking problem (Table 7-B), their rating of the seriousness of their drinking behavior was significantly downplayed. In general, less than one out of five respondents attached some degree of "seriousness" to their drinking behavior.

Our final question in this series inquired whether the respondent had previously sought help for a drinking problem, excluding the present mandatory DUI program

participation (Table 7-D). As in the previous Tables B and C, a majority of respondents indicated no previous attempt to seek help. For Chinese, Korean, Pilipino and Southeast Asian respondents, 70% and higher reported no previous help seeking. Over half (54.2%) of Japanese and 39.3% of pacific Islander respondents never sought help for their drinking problems.

The total proportion of respondents who indicated at least one previous effort seeking help was 31.9% or 65 of our 204 respondents. Japanese, Korean and Pacific Islander respondents accounted for three-quarters of these respondents.

The data that indicates nearly one-third of all our respondents had previously sought help for their drinking is surprising in light of official statistics which typically portray underutilization of alcohol related services by Asian pacific individuals. This emerging profile of ambivalence or a conflicted profile of Asian Pacific respondents relative to all aspects of their drinking shows self-evaluations were not consistent with actual behavior. For example, respondent self-evaluations of drinking did not appear to coincide with actual behavior, which in this instance is defined two ways: DUI program participation and alcohol program help-seeking.

4. Reported Reasons for Drinking: Table 8 presents data regarding reasons for drinking. This section of the survey schedule is composed of 15 items and represents a set of reasons suggested in the research literature and used extensively in other studies. Survey instructions ask the respondent to answer a three point scale, i.e. “Yes”, “No,”

“Not sure.”

Data was analyzed in two steps. First, percentages for each item were computed, Next, a cluster analysis of all the items was performed in an attempt to consolidate Interrelated items. This statistical procedure groups items that tend to be correlated with each other. Practically speaking, the procedure assesses the response patterns of our respondents to these items. Next, we identified three groupings of items among many that appeared to suggest significant analytical qualities worth noting. Specifically, these three subsets can be described as three distinct categories, that we labeled as: (A) Social/Peer Influenced (S/PI); (B) Escapist (E); and (C) Self-Actualizing (SA), reasons for drinking.

This analytical approach is highly interpretive and assumes there is a degree of internal consistency to an individual's reasons for drinking. Further analysis is required and is currently underway to provide a more in-depth analysis of within-group constellations of items of reasons for drinking. Given these limitations, a preliminary examination of the groupings of items indicates a reasonable degree of face validity in terms of distinct reasons for drinking. Further, our labels for each of these groupings have been well established in numerous other studies.

An additional note of caution in interpreting the data in Table 8 is that each item is presented in one of three groups. The percentages in the table refer to the proportion of respondents who answered in the affirmative to the item as a reason for drinking. The

percentages associated with each item are for the total sample and for each of the six Asian Pacific ethnic groups separately. Thus, any one percentage figure refers only to the proportion of affirmative responses to that particular item by respondents of that particular item by respondents of that particular respondent group.

Table 8 data clearly indicates that “Social/Peer Influenced” reasons for drinking followed by “Escapist” reasons play a more prominent role in drinking behavior than do “Self-Actualizing” reasons. This pattern holds for the sample overall and for each of the six Asian Pacific groups. All four items pertaining to S/PI reasons reflect percentages that range from approximately 25 to 40%. Two items which appear to be the most relevant are, “I drink to feel good around people,” and “I drink to get along better with friends.” Both suggest as personality enhanced experiential basis for drinking in a social context, in contrast to a peer induced basis as suggest by the other two items.

In direct contrast, items that are characterized as “Escapist” reasons for drinking reflect the use of alcohol to reduce anxiety. Depression and other emotional problems or to eliminate boredom. Another item in this area that appears to be a substantial reason is “I drink because I feel bad when I do not drink”.

Finally, two Self-Actualizing (S-A) items appear to have particular relevance for our respondents. These are, “I drink to enjoy what I am doing,” and “I drink to feel better about myself.” Both reflect a desired enhanced emotional state as the reason for drinking, which is distinct from other items in this category suggesting more of an instrumental

role of alcohol use, such as increasing one's creativity or productivity.

C. IN-DEPTH CLINICAL INTERVIEWS

In-depth Clinical Interviews with Asian Pacific individuals who are admitted alcohol abusers were conducted by the Project. These ethnic case profiles provide a view of a sub-group with clearly identified drinking problems. This sub-group is distinct from the at-risk population groups identified through the Key Informant Surveys, as well as from the first-offender DUI client group, which was identified through a legally recognized action. These case profiles showcased Asian Pacific individuals with long histories of alcohol abuse. Through In-depth Clinical Interviews, social, developmental and precipitating factors associated with excessive alcohol use were determined for this group.

Tables 9 and 10 present data from the In-depth Clinical Interviews with thirteen (13) admitted alcohol abusers with exhibited problematic behavior and who were clients of residential treatment programs for substance abuse. These clients were recruited from the Asian American Drug Abuse program in Los Angeles, the Haight-Ashbury Clinic and the Asian American Recovery. These recovery programs are the three major

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2. Characteristics: Table 10 presents psychosocial indices that include other

substance abuse, parental role, developmental stage (of alcohol/other substance abuse), precipitating factors and treatment experience. Interestingly, all of the clients exhibited marked similarities in these areas.

In all cases, the clients reported heavy use of both alcohol and other substance abuse (tranquilizers, marijuana, amphetamines, etc.). They also reported the presence of extremely permissive parents or other authority figures, who ignored their problems caused by drugs/alcohol in their childhood years. In eleven (11) cases, clients reported extremely unstable home lives. The two Korean interviewees reported they had parents who were physically abusive. The parents of one Pacific Islander client “turned cold,” and the other Pacific Islander was “shuffled from one relative to another”. All the clients reported that they themselves denied problems induced by excessive substance abuse.

Precipitating factors included: peers who also drank heavily and/or abused other drugs; the need to drink to socially fit in; the need to escape or forget about their problems and/or surroundings; feelings of isolation as well as inadequacy - - not always fitting in among Asian or White peer groups (see Table 10).

Two of the Japanese clients were Vietnam war veterans who cited their military experience as the main factor contributing to their substance abuse. They reported that alcohol and other drugs were readily available, and they were expected to use them in significant quantities. The Japanese sample group was the only group which included war veterans. We surmise that other violent and stressful situations can be precipitating

factors for substance abuse. Although there was only one Southeast Asian client surveyed, it is highly probable that the stressful circumstances of Southeast Asian refugees who fled from a war-torn homeland could be at-risk for physical and mental problems, possibly exacerbated by alcohol/other staff were somehow inadequate. However, all of the clients reported feeling more at ease with Asian staff, particularly if they shared the same national origin (e.g., Chinese felt more comfortable with Chinese counselors, Koreans felt more comfortable with Koreans, etc.) All of the clients, including those who were foreign born, spoke English adequately, except for the Southeast Asian client, who was interviewed by a bilingual interviewer.

Because of the small sampling size, assumptions and generalizations to each of the Asian Pacific groups as a whole are not possible. The results are indicative of a significant subgroup within the Asian Pacific population that is often bypassed or disregarded in the general literature.

