

CSAP Cultural Competence Series 4

Cultural Competence for Social Workers: A Guide for Alcohol and Other Drug Abuse Prevention Professionals Working With Ethnic/ Racial Communities

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Editors:

Joanne Philleo, M.S.W.

Frances Larry Brisbane, Ph.D., Dean

School of Social Welfare

State University of New York at Stony Brook

Managing Editor:

Leonard G. Epstein, M.S.W.

Division of Community Prevention and Training

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Asian Americans

*Ford H. Kuramoto, D.S.W.
Executive Director
National Asian/Pacific American
Families Against Substance Abuse*

History

Asians and Pacific Islanders are frequently combined in discussions of cultural competency. They are, however, very diverse populations, and the focus of this chapter is limited to Asian Americans. Asian Americans represent about 95 percent of the 7.2 million U.S. Asians and Pacific Islanders. According to the U.S. Census Bureau (1991), Asian Americans include people from more than 20 countries along the Pacific Rim and in Central, South, and Southeast Asia (O'Hare and Felt 1991). About 23 percent of the total are Chinese Americans. About 63 percent of the Chinese American population is foreign born (Zane et al. 1994). This chapter will focus on only the largest of the Asian American populations. A brief historical perspective on these populations is presented in this section.

There are reports that some Asians lived in parts of the United States as early as 498 A.D. However, most Asians began arriving in America at the time of the California Gold Rush, around 1850. There is a historical connection between the immigration of Asians and the history of drugs in America, specifically opium.

The first group of Asian immigrants to arrive in the United States in large numbers was the Chinese, beginning about 1850 (Zane et al. 1994). According to Zane and colleagues, between 1849 and 1882 over 275,000 Chinese entered the United States to work in California during the Gold Rush, as well as on the transcontinental railroads. The Chinese laborers, about 90 percent of whom were single men, brought with them opium to smoke. It is estimated that by 1875, opium smoking had become widespread in the United States among all segments of society (Inciardi 1992).

After the Chinese Exclusion Act of 1882, Japanese laborers were brought to America in increasing numbers from 1885 to about 1910. The National Origins Act barred Japanese and other Asians from entering the United States after 1924. According to the 1990 census, Japanese Americans represented 12 percent of Asians and Pacific Islanders, the third largest subgroup (Census Bureau 1991).

Although Filipinos are generally considered Asians, some Filipino Americans identify themselves as Pacific Islanders. In contrast to the Chinese and Japanese nationals who immigrated to America, the Filipinos were considered American nationals because of the colonial control the United States held over the Philippines. They are the second-largest Asian and Pacific Islander population in the United States, with 1.4 million or 19 percent of all Asians and Pacific Islanders. Over 64 percent of Filipino Americans are foreign born (Zane and Kim 1994).

Koreans began immigrating to the United States around the turn of the century as a result of war (e.g., the Tonghak Rebellion, the Sino-Japanese War, the Russo-Japanese War), disease, and famine. According to the 1990 census, Korean Americans represented 11 percent of Asians and Pacific Islanders. More than 80 percent of Korean Americans are foreign born (Zane and Kim 1994).

There were relatively few Southeast Asians in the United States prior to 1975. After the fall of Saigon in 1975, Cambodians, Laotians, and Vietnamese tried to escape war, political purges, and famine by relocating to refugee camps, the United States, and other countries. In the 1990 census, the Vietnamese population represented 8 percent of all Asians and Pacific Islanders, Cambodians 2 percent, Laotians 2 percent, Hmong 1 percent, and Thai 1 percent (Zane and Kim 1994).

South Asians, primarily Asian Indians, began coming to the United States around 1900. The early immigrants were laborers in the lumber industry in Washington State and the farms of California (Takaki 1989). According to the 1990 census, Asian Indians represented 11 percent of the Asian and Pacific Islander population (Census Bureau 1991).

Extent of the Problem

The sheer lack of research data on tobacco and alcohol and other drug (AOD) use in these populations is a basic and serious problem for Asian Americans and Pacific Islanders. A review of the available literature will show how much research is needed.

The National Institute on Drug Abuse (NIDA) monograph on people of color by Trimble and colleagues (1987) is one of only a few publications with a section on Asians and Pacific Islanders. The NIDA monograph discusses a few studies that give a mixed picture of the incidence and prevalence of alcohol and other drug abuse (AODA) among the diverse Asian and Pacific Islander populations. Most of the studies cited in the monograph are anecdotal or limited to relatively small samples in specific local communities. While the incidence and prevalence of AODA among Asians and Pacific Islanders is generally considered to be lower than in those of other groups, the monograph indicates that conclusions should be cautiously drawn, since many of the studies had methodological weaknesses.

One of the early studies on Asian and Pacific Islander populations was conducted by Nakagawa and Watanabe (1973) in Seattle, WA. An Asian student population was surveyed in junior high and high schools on the personal use of drugs other than marijuana and alcohol. There were 393 males and 367 females in the sample. Twelve percent of the males and 7 percent of the females were classified as drug users. By ethnic groups, 45 percent of the drug users were Filipino, 29 percent Japanese, 22 percent Chinese, and 49 percent other Asians. The drugs used by these youths included amphetamines, barbiturates, psychedelics, cocaine, and heroin.

Porter and colleagues (1973) surveyed all students in grades 6 through 12 in Anchorage, AK. Of the 15,634 students surveyed, 0.6 percent were Asians and Pacific Islanders. Compared with the drug use rates of Native Alaskans (44 percent), Whites (36 percent), and African Americans (32 percent), the Asian and Pacific Islander students reported the lowest rate of use of "at least one drug," at 26 percent.

Stimbu and colleagues (1973) surveyed college students in a large southeastern state regarding drug use. Asian and Pacific Islander students represented 1 percent of the 20,547 respondents. Asians and Pacific Islanders in the sample reported the lowest use of alcohol and tobacco, the second-lowest use of marijuana and strong stimulants, and the third-lowest use of all other substances compared to American Indian, African-American,

can, and White respondents. None of these studies specifically identified the Asian and Pacific Islander subgroups with respect to patterns and characteristics of drug use.

Data derived from the treatment of Asian-American patients for drug abuse are another source of information. Some of the early focus on Chinese opium users is considered to be influenced by anti-Chinese, xenophobic sentiments around 1900, and the victimization of Chinese immigrants by drug enforcement authorities was motivated by racial and political attitudes of the day (Johnson and Nishi 1976; Musto 1973). According to Trimble and colleagues (1987), some studies indicated that Chinese immigrants were overrepresented among drug addict populations receiving treatment between 1920 and 1962. The profile of the typical Chinese addict is telling: "an immigrant from China, English-limited facilities, mean age of 53, a social isolate with a lack of social, recreational, and spiritual outlets."

Chinese narcotic addicts constituted less than 3 percent of the 32,309 male addicts treated at the U.S. Public Health hospital in Lexington, KY, between 1920 and 1962. This figure overrepresented Chinese Americans in proportion to the total population. However, in San Francisco, during the period 1981-82, Asians and Pacific Islanders represented 3.3 percent of all admissions to drug treatment programs. This proportion is considered low, since about 22 percent of the city's population at that time were Asians and Pacific Islanders. Another drug abuse prevalence study based on a key informant needs assessment found that Chinese-American drug use and Filipino-American drug use were lower than that of the general population, while Japanese-American drug use was estimated to be about the same (Trimble et al. 1987).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) publication on ethnic minorities (1989) reported a number of studies of alcohol use among Asian and Pacific Islander populations, including surveys in Hawaii and the continental United States. According to Ahern (1989), the prevalence of alcohol use on Oahu in 1960 indicated that Caucasians had the highest prevalence rate (74 percent), followed by Native Hawaiians (62 percent), Chinese (58 percent), Japanese (50 percent),

Filipinos (46 percent), and others (62 percent). Subsequent surveys in 1974 and 1979 indicated similar patterns.

Yu and colleagues (1985) studied alcohol use among Chinese in Shanghai and the United States. This study found that the average annual death rates attributed to chronic liver disease and cirrhosis specified as alcoholic (1979-1981) indicated that African Americans had the highest rates (10.5 per 100,000), followed by Whites (4.7 per 100,000) and Chinese (1.2 per 100,000).

Murakami (1985) studied alcohol and drug problems in Hawaii among four ethnic groups. The prevalence rates of alcohol consumption in the category of "heavy" drinkers were highest for Caucasians (13.6 percent), followed by Native Hawaiians (11.0 percent), Filipinos (6.7 percent), and Japanese (5.2 percent). Similar alcohol consumption patterns in Hawaii were found by Marchand and colleagues (1989).

Kitano and Chi (1985) studied Chinese, Japanese, Korean, and Filipino alcohol consumption in Los Angeles. This study found that Japanese had the highest percentage of heavy drinkers (25 percent), followed by Filipinos (20 percent), Koreans (15 percent), and Chinese (10 percent).

