

# **Literature**

**Health and Social Impact**



# Literature—Health and Social Impact

## Defining Ethnicity

Ethnicity is closely linked with culture and identity and has long been acknowledged as a complex phenomenon. A working definition of an 'ethnic group' is where a portion of the population holds in common a shared culture or tradition that is not shared by the population as a whole (De Vos 1982; Barthwell et al, 1995). What sets one ethnic group apart from others can be primarily based on shared cultural traditions or characteristics. These shared traditions or characteristics include religious beliefs, certain cultural practices, language, nationality, a sense of historical continuity and common ancestry or place of origin (De Vos 1982; Encel 1981; Cheung, 1990–91; Jenkins, 1997).

While ethnicity involves group membership, it can also imply cultural differences that may (or may not) exist within the group. This supports a theory elicited from the literature that an ethnic community is not necessarily an ethnically homogeneous entity (Cheung, 1993; Barthwell et al, 1995). Considering the complexity of 'ethnicity', many of the so-called indicators of ethnicity used – or more importantly, *not* used – in databases fail to provide researchers with adequate information to determine accurately a person's ethnic or cultural orientation.

The problem of accurately determining ethnicity is further complicated by an individual's level of identification with a particular ethnicity, which can range from a weak to a strong association (Smith, 1980). When an individual identifies with two cultures, whether strongly or weakly, ethnic identity may become multi-layered, possibly resulting in inaccurate information collected from databases about different ethnic groups (Collins, 1996). Identifying with a particular ethnicity does not necessarily mean an individual, or ethnic subculture, is representative of all members of that ethnic group. It must be emphasised that generalisation of any research results from databases to all members of an ethnic group should not occur. The failure to acknowledge the heterogeneity of ethnic groups could pose a source of measurement error, which may obscure significant differences between and within certain ethnic groups (Collins, 1992). Conscientiously avoiding what Trimble (1990–91) calls the 'ethnic gloss' will increase validity and reliability of research findings.

The common definition of 'ethnicity' within an Australian context stems from the concept that those with an ethnic background are different from that of the majority – the wider Anglo-Australian population – that is, those who do not originate from the British Islands nor embrace either Anglo-Saxon or Celtic ethnicity. The indigenous Aboriginal population, while clearly constituting a distinct minority group, is not categorised as an 'ethnic minority', largely because of their unique status as the first peoples of Australia (Zelinaka, 1995).

## Ethnicity and Databases

Many databases incorporate a range of variables to elicit ethnicity. These variables include: race, place of origin, language and, albeit rarely, an individual's perception of ethnic identity. However, many of these variables are flawed when used in isolation because there is a frequent and pervasive lack of understanding of the complexity of ethnicity, as alluded to above.

Some databases have used 'racial appearance' as a variable to suggest an ethnic group categorisation. Race involves physical characteristics, including (for social classification) skin colour (Cheung, 1990–91). The shortcoming with this variable is that people of the same race can actually belong to different ethnic groups and therefore are likely to have different cultural values and behaviours (Cheung, 1990–91; Almog et al, 1993). Some databases, such as those used for the Australian notification of HIV, are often grossly over-inclusive with ethnic/racial backgrounds (that is, Asian, African, European), totally ignoring the diversity that exists within each different ethnic/racial group. (Almog et al, 1993). It is precisely because of these highly flawed factors that race in itself should no longer be considered an ethnic variable.

The 'place of origin', commonly referred to as 'country of birth', is another variable widely used to determine a person's ethnic identity. However, the literature disputes this variable as an accurate indicator of ethnicity, since 'country of birth' implies that country's cultural values and norms belong to that person (Cheung, 1993). Some databases do, however, inquire about the birthplace of the mother and father as a more in-depth indicator of ethnicity, even though there is no guarantee that there will be a continuum of cultural retention and practice. For second, third or even fourth generation ethnic groups the relevance of their parent's county of birth is dubious. There may be absolute immersion and maintenance of the parent's culture; there may be a possible rejection of the cultural and ethnic heritage of the parents; or, as is not uncommon, there may be a development of a bicultural identity (Cahill and Ewen, 1982).

Language is another variable often cited as a major component and characteristic feature in the maintenance of a separate ethnic identity (De Vos, 1982). Many databases collect information regarding primary language or a language spoken other than English in an attempt to determine a person's ethnic orientation. This is in view of Rissel and Rowling's (1991) suggestion that the frequency with which the native tongue is spoken at home reflects the degree to which an original culture has been retained, or the extent to which a person has been acculturated to the norms of Australian-born people.

In recent years questions regarding perception of ethnicity or 'ethnic identification' has been used by some databases as a variable to determine a person's ethnicity. Ethnic identification asks that a person express a feeling of *psychological* attachment to a particular group on the basis of cultural origin or heritage (De Vos, 1982). As a social identifier, ethnicity may be collective as well as individual, and may be formed initially through social interaction and then internalised through a process of self-identification (Spathopoulos and Betram, 1991; Jenkins, 1997). A major limitation of

this variable, as suggested by Cheung (1993), is the fact that a person may not be able to identify easily with a particular ethnic culture the further removed they are from the first generation.

The dimensions of ethnic identification may be multilayered, and each layer of identification may function independently (Kim et al, 1992). It is important to remember that the retention of, and identification with, an ethnic culture by an ethnic person is not a static quality and remains a dynamic process (Cheung, 1990–91; Romios and Ross, 1993; Morrissey, 1994). As suggested by Trimble (1990–91), ethnic identification changes over time depending on varied social circumstances or cultural contexts. This needs to be recognised when analysing ethnicity data.

Many databases provide little opportunity to assess ethnicity identity accurately, due to the restrictive nature of the variables in use. It must be emphasised that ethnicity is a multidimensional, complex concept—something that is rarely acknowledged in current databases. Consequently, there exists a widespread paucity of appropriate data on ethnicity. What is available should be interpreted with caution.

## **Multicultural Australia**

Since the time of British colonisation, Australia has experienced the immigration of many different national groups. This immigration has been dominated, however, by those of British and Irish descent—largely due to the ‘White Australia’ policy that was active up until the early 1970s. Nevertheless, from the mid-1940s through to the 1960s there was a predominant influx of Western Europeans to Australia, particularly from Italy and Greece. By the early 1970s there were nearly 300,000 Italian- and Greek-born people settled in Australia (Bureau of Immigration, Multicultural and Population Research [BIMPR], 1996).