Following are brief synopses of each of the interviewed clients:

ETHNIC GROUP: CHINESE

The first Chinese client to be interviewed was a foreign born male, 23 years of age and currently completing college. He began taking tranquilizers and experiment with other drugs at 13, and began drinking heavily at age 17 – going to selected bars known for selling liquor to minors. His family initially ignored the problem then tried to confront him at later stages when he was out of control. “Parents had little control,” he said, “. . . I broke them, basically . . . I tamed them until. . . there was no communication.” He sold marijuana to make money. After he was involved in several car crashes, he was court ordered to attend a residential treatment program. He chose an Asian Pacific treatment program.

The second Chinese client interviewed was a second generation female, 28 years of age, She had attended, but never completed college. She began drinking in her late teens and recognized she had a problem by the time she was 20. She denied the problem, however, even when her immediate family (mother and brother) pleaded with her to get help. She became paranoid of others. She considered AA, but felt that “. . .no one was Asian.” She tried counseling, but felt they could not understand her. She had a poor relationship with her parents, who were divorced. Her mother often criticized her and compared her to her absent father.

ETHNIC GROUP: JAPANESE

The first Japanese client interviewed, was a second generation male, 26 years old. He had completed high school and had temporary jobs, usually as a stock clerk. His parents had little control over him; and his older brother, who was heavily into buying and selling illegal drugs, including marijuana and tranquilizers, among his peer group. As a teenager (from the time he was 13 years old), his older brother used him to deliver the drugs and would “pay him off. . . with some of the drugs. . .”. His parents knew their sons were involved in such activities, but they chose to ignore the problem and got extremely angry over other things, such as not cleaning their rooms, coming home late, etc. He started stealing from his mother’s purse and was eventually kicked out of his parent’s home.

The second Japanese client interviewed was a third generation male, 27 years old. He had completed high school and was working as a travel agent at the time he was interviewed (he was still a resident at the drug treatment program, but was in the latter stages of the program wherein an outside job is permitted). He had been heavily into illegal drugs and alcohol since high school. He knew he had a problem, but kept deluding himself that he could stop if he wanted to. His drugs of choice included amphetamines, marijuana and alcohol. His home life was fairly stable, but there was very little interaction between family members. Personal issues were never discussed.

He felt isolated from both his family as well as from the “Asian in-crowd” (sic). He felt he needed alcohol and other drugs to gain the self-confidence to talk with females.

The third Japanese client was a first generation male, 37 years old. His parents moved to the U.S., where he was raised from the age of five. He was college educated and had been employed as a graphic designer. He experimented with drugs at 13, but did not indulge in excessive substance abuse until his late teens/early 20's. He was a Vietnam veteran. He explained that the war experience was the main reason he became heavily involved with alcohol and heroin. His girlfriend tried to help him, but he kept denying he had problems. He did not seek help until he lost his job. He was more at ease with Asian counselors, but wished there was someone he could talk with who could relate to his military experience.

The fourth Japanese client was a third generation male, 40 years old. He had completed college as well as graduate school (theater arts). As a teenager, he described himself as “a rebel. . . hung out with other outcasts. . .” He smoked pot and drank beer in high school as well as in college. He was a Vietnam veteran. Like the other Vietnam veteran, he credited the war experience as the main reason he became heavily involved with excessive alcohol consumption and other drug abuse. Using drugs gave him confidence to talk with females. His drugs of choice included heroin, cocaine and alcohol. He admitted to being afraid of success, and thus used drugs to sabotage his career after the war. He described his parents as typical Asian parents who denied problems and were unwilling to discuss personal issues.

ETHNIC GROUP: KOREAN

The first Korean client interviewed was a foreign-born female, 25 years of age. She grew up in the U.S. where her family moved when she was two years old. She completed junior high school (9th grade) and did not attend high school. Her home life was extremely unstable - - her parents were divorced when she was seven years old, and her mother was an alcoholic. Her mother remarried eventually, but her mother had relationships with many men. She was molested by one of her mother's boyfriends and a neighbor. She tried to run away when she was 13 years old. She associated with older adolescents and there was much peer pressure to engage in substance abuse and sex. Drinking made her feel socially accepted and independent. It also led her stealing from her parents and from liquor stores. She became a prostitute by the age of 17. Her mother closed her eyes to the problem and advised her not to drink too much, while at the same time offering her beer. She tried AA at 18, but did not “like” the people; she felt isolated. She denied her problems and kept believing things would eventually fall into place. She eventually sought an Asian program because she felt she would fit in more easily.

The second Korean was a foreign-born male, 40 years of age, with a sixth grade education. He grew up in Seoul, Korea and came to the U.S. when he was 22. His parents, especially his father, were physically abusive when he was a child and he was often sent to live with other family members, who also treated him harshly. He married and came to live in the U.S. He drank heavily with his peers. He was eventually divorced and began drinking every day to the point of passing out. He felt guilty, but didn't care. The problem was ignored by family and friends. He sought help when he lost his job, money and friends. He noted that he felt more comfortable with a bilingual counselor and other Asian clients.

VI. DISCUSSION

The target population of the Needs Assessment for the Asian Pacific Peer Consultation and Training Project included Asian Pacific individuals who are at-risk for serious alcohol drinking problems or have long histories of alcohol abuse. The population was divided into six major Asian Pacific groups - - Chinese, Japanese, Korean, Pacific Islander, Pilipino and Southeast Asian. Our knowledge regarding Asian Pacific alcohol consumption patterns and related treatment issues is sparse, not specific to many Asian Pacific groups, and above all, is not informative about Asian Pacific individuals who are at-risk or are admitted alcohol offenders.

The assessment and study of these at-risk Asian Pacific individuals are clearly relevant and useful in the development of effective treatment and service delivery models. This assessment is based on the framework and models developed in the Asian American Community Mental Health Training Center programs between 1972 to 1982. Our Needs Assessment challenged the traditional view of Asian Pacific groups as a low-risk "model minority" group. In order to critically assess this at-risk population group, the Project devised a unique methodology incorporating community input and assessment, surveys of individuals who have been legally cited for problematic behavior due to alcohol (DUI clients) and in-depth interviews with admitted alcohol offenders.

KEY COMMUNITY SURVEYS: Though the Key Community Survey, community leaders and experts described alcohol-related problems. (risk groups, barriers

to treatment, etc.) Within their respective Asian Pacific communities.

As accepted members/leaders in their communities, these participants were uniquely qualified to give authentic and accurate portrayals of their community.

It was shown that in spite of ethnic group differences, there were similarities among those who were identified as most likely to drink. Males in general were prioritized as an at-risk sub group, although the Japanese, Korean, Pacific Islander and Pilipino groups noted a rising trend among young women who increasingly adopt Western-style drinking behavior patterns of non-Asian Pacific women. It appeared that acculturation and changing traditional values were the reasons most cited for this increasing trend. In particular, the Southeast Asian group as a whole was considered to be an at-risk group due to the stresses of acculturation in combination with the history of their war-torn homeland.

Male businessmen, both foreign and U.S. born were more likely than those in non-professional occupations to engage in frequent alcohol consumption, as alcohol is often regarded as an intrinsic part of business transactions. Japanese, Chinese and Korean business were cited as at-risk for alcohol-related problems. It was noted that they may often be “hidden” because they tend to cluster in bars/nightclubs specifically catering to Asian clients.

Violent behaviors are not usually manifested, and peers will often shield an inebriated individual from exhibiting problematic behaviors (e.g., not allowing him to

drive, etc.).