Kandel and colleagues (1976) studied youth in New York State, a small number of whom were Asian American. The Asian-American students in the sample reported the lowest use of hard liquor, wine, beer, and cigarettes. For example, only 18 percent reported that they had ever tried hard liquor, versus 68 percent of White students. In contrast, a national sample of 7th to 12th graders, studied by Wilsnack and Wilsnack (1978), found that 90 percent of Asian-American male youth reported that they drank, compared to 80 percent of White males in the sample. Asian-American females reported less drinking than White females reported. In the Barnes and Welte (1985) study of the same grade levels in New York, 45 percent of the Asian-American youth reported that they drank, whereas 76 percent of the White students so reported. Yet, Asian-American male drinkers consumed more alcohol per day than all other groups except Native American males. Further, Asian-American male drinkers reported the greatest number of drunken episodes per month. Finally, Asian-American males also reported relatively high

mean numbers of illicit drug use (a mean of 42 times, versus 29 times for White males).

In a study of drug abuse among African-American, White, Hispanic, Native American, and Asian-American high school seniors between 1976 and 1989, Bachman and colleagues (1991) studied prevalence, trends, and correlates. From 1976 to 1979, 439 Asian Americans represented 0.7 percent of the sample. In the 1980 to 1984 sample, Asian Americans represented 1.5 percent of the sample (1,139 high school seniors) and from 1985 to 1989, 2.6 percent (1,899) of the national sample. In the Bachman study (1991), the Asian-American sample reported the lowest rates of drug use. Asian Americans also reported the lowest rate of lifetime marijuana use at 29 percent. In all of the other groups, approximately half of the males reported some lifetime use of marijuana. Annual, monthly, and daily prevalence rates for marijuana use were also relatively low for Asian-American males and females. Reported cocaine use also indicated the lowest rates for Asian-American males and females on an annual basis. Monthly prevalence rates for cocaine use were consistently lower for Asian Americans than for other groups.

Other illicit drug use—including inhalants, hallucinogens, heroin, other opiates, stimulants, sedatives, and tranquilizers—indicated the lowest rates of reported use among African Americans and Asian Americans. With regard to the prevalence of alcohol consumption, the reported use by Asian-American seniors was among the lowest, with about half of the males and one-third of the females reporting alcohol use during the past month. Heavy drinking (defined as five or more drinks at a single sitting) was also lowest among African-American males and Asian-American males. Asian-American female seniors reported heavy drinking at a rate about half that of males.

Cigarette smoking (i.e., reported use of a half pack daily) prevalence was highest among Native American seniors and significantly lower for all other groups, including Asians and Pacific Islanders.

The study by Hansen and colleagues (1988) of seventh and eighth graders in Los Angeles included a significant sample of 275 Asian-American students, who reported a relatively low

lifetime marijuana use rate (2.6 percent). However, their lifetime cigarette use (12 percent) and alcohol use (11 percent) were comparable to or greater than the rates for other ethnic groups. Sasao (1987) reported that Asian and Pacific Islanders ($n = 596$) in Los Angeles had higher rates of lifetime drug use for cigarettes (11 percent), alcohol (14 percent), and marijuana (3 percent) than African Americans, Hispanics, and Whites. Similar results were found in a statewide biannual survey of drug and alcohol use among students in grades 7, 9, and 11 (Skager et al. 1986, 1989). Asian and Pacific Islander students had relatively low rates of alcohol use compared with other groups at all grade levels. However, none of these studies differentiated among the various specific Asian and Pacific Islander subgroups.

Studies of college-age samples have also found similar patterns of AOD use among Asian and Pacific Islander students. Adlaf and colleagues (1989) studied drug use among eight ethnic groups in Ontario, Canada. The Asian and Pacific Islander sample consisting of Chinese and Japanese respondents reported the lowest rates of tobacco, alcohol, and marijuana use. Sue and colleagues (1979) studied the drinking patterns of Asian and Pacific Islander and White students in Washington State. The Asian and Pacific Islander students reported lower rates of drinking, had more negative attitudes toward drinking, and needed fewer cues to regulate their own drinking than did the white students. More Asian and Pacific Islander students (15 percent) than Whites (9 percent) reported abstinence or light drinking. Akutsu and colleagues (1989) also found that Asian and Pacific Islander students reported lower levels of alcohol consumption than White students. Self-reported physiological reactions to alcohol and drinking attitudes accounted more for the ethnic differences in use than did generalized cultural values.

Klatsky and others (1983) studied interethnic differences in alcohol consumption of Kaiser Permanente medical patients examined from 1978 through 1980. They found that Asians and Pacific Islanders reported significantly less drinking than individuals from other groups. There were, however, significant differences in patterns among the Asian and Pacific Islander subgroups. Japanese Americans reported the most alcohol use,

and Chinese Americans reported the least drinking. Among women, Filipino women reported the least alcohol use, and Japanese women reported more drinking than the others. Foreign-born respondents more often abstained or drank less than did those who were American born.

McLaughlin and colleagues (1987) studied specific Asian and Pacific Islander groups in Hawaii. The sample included a large number of households, with in-person interviews to assess lifetime prevalence of AOD use. The prevalence rate for Chinese Americans was 4 percent; for Japanese Americans, 22 percent; for Filipino Americans, 11 percent; for Native Hawaiians, 19 percent; and for White Americans, 29 percent. Whites reported higher lifetime prevalence for most drugs than Asians and Pacific Islanders. However, Hawaiians tended to have higher lifetime prevalence rates than other Asians and Pacific Islanders for alcohol, cocaine, amphetamines, and marijuana. Japanese and Chinese Americans had a higher prevalence of tranquilizer use than other Asians and Pacific Islanders. However, it is difficult to generalize these findings to Asians and Pacific Islanders outside Hawaii. Asians and Pacific Islanders in Hawaii differ from their counterparts in the continental United States because of their nonminority status, acculturation levels, English-language proficiency, community cohesiveness, sociopolitical identification, and generational status (Zane and Kim 1994).

Sasao (1991) also sampled specific Asian and Pacific Islander groups in California. This drug use assessment found that Japanese Americans had the highest percentage of reported lifetime use of cigarettes and tobacco products (45 percent), followed by Filipinos (38 percent), Vietnamese (36 percent), Koreans (36 percent), Chinese (25 percent), and Chinese-Vietnamese (24 percent). These rates are lower than the general population rate, which is approximately 80 percent. When asked about lifetime alcohol consumption (at least 10 alcoholic drinks in their lifetime), the Japanese Americans had the highest level of lifetime use at 69 percent, followed by Koreans at 49 percent, Chinese at 42 percent, Vietnamese at 43 percent, Filipinos at 39 percent, and Chinese-Vietnamese at 36 percent. These rates are significantly lower than the national prevalence rate of 85 percent. It was

reported that most of the Asian and Pacific Islander drinking was related to social occasions. Sasao (1989) also conducted a bilingual telephone survey among Japanese respondents in Southern California. Both U.S.-born and Japan-born respondents reported lifetime alcohol use of 73 percent and cigarette use of 55 percent. These rates are slightly lower than those of the general U.S. population. There were significant differences between the U.S.-born and foreign-born Japanese respondents. For example, the two subgroups defined substance abuse differently. The Japan-born respondents tended to limit the definition of substance abuse to drugs such as marijuana, LSD, and heroin while excluding alcohol and tobacco.

Kitano and colleagues (Kitano et al. 1988; Kitano and Chi 1985, 1989) studied alcohol drinking patterns among several Asian and Pacific Islander subgroups. Their studies found that alcohol drinking patterns of young Asian and Pacific Islander males were comparable to national norms, which was inconsistent with the myth that Asians and Pacific Islanders are basically nondrinkers. The studies also found that many Asian and Pacific Islanders were heavy drinkers. The Japanese respondents (most of whom were American born) had the highest percentage of heavy drinkers at 25 percent, followed by Filipinos at 20 percent, Koreans at 15 percent, and Chinese at 10 percent. The results were attributed to more permissive attitudes associated with greater acculturation. This study reported relatively few problems as a result of the heavy drinking. Few respondents reported being arrested for drinking or other serious results of heavy drinking. Apparently, the emphasis on drinking only at special occasions and the apparent social controls on drinking behavior tended to mitigate against social and legal problems as a result of alcohol consumption. Also, Maddahian and colleagues (1985) found that Asians and Pacific Islanders were the largest group that tried only alcohol and no other substances.

Some studies have implied that the low rates of alcohol use among Asian and Pacific Islander groups are related to the physiological flushing reaction among some Asians and Pacific Islanders. This flushing response is an alcohol-related physiological sensitivity. While some researchers attribute the rela-

tively lower drinking rates to this physiological response (Agarwal et al. 1984), others question this basis for the difference in drinking patterns (Chan 1986; Johnson and Nagoshi 1990).

A binational study of alcohol patterns was conducted, sampling Japanese in Japan, Japanese Americans in Hawaii, and Japanese Americans and whites in California (NIAAA et al. 1991). The study found that the proportion of current drinkers (those who drank alcohol within the past year) in all those study sites was somewhat higher than rates for the adult population in the United States as a whole. Japanese men in Japan had the highest percentage of current drinkers at 91 percent, followed by white men at 85 percent, Japanese-American men in California at 84 percent, and Japanese-American men in Hawaii at 80 percent. As is usually the case, women drank less than men. white women had the highest proportion of current female drinkers at 81 percent, followed by Japanese-American women in California at 75 percent, Japanese-American women in Hawaii at 68 percent, and Japanese women in Japan at 61 percent. Sixty-two percent of Japanese men in Japan reported drinking at least three times per week, followed by 44 percent of White male drinkers. The other respondents drank much less frequently. white women in California had the highest proportion of females who drank three or more times per week at 32 percent, followed by Japanese women in Japan at 21 percent and Japanese-American women in Hawaii and California at 9 percent.