In 1973 a dramatic shift in immigration policy occurred which resulted in non-discriminatory selection of newcomers that no longer resorted to race, colour or nationality. Immigration from the United Kingdom and the European continent was on the decline, while people from Culturally and Linguistically Diverse Background (CLDB) countries were arriving in large numbers. During the 1980s the greatest proportion of migrants to Australia were born in CLDB countries. By 1995–1996 these people represented around 70 per cent of the migrant intake (Williams and Batrouney, 1998).

Furthermore, the dismantling of the ‘White Australia’ policy in the early 1970s meant that Asia became the main source of immigration (Williams and Batrouney, 1998). It was at this time of rapidly changing social realities that the national policy of ‘assimilation’ was replaced by a policy of ‘integration’. By 1996, 45 per cent of all Victorians, regardless of ethnicity, were either born overseas or had at least one parent born overseas. Of these Victorians, 73 per cent were born in Australia while 17 per cent were born in CLDB countries. Victoria was now made up of a population of people from 208 countries who spoke 151 languages (Multicultural Affairs Unit, 1997).

The broad policy of multiculturalism adopted during the 1980s has remained throughout the 1990s. Currently there are more than 100 different ethnic groups in Australia, each with their own distinct characteristics, making it impossible to validly classify them as a homogeneous group (Boss et al, 1995).

## **Illicit Drug Use in Ethnic Communities**

Research investigations outlined in the literature fail to adequately examine the link between ethnicity and illicit drug use. This is largely due to this fact that little is known about the actual levels of drug use among different ethnic groups, particularly where there is a significant under-representation of any one ethnic group among a known population of illicit drug users (Smith and Citta, 1994; Pearson and Patel, 1998).

Some of the literature suggests that the rate of illicit drug use among ethnic groups is not significantly higher than among Anglo-Australians. However, drug use within an ethnic group may be just as proportionally prevalent as in the mainstream group (Alcorso, 1990; Johnson and Carroll 1995; Ezard, 1997). Other writers propose that the percentage of illicit drug use is in fact higher in these groups than in the general community (Van de Wijngaart, 1997).

The literature also suggests that the lack of any systematic data examination of illicit drug use and addiction among minority groups may be due to a reluctance to emphasise ethnic/racial undercurrents, and this may inadvertently result in ethnic and racial stereotyping (Ezard, 1997; Centre for Disease Control and Prevention, 1998; Khan, 1999).

The persistent conjecture surrounding the extent of illicit drug use among ethnic groups exists largely because of the paucity of available data on this topic. Although information, including statistical data, has been collected by drug treatment services, the amount and quality of the information is not detailed, adequate or accurate enough to draw any significant conclusions because assistance is often only sought when a drug problem manifests itself beyond the control of the individual or their family (Hatty, 1990).

Given that the extent of illicit drug use among ethnic groups remains unknown, Hunt (1992) nevertheless, suggests that the consumption of illicit substances increases among ethnic groups once they have experienced a period of long-term settlement in the country of their adoption. There is a belief that the use of illicit drugs varies between those who have recently arrived and those who are first or second generation migrants (Smith and Citta, 1994).

The obstacles and complexities (such as those indicated by the variables above) which become apparent when attempts are made to measure the extent of illicit drug use in Australia's ethnic communities are major impediments to any meaningful research in this area. As previously discussed, the inability of most existing databases to define ethnicity comprehensively is problematic, and remains an unresolved issue for both government agencies and researchers. Even when study data are made available, statistical analysis cannot permit any firm conclusions about comparative

rates of illicit drug use among the different ethnic groups (Catalano et al, 1992; Romios and Ross, 1993). Additionally, allocating people into neat ethnic categories purely for simplicity also poses problems. Smith and Citta (1994) and Morrisey (1994) suggest that ethnic identity does not remain static. For example, it is possible for an individual to embrace the ethnic identity of their own group while at the same time adopt (and have an integral sense of belonging to) the characteristics of the mainstream community in which they live.

International literature is not necessarily illuminating, nor does it prove to be relevant to the Australian context. Much of the research in the area of illicit drugs in ethnic minority groups has been done in the United States. Most of these studies categorise ethnic groups into Afro-American, Hispanics (a person of Mexican, Puerto Rican, Cuba, Central or South American or other Spanish culture regardless of race) and Chicano (a name applied to Mexicans residing in the US) (Ezard, 1997). None of these categories is relevant to the Australian context.

Another major limitation of the many American-based studies that focus on ethnicity and illicit drug use is the tendency to classify ethnic groups into five main racial categories. These include:

1. American Indian/Alaskan Native
2. Asian/Pacific Islander
3. African-American
4. Hispanic
5. White (National Institute on Drug Abuse, 1995).

Such racial classifications totally and blatantly deny the heterogeneity existing between and within the different ethnic/racial groups. The 'Asian/Pacific Islander' category, for instance, comprises more than 60 separate racial/ethnic groups and sub-groups, while 'white' refers to a person originating from any one of the vastly diverse countries of Europe, North Africa and the Middle East (National Institute on Drug Abuse, 1995). Subsequently, when, for example, drug use among the Asian-American community is reported to be low, it would be appropriate to question the validity of any suggestion that a low level of drug use in one Asian community is the same for all Asian groups (Seal, 1992).

Much of the data collected in Australia regarding drug use does not prioritise the origins of a person's ethnicity. Nor is it collected for the purpose of identifying any differences in patterns of drug use between ethnic groups. However, when ethnicity has been examined, ethnic groups tend to be classified together (possibly as an attempt to boost sampling numbers) which only results in flawed conclusions.

For example, in the recent 1997 New South Wales Drug Trends Survey a number of diverse ethnic groups were identified as injecting drug users. This survey comprised 154 injecting drug-user clients, of which 23 were of CLDB, and 22 of these, 23 clients were living in areas with the greatest concentration of ethnic groups of south-west Sydney. Unfortunately, however, the CLDB group was not further defined by

country of birth, making it difficult to correlate a client's ethnicity with their drug use accurately (Hando and Darke, 1998).

As well as the obvious cultural differences there are a number of more subtle ethnic differences which should be taken into account by researchers and service providers. For example, social and economic vulnerability factors faced by one ethnic community may not be encountered by another, or may not prove to be important to the same degree. Consequently, adolescents from different ethnic groups (as purported by the literature) may have different prevalence and patterns of drug use (Maddahain et al, 1988). Much of the research undertaken on illicit drug use and ethnicity fails to analyse any socioeconomic characteristics comprehensively. Therefore, theories relating to the impact of socioeconomic variables, as opposed to ethnicity, often lack supporting evidence. Sociocultural variables are essential to any substance use study and should always be considered in analysis of research results (Collins, 1996). This is particularly so when social problems identified in many ethnic communities are considered to enhance the likelihood of experimentation with illicit drugs (Alcorso, 1990; Van de Wijngaart, 1997).

