PATTERNS AND TRENDS: VIETNAMESE ALCOHOL SURVEY

RESEARCH REPORT

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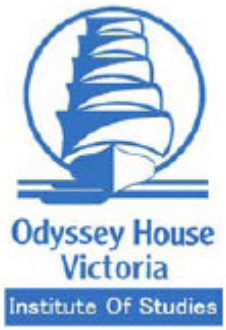
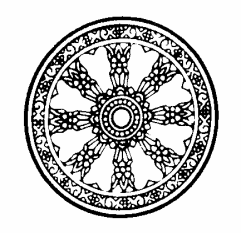
Odyssey House Victoria, Institute of Studies,

Centre for Psychiatric Nursing Research and Practice, University of Melbourne

With the Quang Minh Temple: Braybrook, Victoria.





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EXECUTIVE SUMMARY

Introduction

- The "Patterns & Trends: Vietnamese Alcohol Survey" project investigated: the patterns of alcohol consumption; reasons for drinking alcohol and the context of its use; the effects of drinking alcohol and any associated problems such as debt, gambling, drink-driving, and violence; and the associated health and well-being of the Vietnamese community of Melbourne.
- The project was funded by the Alcohol Education and Rehabilitation Foundation through a research grant and was conducted by Odyssey House Victoria, University of Melbourne and the Quang Minh Temple.
- Most previous research has shown that Vietnamese Australians consume less alcohol and engage in alcohol abuse at a lower level than the wider population (e.g. Bertram, Flaherty & Everingham, 1996; Steel, Silove, Phan and Bauman, 2004). However, this is challenged by a local study (Cao & Pham, 2002) and anecdotal evidence from Vietnamese welfare agencies in Melbourne which suggest high levels of alcohol related harm. In addition, there are assertions that men with Vietnamese backgrounds engage in more binge drinking than the general population in other countries (e.g., in the USA; Amodeo et al., 1997).
- Studies also highlight the poor help-seeking behaviour of Vietnamese populations with a propensity for General Practitioners (GP) only, although it is unclear whether this only applies to GPs situated within Vietnamese communities (e.g. Bertram et al., 1996; Drug and Alcohol Multicultural Education Centre, 1992-97). Vietnamese prefer informal networks for assistance with alcohol-related problems instead of accessing drug services, with a reluctance to discuss drug use with people outside the family structure or the network of traditional healers (Ali et al., 2000).
- It has not been clearly understood whether lower than average drinking levels previously reported in the literature occur across all gender and age groups within the Vietnamese community of Melbourne. Furthermore, it is unknown whether subgroups within the community are experiencing serious consequences as a result of their drinking, even if levels of consumption are lower than in the general population. This study will help identify if unique problems exist among specific sub groups of Melbourne's Vietnamese community. This information will fill a critical gap in knowledge and is essential if services and educational campaigns are to effectively reach these subpopulations.

Method

- The project consisted of two stages.
- Stage One involved focus groups and individual interviews with twelve members of the Vietnamese community (aged 16 years and older), to obtain a formative understanding of the types of problems associated with alcohol and drug use and to identify the social and cultural context of drinking within the Vietnamese community.
- Data from interviews informed the development of the questionnaire used in Stage Two.
- Stage Two involved developing and administering a survey to 1080 people (men and women aged 16 and older) within the Vietnamese Community of Melbourne.

Results

- Stage One results revealed themes concerning perceptions of alcohol use in the Vietnamese community, cultural issues and help seeking behaviours. The interviews revealed that drinking alcohol is a common social activity, which is generally encouraged by Australian friends. Certain cultural issues were raised, such as Vietnamese males drink more than females, older women do not drink, domestic violence or verbal abuse due to drinking was mentioned several times, especially if a wife tries to limit her husband's alcohol intake, and flushing seems to be more associated with the older generation. Help-seeking behaviour is not usual in the Vietnamese cultural because consuming alcohol is seen as 'normal'. Participants also raised the issue of the lack of language specific services. Cultural values were also raised such as the importance of maintaining a good reputation, and being in control of one's behaviour.
- Stage Two results appear consistent with previous research which shows that fewer Vietnamese Australians drink alcohol, and those that do drink, do so at somewhat lower levels than the wider Australian population. Despite this however, those that do drink appear to experience more serious problems as a consequence. Middle age men and young adult women were most likely to drink, smoke tobacco regularly, and experience problems with alcohol. Vietnamese in Melbourne prefer to keep their problems within their families and are unlikely to report alcohol related violence to the Police.