Two studies were identified that focused on Southeast Asian respondents. Yee and Thu (1987) used household interviews to sample adult Southeast Asian refugees, mainly Vietnamese, in Texas. A majority of the sample (52 percent) reported problems with alcohol or tobacco use. About half the respondents reported that they used alcohol or smoked tobacco to cope with stressful situations or personal problems. In a study of Job Corps members in San Diego, Indo-Chinese youth had the lowest levels of drinking (use in the past 6 months) compared with Whites, African Americans, and Hispanics (Morgan et al. 1984). Sixty-six percent of Indo-Chinese males and 43 percent of Indo-Chinese females drank, compared with an average of 87 percent for males and 88 percent for females in the other groups. The Indo-Chinese

youth who drank reported very low levels of other drug use: None had used cocaine, and only 3 percent reported using marijuana.

A Canadian study of Chinese, Indo-Pakistani, and Latin American subjects (Legge and Sherlock 1990-1991), found that Chinese subjects reported a low frequency and quantity of alcohol consumption compared to Indo-Pakistani and Latin Americans (9 percent, 52 percent, and 41 percent, respectively). Chinese and Indo-Pakistani respondents were similar in their self-reports of excessive alcohol use. However, drinking was attributed to coping with failure by more Chinese respondents (52 percent) than Indo-Pakistanis (32 percent). A higher proportion of Indo-Pakistani respondents (30 percent) than Chinese respondents (18 percent) mentioned easy availability of alcohol as a reason for use. Similarly, the low cost of alcohol in Canada was considered a reason for use by more Indo-Pakistani respondents (12 percent) than Chinese respondents (7 percent). Chinese and Latin American respondents indicated that health-related problems were the biggest problems resulting from excessive alcohol use (71 percent for both groups). For the Chinese respondents, family disruption, trouble with the law, child abuse, and wife abuse were the other problems identified as resulting from excessive alcohol use. Among the Indo-Pakistani respondents, the greatest concern was family disruption, followed by wife abuse, child abuse, and family breakup.

A San Francisco study (Wong 1985) differed from most other studies in that it found relatively high rates of AODA among Chinese youth in San Francisco's Chinatown. Their use of cigarettes, marijuana, cocaine, and Valium was comparable to use by Whites, African Americans, and Hispanics. The following percentages of Chinese respondents reported consumption of these substances: beer, 77; cigarettes, 75; marijuana, 59; wine, 54, hard liquor, 49; quaaludes, 42; cocaine, 40; hashish, 22; Valium, 16; and LSD, 15. Chinese males and females had similar levels of use for most drugs; however, although females more often reported use of Valium, codeine, and quaaludes.

Only one study has focused on elderly Asian and Pacific Islander males and alcohol abuse (Yamamoto et al. 1987). This

study found that Filipinos had the highest rate of alcohol abuse or dependence (11 percent) according to DSM-III diagnostic criteria, followed by Japanese at 6 percent and Chinese at 4 percent.

Austin (unpublished) pointed out that Asian and Pacific Islander respondents did not always report the lowest incidence and prevalence rates. In a national survey of junior and senior high school students in 1974, African Americans had the highest percentage of lifetime abstainers (41 percent), followed by Asians and Pacific Islanders at 35 percent. A California study conducted in the 1980's found that Asian and Pacific Islander students reported higher drinking rates than African Americans, and at times higher than Hispanics (Maddahian et al. 1986). These alcohol studies found that Whites had the highest mean rates, followed by Hispanics, Asians, and African Americans. The differences among Asians, African Americans, and Hispanics were not significant, although the rates were substantially lower for Whites. As a result of several estimates regarding the use of illicit drugs or alcohol use, Asians and Pacific Islanders rank higher than African Americans (Barnes and Welte 1985; Barnes et al. 1993; Kim et al. 1992; Segal 1992).

In some categories of the national high school seniors survey, the limited sample of Asians and Pacific Islanders reported rates similar to African Americans in terms of the use of cocaine, stimulants, and LSD. In some cases, Asians and Pacific Islanders reported higher rates than African Americans for inhalants, tranquilizers, sedatives, and other opiates (Austin unpublished, p. 10). In the Los Angeles longitudinal study (Maddahian et al. 1986), Asians and Pacific Islanders showed only a slightly lower average for drug use (other than alcohol, tobacco, and marijuana) than did Whites and Hispanics. There were also indications that the use of nonprescription medication (e.g., sleeping pills, stimulants, cough medicines, cold and allergy medication) was higher for Asians and Pacific Islanders than for other ethnic groups. Asians and Pacific Islanders reported using nonprescription medications and drugs at a higher rate than African Americans. In a 1991 New York survey, Asians and Pacific Islanders reported using marijuana the least (10 percent) compared to Whites

(27 percent), Hispanics (23 percent), and African Americans (21 percent). Similar rates were found for use of analgesics and cocaine when compared to Whites and Hispanics only. However, Asians and Pacific Islanders reported the same rates for cocaine use as African Americans. Asian and Pacific Islander inhalant use (at 14 percent) was higher than African American use (11 percent) and similar to the rate for Hispanics (16 percent), although substantially lower than for Whites (23 percent). There were regional differences, so that the Asian and Pacific Islander rates for use of marijuana varied significantly depending on the region of the State (Austin 1994).

In the Mecklenburg County, NC, study, the rate of total AOD use among Asians and Pacific Islanders was higher than for African Americans, although lower than for other ethnic groups (Kim et al. 1992). Although marijuana use was relatively low, Asians and Pacific Islanders used inhalants, cocaine, amphetamines, and barbiturates at the same rate as Whites and other ethnic groups, or higher.

A West Coast study of secondary schools that participate in a prevention program evaluation indicated that Asians and Pacific Islanders may be at relatively higher risk for use of illicit drugs than for use of alcohol (Ellickson et al. 1992). The study of drug use patterns among students found that Whites used illicit drugs at the highest rate, 72 percent, followed by Asians and Pacific Islanders at 10 percent, Hispanics at 8 percent, and African Americans at 7 percent. Also, the pattern of use among Asians and Pacific Islanders began with pills and other drugs, followed later by regular smoking and drinking. Other groups followed a different pattern, in which weekly alcohol use was followed by use of marijuana and all other illicit drugs.

In the 1991 California Student Substance Abuse Survey, approximately 50 high schools were sampled statewide (Austin unpublished). This study found that Asian and Pacific Islander 9th and 11th graders generally reported lower prevalence rates in 10 categories of legal and illicit drugs. However, in several categories, Asians and Pacific Islanders equaled or exceeded the rates reported by African Americans, including weekly drinking, current and daily cigarette smoking, and the use of cocaine,

amphetamines, and LSD. The California study concluded that the results further supported the hypothesis that Asian and Pacific Islander youth may be at relatively high risk for use of stimulants (cocaine and amphetamines), inhalants, LSD or hallucinogens, depressants, and psychotherapeutics in general (Austin unpublished, p. 17). This study and others have found that Asians and Pacific Islanders have similar or higher use rates than African Americans for cocaine, amphetamines, and stimulants. In addition, Asians and Pacific Islanders also used depressant drugs—such as sedatives, barbiturates, and tranquilizers—more than African Americans, sometimes close to the rates of Whites. According to Austin (unpublished), the alcohol, tobacco, and other drug use rates among Asian and Pacific Islander women may be a concern, because although rates are generally low, they may rise as Asian and Pacific Islander women become more acculturated. Some research indicates that the more acculturated Asian and Pacific Islander females become, the more traditional values and the stigma of alcohol, tobacco, and other drug use among Asian and Pacific Islander females may attenuate (Chi et al. 1989).

The gender patterns indicate that males almost always use alcohol and cigarettes more frequently than females (Austin unpublished). However, the annual prevalence rate among Asian and Pacific Islander males and females are similar with regard to the use of LSD, cocaine, sedatives, barbiturates, stimulants, and marijuana. Asian and Pacific Islander females exceeded the males in use of cocaine and stimulants. Drug use among Asian and Pacific Islander females was relatively higher in relation to females of other groups, compared to their male counterparts. Compared to the current and annual prevalence rates for African-American females, Asian and Pacific Islander females had higher use rates for sedatives, marijuana, cocaine, stimulants, and inhalants. Asian and Pacific Islander females are at relatively high risk for marijuana, cocaine, and stimulant use. Asian and Pacific Islander females reported much higher rates of daily smoking than African-American females and slightly higher rates of daily smoking than Hispanic females.

Although Asian and Pacific Islander males use marijuana significantly more than females, both males and females had similar rates of use for cocaine, amphetamines, inhalants, and depressants. In all cases except inhalant use by males, Asians and Pacific Islanders exceeded African Americans of the same gender. In terms of sedatives and barbiturates, the Asian and Pacific Islander use rates were similar to those of Hispanics and higher than African-American rates.