The Pacific Islander and Pilipino groups noted the rise in drug use and gang activity among their youth. The easy availability of alcohol was a major concern. Also, these groups noted there is a severe breakdown in traditional familial and sexual roles which exacerbate the problem with substance and gang activity.

As Asian Pacific individuals become more and more acculturated (more Western-style drinking), adhere less and less to traditional customs and norms, it will almost certainly lead to more visible & greater number of alcohol related problematic behaviors.

Overwhelmingly, all of the Asian Pacific Key Informant Surveys reported the denial factor as the single most important factor contributing to barriers to alcohol recovery services. The surveys also revealed that parents, extended family and friends also ignored problematic drinking behavior.

There is a dearth of bilingual/bicultural educational materials in many of the Asian Pacific communities. Especially lacking are materials targeted for recent immigrants. Pacific Islander and Southeast Asian groups. The Pacific Islander group felt that training programs are needed to educate the community and that there is a severe need for bilingual/bicultural professionals in all fields.

The fear of intolerance and not being understood because of cultural differences discouraged them from seeking treatment in mainstream programs. Many of the clients

who had been in Western-based recovery programs felt uncomfortable.

DUI CLIENT SURVEYS: Our survey of DUI participants provides important new information to the sparse available knowledge base regarding Asian and Pacific islander alcohol abuse. Our data should dispel any remaining beliefs that Asian Pacifics are not at-risk for alcohol problem behavior. The limited scope of our sample of DUI respondents suggests that the extent of problematic drinking among Asian Pacifics is much more extensive than indicated in official service statistics. Our results confirm observations made by many Asian Pacific professionals and service providers that the problem is indeed hidden.

There is consistent evidence across all of our groups that alcohol is consumed regularly and in sufficient amounts to classify them as significantly at-risk for continued problematic behavior including DUI offenses. A majority of our respondents described actual consumption levels that can be classified as at-risk (i.e., heavy and moderate consumption levels). This pattern hold across all the six Asian Pacific ethnic group subsamples. Pacific Islanders (96.5%), Japanese (75%), Southeast Asian (70.8%) and Koreans (65.6%) had the largest proportion of respondents who fell into these two risk categories. Overall, one quarter of all respondents fell into the “heavy” classification.

While alcohol risk may be definable by utilizing only the “heavy” classification of the Cahalan Scale, we argue that the interpretation of at-risk should be extended to

include those individuals who fell into the “moderate” classification as well. This appears valid for two reasons: (1) the arbitrary definition assigned to the heavy and moderate classifications does not account for ethnic group variation, nor individual differences, i.e. one person may easily move from one category to another, and (2) our data clearly establishes that alcohol consumption is tied to social and psychological incentives that tend to encourage drinking in greater quantities and frequency.

Our data on Japanese, Chinese and Korean respondents supports in large part the sociodemographic profiles of heavy drinking behavior noted by previous research, i.e., Kitano, et al. Our respondents were also typically immigrant, male, under 45 years of age and educated. Our data also suggests that risk groups are ever-present among the less studied Asian Pacific groups, Pacific Islanders and Southeast Asians. Our data indicates characteristics of DUI respondents from these two groups that are distinguishable from the remaining four Asian Pacific groups. Specifically, they tend to be a younger more recent immigrant/refugee group with fewer years of formal education, and are generally employed in blue collar or semi-skilled occupations. These characteristics are coupled with high proportions of heavy and moderate drinkers, i.e. Pacific Islanders (96.3%) and Southeast Asians (70.8%).

The size of our sample prohibits detailed analysis of each of the six Asian Pacific ethnic subsamples, the data should dispel any remaining notion of the social or cultural homogeneity of drinking behavior among Asian Pacific groups. Our DUI respondents appear to vary significantly by social and cultural background in relation to alcohol

consumption. Moreover, drinking occurs predominantly among peers of the same background in terms of ethnicity, language spoken, education, occupation and degree of acculturation. These social and cultural variations have significant implications in terms of designing responsive intervention programs.

RECOMMENDATIONS

These recommendations are so listed to be the basis for planning, consultation and training. The enumeration is not arranged according to priority.

- Identification, recruitment and training of bilingual, and/or bicultural competent staff, interns and volunteers to serve on various levels of the recovery process, with the provisions of incentives and benefits - stipends, awards and scholarships.
- Continuous in-depth discussions and presentations of alcohol related issues and concerns, problems and solutions, to counter the denial, stigma, and shame associated with the disease of alcohol use, misuse and abuse; with the assurance that “outside” help and assistance are acceptable and congruent to the recovery process.
- Identification and recruitment of qualified and knowledgeable Pacific Islanders, Asian Americans and Southeast Asians to serve on local and state decision making bodies, providing ideas, policies and relevant input so as to impact effective delivery services, for and by the communities.
- The recovery process be based on the Social/Public Health Model which would include innovative services, incorporating honored values and traditions; a culturally competent and congruent to such values as shame, “loss of face”,

respect of elders, authorities; sensitive to indirect and non-confrontational approaches, including some “one-to-one” intervention, use of significant others - extended family members, monks, priests, ministers and chiefs; and involvement of the family as the focal point of intervention, education and recovery process.

- Provision of funds toward the collection of data, community research and surveys on the extent of alcohol related problems; for needed demonstration projects focused on the underserved and unserved communities and to research innovative, non-traditional services.
- Provisions of funds for technical assistance and training of staff from PAI agencies toward development of skills, knowledge and understanding of data base, detection and documentation of effective recovery services.
- Utilization and extensive dissemination of the Asian Pacific Curriculum Framework and Modules, a conceptual model based on a holistic, social system and social model recovery modality and philosophy. Outline of the Framework and Modules are in the Appendix.
- Understanding of the population socio-characteristics and profile of the Asian Pacific and Southeast Asian communities based on relevant census data; similarities and differences, histories, contemporary problems faced, resources

and contributions.

- Development and compilation of related educational materials (legal age limits, blood alcohol content, physiological and psychological effects, etc.) that are culturally sensitive and linguistically specific and appropriate.

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ASIAN PACIFIC ALCOHOL PEER CONSULTATION AND TRAINING PROJECT

CURRICULUM MODULES

The project which is funded by the California State Department of Alcohol and Drug Programs suggests the following curriculum to be utilized to the fullest extent; modified appropriately according to geographical areas and the target population. It is framed with the basic fundamental concepts and assumptions based on the article, "Education for Social Work Practice in Asian and Pacific American Communities (Kuramoto, Morales, Munoz and Murase, (1981)" and the "Social Model", principles of resolving the alcohol problems in the community.

The curriculum outline includes:

1. Framework for the Alcohol Problems in the Asian/Pacific Islander Communities
2. Administrative and Programmatic Issues
3. Assessment and Screening Issues
4. Alcohol Service Delivery and Treatment
5. Culturally Appropriate Treatment Services
6. Role of Translators in the Service Delivery
7. Social Model of Recovery

Readings and References

All the modules (I - VII) cover three learning objectives: information getting, change of attitude and the acquisition of skills. These objectives will be evaluated through the

administration of Pre- and Post-test instruments.