Recommendations

- Help seeking would be made easier if there were confidential, language specific services, which understand Vietnamese culture. While doctors were the preferred helpers, other services would also be accessed by Vietnamese in Melbourne, with half of Melbourne's Vietnamese (typically older members) preferring Vietnamese specific services.
- Findings from this research will be widely disseminated via journal articles, conference presentations, and through the media.
- The findings will be used to inform targeted alcohol services and education programs within the Vietnamese community.

LITERATURE REVIEW

BACKGROUND AND AIMS

Alcohol remains one of Australia's most widely used drugs. While certain benefits may be attained through mild and moderate use of alcohol (e.g., recreation), excessive use is well recognised to be associated with a number of direct harms (e.g., increased risk of Cirrhosis; alcohol-related deaths, Chikritzhs, 2001) and numerous indirect harms (e.g., drink driving and domestic violence).

The Quang Minh Buddhist Temple in Melbourne Victoria has expressed concerns regarding the unique vulnerability of those of Vietnamese background to problems associated with alcohol misuse (including overuse by particular sub-groups, as a precursor to illicit drug use, and a general lack of confidence in addressing alcohol-related problems effectively (Cao & Pham, 2002). This concern led to a small scale study conducted by Odyssey House Victoria (Cao & Pham, 2002), which found that those of Vietnamese background were commonly experiencing problem drinking, and that some segments of the community, including younger females, seemed to demonstrate a significant lack of knowledge regarding the ill-health effects of alcohol use and misuse. These troubling findings confirmed the need for a larger scale study.

The purpose of the current project[1] is to inform the community and policy makers on the needs of Vietnamese Australians in relation to alcohol, particularly in relation to the prevalence of alcohol consumption patterns, degree of association with problem behaviours, knowledge of alcohol effects and sources of help, as well as to pinpoint aspects of the Vietnamese Australian culture that may buffer or play a protective role. The establishment of a qualitative understanding and a representative quantitative database on the Victorian Australian Vietnamese population has the potential to aid current drug education, service providers and the community, and to enable further understanding of drug-related issues for non-English speaking cultural groups in Australia.

The "Patterns & Trends: Vietnamese Alcohol Survey" research project represents a collaborative partnership between Odyssey House Victoria (Institute of Studies), the Quang Minh Temple, and the Centre for Psychiatric Nursing Research and Practice, University of Melbourne.

The project is composed of five inter-related stages: (1) interviews and focus groups on alcohol use and misuse and its significance within Vietnamese Australian culture, towards (2) survey development (including the identification of standardised items for comparative purposes), (3) collection of data from around 1,000 Vietnamese Australians through the new interview-administered survey, (4) data analysis, and (5) dissemination of the results to the relevant stakeholder groups.

The current literature review was conducted to determine the extent of alcohol use and the nature of the problems associated with alcohol use and misuse from a socio-cultural perspective.

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[1] This project is funded by the Alcohol Education and Rehabilitation Foundation.

AIMS

More specifically the literature review aimed to:

- Establish current estimates of the prevalence of alcohol intake, alcoholism and related problems (e.g., illicit drug use) within Vietnamese communities and in comparison to the wider population.
- Summarise current knowledge of Vietnamese cultural orientations to alcohol-related behaviour (e.g., attitudes, beliefs, cultural practices and help-seeking behaviour), in particular when they interact with other cultures in the host country.

Secondary aims, in preparation for the first three stages (focus group, questionnaire development and sampling strategy), were to:

- Provide information on the makeup of Vietnamese communities in Melbourne (see Appendix A).
- Identify other programs that focus on alcohol use in Vietnamese communities, in Australia and abroad (see Appendix B)

While "complete" for the initial phase[2], this review is a work in progress for the larger project. In view of Stage Five, it is hoped that the review will pave the way for peer-reviewed papers with joint authorship between Odyssey House and the Centre for Psychiatric Nursing Research and Practice (University of Melbourne).

A number of data/sources touched on in this review are in need of examination in their own right as part of study design development.[3]

SEARCH STRATEGY

Electronic searches were conducted (inc. Google scholar, Informit and PsychINFO) primarily with the combined search terms "alcohol*" and "vietnam*", and manual examination of relevant specialist journals. Local and national drug agencies were contacted (e.g., Alcohol and Other Drugs Council of Australia)[4].

STRUCTURE OF THE LITERATURE

There was a paucity of literature comparing alcohol behaviour patterns in Vietnamese Australians to the general population, and only one peer-reviewed paper on examining alcohol-related variables, in detail, for adult Vietnamese Australians. This literature can be compared to a larger body of work in Australia on migratory movements of Vietnamese to Australia and community issues in relation to heroin use in younger Vietnamese Australians; and in the US on Vietnamese American drug and alcohol use (which focuses on younger adults) and acculturation.