In the 1991 California student survey, alcohol consumption across Asian and Pacific Islander groups was lower than other ethnic groups. Among the Asian and Pacific Islander groups, Pacific Islanders consistently reported the highest rate of alcohol consumption, followed by Koreans, Filipinos, Japanese, Southeast Asians, and Chinese. A similar pattern held true for cigarette smoking.

With regard to illicit drug use, a similar pattern was reported. However, Southeast Asians reported using illicit drugs at relatively high rates, comparable to those of Filipinos. Southeast Asians ranked first in cocaine use and high in amphetamine use. Pacific Islanders, however, reported relatively low rates of both cocaine and amphetamine use. Pacific Islanders reported the highest rates for use of illicit drugs, marijuana, and inhalants, at rates close to non-Asians and Pacific Islanders. Filipinos and Koreans were relatively high users of marijuana, while Filipinos and Japanese were relatively high users of cocaine and amphetamines. Asians and Pacific Islanders used inhalants at a rate similar to that of non-Asians and Pacific Islanders (Austin unpublished).

Incidence and prevalence estimates based on treated cases may initially appear to indicate a lower need for services. However, the relatively low utilization rates of existing AODA services by Asians and Pacific Islanders could also mean that the services are needed at a higher rate, and there may be various circumstances that make the use and access of services difficult (Murase 1977; Sue and Morishima 1982). Through a sample of individuals in treatment for AODA in San Francisco (Asian, Inc. 1978), it was estimated that the AODA rate among Japanese Americans is similar to that of the general population in San

Francisco. However, the AODA rates for Chinese and Filipino Americans were lower. A national study of drug abuse programs (Phin and Phillips 1978) found that 55 percent of Asians and Pacific Islanders in treatment and about 65 percent of Whites were admitted primarily for heroin use. Asian and Pacific Islander clients reported higher levels of barbiturate use (45 percent) than Whites (11 percent). It was also found (Namkung 1976) that 95 percent of Asian and Pacific Islander inmates in California prisons were incarcerated for drug-related crimes.

Finally, Zane and Sasao (1992) identified a number of trends based on recent studies. First, the use of drugs such as alcohol, nicotine, cocaine, and marijuana appeared to be lower for Asian and Pacific Islanders than for Whites and other groups of color. However, it is important to identify the variations in AOD use among the different Asian and Pacific Islander subpopulations. For example, while most Asian and Pacific Islander subgroups reported less alcohol use than Whites, Hawaiians reported AOD use at a level comparable to Whites. Second, it appeared that alcohol use has been underestimated for some Asian and Pacific Islander groups, such as Japanese-American males and Filipino-American males. Third, there is evidence that suggests that Chinese and Japanese Americans use barbiturates and tranquilizers more than was expected, and this use may be an increasing problem. Fourth, cultural factors play an important role in limiting and sometimes enhancing AOD use among Asian and Pacific Islander groups.

Cultural Characteristics of the Group

To discuss the cultural characteristics of Asian Americans, it is necessary to understand the diversity and some of the demographic characteristics of this heterogeneous population.

The O'Hare and Felt (1991) report is used extensively in this section because it captures the contrasts and diversity in the Asian and Pacific Islander populations. In this report, based on the March 1990 U.S. Census Bureau Current Population Survey, references made to Asians and Pacific Islanders include people from China, Mongolia, Pakistan, Sri Lanka, Maldives, India,

Nepal, Bhutan, Bangladesh, Burma, Laos, Thailand, Vietnam, Cambodia, North Korea, South Korea, Japan, Hong Kong, Macao, Taiwan, Philippines, Malaysia, Singapore, Indonesia, and the island groups that form Melanesia, Micronesia, and Polynesia.

In 1990, the States with the largest numbers of Asian and Pacific Islander populations are California, with 2,845,659 or 9.6 percent of the State's population; New York, with 693,760 or 3.9 percent; Hawaii, with 685,236 or 61.8 percent; Texas, with 319,459 or 1.9 percent; and Illinois, with 285,311 or 2.5 percent.

The rapid increase in the Asian and Pacific Islander population is due to immigration and an influx of refugees. During the 1980's, 75 percent of the increase in the Asian and Pacific Islander population was due to immigration.

During the 1980's, the average household income of the Asian and Pacific Islander population was slightly higher than that of non-Hispanic Whites. During this same period, however, the poverty rate among Asians and Pacific Islanders increased and is currently nearly twice that of non-Hispanic Whites. This rise is due to a bimodal income pattern, wherein some immigrants are skilled, educated, and able to develop careers in business, while others tend not to have the education and skills needed to develop similar careers and businesses in the United States as easily.

Asian and Pacific Islander families averaged slightly higher incomes than non-Hispanic White families, and more Asians and Pacific Islanders attended college. However, the personal income of Asians and Pacific Islanders was less than non-Hispanic Whites. In all age groups, non-Hispanic White males earned more money than Asian and Pacific Islander males of the same age and educational background. Even though Asians and Pacific Islanders had more education than non-Hispanic Whites, their return on earnings was 21 percent lower. This indicates that the glass ceiling effect of employment discrimination may be keeping Asians and Pacific Islanders from benefiting appropriately from their education and work performance.

The following discussion addresses the various cultural characteristics of the major Asian and Pacific Islander groups with respect to AODA issues. The discussion regarding cultural char-

acteristics in relation to alcohol use is based extensively on an Asian and Pacific Islander alcohol peer consultation and training project needs assessment conducted in California (Hatanaka et al. 1991). The study hypothesized that while cultural backgrounds and drinking styles among Asian and Pacific Islander groups differed, these groups were similar in their encouragement of moderate drinking. Thus, culture as a variable is considered by many to be an important aspect of drinking patterns. Acculturation has also been identified as having a major influence on drinking patterns, that is, the greater the acculturation levels, in general the greater the amount of drinking (Austin 1989; Austin and Gilbert 1989). According to this theory, Asians and Pacific Islanders who are recent immigrants should have a drinking pattern similar to their country of origin, while Asians and Pacific Islanders who are more assimilated should demonstrate drinking patterns more similar to American culture (Chi et al. 1989). Also, it has been hypothesized that alcohol consumption among Asians and Pacific Islanders increases as a way of coping with stress that is the result in changes in social norms, family relationships, and upward mobility (Yu and Liu 1987). Note, however, that the extent to which acculturation affects Asian and Pacific Islander drinking patterns is unclear.

The acculturation hypothesis is supported by a study of younger Japanese males and females who reported heavier drinking and a lower percentage of abstinence than an older Japanese sample (Kitano et al. 1988). Also, Sue and colleagues (1979) found that highly assimilated Asian and Pacific Islander college students drank more than less assimilated students. Yuen and Johnson (1986) found that daughters of Chinese and Japanese ancestry drank significantly more than their mothers. On the other hand, the acculturation hypothesis is contradicted by other studies such as Akutsu et al. (1989), in which Filipino women in Los Angeles retained the drinking patterns of their culture of origin, while Filipino men's drinking resembled that of the dominant society. Thus, it is important to note that sociocultural factors, including acculturation and physiological factors (such as the flushing response) do not adequately explain all aspects of Asian and Pacific Islander drinking patterns. Sue

and Nakamura (1984) have therefore proposed the reciprocity model, a concept that includes the interaction of all of the pertinent variables. This hypothesis suggests that alcohol consumption is an interactive phenomenon in which the physiological, social, and psychological factors interact with one another. The reciprocity model assumes that drinking behavior is influenced by the native culture, the mainstream American culture, and the generational status of individuals.

The figures from the Hatanaka and colleagues (1991) needs assessment study provide a helpful outline of various issues that relate to cultural characteristics. Table 1 identifies some risk groups in six Asian and Pacific Islander populations. These include American-born as well as foreign-born individuals, both genders, college-age students and the elderly, and individuals who may have experienced traumatic wartime refugee trauma. Table 2 outlines several culturally based behaviors across Asian and Pacific Islander groups that are barriers to treatment and recovery. The most common and most difficult barrier is denial. Table 3 shows data for clients in a program targeting driving under the influence (DUI) of alcohol. This survey asked questions regarding individual drinking behavior. The table illustrates how both the self-perceptions and the drinking patterns of these Asian and Pacific Islander groups varied significantly. Figure 4 also shows data for clients in a DUI program. This survey asked individuals for their reasons or motivation for drinking. Again, there were significant differences among the six Asian and Pacific Islander groups. Note that peer influence was a relatively low factor, while wanting to feel good or at ease around people, escaping from boredom, reducing anxiety and tension, and drinking to enjoy what the person is doing more ("self-actualizing") were higher.

The following section addresses AODA and the relationship to cultural characteristics by individual Asian and Pacific Islander subgroups. This section relies heavily on a statewide Asian and Pacific Islander drug services needs assessment conducted in California (Sasao 1991). The statewide drug abuse needs assessment obtained data through a number of mechanisms. One mechanism was a series of community forums for

Table 1

RISK GROUPS AS IDENTIFIED THROUGH KEY INFORMANT SURVEYS		
Chinese	Japanese	Korean
1. Businessmen (male)—alcohol an intrinsic part of business transactions.	1. American-born males—pack drinking, keeping up with peers.	1. Males (both American-born and foreign-born)—high alcohol consumption rates. Pack drinking.
2. Youth—teens and college-age youth, both male and female. Specific subgroups: new immigrants (Taiwan) and second generation and later.	2. Youth and young adults—socially expected. Often, the only drug of choice although polydrug use is also significant. Males at greater risk than females.	2. College-age males and females—increasing trend among young men and women. Social expectations high.
3. Females—generally agreed there is a greater problem than with males. Hidden cases a problem among females.	3. Japan-born businessmen ("shosha")—Japanese nationals temporarily living in the USA. Business obligations.	3. Females in general—increasing trend, but significantly less than men. High-risk subgroup: waitresses and hostesses in Korean bars, encouraged to drink with clients.
	4. Isolated elderly—widowers, monolingual individuals without a strong social support network.	

specific groups. These forums were held in three locations: San Francisco, Los Angeles, and San Diego.