Another factor contributing to social vulnerability is that feelings of affiliation with one's ethnic background may change with time and may affect how one responds to a particular issue or arrives at a particular solution to any given problem.

Cultural clashes between and within an ethnic group (depending on the individuals involved) may also contribute to subtle cultural differences among ethnic groups.

Determining the perceptions and needs of people from CLDBs is particularly problematic when surveys exclude people whose English language fluency is poor or where there is no response to questions. The 1991 Census found, for instance, that Vietnamese-born people (44.7 per cent) lacked English fluency more than other groups (NSW Health, 1993).

The degree to which some ethnic groups are at greater risk of, or are vulnerable to, illicit drug use (and the reasons for their vulnerability) require much more detailed analysis than has been attempted to date.

## **Key Vulnerability Issues Common to All Ethnic Groups**

Since the early 1980s research in the United Kingdom has shown that higher concentrations of illicit drug use exists in areas of unemployment and social deprivation. For instance, in Britain it was believed the heroin epidemic coincided with the recession and a period of deindustrialisation—social changes that actually devastated many lower socioeconomic areas (Pearson and Patel, 1998).

By extrapolation to an Australian context the literature suggests that, even without looking at ethnicity, illicit drug use is more widespread among neighbourhoods which encounter a higher degree of social exclusion in terms of poverty, housing deprivation, unemployment and educational disadvantage. Adding racial discrimination to that list, particularly in employment, the outcome will be an even greater denial of access to the various social, economic and political institutions that

exist, severely hampering an ethnic group's structural assimilation to the larger society (Cheung, 1989; Pearson and Patel, 1998).

In some ethnic groups the stresses of migration and aspirations for assimilation may result in a decline of religious and cultural unity, as well as an erosion of social control within the ethnic community, due to a possible weakening of the family structure. Importantly, there are many people of CLDBs, particularly since the late 1970s, who have experienced stresses which may affect how well they adjust to a new cultural environment, such as living as refugees (sometimes extended periods of time) before their arrival in Australia. Among these people, there may be many who have suffered major stressors, such as war, loss of home, broken families, deaths of relatives, repression, torture, rape and imprisonment (Viviani, 1996; Jordens, 1996).

When immigrants from CLDBs arrive in a new country, they experience varying degrees of language and cultural difficulties as well as unemployment, under-employment and social and health difficulties. The social, psychological, emotional and family pressures associated with being new arrivals may be exacerbated by being generally financially poorer than the mainstream community, not understanding the language well and being a minority group in an unfamiliar society. The result is a myriad of challenges to be faced while adjusting to a new life (Kuramoto, 1997). Immigrants, particularly those who do not speak English or who have been refugees, often face inadequate housing and increasing socioeconomic hardships resulting from a lack of those vocational skills commonly considered desirable by the new wider community. Some of the literature suggests that families may become dysfunctional in the process of immigration due to a culmination of the various stresses encountered (Ja and Aoki, 1993). The stressors of migration are numerous and may lead to feelings of separation, cultural dislocation and confusion with the new environment and society (Jackson and Flaherty, 1994).

The interaction of a range of complex factors increases the vulnerability of ethnic groups to illicit drug use. The age structure of a population may be important, since drug use can be more or less relevant for different age groups (Rissel and Rowling, 1990). For instance, socioeconomic factors, poor academic achievement, low religiosity, chronic low self-esteem, poor relationship with parents, sensation seeking and peer drug use all have the potential to place young people of CLDBs at risk of illicit drug use. (Maddahain et al, 1988; Van de Wijngaart, 1997). However, Newcomb et al (1990) suggest (for good or bad) that illicit drug use for many contemporary teenagers, regardless of ethnicity, has simply become a natural curiosity and a rite of passage.

Specific vulnerabilities to illicit drug use are discussed below.

## **Social and Economic Factors**

Research has indicated that many ethnic groups within the community have comparatively low socioeconomic status. Ethnicity is often used to explain social behaviours. However, social behaviour may actually stem from class, educational attainment, age or residential environment (Almog et al, 1993; Collins, 1996). It is important to recognise that the macro social structures, and an individual's position

in them, can shape behaviour and values. These in turn may explain health behaviour and illicit drug use. Ignoring macro socioeconomic factors in any health assessment or research data will limit any potential of change in lifestyle or the health status of an individual, ultimately giving rise to various risk factors for bad health behaviours (Takeuchi and Young, 1994).

However, as suggested by Syme (1998) social class has rarely been studied in public health because this factor, if not adjusted for statistically in the research, would often merely overwhelm everything else under study. Consequently, as suggested by Syme (1998), 'why study the risk factor of social class if this problem cannot be resolved?'

Recent research found that poverty and low income exists to a greater extent in CLDB families than in the broader community, and that this problem has been significantly increasing over the past two decades. This compares with the opposite trend for those classified as main English speaking families (Williams and Batrouney, 1998; Healy, 1998). Williams and Batrouney (1998) believe a large proportion of recent migrants in Australia would now be classified as poor, compared with 20 years earlier. Poverty, of course, can be multifaceted, and may be linked to unemployment, barriers to employment, lack of English proficiency or the hardships associated with accessing income support.

During the 1970s, for young people of CLDBs, the main disadvantages or vulnerabilities were based primarily on language difficulties and relative poverty. However, policy and service changes in the 1990s, together with advances in technology and changes to the job markets, appear to have increased these difficulties even more for immigrant families facing *absolute*, rather than *relative* poverty (Mitchell, 1998). The changes to policy and service include:

- A restriction of unemployment and sickness benefits for recently arrived immigrants for the first two years (other than refugees and special humanitarian intakes).
- The introduction of fees for English classes.
- Cost recovery arrangements for interpreting services imposed upon service providers.
- Changes that have been implemented for asylum seekers.

Additionally, rising unemployment rates (particularly for youth), restrictions on income support and the downsizing of a broad range of services to those needing assistance have all affected disadvantaged people in general (Taylor and MacDonald, 1994; Collins, 1998).

The 1990s saw an apparent increase in family breakdown, street frequenting behaviour and homelessness – particularly for young immigrants of Cambodian, Laotian and Vietnamese backgrounds (Frederico et al, 1997; Williams and Batrouney, 1998). Such trends affect all communities. However, the literature suggests that people of Asian backgrounds are at the lower end of the income distribution

spectrum more often than other migrant groups (Williams and Batrouney, 1998). Minority ethnic groups who experience discrimination and a sense of powerlessness and social exclusion from the formal economy may find a convenient niche in the informal economy (Pearson and Patel, 1998). As suggested by Cheung (1989), socially and economically deprived people face greater separation between aspirations and opportunities. The result is greater pressure into deviance from mainstream lifestyles, which may include the supply and use of illicit substances.