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[2] The literature review did not reach the stage of detailed documenting of policy and drug service frameworks in Victoria and the (Vietnamese) cultural competence of these frameworks. Later versions of the literature review, in combination with the new data, will evaluate the appropriateness of current policy on alcohol-related services for meeting the (special) needs of Vietnamese communities. Important references thus far are: DHS (2000), Gutmann (1999) and Tesoriero (2002).

[3] These are: Gutmann (1999), Kaplan et al. (2003), Nghe et al. (2003) and Dawe et al. (2002).

[4] Organisations contacted were the National Drug and Alcohol Research Centre, Australian Bureau of Statistics, Australian Drug Information Network, Australian Vietnamese Women's Welfare Association, and the Drug and Alcohol Multicultural Education Centre.

OVERVIEW

The literature review has two parts:

(1) the reporting of prevalence rates of alcohol use, associated harms, and use of health services. This will be for the Australian samples and then peoples of Vietnamese background in other Western countries.

(2) literature that has analysed the socio-cultural context of Vietnamese migrants and refugees including explanations for alcohol behaviour patterns and attitudes and efficacy for help-seeking behaviour.

ALCOHOL PRACTICES IN VIETNAMESE AUSTRALIANS

There was a lack of research literature on alcohol prevalence rates for Australian Vietnamese. No direct statistical comparisons of average consumption patterns for those of Vietnamese background compared to those of non-Vietnamese background were located. Steel, Silove, Phan and Bauman (2004) assessed mental illness prevalence in the NSW Vietnamese refugee population using a Vietnamese back-translated DSM-IV Composite International Diagnostic Interview Schedule. There were lower rates of alcohol-use disorder in Vietnamese-born refugees (1.1%, 95% CI: 0.1-2.1%, n=1,161) than in Australian-born (6.7%, CI: 6.5-6.9%, n=7,961). Significant differences in the same direction were also found when comparing all Vietnamese-born males (2.3%, CI: 0.3-4.2%) to Australia-born males (10.1%, CI: 9.8-10.5%), and similarly for females (0.0%, CI: 0.0-0.0% vs. 3.5%, CI: 3.4-3.6%).

Rissel, McLellan and Bauman (2000) examined the prevalence of alcohol use for a sample of Year 10 and 11 students in Sydney (South West and Central regions). Three indicators were (1) alcohol experimentation, (2) drunkenness experience and (3) binge drinking. For alcohol experimentation the survey cue was: "Have you ever tasted an alcoholic drink (that means beer, wine, coolers or spirits like Vodka)?" Experiences with drunkenness was tapped through the following: "Have you ever had so much to drink that you were really drunk?", and binge drinking: "Thinking back over the last two weeks, how many times have you had five or more alcoholic drinks in a row?". The respective prevalence levels are presented in Table 1.[5]

Table 1 shows that Vietnamese students (both overall and per gender) had lower prevalence levels than English students on all indicators (tasted alcohol, have been drunk and hazardous drinking). In addition, Vietnamese males scored higher than females on all indicators.

When compared to students of English, Arabic and European background, Vietnamese students reported the lowest prevalence of having a "drunk behaviour experience" (17%) and "drinking at hazardous levels" (34.7%) having more than 5 drinks in a row, in the last 2 weeks.

[5] Prevalence levels were also provided for English, Arabic and European students (p.148).

Table 1. Proportions of males and females (English vs Vietnamese/South East Asian) for three alcohol indicators ("Tasted Alcohol", "Have Been Drunk" and "Hazardous Drinking").

Subsample	Tasted Alcohol %	Have been drunk %	Hazardous Drinking %
English			
Overall n=307)	92.5	36.2	59.0
Male (n=145)	95.2	43.0	63.9
Female (n=162)	90.3	30.1	54.5
Vietnamese/South East Asian			
Overall (n=592)	70.2	17.0	34.7
Male (n=308)	77.2	22.8	45.3
Female (n=283)	63.8	10.6	22.8

Note: This table is largely reproduced from Rissel, McLellan & Bauman (2000).

The most direct study comparing Australian Vietnamese community knowledge and alcohol intake practices to the general population was conducted by Bertram, Flaherty and Everingham (1996).[6] A cluster sampling approach was adopted and concentrated on Fairfield, Bankstown and Marrickville in Sydney (n=341, all over 15 years of age). Almost three-quarters (72%) of the sample did not speak English and almost half (47%) had resided in Australia for less than five years; 5% were born in Australia. Alcohol consumption was operationalised as at least one episode of alcohol intake in the week prior to the survey. Prevalence rates for this sample were compared to NSW general population estimates (1991 National Campaign Against Drug Abuse Social Issues Household Survey). Both males and females who spoke Vietnamese engaged in less alcohol consumption than the general population. That is, for engagement in at least one episode of alcohol consumption in the previous week it was found that 43% of Vietnamese speaking men drank compared to 61% for men in general, and 8% of Vietnamese speaking women compared to 39% of women in general.