The first forum to be summarized focused on the Chinese-American population. The community forums indicated that tobacco and alcohol were the most prevalent substances used by Chinese populations. Chinese populations were reported to use a range of other drugs, but not at the prevalence rates reported for tobacco and alcohol. According to the community forums, Chinese immigrants underestimate the health hazards of alcohol,

Table 1 (cont'd)

RISK GROUPS AS IDENTIFIED THROUGH KEY INFORMANT SURVEYS		
Pacific Islander	Filipino	Southeast Asian
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 familial and sexual roles.	1. First generation seniors, often male.	1. Recent immigrants—exacerbated by problems of acculturation and posttraumatic stress syndrome.
2. High incidence of low-income and poverty-level persons. Alcohol and related problems exacerbated.	2. Immigrant youth—exacerbated by other drugs and gang activity.	2. Males in general—peer and social pressures.
	3. American-born youth and young adults—social pressures, acculturation.	3. Women in general—significantly less than males, although there is a custom to drink alcohol after giving birth to a child to restore the mother's health.
	4. Males in general—pack drinking, peer pressures. Females in general drink alcohol less than men, although there is an increasing trend of substance abuse.	

Source: Adapted from Hatanaka, H.; Morales, R.; and Kaseyama, N. Asian Pacific Alcohol Peer Consultation and Training Project. Los Angeles, CA: Special Services for Groups, Inc., 1991.

tobacco, and prescription medication because these drugs are legal and culturally accepted in both China and the United States. High-risk populations among Chinese were older adult males, adolescents, young adults, immigrants, and members of low-income households. The specific emphasis on older adult males was interpreted as a cultural factor that places heavy responsibility on males within Chinese households. In addition,

Table 2

BARRIERS TO ALCOHOL RECOVERY SERVICES AS IDENTIFIED
THROUGH KEY INFORMANT SURVEYS

Chinese	Japanese	Korean
1. Denial—the single most important factor contributing to barriers.	1. Denial—embarrassment is probably the key factor motivating the denial response.	1. Denial—especially because drinking is culturally accepted, and in such a close-knit community, a sense of shame is heightened.
2. Lack of Chinese-American counselors and bilingual outreach programs.	2. Only a few Japanese-American counselors and bilingual outreach programs.	2. Korean media (probably watched by 90% of the community) tends to glamorize drinking.
		3. Only a few Korean-American counselors and bilingual outreach programs.

the immigration experience and the cultural adjustment from the country of origin to the United States are strongly associated with AODA. In addition, peer pressure, family and marital issues, and juvenile delinquency and gang activity are associated with AODA. Conflicts between the older and younger generations often isolate youth from other members of their family and can lead to depression. This isolation can lead to juvenile delinquency and AODA as a coping mechanism. In the Chinese community, heavy emphasis is placed on the continuity of generations, harmony, and filial respect. Furthermore, consequences of socially unacceptable behavior focus on the welfare of the family and future generations, as opposed to the individual.

The Japanese-American community forums reported that alcohol and marijuana were the most prevalent substance used, although tobacco, crack cocaine, and amphetamines were also commonly abused. The Japanese forums also identified adolescents, young adults, and single adults (especially those who are

Table 2 (cont'd)

BARRIERS TO ALCOHOL RECOVERY SERVICES AS IDENTIFIED
THROUGH KEY INFORMANT SURVEYS

Pacific Islander	Filipino	Southeast Asian
1. Denial—especially because there is a lack of culturally relevant substance abuse education.	1. Denial—unwillingness to admit to any problem of this type.	1. Denial—and lack of knowledge about substance abuse, especially among recent immigrants. Also shame to the individual as well as to the family.
2. Lack of Pacific Islander (e.g., Tongan, Samoan) professionals in all fields.	2. Lack of Filipino counselors and bilingual outreach programs.	2. Lack of Southeast Asian counselors and bilingual outreach programs.

Source: Adapted from Hatanaka, H.; Morales, R.; and Kaseyama, N. Asian Pacific Alcohol Peer Consultation and Training Project. Los Angeles, CA: Special Services for Groups, Inc., 1991.

divorced) as high-risk groups. AODA-related problems included parents who used legal and illegal substances and became negative role models for their children. This negative role modeling was later reinforced by peer pressure. New immigrants often felt isolated from mainstream society and coped with their resulting depressed feelings by using AOD. They sometimes joined a drug-using subculture as a way of finding a peer group and social acceptance.

The Korean-American community forums identified whiskey, rice wine, and crack cocaine as the most commonly abused substances. The high-risk groups were reported to be adolescents, young adults, and, to a lesser extent, elderly individuals who abuse prescription or over-the-counter medication bought in Korea. Males are considered at especially high risk, because

Table 3

SELF-PERCEPTION OF DRINKING BEHAVIOR, BY ETHNICITY
(Percentage of Responses)

	Total	Chinese	Japanese	Korean	Pacific Islander	Filipino	Southeast Asian
n =	204.0	11.0	24.0	90.0	28.0	27.0	24.0
A. How would you characterize your drinking pattern?							
Always have been a nondrinker	2.0	0.0	0.0	1.1	0.0	7.4	4.2
Nondrinker now, drank in past	19.6	18.2	16.7	22.2	32.1	11.1	8.3
Nondrinker now, was an alcoholic or very heavy drinker	4.9	0.0	4.2	1.1	14.3	11.1	4.2
Presently a light drinker	42.6	45.5	37.5	44.4	28.6	37.0	62.5
Presently a moderate drinker	26.5	27.3	29.2	27.8	25.0	29.6	16.7
Presently a heavy drinker	2.9	9.1	4.2	3.3	0.0	0.0	4.2
Presently an alcoholic	1.5	0.0	8.3	0.0	0.0	3.7	0.0
B. Do you think you have a drinking problem?							
No	63.7	54.5	54.2	68.9	53.6	70.4	62.5
Not sure	23.5	27.3	16.7	18.9	46.4	18.5	25.0
Yes	12.7	18.2	29.2	12.2	0.0	11.1	12.5

Table 3 (cont'd)

SELF-PERCEPTION OF DRINKING BEHAVIOR BY ETHNICITY
(Percentage of Responses)

	Total	Chinese	Japanese	Korean	Pacific Islander	Filipino	Southeast Asian
C. How serious is your drinking problem?							
Does not apply	22.5	45.5	25.0	14.4	7.1	48.1	29.2
Not at all serious	31.4	18.2	33.3	37.8	25.0	29.6	20.8
Not too serious	27.5	27.3	37.5	27.8	32.1	14.8	25.0
Somewhat serious	13.7	9.1	4.2	14.4	28.6	0.0	20.8
Serious	3.9	0.0	0.0	5.6	3.6	3.7	4.2
Very serious	1.1	0.0	0.0	0.0	3.6	3.7	0.0
D. How many times have you sought help for a drinking problem?							
Never	68.1	82.8	54.2	74.4	39.3	70.3	83.3
Once	27.9	18.2	37.5	22.2	57.1	25.9	12.5
Twice	1.5	0.0	0.0	1.1	3.6	0.0	4.2
Three times or more	2.5	0.0	8.3	2.2	0.0	3.7	0.0

Source: Adapted from Hatanaka, H.; Morales, R.; and Kaseyama, N. Asian Pacific Alcohol Peer Consultation and Training Project. Los Angeles, CA: Special Services for Groups Inc., 1991.

Table 4

REPORTED REASONS FOR DRINKING, BY ETHNICITY
(Percentage of Responses)*

Reasons		Total	Chinese	Japanese	Korean	Pacific Islander	Filipino	Southeast Asian
Reasons	n =	204.0	11.0	24.0	90.0	28.0	27.0	24.0
A. Social/peer influence								
Because everyone else drinks		26.4	30.0	19.0	16.9	33.3	25.9	60.9
To feel good around people		40.7	45.5	40.9	41.6	44.4	14.8	60.9
To get along better with friends		38.7	27.3	43.5	47.7	25.9	14.8	47.8
Because friends pressure me into drinking		26.1	18.2	40.9	23.9	14.3	26.9	37.5
B. Escapist								
To stop boredom		37.7	36.4	40.9	31.5	29.6	55.6	47.8
To reduce anxiety and tension		33.8	36.4	36.4	36.4	11.1	33.3	47.8
Because I feel bad when I do not drink		8.5	0.0	4.5	7.9	0.0	14.8	21.7
Because I feel sad or depressed		30.7	18.2	40.9	36.0	18.5	22.2	30.4
Because it helps me with problems		27.0	36.4	27.3	19.1	33.3	40.7	30.4

Table 4 (cont'd)

REPORTED REASONS FOR DRINKING, BY ETHNICITY
(Percentage of Responses)*

Reasons		Total	Chinese	Japanese	Korean	Pacific Islander	Filipino	Southeast Asian
C. Self-actualizing								
To enjoy what I am doing more		43.0	9.1	77.3	38.2	53.6	37.0	39.1
To help me through the day		15.7	9.1	18.2	15.9	7.7	18.5	21.7
To know myself better		15.1	9.1	13.6	16.9	14.8	14.8	13.0
To be more creative and productive		11.6	0.0	27.3	12.4	7.4	7.4	8.7
To understand things differently		16.1	0.0	27.3	20.2	3.7	14.8	13.0
To feel better about myself		27.0	0.0	36.4	27.0	39.3	18.5	26.1

*Note: Percentages refer to mutually exclusive within-group responses to each item. Thus, row totals and column totals do not equal 100 percent.