European studies have suggested that there is an increasing connection between socially excluded minorities (including ethnic groups) and various forms of informal and illicit economies (Pearson and Patel, 1998). The growth of an underclass, due to the socioeconomic disadvantages outlined above, might mean that selling drugs to make a living becomes a legitimate occupation, particularly perhaps for young people who possibly perceived that they have nothing to lose (Ethnic Youth Issues Network [EYIN] et al, 1996).

In Britain, two decades of aggravated social deprivation has resulted in what was once a lower crime rate among Asians during the mid 1970s to what is now comparable with crime rates for 'whites'. Following an examination of a British housing estate during the mid 1990s where heroin became available in 'two pound deals', it was found that when an illicit drug was brought within the economic reach of even the poorest, albeit in tiny amounts, the problem of drug use became worse (Pearson and Patel, 1998).

## **Proficiency in the English Language**

English proficiency is of great importance when accessing services. Research has indicated that CLDBs frequently have poor proficiency in English (NSW Health, 1993). Having poor English language skills inhibits people from asking questions and from talking about fears and anxieties. This potentially further ostracises such people from a much-needed service which, to the ethnic group, may already seem out of reach (Jackson and Flaherty, 1994). As Jacobowicz and Buckley (1975: 16, citing Williams and Batrouney, 1998) write: 'If lack of resources is one measure of poverty then the absence of language skills or inferior language ability will prevent or restrict access to those resources and contribute to poverty.'

It is of particular concern that those who lack basic English skills are ill-equipped to deal effectively or expediently with a health crisis. Not only may people of CLDBs who have poor language skills have difficulties in seeking help, but they may also have trouble understanding the explanations and recommendations from health professionals (Health Department Victoria, 1988; National Health Strategy, 1993). The problem of inadequate language skills is a challenge for all health professionals.

A number of obstacles to improving proficiency in English for people of CLDBs have been identified. For example, in more recent years, some immigrants have been excluded from assisted English-language training services because they were considered to have been in Australia 'too long' irrespective of their level of need. The government funding cuts to adult migrant education centres have only exacerbated

the difficulties of acquiring English proficiency (Taylor and MacDonald, 1994; Collins, 1998).

CLDB job seekers whose English may be limited often perform the least well in the labour market, making English training sessions of even greater importance (Stevens, 1998). However, even where English proficiency is at a higher level among those of CLDBs there still remains a crucial need for more creative employment opportunities (Taylor and MacDonald, 1994).

## **Employment**

Ethnic communities are often in positions of social and economic disadvantage for significant periods of time (Smith and Citta, 1994; Van de Wijngaart, 1997). This observation was also made in Australia by the National Health Strategy (1993), which reported that groups from CLDBs tend to be more socially and economically disadvantaged than their English speaking counterparts. Van de Wijngaart (1997) found that unemployment among ethnic groups was higher than in the wider community, that average net incomes were lower and that most of the jobs this group had undertaken required less schooling. Alcorso (1990) writes that many medical doctors who have close associations with ethnic groups firmly believe that unemployment, along with the difficulties of entering a highly structured and inflexible job market, place such people at greater social risks increasing the potential to use illicit drugs.

The impact of unemployment can adversely affect health, self-esteem and confidence, and may instigate boredom and depression. This in turn may significantly influence the desire to use drugs (Health Department Victoria, 1988; Parker et al, 1995). Unemployment and underemployment impact upon all communities, but those of CLDB appear to be more seriously affected. Whether or not a person originates from a mainly English speaking country appears to affect employment prospects. In Australia in 1996, unemployment rates for people from the Middle East and North Africa rose more than 40 per cent. This compares with people from the United Kingdom, where unemployment was estimated at that time to be seven per cent (Williams and Batrouney, 1998).

Unemployment rates have generally continued to rise over the past three decades. In 1974 unemployment rates for Australian-born people was 1.6 per cent while for those born overseas it was 1.8 per cent. In 1996, the unemployment rate for Australians was 8.4 per cent and for those born overseas it was 10.3 per cent. These figures can be partially explained by changes in the industrial composition of the country (Hogan 1984; Williams and Batrouney, 1998). Long-term unemployment for those of CLDB has become increasingly bleak. Unemployment as a major concern emerged during the late 1970s. The average duration for unemployment at that time among both Australian-born and CLDB-born was 24 weeks. By 1995 a significant change occurred. The average duration of unemployment for an Australian born rose to 52 weeks while for those of CLDB it more than tripled to 74 weeks (Watson, 1998).

Ethnic groups are frequently engaged in low status-type work, which is most susceptible to retrenchment during periods of an economic downturn. People of

CLDB are often under-represented in professional, administrative, clerical and sales occupations. They are over-represented in production, factory and labouring occupations (Health Department Victoria, 1988). Recent migrants in particular are often concentrated in the most poorly paid, monotonous, dangerous and dirtiest jobs throughout both male and female dominated segments of the labour market – particularly in the manufacturing industries (NSW Health, 1993; National Health Strategy, 1993). In Australia, there have been major changes to the manufacturing sector, and this has resulted in a considerable reduction to the traditional employment base of CLDB migrants (Viviani et al, 1993; NSW Health, 1993). Healy (1998) reports that in 1966 the manufacturing industry accounted for 28 per cent of Australia's employment. By 1998 this same industry accounted for only 14 per cent.

Research shows that young people generally have a high level of unemployment and that this is probably compounded when the young person has a CLDB. It has been suggested that young people have a need to build self-confidence by taking risks and surviving them. For young unemployed people unable to establish economic independence or occupational competence, there is potential for illicit drug involvement to become an attractive economic alternative (Westermeyer 1987; Kim et al, 1992).

## **Education**

Research suggests that educational attainment and the age of leaving school can be related to the use of illicit drugs among adolescents. Recent reports suggest the rates of lifetime substance use are much higher among those who drop out of school compared with those who remain at school (Swaim et al, 1997; Office of Applied Studies, 1998). One hypothesis is that students from ethnic backgrounds are at an increased risk of dropping out of school since they may be more likely to encounter learning difficulties as well as being more likely to be economically and socially disadvantaged.