INDIVIDUAL DIFFERENCES IN ALCOHOL BEHAVIOUR

In additional analyses by Rissel, McLellan and Bauman (2000), youth binge drinking was significantly associated with smoking, and social contact with friends during the evening. Using multiple regression, Bertram, Flaherty and Everingham (1996) investigated what individual differences predicted alcohol use. In one regression equation 27% of (adjusted) variance in alcohol consumption was accounted for by three indicators: (1) being male, (2) daily tobacco use, and (3) higher education. Also, marijuana use among Asian students (including Vietnamese) was associated with gender (male), smoking status (smokers), acculturation, hazardous drinking, and night time socialising with friends. Being female and low acculturation were both significantly associated with the reduced risk of hazardous drinking in the youth sample (Rissel, McLellan & Bauman, 2000).

ALCOHOL-RELATED KNOWLEDGE AND HELP-SEEKING

Of the Vietnamese interviewed by Bertram, Flaherty and Everingham (1996), only19% perceived alcohol to be a drug (compared to 77% for the general population)[7], 26% viewed

[6] All comparisons from Bertram, Flaherty & Everingham (1996) need to be interpreted with caution- confidence intervals for the sample and NCADA survey data were not provided in the paper.

[7] Cao and Pham (2002) found 38% of their sample either did not think alcohol was a drug, or were not sure.

doctors as the priority source of information on drugs (compared to 52% for the general NSW population), and 11% viewed drug advisory centres as the primary source of information on drugs (compared to 27% for the general NSW population). Approximately one-quarter (26%) of the Vietnamese speakers did not possess knowledge of avenues for assistance with alcohol/drug related problems. Vietnamese were similar to the wider NSW population in reporting alcohol as the leading cause of fatalities attributable to drug use.

The Drug and Alcohol Multicultural Education Centre (DAMEC, 1992-97) compared Vietnamese to five other communities with a non-English speaking background.[8] In a preliminary report it was noted that Vietnamese preferred GPs to drug advisory centres for both alcohol and other drug information, and help. In terms of both information and help from a GP, the proportion of Vietnamese who indicated a GP for both information and help was the lowest among all other groups (Greek, Chinese, Arabic and Italian) except Spanish. For "Drug Advisory Centre" as an avenue to gain information or help, Vietnamese ranked lowest among all these groups.

The above studies suggest highlight the poor help-seeking behaviour of Vietnamese populations with a propensity for GPs and a lack of confidence and familiarity with alternative sources of help, such as telephone counselling. What type of GPs Vietnamese Australians prefers, such as whether or not they have a Vietnamese background, deserves further exploration.[9]

The Bertram study also provides some information on perceived problems held by Australian Vietnamese associated with excess alcohol use. For example: 61% of participants reported "domestic problems" as associated with "too much" alcohol intake; 78% of participants reported high-risk driving as an associated problem with "too much" alcohol intake; and 66% of participants reported harm to the liver as associated with the problem of "too much" alcohol intake. This is comparable to Cao and Pham (2002) who found that self-reported actual experienced problems with alcohol, such as drink driving, were common.

AMERICAN-VIETNAMESE POPULATIONS

Vietnamese Americans and the wider sub-group, South-East Asian (including Cambodia), have been studied less than Japanese, Chinese and Koreans, partly because the former sub-group is recognised as displaying different alcohol behaviour patterns to the other Asian groups (Makimoto, 1998). For instance, based on comparisons of mortality prevalence due to Cirrhosis it can be argued that Asian-Americans engage less in heavy drinking than Caucasians (Gardner et al., 1994, cited in Makimoto, 1998). However, prevalence of heavy drinking is higher in Southeast Asian-American males than in the wider US population of males (Amodeo et al., 1997; cited in Makimoto, 1998).

It is consistently found that there is large variation between ethnic groups on alcohol variables within a host nation (Caetano, Clark & Tam, 1998; Galvin & Caetano, 2003). Caetano, Clark and Tam (1998) reviewed alcohol epidemiology for various ethnic groups. They found that while

[8] DAMEC indicated that this project is still underway and data will be available at a later stage (see Appendix D for this and other contacts).

[9] Steel et al. (2004) found Vietnamese refugees consulted more with primary care physicians who spoke Vietnamese.

Asian-Americans overall tended to consume lower amounts, there were nevertheless numerous differences between Asian groups. However, Vietnamese patterns could not be discerned reliably from the behaviour of the other groups (e.g., Japanese Americans). It is also important to distinguish between raw proportions of alcohol use and the level of individual use. For example, Makimoto (1998) asserted that literature indicated that Southeast Asian males were a high risk group for heavy drinking. He cited (Amodeo et al., 1997) where it was found that the prevalence of binge drinking in Vietnamese American males was double that of the wider population, despite lower raw proportions.