Source: Adapted from Hatanaka, H.; Morales, R.; and Kaseyama, N. Asian Pacific Alcohol Peer Consultation and Training Project. Los Angeles, CA: Special Services for Groups, Inc., 1991.

they are encouraged to drink and smoke as a sign of masculinity in Korean culture. AODA-related problems in the community include driving under the influence, traffic citations, domestic violence, juvenile delinquency and gang activity, school truancy, and runaways (Sasao 1991).

The Filipino-American community forums identified alcohol, marijuana, and cocaine as the most frequently abused substances. The high-risk groups were identified as adolescents, young adults, males, and recent immigrants. The AODA-related problems in the community included family and marital problems, problems associated with immigration and adjustment to the mainstream culture, juvenile delinquency and gang activity, underemployment, crime, high school dropout rates, broken families, suicides, and alcohol-impaired driving arrests and accidents. Traditional acceptance of drinking and smoking for males in Filipino culture was reported to perpetuate the problem. Filipino females are also vulnerable to AODA when they get involved in gang activity.

The Vietnamese-American forums identified cigarettes and marijuana as the most prevalent abused substances. Alcohol is also a problem among the older generation, especially Vietnamese veterans of the Vietnam War. High-risk groups include adolescents, males, and members of low-income households. Adolescents were said to be at risk because they tend to have little parental supervision; most parents are at work for long hours. Immigrant adult males are vulnerable on account of the frustration and depression they experience adjusting to mainstream American culture. Males are particularly at risk because they often feel they lose control over their families amid the changing roles that the families experience in the United States. The changing of roles in families and the loss of traditional status create vulnerabilities to AODA. This is particularly true when Vietnamese immigrant fathers who speak little English have to rely on their children to interpret and on their wives to provide much of the financial support. AODA-related problems in the community include peer pressure, juvenile delinquency, gang activity, immigration and cultural adjustment, refugee status, economic hard-

ship, stress on the family related to changing roles, and economic difficulties (Sasao 1991).

The Cambodian-American community forums identified alcohol and tobacco as the two most prevalent substances abused by Cambodians. However, crack cocaine and "ice" (methamphetamine) were also major problems. The high-risk groups included low-income Cambodians of all ages and genders. The AODA-related problems in the community included family or marital conflict, juvenile delinquency, gang activity, and peer pressure (Sasao 1991).

The Lao-American community forum identified alcohol, tobacco, and marijuana as the most prevalent substances abused. All segments of the community were considered at high risk, particularly males. The AODA-related problems in the community included family and marital conflicts, juvenile delinquency, gang activity, unemployment, and the trauma caused by the refugee experience (Sasao 1991).

The Hmong-American community forum identified alcohol, tobacco, and opiates as the most prevalent substances of use or abuse. The forum reported that the use of these substances seemed to be declining in the previous 5 years because of substance users becoming ill and voluntarily discontinuing use of the drugs. The high-risk groups were identified as adolescents and adults, particularly those under stress or peer pressure (Sasao 1991).

The Thai-American community forum identified alcohol, tobacco, marijuana, and amphetamines as the most often abused substances. Those considered to be in the high-risk group were immigrants; those who were monolingual, Thai-speaking, single adults; less educated Thais; and young adults. AODA-related problems in the community included immigration and cultural adjustment, family and marital conflicts, and unemployment. The forum also reported that an increase in fights among community members had occurred as a result of participants being intoxicated. Also there had been an increase in smoking American-made cigarettes.

Several figures follow that outline AODA-related factors, including social and cultural aspects. Tables 5 and 6 list the motivations cited for six Asian and Pacific Islander groups, in-

cluding Chinese-Vietnamese. These figures illustrate the diversity among the groups in terms of their self-report regarding their reasons or motivations for AOD use.

Tables 7 and 8 identify the reasons why adults in these groups use AOD. Again note the variability in motivating factors among the groups. Note that job stress, marital and family problems, social settings, addiction, and depression are relatively prominent among adults. Tables 9 and 10 indicate that social events, restaurants, and home are among the places most associated with alcohol use. However, the patterns differ among the populations.

Although the limited incidence and prevalence data on Asians and Pacific Islanders tend to indicate that the rates for Asians and Pacific Islanders are relatively low, these data must be interpreted cautiously. The study by Barnes and Welte (1985) reported that the alcohol use rates for Asian-American males was relatively high. In several of these studies, there were significant differences in rates among groups when gender was a variable. Furthermore, when the sample is "Asian American" and not specifically disaggregated by specific Asian and Pacific Islander subgroup, the results become a composite of data for several unidentified subgroups. Because the Asian and Pacific Islander population is so diverse, specific identification of the subgroup in a study is important. The studies by Kitano and Chi and by Murakami mentioned earlier both reported significant differences in the drinking patterns among specific Asian and Pacific Islander subgroups. Zane and Kim (1994) stated that studies regarding Asians and Pacific Islanders must disaggregate the data to identify specific subgroups.

Suggested Prevention Strategies

The Statewide Asian Drug Service Needs Assessment (Sasao 1991) provides grassroots community suggestions for prevention strategies. A series of community forums, similar to focus groups, was convened in California for each of six Asian and Pacific Islander groups. Part of the discussion in each of these forums addressed service utilization and program effectiveness issues, barriers to prevention and treatment, and program needs. The

Table 5
REASONS CITED FOR AOD USE AMONG ASIAN YOUTH
(Percentage citing problem)

Problem	Chinese	Japanese	Korean	Filipino	Vietnamese	Chinese-Vietnamese
n =	406.0	416.0	399.0	150.0	322.0	78.0
Marital/family problem	84.4	81.7	90.0	86.7	62.1	65.4
Academic/school problem	63.8	72.6	72.4	64.0	28.3	39.7
Peer pressure	86.8	93.3	91.2	90.0	92.5	92.3
Curiosity	82.6	93.8	93.2	81.3	87.9	84.6
Low self-esteem	58.2	74.8	45.4	66.0	34.8	29.5
Loneliness	61.9	77.3	77.4	69.3	59.6	54.5
Other	21.3	17.1	25.6	8.7	19.6	12.8

Source: Adapted from Sasao, T. Statewide Asian Drug Service Needs Assessment. Sacramento, CA: California Department of Alcohol and Drug Programs, 1991.

Table 6

"OTHER" REASONS CITED FOR AOD USE AMONG ASIAN YOUTHS

Reasons	Ethnicity						Total
	Chinese	Japanese	Korean	Filipino	Vietnamese	Chinese-Vietnamese	
Parental modeling	8	16	4	0	16	3	47
Easily available	11	15	14	4	11	2	57
Depression	13	2	10	0	2	0	27
Social/peer pressure	27	22	14	3	8	4	78
Stress	2	4	9	0	1	0	16
Ignorance	5	0	0	0	7	1	13
Addiction	1	0	4	0	6	1	12
Family problems	7	6	21	4	4	0	42
Immigration adjustment	1	0	11	0	2	0	14
Total	75	65	87	11	57	11	306

Source: Adapted from Sasao, T. Statewide Asian Drug Services Needs Assessment. Sacramento, CA: California Department of Alcohol and Drug Programs, 1991.

Table 7

REASONS CITED FOR AOD USE AMONG ASIAN ADULTS
(Percentage citing problem)

Problem	Ethnicity (Sample size)					
	Chinese (409.0)	Japanese (416.0)	Korean (399.0)	Filipino (150.0)	Vietnamese (322.0)	Chinese-Vietnamese (78.0)
Job stress	82.6	90.6	86.2	73.3	51.6	57.7
Marital/family problem	84.8	88.0	83.7	81.3	79.2	78.2
Financial/economic issues	71.4	79.8	68.7	76.7	57.0	61.5
Social settings	88.5	72.1	84.8	72.2	83.3	83.9
Discrimination	31.5	34.5	45.9	33.3	10.0	15.4
Other	23.7	22.0	24.7	10.0	22.7	6.7

Source: Adapted from Sasao, T. Statewide Asian Drug Services Needs Assessment. Sacramento, CA: California Department of Alcohol and Drug Programs, 1991.