MODULE I

FRAMEWORK CURRICULUM FOR ALCOHOL RELATED PROBLEMS IN THE ASIAN PACIFIC COMMUNITIES ASIAN PACIFIC 101

GENERAL OBJECTIVES:

- 1.0 To know the following guiding principles
 - 1.1 On racism
 - 1.11 The nature of racism
 - 1.111 roots of racism
 - 1.112 personal and institutional
 - 1.12 The role of race and color in American society
 - 1.14 The sociology of poverty
 - 1.15 The consequences of racism on the Asian Pacific communities
 - 1.2 Ethnic, cultural and language diversities
 - 1.3 The failure of public policies resulting in the lack of Resources in the Asian Pacific communities
 - 1.4 The goal of empowerment
- 2.0 To understand the Asian Pacific communities
 - 2.1 Definition of terms
 - 2.2 Geographical origins and ethnic identities
 - 2.3 Historical, linguistic and sociocultural backgrounds
 - 2.4 Similarities and differences
- 3.0 To understand the Systems Theory as an Organizing Framework
 - 3.1 Internal colonization and exploitation
 - 3.2 Collective Asian Pacific experience
 - 3.3 Individual experience

3.4 Family experience

4.0 To know the application of a holistic view of the Framework (as illustrated below)

4.1 The pyramidal model

4.2 the triangular reflection of several modules/syllabi
A curriculum

Asian and Pacific Americans

HOST ----- ENVIRONMENT

Figure 1
A Holistic View

MODULE II

ADMINISTRATIVE AND PROGRAMMATIC ISSUES

This module reviews the concerns of Pacific Asians as documented in the NEEDS ASSESSMENT and SURVEYS, and presents problem-solving strategies for addressing the identified needs. Approaches include the exploration of services and networking with other agencies to ensure a continuum of care and reduce cost of services through early intervention. Funding and person power issues are addressed and concrete suggestions for tracking or evaluating the efficacy of programs.

This module maybe formatted as a working conference for administrative and program staff or for educational and advocacy workshop.

NEEDS ASSESSMENT SURVEY

ABSTRACT:

The NEEDS ASSESSMENT SURVEY of the Asian Pacific Alcohol Peer Consultation and Training Project was designed to identify the alcohol problems and needs of Asian Pacific population groups in order to identify gaps in services and design strategies for improving and initiating services to the targeted Asian Pacific communities (i.e., Chinese, Japanese, Korean, Pilipino, Southeast Asian and Pacific Islander).

The Project utilized a three-pronged approach to complete the Needs Assessment. These three include:

1. Key Informant Surveys - a gathering of community leaders in each targeted community for their assessment and first-hand knowledge of alcohol problems in their respective community
2. Interviews with 205 Asian Pacific DUI clients and ex-clients, utilizing a survey questionnaire form.
3. In-depth clinical interviews with 13 Asian Pacific recovering alcoholics currently in an alcohol and/or residential program.

The Key Informant Surveys, in which community leaders, experts in alcohol/drug use in their respective community, other interested community members were asked to participate in a meeting to assess the community perspective on alcohol usage and related issues of treatment. Nine (9) Key Informant Surveys have been completed.

MODULE III

INTAKE (SOCIAL MODEL)

SCOPE:

1. General Data
 - 1.1 personal history
 - 1.2 family history
 - 1.3 Ethnic and community identification
- 2.0 Narrative of participation alcohol programs
 - 2.1 detox
 - 2.2 social model recovery homes
 - 2.3 out-patient programs
 - 2.4 AA
- 3.0 Reasons for desiring recovery

- 4.0 Survey of skills, talents and resources
- 5.0 Recovery plan
 - 5.1 utilization of bilingual and bicultural mode
 - 5.2 referral to community programs
 - 5.3 utilization of support groups
- 6.0 Termination plan
 - 6.1 sober living
 - 6.2 independent living
 - 6.3 support group
 - 6.4 volunteerism

SOCIAL MODEL ETIQUETTE: How to relate to participants

PRINCIPLES:

- 1.0 Make them feel at home
- 2.0 Promote a sense of belongingness
- 3.0 Provide an environment which would later on give them a sense of “Ownership and opportunity for leadership”
- 4.0 Active “ushering” into the life of sobriety
 - 4.1 actively engaging the participant in converting his/her experiences into opportunities for learning
 - 4.2 encouraging the participant to get involved with the program of the center, either as follower or co-leader
 - 4.3 involving the participant in program development, encouraging him/her to be a volunteer and involving him/her in recruiting volunteers
- 5.0 Provide the atmosphere where the participant may be able to choose the activities he or she may want to be involved in

- 6.0 Avoid patronizing
- 7.0 To a newcomer, use examples in your life which will help and guide him/her to enter into recovery until such time and she or he will feel comfortable in sharing his or her experiences for others to learn from
- 8.0 As time goes , the end result of the relationship will be the joint effort and “ownership” of staff and participant

MODULE IV

**ALCOHOL PROBLEMS
INTERVENTION, TREATMENT
AND SERVICE DELIVERY**

This module focuses on the difficulties in delivering alcohol services to Asian Pacific communities. A framework on the development of solutions to alcohol problems is presented with the following chart illustrating the flow between alcohol problems to the various levels of solutions which may be required.

As shown in the chart and schema below, alcohol problems impacting the Asian Pacific and Southeast Asians are reviewed. The first step is to examine ways individuals and families attempt to cope with the problem, prior to seeking help, then look at the three types of coping: personal coping, social support and formal traditional healing practices. In addition, certain service barriers must be minimized before entering into services, and finally, certain problems may prevent the effective treatment process.

FLOW CHART

ALCOHOL PROBLEM
SOLUTIONS

TO VARIOUS LEVELS OF

ALCOHOL PROBLEM

PERSONAL COPING

SOCIAL SUPPORT

FORMAL TRADITIONAL

HEALING

BARRIERS TO

SERVICE UTILIZATION

1.0 SCHEMA (Southeast Asian: Cambodian, Lao and Vietnamese)

1.1 Alcohol problems and help seeking pattern

1.11 Moon's study (a mental health modality)

1.12 entry into health care

1.13 perceptions of problems requiring treatment

1.2 Mental health and alcohol problems

1.21 need for treatment

1.22 medical and related problems, e.g. substance abuse

2.0 Individual Ways of Coping

2.1 reuniting families

2.2 maintaining ties

2.3 pseudo-families

2.4 work ethic

2.5 hopes for children

2.6 fatalistic acceptance

3.0 Social Support

3.1 family support; familiar obligation and prolonged support

3.2 community support: clustering of housing, MAAs, Religion

3.3 others: churches, VOLAGS, CBOs

4.0 Formal Traditional Healing

- 4.1 medical psychological, social, economic
- 4.2 folk healing
- 5.0 Conflicts Between SEA Expectations vs. Western Providers: “Symptom Relief”, Role Expectation, Duration of Treatment
- 6.0 Problems in Providing Services and Treatment
 - 6.1 myths and stereotype on psychotherapy
 - 6.2 problems of early termination
 - 6.21 fears about confidentiality
 - 6.22 loss of face and shame
 - 6.23 violation of role relationship
 - 6.24 family involvement
 - 6.25 cultural signs and behavior
 - 6.3 cultural differences in communication styles
 - 6.31 Modes of emotional expressions
 - 6.32 Language of emotions
 - 6.33 Self-disclosure
 - 6.4 culturally responsive services and intervention
 - 6.41 problem focused approach
 - 6.42 need for immediate results/benefits
 - 6.43 responsive and meaningful intervention/treatment process

THE ALCOHOL SERVICE DELIVERY SYSTEM

1.0 Overview of the Alcohol Programs in California

- 1.1 structure of the state system
- 1.2 Funding for services
- 1.3 county system