Caetano, Clark and Tam (1998) found four models aimed at accounting for the generally lower rates of alcohol patterns in Asian Americans: (1) abstaining as a response to unpleasant symptoms such as flushing (a more common response in Asians), (2) the influence of cultural and religious values (e.g., harmony and moderation), (3) acculturation to American society, and (4) a coping mechanism for immigration-related stress.[10]

Kaplan et al. (2003) examined risk behaviour patterns in 783 adolescents of American-Vietnamese background in Vietnamese strongholds in California (Los Angeles, Orange, San Fransicsco and Santa Clara). Over three-quarters (77%) of the overall sample reported to not have ever tried alcohol in a substantive way (i.e., "more than a sip"). Males had experimented with alcohol more than females (Kaplan et al., 2003). Acculturation was measured as use of English in various modes (speaking, reading) relative to Vietnamese, with more use of English representing a higher score on acculturation. Interestingly an acculturation-risk behaviour profile link was found for females but not males. The authors suggested that this may be due to the faster pace of acculturation of females than males.[11]

A number of other studies made reference to Vietnamese populations, but this was merely for the purpose of comparisons them to other ethnic groups on drug-related indicators (e.g., Kaplan et al., 2003; Copeland, Toms, Chambers & Taylor, current). For instance, Galvin and Caetano (2003) summarized national US data comparing four ethnic groupings; namely, Hispanics, Blacks, Asian Americans and Native Americans. Asian Americans ranked favourably to the other groups in terms of Cirrhosis mortality (a condition associated with alcohol abuse), prevalence of Cirrhosis and chronic liver disease, and motor vehicle deaths linked with alcohol use.

Yee and Thu (1987; cited in Sowey, 2005) surveyed Indo-Chinese refugees in the US, 90% of whom were from Vietnam. In terms of experiencing "trouble" with alcohol or tobacco, 45% of the participants acknowledged problems some of the time and 8% all of the time. Also, 40% occasionally used alcohol as a response to personal problems (and 6% a lot, for this reason).

Compared to women from other regions, Asian American women have lower consumption levels (Gilbert & Collins, 1997, cited in Collins & McNair, 2002).

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[10] No detail will be provided here as it was not referring to the Vietnamese per se.

[11] It was unclear from the information given how much of the overall health risk profile was based on alcohol experimentation; however this form of risk behaviour was part of the profile. Acculturation was operationalised as use of the English language in various contexts (e.g., when reading, when with friends).

DISCUSSION

The literature suggests that Vietnamese Australians consume less alcohol and engage in alcohol abuse at a lower level than the wider population. However, there are at least four concerns here. First, the main evidence for this comes from the Bertram study which, while representative for NSW may not generalise to Vietnamese communities in other cities and states. Researchers have repeatedly noted the presence of variability in a non-English speaking background community across regions/localities/genders/ages within a country (Gutmann, 1999; Galvin & Caetano, 2003).

Second, there is the persistent issue of whether the measures used in prevalence studies provide accurate data on consumption patterns, given the multidimensionality of alcohol use and the high propensity in Vietnamese to be highly sensitive to du mat ("saving face"), where excessive drinking and associated behavioural problems are likely to be under-reported.

Third, the lower use of alcohol in Vietnamese Australians reported in the literature is incommensurate with the high prevalence of problems reported thus far through feedback from Vietnamese welfare agencies in Melbourne[12] and from a self-initiated community pilot study, which found significant self-reported affects of alcohol on the Vietnamese community (e.g., violence, losing one's job, drink driving and trouble with the law (Cao & Pham, 2002). Put another way, even if the raw proportions who use alcohol, and the typical level of consumption is lower in Australian Vietnamese, it is suspected that the consumption level-harm association could be as high or higher in Vietnamese than Australian communities with other backgrounds, especially with low help seeking behaviour. For instance, levels of consumption regarded as low, medium and high risk is gauged on the basis of epidemiological (overall) data. In the Cao and Pham (2002) study, while the average drinks per session were under four, which is not excessive according to prevailing guidelines, the reported associated harm was higher than anticipated, with over a quarter committing violent behaviour, around one in five experiencing legal transgressions, and one in ten reporting alcohol-related job loss (Cao & Pham, 2002). There is a need to examine whether there is a lower drink-harm threshold for those with a Vietnamese background, and if so, the reasons why.