Table 8

"OTHER" REASONS CITED FOR AOD USE AMONG ASIAN ADULTS

Reasons	Ethnicity						Total
	Chinese	Japanese	Korean	Fillipino	Vietnamese	Chinese-Vietnamese	
Poor spouse relations	1	0	1	0	0	0	2
Peer/social pressure	35	22	12	4	11	2	86
Stress	3	6	6	3	1	1	20
Depression	12	18	24	4	17	0	75
Addiction	4	17	31	0	26	3	81
Easily available	32	20	0	0	12	1	65
Immigration adjustment	0	0	5	0	7	1	13
Parental influence	0	0	0	0	2	0	2
Total	87	83	79	11	76	8	344

Source: Adapted from Sasao, T. Statewide Asian Drug Services Needs Assessment. Sacramento, CA: California Department of Alcohol and Drug Programs, 1991.

Table 9

OCCASIONS AND LOCATIONS FOR PERSONAL ALCOHOL USE AMONG RESPONDENTS
(Percentage citing location)

Occasions	Ethnicity					
	Chinese	Japanese	Korean	Fillipino	Vietnamese	Chinese-Vietnamese
n =	169.0	286.0	204.0	69.0	160.0	32.0
Business meetings	14.2	22.7	26.1	36.2	17.3	12.5
Social events	85.2	91.6	77.0	89.9	86.3	81.2
Home	59.8	51.7	58.8	40.6	60.6	65.6
Bars	23.7	37.4	39.7	33.3	22.5	15.6
Restaurants	65.7	71.7	51.5	37.7	47.5	46.9
Other	14.7	13.2	19.3	8.7	15.0	12.5
Currently abstaining	59.0	31.0	50.0	54.0	53.3	60.3

Source: Adapted from Sasao, T. Statewide Asian Drug Services Needs Assessment. Sacramento, CA: California Department of Alcohol and Drug Programs, 1991.

Table 10

"OTHER" OCCASIONS AND LOCATIONS FOR PERSONAL ALCOHOL USE

Occasions	Ethnicity					Total
	Chinese	Japanese	Korean	Filipino	Vietnamese	
Cultural events	12	17	10	3	20	65
With friends	5	4	6	1	5	21
Sports events	2	8	5	0	1	17
Picnic	2	0	5	0	0	7
Job stress	0	7	5	0	1	14
Depression	0	0	2	1	0	3
Addiction	0	1	0	0	1	3
Total	21	37	33	5	28	130

Note: Respondents were allowed to indicate multiple "other" occasions.

Source: Adapted from Sasao, T. Statewide Asian Drug Services Needs Assessment. Sacramento, CA: California Department of Alcohol and Drug Programs, 1991.

reports from the Chinese-American community forums indicated that insufficient funding for community-based agencies was the most serious barrier to effective prevention and treatment services. The other major barriers include the denial of the existence of AOD problems and the stigma of seeking help. Family counseling was recommended to promote better parent-child communication and to teach alternative coping skills (rather than turning to drugs). Recreational, sports, and other positive social activities were recommended, as were bilingual and bicultural youth counselors, peer support systems as alternatives to gang involvement, antismoking education campaigns, health education, and the use of indigenous churches to help reach out to and educate the community.

The Japanese-American community forums emphasized the need to overcome the stigma of seeking help in order to improve service utilization. Many Japanese-American families keep AODA problems hidden. Another problem is the lack of funding to offer culturally sensitive services for prevention and treatment. The forums recommended information and education as an important way to fight AODA, including outreach services, training of bilingual and bicultural professionals, and family counseling. Training children and adults about the hazards of AOD was a top priority.

The Korean-American community forums reported that a lack of funding for community-based, culturally competent programs was a major barrier. Because these types of programs are not available, Korean families are reluctant to come forward and seek services in existing mainstream programs. These forums also emphasized the critical need for family-oriented educational programs. They recommended that prevention programs make parents aware of the types of messages they convey to their children in order to keep Korean youth off drugs. They also encouraged establishing more programs for both parents and children in order to promote both positive parent-child communication and mutual support in dealing with personal problems.

The Filipino-American community forums cited the stigma of seeking help, the lack of bilingual and bicultural personnel in prevention and treatment programs, the lack of culturally sensi-

tive services, the lack of community programs, and insufficient agency funding as major reasons for underutilization of prevention and treatment services by Filipino-Americans. It was emphasized that bilingual and bicultural staff are essential to the effectiveness of prevention and treatment programs. It was suggested that more organizational involvement and leadership within the Filipino community is necessary to address AODA problems. The forums also stated that political clout is vital in order to achieve the goals of implementing successful community-based programs. Drug education, outreach, and family involvement were also cited as important factors. Because many Filipinos are recent immigrants, they need more education on the hazards of AODA to modify the attitudes and habits they acquired in their native country.

The Vietnamese-American community forums reported that the lack of bilingual and bicultural staff in prevention and treatment programs, the lack of appropriate referral systems, the lack of community-based programs, and the stigma associated with seeking help were the major barriers to service utilization. In addition, many Vietnamese Americans were not aware of existing services in their communities. This lack of awareness is largely due to the differences between public health systems in Southeast Asia and mainstream U.S. programs. For example, Vietnamese individuals who are recent immigrants might seek the help of native "fortune tellers" to solve mental health problems, rather than going to Western professional clinics. The forums suggested more community education and outreach efforts and making available more prevention and treatment services. Vietnamese children should be provided positive alternatives to being at home alone or with their peers on the streets while their parents are at work. Recreational programs are needed in the community to help provide positive leisure activities and to help new immigrants adjust to mainstream American culture.

The Cambodian-American community forums reported that the lack of bilingual and bicultural staff, the lack of community-based prevention and treatment programs, and the lack of established referral systems were all significant barriers to meeting the

service needs of their community. Public health education campaigns were also suggested to educate recent immigrants.

The Laotian-American community forum reported that the lack of bilingual and bicultural program staff, the lack of culturally sensitive services, the lack of community-based programs indigenous to the Lao community, and insufficient agency funding were major barriers. Further, educational programs for the Lao community were recommended, since no drug abuse laws in Laos are similar to those in the United States.

The Hmong-American community forum reported that the cost of treatment and transportation made many services inaccessible. Communication is difficult without bilingual and bicultural translators. There are insufficient bilingual and bicultural services, and it is estimated that a significant number of individuals are isolated and unable to access AODA prevention and treatment services. Educational programs with bilingual staff are needed to educate and assist the Hmong community. This population needs public health education regarding AODA. Mainstream services must have the language capability and provide the necessary transportation in order to meet the needs of the Hmong.

The Thai-American community forum reported that the most significant barriers to service utilization were the lack of bilingual and bicultural personnel, the lack of culturally sensitive services, the lack of available information in the appropriate language, the lack of transportation, and the lack of conveniently located facilities. There is also an overall lack of public health education and information, family counseling and support groups, bilingual and bicultural agency staff, and linkages between community service programs and Buddhist temple programs. There are currently no specialized AODA prevention programs targeting the Thai-American community.

The Asian Pacific Alcohol Peer Consultation and Training Project needs assessment (Hatanaka et al. 1991) provides additional suggestions regarding prevention strategies. This statewide alcohol needs assessment in California for six Asian and Pacific Islander groups found that prevention strategies needed to include more and improved bilingual outreach and educational services, educational materials that included general infor-

mation, and referral and health education materials. Outreach is needed to each of the six populations (i.e., Chinese, Japanese, Korean, Pacific Islander, Filipino, and Southeast Asian), with an emphasis on reaching the indigenous, community-based social networks. Community leaders, churches, temples, and schools are often effective ways to reach the respective communities. Because of the desire to avoid "losing face," individual counseling for at-risk individuals can be more effective than group treatment approaches. Close family members should be included whenever possible in the treatment plan. Southeast Asian groups in particular emphasize the importance of including the immediate family in any prevention and treatment effort, because the whole family assumes the shame and guilt of an individual member. It was suggested that the media be used as an outreach tool to these communities. The Japanese-American respondents suggested health-focused media efforts to get the attention of both American-born and foreign-born Japanese audiences. It is presumed that the Japanese population is extremely health conscious and is interested in health-related issues such as AODA. The Korean respondents emphasized a media approach that had a strong shock value to deter AODA. For example, they suggested that true-to-life scenes of alcohol-related traffic crashes be shown on 30-second public service announcements.

Finally, there is a lack of bilingual and bicultural educational materials for Asian and Pacific Islander populations. Especially lacking are materials targeting recent immigrants, Pacific Islanders, and Southeast Asian groups. Specialized public health and community education is needed to overcome the denial and stigma that are major barriers to alcohol abuse prevention and treatment. In addition, there are too few bilingual and bicultural service providers for these populations.

National Asian Pacific American Families Against Substance Abuse (NAPAFASA) conducted a demonstration project to describe promising AODA prevention programs for Asian and Pacific Islander youth between 1990 and 1993. The project was funded by the Center for Substance Abuse Prevention under the Programs of National Significance demonstration program. Over the 3 years, 18 existing programs were selected, visited, and

monitored to identify the elements that seem to be effective prevention strategies (NAPAFASA 1993).