2.0 Models of Alcohol Service Delivery

- 2.1 mainstream vs. parallel service models
 - 2.11 continuum model
 - 2.12 mainstream services
 - 2.13 parallel services

2.0 Establishing Therapist Credibility

- 2.1 a general model
 - 2.11 ascribed credibility
 - 2.12 achieved credibility
 - 2.13 gift giving
- 2.2 problems of confidentiality in small Asian Pacific communities
 - 2.21 minimizing loss of face and stigma
- 2.3 establishing treatment contracts with Asian Pacific Clients
 - 2.31 unfamiliarity with contracting
- 2.4 educating the client about the therapeutic process
 - 2.41 prescription of client role in therapy
- 2.5 Addressing client expectations regarding medications
 - 2.51 need to discuss medication issues early in treatment
 - 2.52 Previous experience with medications
 - 2.53 monitoring medication usage
- 2.6 establishing the role of the therapist when using interpreters
- 2.7 providing immediate support for the client (gift giving)
 - 2.71 conceptualizing problems in a normalized manner
 - 2.72 universalization
- 2.8 motivating the client
 - 2.81 invoking traditional obligations
 - 2.82 role-based or family-based goals

MODULE V

CULTURALLY APPROPRIATE RECOVERY PROCESS

1.0 Common Problems in Conducting Recovery with Asian Pacific Clients

- 1.1 value differences between client and therapist
 - 1.11 general philosophical differences
 - 1.12 impact on therapy
- 1.2 Specific value and attitudinal conflicts between Asian Pacific Clients and therapists
 - 1.21 interdependence vs. autonomy and independence

- 1.22 hierarchical role relationships vs. social relativity
- 1.23 harmony vs. mastery
- 1.24 saving face vs. problem solving in response to interpersonal conflicts
- 1.25 cosmic and supernatural vs. psychological and biological causes of alcohol related problems
- 1.26 stigma and fear vs. an accepting attitude of psychological problems
- 1.27 refugee status and identity vs. secure status of therapist

- 1.3 role expectations of the healer
 - 1.31 directive and active role in diagnosis and treatment
 - 1.32 rapid symptom relief
 - 1.33 confirmation of the sick role

- 1.4 methods for coping with and solving emotional problems
 - 1.41 need for extended psychotherapy
 - 1.42 focus on somatic symptoms and problems
 - 1.43 emphasis on medical model
 - 1.44 avoidance of morbid thinking and the expression of negative feelings
 - 1.45 unwillingness to self-disclose

- 1.5 perceived goals and objectives of therapy
 - 1.51 social and objective rehabilitation vs. personal and subjective restoration
 - 1.52 immediate problem-solving of socially-relevant difficulties

MODULE VI

PARAPROFESSIONALS AND INTERPRETERS IN ALCOHOL SERVICE DELIVERY

FOR

- 1.0 Bilingual/bicultural paraprofessionals
- 2.0 Professionals who utilize paraprofessional services
- 3.0 Professionals who provide supervision and ongoing training.

GENERAL CONTENT:

- 1.0 Guidelines for the successful and ethical utilization of paraprofessional and Interpreter services in alcohol-related services delivery
- 2.0 Practical problem-solving strategies for overcoming difficult situations during

Some sessions conducted by professionals, paraprofessionals and interpreters.

- 3.0 Some ways to increase skill levels for both providers and users of alcohol-related services.

COURSE OF STUDY:

1.0 Models of Service Provision Using Bilingual/Bicultural Paraprofessionals and Interpreters

1.1 Some Functions of Paraprofessionals

- 1.11 translator
- 1.12 interpreter
- 1.13 paraprofessional counselor
- 1.14 culture broker
- 1.15 outreach worker
- 1.16 community advocate/organizer
- 1.17 educator of service providers about participant's culture (Egli, 1987)

Although supervised by professionals, paraprofessionals may be expected to function independently.

1.2 Providing Services Through Interpreters

- 1.21 More limited function than bilingual/bicultural paraprofessionals. Provide only linguistic services.
- 1.22 Involvement not to extend beyond the individual or group session.
- 1.23 Verbatim vs. Content Interpretation:
 - Verbatim: interpreting without elaboration
 - Content: involve elaboration to include nonverbal component and cultural subtleties

The distinction is often blurred in actual practice.

However, it is important that person utilizing interpreter services makes known what method would predominate.

2.0 Functions of a Bilingual/Bicultural Provider/Staff

2.1 Case management function: link participants with appropriate services

Preparatory training include:

- orientation of alcohol-related and human services which are available
- referral practices and policies

2.2 Outreach activities:

2.21 facilitate identification of community needs

2.22 facilitate appropriate referral

2.23 provide timely intervention

2.24 enhance the image of the alcohol-related program as a readily accessible and responsive community resource.

2.25 opportunity to provide consultation services

3.0 Issues of Recruitment, Training, Retention and Supervision

3.1 Characteristics of Successful Provider/Staff and Interpreters

3.11 Community standing

3.12 Language skills

3.13 Interpersonal skills

3.2 Cultural Expertise vs. Alcohol-related Program Expertise

- A crucial issue in supervision

3.3 Issues of Identification and Burnout

- need to be addressed because the risk is high.

3.4 Special Problems for Interpreters (Marcos 1979)

- 3.41 Tendency to distort content of participant's Verbalizations
- 3.42 Embarrassment about sensitive topics
- 3.43 Overwhelmed with responsibility to interpret
- 3.5 In service training and Supervision
 - 3.51 Orientation to alcohol-related issues
 - 3.52 Debriefing procedures
- 4.0 General Guidelines for Monolingual Providers in a Cross-Cultural Environment (Putsch, 1985)
 - 4.1 Unless you are thoroughly effective and fluent in the target language, always use an interpreter.
 - 4.2 Avoid using family members as interpreters.
 - 4.3 Learn basic words and sentences in the target language
 - 4.4 Utilize dictionaries of languages used by the participant population. Beware of brief definitions; they only serve as labels.
 - 4.5 Become familiar with the special terminology used by the participant. Specific beliefs, practices and traditions are often referred by indirect language or special terms. Local beliefs and moral tenets may lead to overemphasis or under-reporting of symptom, issue and events.
 - 4.6 Check the quality of translated alcohol-related and other health-related materials by having them back-translated.
 - 4.7 Meet with your interpreters on a regular basis. They will provide both a window and mirror when you deal with another language and another culture.
 - 4.8 Personal information is often closely guarded and difficult to obtain. Participants often request a specific interpreter or even bring one.
 - 4.9 Evaluate the interpreter's style and approach to the participants. For special situations and problem cases, try to match the interpreter to the task.
 - 4.10 Be patient. Careful interpretation often requires that the interpreter use long explanatory phrases.