Fourth, epidemiological data, while providing a broad comparison of ethnic groups, tends to gloss over important cultural and behavioural variations within cultures and the actual extent of harm associated with alcohol over-consumption. Overall comparisons neglect sub-groups that are at higher risk. For instance Cao and Pham (2002) found typical drink frequency and quantity per session was higher in females between 15 and 35 (3.4) than both males in the same age category (2.9) and females in the older age categories. Importantly, females are more likely than males to be more vulnerable to the same alcohol consumption level due to biological differences, such as alcohol metabolism rates (Collins & McNair, 2002).

In light of these issues it was important to review research on the interface of Vietnamese culture and alcohol.

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[12] For instance, a drug counsellor from the Australian Vietnamese Women's Welfare Association has informally reported a disproportionately high demand for services by clients who are engaged in drink driving. It should be noted that the Cao and Pham (2002) study adopted a small sample size (n=62) and was non-random.

CULTURE AND ALCOHOL USE

The cultural significance of alcohol-related behaviour has been studied in various fields, including sociology and psychology (counselling). Broadly put, this research literature suggests that systematic variations in alcohol and associated risks are a function of a dynamic interplay between social-cultural factors in the host country and country of origin, including values, social norms, gender-defined familial roles and acculturation processes. These factors may interact with socio-economic (employment status, income, education), biological (Collins & McNair, 2002) and situational effects (Alaniz, 1998). While all these factors are important, it is acknowledged that a critical part of any research on 'ethnic' communities in a host country is an examination of the cultural context of the peoples within those communities (e.g., a combination of where they have come from and their ongoing life in Australia). Regarding issues of alcohol use:

> "The cultural context, or the set of beliefs, norms, and values used and transmitted among a group of people, shapes the social norms and interpersonal interactions that ultimately facilitate or constrain drug use." (Unger et al., 2004, p.1780):

While cultural issues will be the focus of this review, factors relating to biology and place will also be examined briefly.

SOCIAL RELATIONS IN TRADITIONAL VIETNAMESE CULTURE

Consistent with other south-east Asian backgrounds, the family unit is integral to Vietnamese culture. The structure of the family unit and wider social relations are guided by religious principles such as Confucianism (Bui & Morash, 1999).

Within traditional Vietnamese culture there is general view of subservience of women to men and this holds for the family power structure where the father is dominant and financially provides for the family (Nghe, Mahalik & Lowe, 2003). These intra-familial relations can change; for instance, the mother taking on employment, thereby diminishing patriarchy as held by the husband (Nghe, Mahalik & Lowe, 2003). Children are normally expected to be respectful and obedient, which includes accepting and non-challenging of family relations; and obligations are not restricted to the early adult years as is found in Western families (Ali et al., 2000). Parents hold high expectations of their child(ren) and equally feel responsible for their child(ren)'s progress and wellbeing throughout the child(ren)'s lifespan (Ali et al., 2000).

The primary religions in Vietnam are Confucianism and Mahayana Buddhism, with minority Hoa Hao, Cao Dai, Catholic and Protestant followings, and the non-religious. As will be discussed, researchers and practitioners argue that these and other cultural aspects have far reaching implications in relation to alcohol use, help-seeking, and the nature of participation in research.

Potential protective and risk factors in Vietnamese cultures

Certain religious principles, if committed to, may provide a protective role. Yee and Thu (1987; cited in Sowey, 2005) suggest that as far as alcohol consumption leads to a loss of behavioural control (in contrast to moderation as valued in Taoism), alcohol use does not align well with this

value. However, there are certain aspects that may prevent solutions to problems being found once they have occurred. For example, in Taoism, endurance and resilience of hard times is an ideal trait (Tung, 1985, cited in Nghe, Mahalik & Lowe, 2003), and in this context problems due to drugs may (or should) be tolerated.

Certain cultural practices, such as strict parenting and "restrictive gender roles" may work against the adoption of alcohol consumption, for instance, by limiting time with friends and subsequent exposure to alcohol (Rissel, McLellan & Bauman, 2000).

VIETNAMESE CONCEPTUALISATIONS OF "DRUG", "ALCOHOL", AND "DRUNKENNESS"

The meaning of drug and other alcohol-related concepts (such as drunkenness) are socially constructed (cf. Unger et al., 2003). Therefore caution must be taken in including alcohol in Vietnamese personal conceptions of "drug". Vietnamese may not view alcohol as a drug, just as they do not necessarily see beer as "alcoholic". This was supported by findings in the Bertram, Flaherty and Everingham (1996) study: 19% of those with a Vietnamese background acknowledged alcohol as a drug compared to 77% of the wider population.