The participants gave each of the programs high ratings and would recommend the programs to their peers. The factors that appeared to make the programs successful in engaging Asian and Pacific Islander youth and preventing AODA at least during the course of the program, were the following:

- The organizations that sponsored the programs were well known to the Asian and Pacific Islander populations; they had community credibility and were indigenous to the infrastructure of the communities in which they provided the services. In most cases, the organizations that provided the services had served the Asian and Pacific Islander populations for at least 5 or 10 years and in some cases as long as 20 years.
- The organizational management and the project staff were, in most cases, Asians and Pacific Islanders, most of whom were bilingual and bicultural.
- While recruiting and maintaining parent participation was difficult, the parents of the youth and the adults in the community were very supportive of the agency and the programs.
- The community at large supported and recognized the organizations as making positive contributions to the Asian and Pacific Islander population as well as to the community at large.
- The youth involved in the programs were highly motivated and wanted to participate in these various programs. In one case, the youth were actually paid a stipend for being peer educators and counselors regarding AODA and HIV/AIDS. However, all of the other programs involved youth who were volunteers. Many of the youth leaders who were mentors, tutors, and counselors were also volunteers.
- There was an emphasis on taking pride in one's culture, ethnicity, language, traditions, holidays, and ceremonies, as well as on enhancing self-esteem. Many of the activities involved cultural festivals, traditional ceremonies, ethnic

foods, and drama, music, and artistic work that related to their cultures and history.

- All of the programs had a great deal of group activity. The members of the groups were made to feel accepted, supported, needed, and part of an effort that was doing something worthwhile. Many of the groups engaged in community service activities for which they were publicly recognized (for example, performances by the "Creative Images" group of the Asian-American Drug Abuse Program, Los Angeles).
- Cultural norms, philosophy, religion, and culturally based values were supported and reinforced. As a result, immigrant youth were helped to adjust to mainstream American society. One program was sponsored by a Catholic parish that was indigenous to the local Asian and Pacific Islander community.
- AODA prevention was presented within the context of related health and social issues important to youth. Thus, the programs were relatively comprehensive in terms of addressing the issues and needs of youth. Most of the programs collaborated with the schools, parents, and other social institutions in the indigenous community.

There are a few research studies regarding prevention strategies for Asian and Pacific Islander youth. Graham and colleagues (1990) reported on an evaluation of a program in Los Angeles. The large sample of seventh graders participating in Project SMART (Self-Management and Resistance Training) was studied. The youth in the study included Asians, African Americans, Hispanics, and Whites. The purpose of the study was to test the efficacy of the social skills and to affect management curriculums for three cohort groups between 1982 and 1985. The aim of the Project SMART program was to prevent or reduce the use of cigarettes, alcohol, and marijuana. In short, the study found that there were significant program effects for females, but not for males. There was a significant program effect for the "Asian" students (the specific Asian and Pacific Islander groups were not identified), a marginal effect for Hispanics, and a nonsignificant

effect for African Americans. There was no apparent trend for program effects for White students.

Zane and Kim (1994) reported on the success of the Asian Youth Substance Abuse Project (AYSAP) in San Francisco. A consortium of seven community-based agencies collaborated in an effort to prevent high-risk youth from getting involved in AODA. They drew on social competence, empowerment, parenting skills, and community resource development strategies. Their success was attributable to the intensive structure of the program. Filipino youth participating in a brief counseling program reported significant improvements in psychosocial functioning, self-esteem, and family support. Increases in interpersonal adjustment were also noted.

The AYSAP project identified a number of important aspects of a culturally responsive prevention strategy. First, it is critically important to link peer and family-oriented prevention approaches into the natural support systems of specific Asian and Pacific Islander communities. It is also important to structure prevention interventions so that they complement this support system. For example, the Filipino community program provided AODA prevention and family empowerment interventions within a religious context at a Catholic parish. Self-disclosure in this spiritual setting made it easier for individuals to overcome the shame and stigma associated with revealing family problems and AODA. Although a fatalistic view of life is dominant in Filipino culture, spiritual practices are seen as a culturally appropriate way of changing one's behavior. This prevention program capitalized on these beliefs to introduce alternative ways of dealing with family problems that often place youth at risk for abusing drugs.

Second, the key to empowering many Asian and Pacific Islander families involves providing immigrant parents with the skills and mastery they need to help their children adjust to American cultural norms and expectations. For example, a prevention approach teaches parents their appropriate role in the American educational system and validates their responsibility as parents. They are encouraged to deal effectively with the educational system and to see themselves as cultural experts who are able to enrich their children's lives. Mass media campaigns

targeting the specific population reinforced antidrug messages and challenged the idea that refugees and immigrants are better off when they become totally acculturated.

Third, the program developed innovative strategies to minimize shame and loss of face among Asian and Pacific Islander families. For example, a Japanese-American community program adopted a graduated approach to handling intergenerational conflicts in Japanese families. In many Asian and Pacific Islander communities, intermediaries are often used to resolve interpersonal problems. These intermediaries (usually individuals with high status in the community) are able to address personal problems without the same degree of loss of face family members would have. This approach recognizes how difficult it is for Japanese and other Asian and Pacific Islander family members to confront one another. By recognizing this cultural factor, the project is able to develop a system using intermediaries (sometimes staff workers of the project) to bridge the communication gap and resolve problems.

Finally, personalized community education programs appear to be more effective than a generic mass media approach. For example, a door-to-door education campaign targeting the Vietnamese community was effective in disseminating information on the effects of drugs and treatment and support services available in the community.

Of course, more prevention research and evaluation studies are needed to identify the specific cultural variables and their relationship to AODA prevention for each specific Asian and Pacific Islander population (Cheung 1989). Similarly, further research is needed to determine how cultural, physiological, and psychosocial variables interact to prevent AODA.

Evaluation of Outcome Measures

There are many important research issues in terms of evaluation and measuring success for ethnic cultural groups such as Asian and Pacific Islanders (Cheung 1989). Cheung emphasizes that ethnic and cultural variables with regard to AODA prevention need to be researched in a way that will not only identify the

differences in AODA patterns but also explain why the differences occur. In order to do so, research must identify the incidence and prevalence among specific population groups (i.e., the specific subpopulations within the Asian and Pacific Islander category), specific risk factors, protective factors, and other prevention factors to determine how specific aspects of ethnicity and culture interact to prevent AODA. In addition, ethnicity at both the individual level and the collective level must be analyzed in order to have a framework that will address AODA prevention and treatment issues in a comprehensive way.

Yen (1992) offers several suggestions regarding cultural competence for evaluators working with Asian and Pacific Islander populations, including analyzing issues such as age and gender, language and dialects, effects of immigration or migration, class and cultural differences, and heterogeneity within the group. It is suggested that mainstream research instruments be used very cautiously with Asian and Pacific Islander subjects. Since the meaning of language is key to the reliability and validity of research instruments, it is important to consider that Asian languages are context oriented. Thus, certain questions may be difficult for Asian and Pacific Islander subjects without additional descriptive, contextual material. Furthermore, the self-disclosure of sensitive issues can be problematic because Asians and Pacific Islanders are concerned about loss of face and may give invalid responses. Gaining access to data and subjects is another potential problem for evaluation designs for Asian and Pacific Islander populations. Yen suggests that the framing of the evaluation questions should involve representatives of the community. Since Asian and Pacific Islander populations, particularly specific subgroups, may be relatively small in number, sampling techniques may not be possible or appropriate. The stereotyping of results based on incomplete data can occur, leading to the "model minority" myth and misinterpretation. For example, what may be considered the "underutilization" of mainstream American AODA and treatment programs may lead to the assumption that Asians and Pacific Islanders have no problems. This lack of utilization may be due instead to the lack of access and the inappropriateness of some programs for this population.

Kim and colleagues (1992) also discuss cultural competence for evaluators working with Asian and Pacific Islander populations. They suggest that the process of evaluation can be empowering for Asian and Pacific Islander communities. The White Anglo-American mainstream culture is quite different from that of Asians and Pacific Islanders. The authors also review a number of conceptual approaches to understanding evaluation and research regarding the patterns of AOD use and abuse by Asians and Pacific Islanders. These conceptual approaches include the cultural content approach, acculturation theory, orthogonal cultural identification theory, cultural conflict approaches, and alienation and identity conflict. Kim and colleagues (1992) also suggest a minority service success rate formula as a way to estimate the degree to which a program serves a particular target population. They suggest that a culturally competent prevention agency would conduct a needs assessment, training to enhance cultural competence of its staff and board members, provide a staffing pattern that has sufficient bilingual and bicultural staff and board, and examine the performance of the agency in terms of its relationship to Asian and Pacific Islander populations, culture, and community institutions.

Classroom Exercises

A classroom evaluation exercise should be as experiential as possible. Before the exercise, the class should be divided into small teams to go into the local community and identify Asian and Pacific Islander populations and service programs. Assuming that there are a reasonable number of Asians and Pacific Islanders living in the local community, the teams should engage in an effort to establish a relationship with community representatives to discuss real program evaluation issues. On the basis of these initial discussions, plans for a needs assessment (which may include etiological, epidemiological, and ethnographic data collection) should be developed as a classroom exercise. A second exercise can involve an existing service program. The class should develop a plan for community residents and student teams to evaluate an existing program. If possible, this program

should be one that serves Asians and Pacific Islanders. Agency representatives can be interviewed to discuss their goals and objectives regarding services to Asians and Pacific Islanders, how their own goals and objectives are evaluated, and their level of success. Asian and Pacific Islander community representatives should also be interviewed to compare their perceptions of the agency's services with that of the agency representatives.

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