While it can be true that some ethnic groups are doing particularly well with education, there are others within the same ethnic group encountering severe learning difficulties due to various social factors. Consequently, they do not achieve higher education standards. However, while there has been increasingly optimistic changes in educational outcomes for CLDB students, staying longer at school does not necessarily imply educational success or upward mobility in the wider community (Vasta, 1995). As reported by Watson (1998), having acquired a tertiary education does not always provide protection against unemployment for those of CLDB, and this is evident from the incidence of long-term unemployment in 1993 which was 35 per cent – nearly double the figure for those born in Australia.

## **Intergenerational Conflict**

Many studies have shown that the children of immigrant parents frequently adapt more quickly to the new culture than their parents. Cultural adaptation by young people to a new environment may result in a culture gap between parents and their children, which could in turn lead to growing tension and conflict between parents,

grandparents and extended family (Health Department Victoria, 1988; Frederico et al, 1997). Cultural-generational clashes within a family may compound communication problems where communication is already severely compromised by external and social difficulties related to adaptation and adjustment in a foreign culture (Hatty, 1990; Kuramoto, 1997).

Some youths from CLDBs are believed to be required to adopt adult roles and responsibilities prematurely, by acting as translators or intermediaries between the older generation of their family and the wider community. This has its own set of stresses, which may be overwhelming for the child or adolescent (Hatty, 1990; Kuramoto, 1997).

Parents may expect their young people to take on adult roles and yet simultaneously remain deferential, obedient and respectful towards their parents. Possible stresses felt by young ethnic groups may manifest in acts of unacceptable juvenile behaviour, attracting parental punishments. Keeping in mind that cautious interpretations of American studies are required due to ethnic/racial categorisations, it is interesting to note that one American study found that Asian parents were more likely than white or black parents to revoke privileges for misbehaviour, rather than talking about problems in an open way. This lack of open dialogue about problems by Asian families was further supported in research where Afro-American and white children were found to have better family communications than Asian children (Catalano et al, 1992). Examinations of certain family predictors and risk factors for behaviour problems, the use of restrained punishment by parents and the open or closed lines of family communication is complex, and any findings that emerge need to be interpreted with caution.

While family tension is common in all communities, intergenerational conflict for ethnic youth may be more extreme and have more adverse consequences. The rapid social changes that are occurring in many urban centres may inspire ethnic youth to abandon the mores and values of their perceived traditional and conservative elders. The traditional patterns of behaviour of particular ethnic groups, which in the past have generally served them well and have been pivotal in determining their sense of identity, may in fact not be appropriate or relevant in tackling the contemporary problems and circumstances facing ethnic youth in Australia (Westermeyer, 1987; Kim et al, 1992).

It has been reported that a number of Asian background youths, both in Australia and in other Western countries, have, due to intergenerational conflicts, separated from their families to create their own support networks with peers. Ethnic youth, in the light of various social stresses, appear to be easily driven from the traditional values of their parents towards peer groups with markedly different social and moral codes. A move toward autonomy and independence by youth can lead to rebelliousness and reliance upon peers for assistance and guidance (Ja and Aoki, 1993; Ho, 1994). Some of the literature suggests that CLDB youths do not want to have any association with new immigrants. However, without family and community support they drop out of school at an earlier age and may live on the streets with their peers. Peer pressure has consistently been found as a strong predictor of illicit drug use among adolescents (Gilmore et al, 1990; Hunt, 1992).

Additionally, immersion into 'street culture' may eventually lead to a number of serious vulnerabilities, of which the potential to become involved in illicit drug use is an important one (Kim et al, 1992).

## **Acculturation and Peer Pressure**

The process of acculturation into the host country may result in the loss of a person's traditional cultural values and norms as they adopt the behaviours and attitudes of the dominant group. This process, which can have both a positive and negative impact, emerges as a result of exposure to a cultural system that is often significantly different from one's own (Oetting and Beauvais, 1990-1991; Collins, 1992).

While each migrant will experience the acculturating process to some degree, all migrants will not experience it in the same way – nor will it occur over a similar period of time (Trimble, 1990-1991).

Immigrants who adopt the customs and practices of the host society or their patterns of drug use will often, over time, parallel those of the new environments. It has been suggested that migrants are less likely to develop illicit drug use habits if they adapt to their new social environment at the same time as retaining important elements of their native culture (Johnston, 1996). However, retention of one's native CLDB cultural norms can be undermined by the impact of peer pressures. Bankston (1995) suggests that young people initiate illicit drug use when the behavioural norms, values and beliefs of their primary reference group encourage such behaviour. A recent study in Cabramatta, Sydney (where up to 70 per cent of the population were born overseas) indicates that peer pressure was high and that up to 88 per cent of drug users had been introduced to illicit drugs by their friends. Among young drug users, peer influence was a major determining factor in the decision to use drugs. Although financial, social and family problems also contributed (Rebach, 1992; Patton, 1995; Le, 1996), peer groups tended to have a more direct influence on potential drug use than family relations:

Simply stated, the greater the influence on adolescents of their peers, the greater incidence of problem behaviours. This finding is well established in the adolescent delinquency area and is theorised to reflect the natural outcome of poor family relations. In the absence of positive family relations, the child turns to peers for support and involvement. In the health area, greater peer influence is associated with alcohol, tobacco and marijuana use, and lack of adequate exercise and nutrition. (Raphael, in press.)

A recent study among Vietnamese youth in the US supports this trend. It found that ties between parents and children had little influence on illicit drug use when close relationships between other adolescents are taken into account (Bankston, 1995).

## **Knowledge of and Access to Drug Services**

In a recent study in Cabramatta, Sydney, where a high proportion of the population were of CLDBs, it was found that most injecting drug users (IDUs) had not used any drug services. Their knowledge about drugs was limited and many adolescents had no idea of the health risks associated with using drugs. This lack of knowledge is attributed to: cultural and language barriers which limited access to drug treatment services; and social pressures to be discreet about drug use since most families and communities consider the issue taboo (Le, 1996). Other reasons for the observed low utilisation rates of drug services by people of CLDB may be that migrants are used to being self-sufficient in dealing with problems and issues which affect them and tend to utilise their family or ethnic community contacts first, wherever possible (Hatty, 1990; Kim et al, 1992).

Effective implementation of treatment depends on drug treatment services having a thorough understanding of the sociocultural factors at play with different types of clients. Cultural factors not only affect a person's reason for drug use but also the level and type of parenting skills, cognitive and social skills, the extent of peer influence and family disruption or conflicts. With the more traditional family, for example, the issues surrounding the use of drugs may be perceived as akin to the issues surrounding a mental illness. The level of fear about shame and loss of face are also issues that greatly affect some clients (De Leon et al, 1993; Kline, 1996).