Consequently, it is difficult to generalise research on illicit drug use to alcohol use in Vietnamese Populations because of the contextual differences (e.g., legality of use, perception as not a drug). However, certain acculturation issues are also worth mentioning from this literature. There is empirical evidence that level to belongingness and support from the original culture for adolescents may serve as a protective factor against drug-related problems (Unger et al., 2004). In addition, within a rational-choice model, cultural values that deter drug use, no matter what their origin, are valuable to the individual in the event of a drug use opportunity in that they provide readily-available reasons why the drug should not be used (Unger et al., 2004).

There may be stigma attached to drug use and in particular 'harder' drugs (Ali et al., 2000). It is not clear though whether a negative stigma also applies to alcohol. It may be useful to explore whether people of Vietnamese backgrounds view alcohol as a type of drug and within what family contexts it is seen in a negative fashion.

ALCOHOL USE AS A COPING STRATEGY

In the stress paradigm (e.g., Folkman & Lazarus), the analysis centres on the discrepancy between demands and coping resources, whether they be intra-individual (e.g., problem-solving skills) or external (e.g., social support) (Unger et al., 2004). In this context alcohol and other drugs are used as a (potentially maladaptive) coping mechanism or as a reaction to over-stress. The interface of acculturation and stress paradigms is the concept of "acculturative stress", which has numerous sources, including the demands of picking up a new language and learning new ways of relating socially (Unger et al., 2004). In general, self-perception of inability to deal with acculturative stress is thought to lead to a reliance on drugs as a form of coping (Unger et al., 2004).

The literature on Vietnamese Populations has tended to focus more on refugee experiences and associations with mental illness and drug use, than on alcohol use.

Refugee Experiences and Stress

Refugees deal with a wide range of challenges including a rapid change in life circumstances, the absence of discretion over where one will end up, over rallying of resources needed to adapt to the new place, and traumatic experiences. Refugees are known to be subject to a higher risk for a range of mental health disorders, and in particular Post Traumatic Stress Disorder (PTSD; see Sowey, 2005). PTSD is associated with substance abuse, including alcohol abuse, where the primary reason among refugees may be as a form of self-treatment for PTSD symptoms (see Sowey, 2005). Various studies note that PTSD and depression are common in Southeast Asian Americans, who may be at greater risk for alcohol abuse (see Makimoto, 1998).

Vietnamese men may see alcohol as a form of self-treatment and recuperation (Amodeo et al., 1997; cited in Makimoto, 1998). As PTSD and other illnesses are common in American Vietnamese men, over use of alcohol for this subgroup is suggested to be due to it serving as a means for relief and forgetting traumatic experiences (see Makimoto, 1998, p.273).

Findings in US studies, however, may not apply to those of Vietnamese background in Australia. Silove et al. (2005) found rates of depression, anxiety and substance use disorders to be lower in Vietnamese Australians than in the general population for NSW, although the typical resettlement period reported was just over a decade (11 years). This finding may demonstrate the mental resilience of Vietnamese refugees in Australia (Silove et al., 2005) and that claims that refugees are a potential burden on health services in Australia are false.

Given the excessively high psychosocial problems that young Vietnamese coming to Australia are likely to experience, it was envisaged that they would demonstrate higher crime rates than the general youth population (Easteal, 1989). However, the opposite was found; younger Vietnamese refugees (10-24 years of age) in Australia were found to participate in crime at lower rates than the general youth population (Easteal, 1989).

Reference has been made to the resilience (and high adaptiveness) as a virtue of Vietnamese particularly in the context of hardship experienced through migration.[13] This resilience is considered one factor that can account for lower reliance on alcohol and harder drugs by those with a Vietnamese background.

ACCULTURATION

A key notion in the sociological literature is that over time since the point of arrival in a new country, immigrants adapt and fall into line with the host country's mainstream culture. Rissel, McLellan & Bauman (2000) adapting Cortes, Rogler and Malgady (1994) describe acculturation as: "the process through which migrants and their children acquire the values, cultural norms and attitudes of the host society" (p.146). This is one of numerous definitions of acculturation, in which 'process' is a common element. However, measurement of acculturation varies widely, and generally adopts rather static indicators. Measurements range from the number of generations a family has been in the host country (cf. Makimoto, 1998) to psychological states (e.g., attitudes).

[13] For an in-depth account of resilience in a Vietnamese family, including refugee journeys and stories of acculturation, see Elliot (1999).