MODULE VII

THE SOCIAL MODEL OF RECOVERY

General Objectives:

- 1.0 To know the social model approach to personal recovery from alcoholism.
 - 1.1 concepts
 - 1.2 beliefs
 - 1.3 philosophy
 - 1.31 alcohol problems are “interactive” in nature.
 - 1.32 a sober environment is a “primary” service.
 - 1.33 recovery services are “natural” in style.
 - 1.34 primary therapeutic relationship is between the individual and the program, not between the individual and a particular therapist. Relationships individual participants have with each other are stronger and more meaningful than between participants and staff members.
 - 1.35 the basis of authority is experiential knowledge. The program emphasizes the importance of living life sober on a day to day basis as the only real way to learn to recover from alcoholism. The people with the most experience in recovery from alcoholism as being the leaders of the group program.
 - 1.36 participants give and receive help.
 - 1.37 participants are considered responsible for their lives, accept the consequences of their actions. Services are based on attraction, not on diagnosis.
 - 1.38 each participant is responsible for choosing recovery activities appropriate for his or her recovery.
 - 1.39 the goal is to provide opportunities for recovery, not treatment. “Alcoholics recover not because we treat them, but because they heal themselves.”
- 2.0 To become familiar with the existing social model programs in the community.
 - 2.1 men and women’s recovery homes
 - 2.2 drop-in centers
 - 2.3 sober-living residential places
- 3.0 To know the similarities and differences between the social model and other models of personal recovery.
- 4.0 To become familiar with the organization, management, staffing and training of a social model program.

Content

1.0 Recovery: Elements and Process

- 1.1_ The alcohol “disease” process
 - 1.11 “Hitting bottom”
 - 1.12 recognition and desire to stop drinking
 - 1.13 acceptance of recovery program
- 1.2 Programs of recovery
 - 1.21 Twelve Step
 - 1.22 Sober living
 - 1.23 peer support
 - 1.24 referral services and resources
 - 1.25 problem area

2.0 Characteristics of the Social Model

- 2.1 Source of learning and interaction: the experiential
- 2.2 Source of authority: the Twelve Steps
- 2.3 Comparison with other models
 - 2.31 medical
 - 2.32 mental health
 - 2.33 case management
 - 2.34 aversion
- 2.4 Advantages and Disadvantages
- 2.5 Role of the community

3.0 Social Model and the Special Population

- 3.1 The ethnic groups: refer to the Needs Assessment
 - 3.11 cultural issues
 - 3.12 social issues
- 3.2 Alcohol Related problems

4.0 Organization and Management

- 1.0 Financing
- 2.0 Staffing
- 3.0 Facilities
- 4.0 Volunteers

READINGS AND REFERENCES

The project, funded by the California State Department of Alcohol and Drug Programs suggests the following curriculum to be utilized to the fullest extent and modified according to geographical locations and target populations. It is framed with the basic fundamental concepts and assumptions based on the following documents and articles:

1. "Education for Social Work Practice in Asian and Pacific American Communities," (Kuramoto, Morales, Munoz and Murase, 1981) **Mental Health and People of Color**, J.C. Chunn, Et al, Eds, Howard U. Washington, D.C. 1983
2. "Mental Health Services for Southeast Asians," Special Service for Groups, 1989. P. Chikahisa, Et. Al, **Social Work with Southeast Asians, Bridging Cultures**, SSG, L.A., 1982.
3. "Social Model Recovery," L.A. County OAP/AI Wright, 1988 - 90, principles and concepts of resolving the alcohol and related problems in the community.

WORKSHOP SAMPLE

- 10:00 Refreshment/Welcome/Purpose
- 10:10 Relating the Social Modal to the Asian Pacific Population
- 10:25 The Asian Pacific Population: Some Cultural Issues
- 10:40 Break
- 10:45 Discussion: Relevance to some existing programs
- 11:15 Wrap Up and Evaluation
- 11:30 End of Session

STATE OF THE ART: PACIFIC ASIAN ALCOHOL PROBLEMS

Sponsored by the Special Service Groups
Funded by the State Alcohol and Drug Programs

Registration Form

Name: _____ Phone _____

Address: _____ State _____ Zip _____

Make check payable to SSG in the amount of \$ _____
defray materials and lunch.

Mail check and this form to SSG: SAPACONTRAP '90-91
1313 West 8th, #201, Los Angeles, CA 90017 213/484/6222
or 213 /738-3361

QUESTIONNAIRE

Please encircle your response. **D:** Disagree **N:** Neutral **A:** Agree

1. Early intervention modalities to the Asian Pacific
is by and large adequate **D N A**
2. There are not enough programs to refer Asian
Pacifics to. **D N A**
3. To be bilingual is to be ethnic-sensitive. **D N A**
4. The training of translators will reduce the
distortion of communication **D N A**
5. The present strategies of prevention, intervention
and referral are adequate. **D N A**
6. The present training programs and networking
activities are applicable to the Pacific Asians. **D N A**
7. The present criteria for assessing the effectiveness
of alcohol-related programs for Pacific Asians
is appropriate. **D N A**

SYLLABUS SAMPLE

(A one day presentation)

Specifics of the syllabus: Based on the Need Assessment and the Curriculum Framework

1. On the Southeast Asians:
 - * Immigration Timetable and Historical Push-Pull forces
 - * Population, Profile, Concentration and Dispersion
 - * Substance Abuse Anecdotal Data, Patterns and Related Socio-Economic Problems
 - * Recommendations, Solutions, and Resources
2. On the Pilipino Americans: same as above
3. Readings and References
4. Comments, Questions and Answers
5. Implications for the developed of effective services which are culturally congruent and staff competent.

5 to 6 hour presentation

MEETING AGENDA FOR THE KEY INFORMANT SURVEY

OF THE ASIAN PACIFIC ALCOHOL PEER CONSULTATION AND TRAINING PROJECT

I. General Introduction

II. Specific Survey Questions

1. Which groups in the community (e.g. immigrants, children, elderly, youth, monolinguals, single females, handicapped, etc.) are at relatively high risk for developing alcohol-related problems?

2. If services exist, is the community aware of these services?

3. If it is not, what are the reasons for this lack of awareness?

4. What types of problems might occur when developing prevention and clinical services for alcohol abuse in your community?

5. What population changes are expected in the community and how will these affect the risk for individuals developing alcohol-related problems in the community?

III General roundtable discussion regarding risk factors, future concerns, possible intervention measures, etc.

IV Conclusion

ALCOHOL EXPERIENCE AND SERVICES SURVEY

Purpose: This survey is being conducted to obtain information on the frequency and circumstances under which people drink. Also, questions are asked about which services a person would use if he or she had an alcohol problem. All of your responses will be kept strictly confidential and cannot be traced back to your name. We ask that you be honest and provide complete responses to all the questions. The survey usually takes less than 40 minutes to complete. Thank you

PLEASE CIRCLE OR FILL IN YOUR RESPONSE.

Demographics

1. Age: _____ 2. Sex: (1) Female (2) Male

3. Marital Status: (1) Married/living in marriage-like situation
(2) Single, never married
(3) Separated
(4) Divorced
(5) Widowed

4. Education: (1) No formal education
(2) 1 - 6 years completed (elementary school)
(3) 7 - 9 years completed (middle school)
(4) 10 - 12 years completed (high school)
(5) 13- 16 years completed (college)
(6) more than college

5. Ethnicity (1) American Indian (6) Hispanic
(2) Black (7) Japanese
(3) White (8) Korean
(4) Chinese (9) Vietnamese
(5) Filipino (10) Other _____

6. Country of Origin: (1) Foreign Born (2) U.S. Born

7. If Foreign born, Number of Years in the U.S.: _____

8. Generation (1) First generation: Foreign born.
(2) Second generation: Born in U.S., parents are foreign born.
(3) Third generation: Born in U.S., parents also born in U.S.
Grandparents foreign born.
(4) Fourth generation: Born in U.S., parents and grandparents
Also born in U.S., great grandparents foreign born.
(5) Other: _____

9. Employment: (1) Employed full-time
(2) Employed part-time, but not a student
(3) Unemployed, seeking work
(4) Unemployed, not seeking work

- (5) Retired
- (6) Disabled
- (7) Student
- (8) Housekeeper
- (9) Other: _____.