Other issues that affect utilisation of drug treatment services by people of CLDBs include whether or not the service has staff who can communicate in the person's first language. Studies in the US have shown that the provision of bilingual and bicultural personnel in the mental health field has dramatically increased the utilisation of these services by Asian-Pacific people (Zane and Kim, 1994).

Involving the family in a drug treatment regime was also considered by the literature to be very important, particularly for people from CLDBs. It is reported that where interventions are sensitive to cultural issues, treatment utilisation rises dramatically (D'Avanzo, 1997).

A number of institutional barriers have prevented people of CLDBs from successfully accessing services, which may explain some of the low utilisation rates. These include ignorance or denial by service providers that a need exists or that current services have cultural bias inadvertently built into their service delivery. Treatment services need a good knowledge of their client base in order to accurately target their service delivery in such a way that a variety of client's needs are met. Despite perceptions, expectations or needs of clients, drug services very often do not know the extent to which different types of people are utilising their services on both the macro and micro level (Zane and Sassao 1992; Zane and Kim, 1994).

The lack of data about illicit drug use in ethnic groups has a number of serious ramifications. In the United States lack of data has helped perpetuate the myth that Asians do not need treatment, even in the face of strong public perceptions that drug use and sale has been increasing among this group. Second, lack of data has resulted in few attempts to develop cultural specific approaches to services, and thus

perpetuated the assumption that general and universal approaches (for example, the 'one size fits all' approach) are adequate. However, if the Asian cultural base, as an example, is not examined, there will continue to be an inability to enrol and then retain Asian background clients. Third, without data, the problem of using scarce resources in the most productive way continues – as does an inability to identify changes in demographics, emerging new groups and gaps in community infrastructure (Ja and Aoki, 1993; Finn, 1996; Kuramoto, 1997).

## **Research Methodologies: Ethnicity and Illicit Drug Use**

Over the years, many studies have failed to come to grips with the complexity of ethnic demographics. Research into illicit drug use among ethnic groups has encountered a number of methodological problems, including: inadequate conceptualisation; inaccuracy of definitions; inappropriate research designs; disagreements over basic concepts and poor data collections related to the over-inclusiveness of ethnic groups (Spathopoulos and Bertram, 1991; Almog et al, 1993; Ja and Aoki, 1993; Jackson and Flaherty, 1994). Studies looking at drug-taking behavioural differences among specific ethnic groups often involve sample sizes too small to be of statistical significance (Morrisey, 1993). Because of the scarcity of population-based studies comparing co-occurrences between drug risk behaviours across diverse ethnic groups, inaccurate estimates of the prevalence of ethnic drug use patterns are frequent (Almog et al, 1993; Ja and Aoki, 1993; Neumarch-Sztainer et al, 1996).

The fact that investigations into socioeconomic status, level of parental care and supervision, education and geographic location are limited, prompts questions about whether any observed differences are truly related to ethnicity – or if they are more related to socioeconomic variables. As suggested by Neumarch-Sztainer et al (1996), it is more probable that lower *socioeconomic status* rather than *ethnicity* is the major contributor to high risk behaviour and drug use. A disregard for the relevant socioeconomic factors is considered by the literature to be both a methodological and conceptual problem when interpreting drug use research results. Undertaking research based on simplistic ethnic categories, without attention to all the other possibly confounding factors of sociocultural variables, is considered to be not only scientifically meaningless, but a great disservice to the ethnic groups under examination (Collins, 1992; Collins, 1996).

A significant problem among known drug users has often resulted in the inevitable exclusion of unknown drug users in both the ethnic and general population.

Key problems that have been identified when examining self-report studies by illicit drug users include the propensity for various errors, such as user memory failure, lying and the social compulsion not to publicly acknowledge an illicit activity. Results from these types of studies often reflect a significant under-reporting of illicit drug use (Cheung, 1989).

# Utilisation of Drug Treatment Services

## Discussion

The available literature commonly reports that illicit drug use among people from CLDBs is often associated with denial, shame and stigma. For some youth of CLDBs the sharing of information with family members would not occur for fear of being ostracised by both their family unit and ethnic community (Smith and Citta, 1994; Frederico et al, 1997). If a drug problem did become obvious, many ethnic families were considered more likely to seek help from their informal network of friends and family rather than 'outside' services, and they are often more likely to only access services when a crisis occurred (such as an overdose). Accessing outside help for an illicit drug problem was frequently thought to be not only logistically difficult but also possibly considered a betrayal to the family and the community (Hatty, 1990; Kim et al, 1992; Ja and Aoki, 1993; Kuramoto, 1997). Ultimately, for a drug user to seek help, they need to perceive that they actually have a problem, that it is a serious disruption to their life, that beneficial results will be gained by using drug treatment services and that the cost of treatment is affordable (Kline, 1996).

When help from services was the required, the literature highlights that access to these services was difficult. Research indicates that few ethno-specific agencies or ethnic groups were actually aware of the drug services available to them. This may be a result of publicity that services were rarely multilingual. Consequently, accessing services was not easy (Romios and Ross, 1993; Kuramoto, 1997; Success Works, 1998a). Ethnic groups needed comprehensive and understandable information about the available services so as to facilitate service access by youth and their families (Schick, 1991; Smith and Citta, 1994). Communities believed that consultation opportunities and adequate communication were obstructed where the community was isolated from services and unable to receive effective delivery of services (Health Department of Victoria, 1988, Success Works, 1998b).

In recent years there has been an increase in demand for inpatient detoxification services. Consequently, in the past few years, major providers of inpatient detoxification services have seen their waiting lists for client admissions increase from 10–14 days to 4–6 weeks (Parsons, 1999).

Where ethnic communities were aware of the existence of services, ethnic leaders were ambivalent as to how they could serve their communities appropriately, or how the community would actually approach them for help (Hatty, 1990; Spathopoulos and Bertram, 1991; Finn, 1996). Examination of the minimal available data has shown that the admission rates of CLDB people into drug treatment services was small in number (Johnson and Carol, 1995; Van de Wijngaart, 1997). This is more likely a reflection of under-utilisation of the service by people of CLDB, rather than a lower need for such services (Sasao, 1992; Legge, 1993; Zane and Kim, 1994; D'Avanzo, 1997). Language and interpreting services were believed to be crucial if a high quality of service was to be achieved. Frequently, however, such services were limited – either through lack of resources or because of inadequate or appropriate staff numbers (Health Department Victoria, 1992; National Health Strategy, 1993).

For a number of decades, drug treatment services have recognised that barriers to service are experienced as a result of language and cultural differences. They have been aware that these issues were not being adequately addressed. In the 1980s it was reported that information imparted to those of CLDB should be linguistically and culturally appropriate, but rarely was this the case (Victorian Ethnic Affairs Commission, 1988; Beninati et al, 1989). Some years later it was again inferred that too few drug treatment centres were able to cater for people who spoke languages other than English. The importance of a heightened awareness and sensitivity of treatment workers to the lifestyles, culture and language of various ethnic groups required even greater emphasis. It is important that materials and strategies within drug treatment services reflect the existence of diversity in the population and it is recognised that neither a minority nor majority culture in society remains static (Spathopoulos and Bertram, 1991; Longshore et al, 1993; Johnson and Carol, 1995). A recently commissioned project in Victoria, Australia identified barriers to access and effective care by drug treatment services. This has led to the production of a cultural diversity workbook for service providers outlining practical and innovative solutions in addressing systemic issues. However, its recent publication has not provided scope for an assessment into the effectiveness of this workbook, or its impact upon service providers towards culturally diverse ethnic groups (Success Works [C], 1998). Hatty (1990), Deitch and Solit (1993) and Sue et al (1994) all suggest that it is important to recognise the very fine line between cultural sensitivity and stereotypic thinking, in order to avoid reproducing conservative ideologies which may ignore the heterogeneity and complexity of 'minority groups'.

Even if a comprehensive level of knowledge about a particular aspect of a culture exists it would still be impossible to know about all of the sub-cultures within it. Cultural sensitivity comes from being able to deal with diversity, a skill that needs to be incorporated into the practice of drug treatment services (Hatty, 1990). People of CLDBs need to feel better equipped to participate in drug issue discussions and in research which uses community development strategies, since positive outcomes are more likely to occur by providing a method which allows people to solve problems for themselves and take responsibility for their own affairs (Majors, 1993). Major (1993) suggests the empowerment of client groups needs further promotion – while remaining sensitive to the complex interrelation between ethnicity, gender, social class and various other factors associated with particular localities.

## **Issues of Communication**

Perhaps the lack of publicity for drug treatment services in languages other than English prevents many people of CLDBs from discovering the service in the first place. Then, once the service is discovered, the lack of appropriate material in their language prevents them from communicating with drug treatment workers in a way which proves the service to be sensitive to their particular cultural needs. Apart from written material, lack of translation services also continues to obstruct the flow of effective information (Success Works, 1998a/b). As suggested by Amodeo et al (1997), the non-availability of interpreters frequently results in a reluctance of clients to return to treatment services. Even where translating and interpreting services are available, anecdotal reports suggest that their expense makes drug treatment services

reluctant to use them. The lack of priority given to language services by either the Commonwealth or the State governments further compounds the under-utilisation of interpreters in drug treatment services (National Health Strategy, 1993; Victorian Ethnic Affairs Commission, 1995). Bilingual staff employed by services might informally assist with assessment, counselling and referrals, but their ability to do this effectively is limited by their unfamiliarity with drug issues (Health Department of Victoria, 1988).

A number of service providers were found to have assumed that clients of CLDBs receiving treatment possessed highly developed communicative skills. Research into this area indicates that in reality English proficiency among those of CLDBs is often poor and that misunderstandings are frequent (Hatty, 1990; NSW Health Department, 1993; EYIN et al, 1998). Most service workers believed that the recruitment of bilingual workers as interpreters was adequate in overcoming the problem of low availability of professional interpreters. Non-specialist translators could not deal effectively or appropriately with the volume or content of translations. For example, a bilingual receptionist or domestic worker, unfamiliar with drug-related issues, might still be used as an interpreter. Family members were another source for interpreting (Beninati et al, 1989; Health Department of Victoria, 1988). The use of bilingual people who have no experience as interpreters is inappropriate because it can result in inaccurate translations, erroneous clinical conclusions and the compromising of confidentiality. In addition, some of the literature suggests the principle of confidentiality is frequently misunderstood in some Asian cultures as well as those from other CLDBs (Nguyen NG, 1992; Amodeo et al, 1997).

## **Type of Service**

Guarantee of confidentiality in the use of drug treatment services is deemed crucial if ethnic youth are to openly speak about these sensitive issues (Success Works [A], 1998). According to the literature, people of CLDBs only seek assistance when a drug problem has reached a crisis stage, such as when there is a physical breakdown. Aside from feelings of shame, attending mainstream treatment services can be daunting, with potential for distrust and fear of officialdom. Consequently, telephone services might be a preferable mode of contact, as it is more able to guarantee anonymity (Zaparas, 1988; Jackson and Flaherty, 1994; Johnson and Carol, 1995). The literature points to local doctors or general practitioners (GPs) as a common option for many people of CLDBs seeking either advice or assistance about illicit drug matters. The doctor's rooms were believed to be less formal and less intimidating (Spathopoulos and Bertram, 1991; Jackson and Flaherty, 1993). However, it was suggested that many doctors were not functioning with maximum efficacy in prevention, detection or early intervention with regards to drug-related problems. Alcorso (1990) suggests that many GPs' knowledge of and liaison with drug treatment services is generally poor, with most GPs in need of more information and education.

Both state and federal governments have adopted the philosophy of mainstreaming with regard to all migrant services. The literature highlights that services, including drug treatment, should be flexible enough to cater for the whole community and be

sensitive to both social and cultural differences (Alcorso, 1990; Romios and Ross, 1993; Dent et al, 1996). However, due to a lack of appropriate staffing, ethnic groups often saw a number of drug services as remote and inaccessible and the need for staff trained in cross-cultural issues (Amodeo and Robb, 1997; Pearson and Patel, 1998; Success Works, 1998a). It has been reported that many drug treatment professionals were not knowledgeable, or had little affinity with, those from CLDBs. Some suggest that these concerns should be addressed by treatment staff adopting interactive styles that reflect the cultural values of ethnic groups in the community (Longshore et al, 1993; Van de Wijngaart, 1997). As reported by Finn (1996), treatment services have a moral obligation to enlighten themselves about the life experiences of disadvantage groups where CLDBs are included. The literature presented firm beliefs that services on offer needed to be friendly, welcoming and that people seeking assistance were valued. The need for open, honest and non-judgmental staff was seen as crucial before an attitudinal change towards using any service could occur (Smith and Citta, 1994).