10. Occupation: _____.

Alcohol Use

11. How much do you usually drink?
- | | |
|---------------------------|------------------------------|
| (1) Never | (6) 1 - 2 times a week |
| (2) Less than once a year | (7) 3 -4 times a week |
| (3) 1 - 8 times a year | (8) Once a day |
| (4) 2 - 3 times a month | (9) More than once a day |
| (5) 2 -3 times a month | (10) Often, every 3- 4 hours |
12. How many drinks do you have in one sitting?
- | | |
|------------------|-----------------------|
| (1) None | (5) 7 - 8 drinks |
| (2) 1 - 2 drinks | (6) 9 - 10 drinks |
| (3) 3 - 4 drinks | (7) 10 or more drinks |
| (4) 5 - 6 drinks | |
13. How would you characterize your drinking pattern?
- (1) Always have been a non-drinker
 - (2) Non-drinker now, but drank in the past
 - (3) Non-drinker now, but was an alcoholic or very heavy drinker
 - (4) Presently a light drinker
 - (5) Presently a heavy drinker
 - (6) Presently an alcoholic
14. How serious is your drinking problem?
- | | |
|------------------------|----------------------|
| (1) Does not apply | (4) Somewhat serious |
| (2) Not at all serious | (5) Serious |
| (3) Not too serious | (6) Serious |

Reasons for Drinking

Indicate the reasons why you drink by circling your response. If you do not drink, skip this section.

15. I drink to stop boredom.
- | | | |
|--------|--------------|---------|
| (1) No | (2) Not sure | (3) Yes |
|--------|--------------|---------|
16. I drink to enjoy what I am doing more.
- | | | |
|--------|--------------|---------|
| (1) No | (2) Not sure | (4) Yes |
|--------|--------------|---------|

17. I drink to help me through the day.
(1) No (2) Not sure (3) Yes
18. I drink because everybody else drinks.
(1) No (2) Not sure (4) Yes
19. I drink to reduce anxiety and tension.
(1) No (2) Not sure (4) Yes
20. I drink to know myself better
(1) No (2) Not sure (4) Yes
21. I drink to feel good around people
(1) No (2) Not sure (4) Yes
22. I drink because I feel bad when I do not drink.
(1) No (2) Not sure (4) Yes
23. I drink because I feel sad or depressed
(1) No (2) Not sure (4) Yes
24. I drink to be more creative and productive
(1) No (2) Not sure (4) Yes
25. I drink to get along better with friends.
(1) No (2) Not sure (4) Yes
26. I drink to understand things differently
(1) No (2) Not sure (4) Yes
27. I drink because it helps me with problems.
(1) No (2) Not sure (4) Yes
28. I drink to feel better about myself .
(1) No (2) Not sure (4) Yes
29. I drink because friends pressure me into drinking.
(1) No (2) Not sure (4) Yes

Other Substance Use

30. How much do you usually smoke cigarettes?
- | | |
|------------------------------|-------------------------------|
| (1) Never | (5) 10 - 19 cigarettes a week |
| (2) 1 - 12 times a year | (6) Less than 1 pack a day |
| (3) 1 - 3 times a month | (7) 1 - ½ packs a day |
| (4) 1 - 10 cigarettes a week | (8) More than 1-2 packs a day |

31. How much do you usually use marijuana?
- | | |
|---------------------------|-------------------------------|
| (1) Never | (6) 1 - 2 times a week |
| (2) Less than once a year | (7) 3 - 4 times a week |
| (3) 1 - 8 times a year | (8) Once a day |
| (5) 2 - 3 times a month | (9) More than once a day |
| (5) 2 - 3 times a month | (10) Often, every 3 - 4 hours |
32. How much do you usually use cocaine?
- | | |
|---------------------------|-------------------------------|
| (1) Never | (6) 1 - 2 times a week |
| (2) Less than once a year | (7) 3 - 4 times a week |
| (3) 1 - 8 times a year | (8) Once a day |
| (6) 2 - 3 times a month | (9) More than once a day |
| (5) 2 - 3 times a month | (10) Often, every 3 - 4 hours |
33. How much do you usually use tranquilizers (muscle relaxers) or barbiturates (sleeping pills, downers, reds)?
- | | |
|---------------------------|-------------------------------|
| (1) Never | (6) 1 - 2 times a week |
| (2) Less than once a year | (7) 3 - 4 times a week |
| (3) 1 - 8 times a year | (8) Once a day |
| (7) 2 - 3 times a month | (9) More than once a day |
| (5) 2 - 3 times a month | (10) Often, every 3 - 4 hours |
34. How much do you usually use amphetamines (speed, diet pills, uppers)?
- | | |
|---------------------------|-------------------------------|
| (1) Never | (6) 1 - 2 times a week |
| (2) Less than once a year | (7) 3 - 4 times a week |
| (3) 1 - 8 times a year | (8) Once a day |
| (8) 2 - 3 times a month | (9) More than once a day |
| (5) 2 - 3 times a month | (10) Often, every 3 - 4 hours |

Services

35. Do you think you have a drinking problem?
- | | | |
|--------|--------------|---------|
| (1) No | (2) Not sure | (3) Yes |
|--------|--------------|---------|
36. How many times have you sought help for a drinking problem?
- | | |
|--|-----------------------|
| (1) Does not apply - I have no problem | (3) Twice |
| (2) Never | (4) 3 times |
| (3) Once | (5) More than 3 times |

Put a check by the services you sought help from for your drinking problem. If the service was provided by an agency, indicate the name of that agency.

37. _____ a medical doctor or physician
38. _____ a lawyer
39. _____ a priest, minister, monk, rabbi, kahuna, or other religious leader.
40. _____ a psychologist or psychiatrist in private practice

41. _____ a mental health clinic Name: _____
42. _____ a substance abuse clinic Name: _____
43. _____ a social service agency Name: _____
44. _____ a public health clinic Name: _____
45. _____ the policed

46. List all the agencies that you know who provide alcohol treatment programs.

Agency name: _____

Agency name: _____

Agency name: _____

Agency name: _____

Agency name: _____

At times people do not seek help when they have a drinking problem. Indicate how important each reason (of the reasons) would be for not seeking help even if you had a drinking problem.

47. I do not know where to go.
 (1) Not important (2) Somewhat important (3) Very important
48. The agency/service is too far away.
 (1) Not important (2) Somewhat important (3) Very important
49. The service is too expensive.
 (1) Not important (2) Somewhat important (3) Very important
50. I am personally too ashamed or embarrassed to go for help.
 (1) Not important (2) Somewhat important (3) Very important
51. I would be personally too ashamed or embarrassed if my family or friends knew about my problem.
 (1) Not important (2) Somewhat important (3) Very important
52. I do not think seeking help for this problem would do any good.
 (1) Not important (2) Somewhat important (3) Very important
53. Professionals with a cultural background similar to mine are not available.
 (1) Not important (2) Somewhat important (3) Very important
54. I am not sure what to expect if I seek help for this problem.
 (1) Not important (2) Somewhat important (3) Very important
55. I cannot go during the hours that the agency is open.
 (1) Not important (2) Somewhat important (3) Very important
56. The agency/service is too formal.
 (1) Not important (2) Somewhat important (3) Very important

57. There are too many procedures or forms to complete before I receive any service.
(1) Not important (2) Somewhat important (3) Very important
58. Before when I sought help, the service/agency was not effective in helping me with this problem.
(1) Not important (2) Somewhat important (3) Very important
59. When I sought help at an earlier time, the staff at the agency did not treat me well.
(1) Not important (2) Somewhat important (3) Very important

If at any time you have sought help for a drinking problem, please answer the following questions. If you have sought help more than once, think about your most recent experience in seeking help and then answer the following questions.