Hatty (1991) suggests that treatment practices that excluded families in the consultative process deprived the family of the opportunity to demonstrate the importance of kinship ties that exist. Involvement of either the whole family or a family member in the intervention process was thought to be crucial both at a local doctor level and during any other treatment process (Alcorso, 1990; Dejong et al, 1998). As suggested by Martin and Zweben (1993), family ties of ethnic youth were often fundamental reasons either to comply with treatment or to drop out of treatment. Therefore, inclusion of family was essential. For many ethnic groups the family unit can be viewed as sacrosanct. Therefore, counselling which focuses an individual alone was widely believed to be a difficult process (Major, 1993; McGoldrick et al, 1996).

## **Service Effectiveness**

The Western concept of counselling and self-disclosure does not exist in many ethnic communities. Therefore, there exists widespread scepticism that personal problems can be best handled by professionals (Major, 1993; Sue et al, 1994; McGoldrick et al, 1996). Counselling can be very individually centred, with an underlying assumption that a client will act as an independent and assertive person who makes their own decisions (Finn, 1996). This may not be true for people of CLDBs. Restraints on strong feelings are often highly valued, particularly in Asian cultures. This results in a very limited sense of confidence in the process of talking about any problems (Sue and Sue, 1990; Lee, 1996). While researchers and practitioners often assume that counselling is not as effective with people of CLDBs, it is not possible to establish for certain whether this is in fact the case, due to the paucity of information available (Sue and Sue, 1990; Sue et al, 1994). While challenges to counselling are great, recent research of treatment services indicates a perception that various approaches have improved engagement with ethnic youth (EYIN et al, 1998). Whether an ethnic person would prefer a non-ethnic counsellor (because of an assumption that they might not trust a member of their own ethnic group to maintain confidentially) remains a moot point (Finn, 1996).

Research has shown that clients of CLDBs were less likely to complete treatment and less likely to reduce or eliminate drug use during or after treatment (Maddux and Desmond, 1996; Van de Wijngaart, 1997). Research indicates that the treatment methods utilised were predominantly based on Anglo-Saxon models, perhaps resulting in those of CLDBs feeling uncomfortable in treatment programs and quitting before the completion of detoxification (De Leon et al, 1993; Van de Wijngaart, 1997). Anglo-centred strategies that may alienate the cultural needs of the client should be avoided. Culturally relevant programs need development because of the differing life experiences and stressors to which many people of CLDB have been exposed, including pre- and post-migration experiences (Tucker, 1985; Maddahain et al, 1988; Major, 1993; Zane et al, 1998). Additionally, those of CLDBs who left treatment early were generally difficult to follow up, and further recruitment into treatment was generally problematic (Collins, 1992; Ezard, 1998).

To resolve these problems it was considered necessary for partnerships and development of intersectoral linkages among all relevant sectors to occur, including government health and educational departments, community organisations and ethnic agencies (Romios and Ross, 1993; Finn, 1996). Treatment services need to be sensitive to community needs by recruiting ethno-specific workers (Smith and Citta, 1994). Mainstream agencies need to display greater flexibility to enhance accessibility. The literature cites peer outreach workers who accompany ethnic youth to appointments, for example, as an increasingly successful method. In recent years research has shown home detoxification programs for people of CLDBs can be successful and should be encouraged and expanded. This is particularly so in light of the increasingly long waiting lists for residential programs. Intensive follow-up after home detoxification should also occur to minimise the return to illicit drug use (EYIN et al, 1998).

## **Prevention**

The literature suggests that prevention programs for people of CLDBs should maintain a focus on the social and political factors surrounding those groups to enable these people to deal with systems that often continually rebuff them (Dorn and Murji, 1992: 26, cited in Johnson and Carroll, 1995). As reported by Dorn and Murji (1992), social behaviour was not the fault of the individual but was often caused by the social/political system of which they were a part. Ethnic communities are often deprived, marginalised and excluded from receiving information about illicit drugs, hindering their understanding of the subject. Johnson and Carroll (1995) suggest low knowledge levels about drug use, rather than negative attitudes among those of CLDBs, are likely to place such people at high risk of drug use. Attention to these problems needs to be tackled before the symptoms of drug use manifest in ethnic communities. Prevention work needs to be both relevant and effective if the need for ethnic groups to have access to drug information is to be successfully met.

Changing the attitudes for those of CLDBs can only be achieved if the approaches are culturally appropriate for that community. Information about how families and communities reduce or manage drug-related harm is invaluable. However, it has been suggested that those of CLDBs lag far behind other sectors of the community in

awareness of illicit drug issues and the harmful health consequences of drug use, such as HIV and hepatitis C (Spathopoulos and Bertram, 1991). Resourcing and consulting with ethnic groups remains crucial in order for the development of an appropriate community education strategy based around drug issues. Community and parent education can include:

- Dissemination of information and materials by ethno-specific peer workers.
- Community forums with particular ethnic groups.
- Distribution of information at community centres or festivals.
- Utilising ethnic media to inform the community about drug issues.
- Live theatre or other artistic methods.
- Collaborative ventures between schools and various ethnic communities (Mudaly, 1996; EYIN et al, 1998; Higgs, 1999; Vietnamese Students Association [VSA] et al, 1999).

Recently, an inventive tool used for preventive education and communication on drug issues for the Indo-Chinese community was a calendar. It was believed to be quite important for this community to actively initiate and promote education by bringing forth social, educational and intergenerational issues that affected family life. The aim was to alter individual risk behaviours within the social and cultural context in which it occurs (Mudaly, 1997). During 1998–99 another interesting way to promote education about drug issues was a community theatre production called the *Dragon's Lair* performed by young Australian-Vietnamese people. This performance expressed the experiences of the heroin culture from an Australian-Vietnamese perspective. The aim of this production was to raise awareness and provide insights into a community (mostly Vietnamese) which may have underestimated the problem within its subculture. The general feedback was overwhelmingly positive, both artistically and educationally (VSA, 1999).

Prevention programs for those of CLDBs should incorporate an empowerment strategy for CLDB parents. In order to avoid loss of face and honour (important to many ethnic groups), intermediaries have been used to manage interpersonal conflicts. The benefits of intermediaries can be their ability to advocate for a person's position without actually personalising the issues with the other person. The aims were to minimise potential loss of face and to reduce violation of the hierarchal relationship within the family (Zane and Kim, 1994).

Ethnic-specific services, which are culturally sensitive to people of CLDBs, would increase the viability of the services and would reduce the stigma associated with seeking help. There is a need to foster extended family networks and for support and education for parents to be implemented in a collaborative manner. While family cohesion has been suggested, it can be both a protective device as well as a social stressor for those of CLDBs. The need to support a community's effort to develop its own resources to tackle problems associated with drug use is believed to be crucial (Zane et al, 1998).