60. How convenient was the location of the agency or service?
(1) not at all convenient (3) somewhat convenient
(2) Not too convenient (4) very convenient
61. In general, did the receptionists and secretaries seem friendly and make you feel comfortable?
(1) Often they were not (3) Most of the time they were
(2) Sometimes they were not (4) Almost all the time they were
62. Do you think the fee you were charged was appropriate?
(1) Just right (3) somewhat high
(2) Somewhat low (4) too high
63. When you first called to see someone, did you feel that you had to wait long for an appointment?
(1) yes, there was a long delay (3) no, I waited a little, but it was not very long
(2) yes, there was some delay (4) no, I was seen without any delay
64. If a friend were in need of similar help, would you recommend this program to him or her?
(1) yes, I definitely would (3) no, I do not think I would
(2) yes, I think I would (4) no, I definitely would not
65. You went to the service or agency with certain problems, after you left how were those problems?
(1) worse or much worse (3) somewhat better
(2) No change (4) much better
66. Did you like your therapist?
(1) yes, very much (3) no, not that much
(2) yes, somewhat (4) no, not at all
67. How satisfied were you in the way your fee was determined?
(1) not at all satisfied (3) somewhat satisfied
(2) not very satisfied (4) very satisfied
68. Did the services that you received help you reduce your drinking problem?
(1) yes, they helped very much (3) no, they really did not help

(2) yes, they helped somewhat (4) no, they seemed to have made things worse

69. In general, how satisfied were you with the services you received?
- (1) not at all satisfied (3) Somewhat satisfied
(2) not very satisfied (4) very satisfied

THANK YOU FOR YOUR PARTICIPATION AND COOPERATION

CLINICAL INTERVIEW PROTOCOL

Personal Background Questionnaire

1. Age: _____ 2. Sex: (1) Female (2) Male
3. Education: (1) No formal education
(2) 1 - 6 years completed (elementary school)
(3) 7 - 9 years completed (middle school)
(4) 10 - 12 years completed (high school)
(5) 13- 16 years completed (college)
(6) more than college
4. Ethnicity (1) American Indian (6) Hispanic
(2) Black (7) Japanese
(3) White (8) Korean
(4) Chinese (9) Vietnamese
(5) Filipino (10) Other _____
5. Country of Origin: (1) Foreign Born (2) U.S. Born
6. If Foreign born, Number of Years in the U.S.: _____
7. Generation (1) First generation: Foreign born.
(2) Second generation: Born in U.S., parents are foreign born.
(3) Third generation: Born in U.S., parents also born in U.S.
Grandparents foreign born.
(4) Fourth generation: Born in U.S., parents and grandparents
Also born in U.S., great grandparents foreign born.
(5) Other: _____
8. Employment: (1) Employed full-time
(2) Employed part-time, but not a student
(3) Unemployed, seeking work
(4) Unemployed, not seeking work
(5) Retired
(6) Disabled
(7) Student
(8) Housekeeper
(10) Other: _____
9. Occupation: _____

Problem Background

1. Can you explain what were the major problems or circumstances in your life that caused you to drink? (e.g. family difficulties, personal inadequacies, peer pressure or influence, loss of an important person, etc.)

2. What types of problems in relationships were you having that may have caused your drinking difficulties or made them worse?
3. What types of problems in work or school were you having that may have caused your drinking difficulties or made them worse?
4. What types of personal problems (e. g., depression) were you having that may have caused your drinking difficulties or made them worse?
5. What were the immediate positive effects of drinking for you? What were the negative effects?

Problem Recognition

1. When did you recognize that you had a problem in drinking? How did this happen?

3. If you considered seeking help but did not, please explain the major reasons that prevented you from seeking help.

4. What would you recommend that would help others seek help sooner?

**ASIAN PACIFIC ALCOHOL PEER
CONSULTATION AND TRAINING
PROJECT**

NEEDS ASSESSMENT

Special Service for Groups
1313 West 8th St., #201
Los Angeles, CA
(213) 484-6222

ACKNOWLEDGEMENTS

The Asian Pacific Alcohol Peer Consultation and Training Project was made possible because of the active involvement of various institutions and individuals. For their invaluable support and assistance, the Project Staff acknowledges the following:

- STATE of CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS, HEALTH AND WELFARE AGENCY, for providing the funds.
- SPECIAL SERVICE FOR GROUPS, for administrative and fiscal support

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MODULE IV

**ALCOHOL PROBLEMS
INTERVENTION, TREATMENT
AND SERVICE DELIVERY**

This module focuses on the difficulties in delivering alcohol services to Asian Pacific communities. A framework on the development of solutions to alcohol problems is presented with the following chart illustrating the flow between alcohol problems to the various levels of solutions which may be required.

As shown in the chart and schema below, alcohol problems impacting the Asian Pacific and Southeast Asians are reviewed. The first step is to examine ways individuals and families attempt to cope with the problem, prior to seeking help, then look at the three types of coping: personal coping, social support and formal traditional healing practices. In addition, certain service barriers must be minimized before entering into services, and finally, certain problems may prevent the effective treatment process.

FLOW CHART

ALCOHOL PROBLEM

TO VARIOUS LEVELS OF SOLUTIONS

ALCOHOL PROBLEM

PERSONAL COPING

SOCIAL SUPPORT

FORMAL TRADITIONAL HEALING PRACTICES

SERVICE BARRIERS

INTERVENTION AND TREATMENT

**PACIFIC ASIAN PEER CONSULTATION
AND TRAINING PROJECT**

EVALUATION FORM

TOPIC _____ DATE _____

PRESENTERS (S) _____

Please circle the letter(s) which best express your thoughts and feelings.

1. FORMAT OF PRESENTATION
 A. Too Formal B. Too Unstructured
 B. Uneven D. Just Right E. Outstanding

- II PRESENTERS(S)
 A. Boring B. Hard to understand
 C. Inadequate knowledge of material D. Good presenters
 E. Very stimulating

- III. CONTENT
 A. Didn't attain the objectives B. Inadequate information
 C. Cluttered data D. New information given
 E. Learning objectives attained

- IV. THIS TOPIC MADE ME FEEL
 A. Confused B. Inspired C. Concerned for other Asians
 D. Motivated to do more E. More aware of my ethnicity

- V. THIS TOPIC HELPED ME LEARN MORE ABOUT
 A. The Asian Community B. Behavior of Asians
 C. Methods and Technique D. Programs E. Concepts

- VI. MY PARTICIPATION DURING THE PRESENTATION
 A. As listener B. With Hesitation C. Spontaneous
 D. As additional resource E. With enthusiasm

- VII. RATING OF TOPIC AS A WHOLE
 A. Don't include in next seminar B. Needs improvement
 B. Fair D. Good E. Excellent

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