While immigrants bring with them the cultural practices of their country of origin, these are likely to be affected (for better or worse) by the cultural orientations in the host country. For instance, Bertram, Flaherty and Everingham (1996) argue that there is the potential for Vietnamese immigrants to adopt the mainstream culture's orientation to alcohol and other drugs and corresponding higher intake of alcohol. Substance use is presumably partly dependent on the extent of acculturation, particularly among younger migrant members (Rissel, McLellan & Bauman, 2000). As younger people are more vulnerable and more receptive to acculturation, they become more acculturated and, in the Australian context, engage in substance abuse to a greater degree (Rissel, McLellan & Bauman, 2000). This can be contrasted with Easteal (1989) who, commenting on the (unexpected) lower rate of crime among young Vietnamese refugees, concluded that:

> "The process of acculturation is neither quick nor complete, particularly for refugees who continue to have strong ties to kin back in Vietnam. One's movements in a small ethnic community are not anonymous and are well-known both within the community and to family elsewhere. Thus the cultural values brought to Australia may well be keeping criminal activity down. The loss of 'face', the identity and loyalty of the individual to the family might promote conformity and/or act as a strong deterrent to those who have been arrested once."

Acculturation Modes for Australian Vietnamese

Acculturation was initially characterised as an all-or-nothing outcome, however, a mass of further research has produced more sophisticated conceptualisations and corresponding measurement tools. In general, the literature has tended to adopt a multidimensional model of acculturation where an individual can be appreciated to retain or abandon various dimensions of both the homeland culture and culture of the host country over time. Most recognised is Berry's model which focuses on the psychological aspects of acculturation. The model consists of four patterns of acculturation: (1) integration, where both host and origin cultures are valued and engaged in, (2) assimilation, where the host culture is adopted as a replacement for the original culture, (3) separation, where involvement in the original culture continues and no inroads into the host culture are made, and (4) marginalization, where neither cultures are valued or committed to (Unger et al., 2004). Berry's taxonomy, adapted for the interests of the current project, would be realised as in Table 2.

Table 2. Berry acculturation model applied to Vietnamese Australian communities.

		Vietnamese Culture	
Australian Culture	Level of adoption	High	Low
	High	**Integrated (Bicultural)**	**Assimilated**
	Low	**Separated**	**Marginalized**

Note: Adapted from Unger et al. (2004).

Acculturation: Conceptual Limitations

Gutmann (1999) provides a critical perspective of acculturation and in particular, in relation to alcohol behaviour. He outlines four "misconceptions" underlying the notion of acculturation (paraphrased as follows): (a) alcohol consumption pattern change is exclusively due to US culture, (b) the country of origin has no influence and culture-specific patterns are essentially homogenous, (c) the rule is for a reduction in "ethnonational identification" and (d) that the unidirectional trajectory models of migration prevail (at the expense of more dynamic multi-trajectory models). According to Gutmann (1999), underlying these misconceptions is the perennial problem that conceptualisations, theories, operationalisations and subsequent policies are oversimplified at the expense of providing outcomes counter to the well-intentioned efforts to reduce alcohol use (Gutmann, 1999). While the simplifying process has a political dimension, it is also driven by psychology of both researchers and their participants (Gutmann, 1999). The very conceptions and stereotypes embedded in research and practice itself can shape the self-perceptions and views of the target group; for instance, beliefs regarding one's propensity to alcohol on the basis of one's ethnicity and country of origin (Gutmann, 1999). Clients themselves hold beliefs about their drinking that are linked to their country of origin; for example, e.g., "my people are highly tolerant to lots of alcohol" (Gutmann, 1999).

In terms of the current project, in view of Gutmann (1999) the term acculturation is problematic and unnecessarily simplifies our understanding of local Vietnamese communities. Unidimensional trajectories discussed thus far herein (Bertram, Flaherty & Everingham, 1996; Easteal, 1989; Rissel, McLellan & Bauman, 2000) reflect the sort of simplification that Gutmann warns against (1999).[14] Critically, there may be no standard acculturation process and there are problems with assuming homogeneity for within cultures and for sub-groups, such as female/male, migrant/refugee (Gutmann, 1999). Others note that complexities in the acculturation process include recognition of within-country regional differences in drinking cultures and norms (Galvin & Caetano, 2003).

These points draw attention to the multi-cultural makeup (cf. Unger et al., 2004) of Australia. For example, it is not quite correct to describe communities in Melbourne as one "host culture". Given this, the cultural influences underlying social networks among Vietnamese participants may require some attention. Overall, it is unclear what acculturation processes the communities are experiencing and whether there may be a clear acculturation process, perhaps dominant in the community, that may be associated with alcohol over-use.

Given these complexities, nevertheless, the initial distinction between status of arrival (refugee vs. migrant)[15] and generation (born overseas or offspring of migrant) is useful.

Challenges in adaptation of Vietnamese families to new places

The dynamic of parent-child relationship can change markedly as a function of acculturation rates of parent(s) and child(ren). The paternal role of parents is to an extent, switched when the children pick up the language of the new country faster. Generally, they are better able to

[14] In defence of those authors, however, the writing conventions for journals (particularly those in epidemiology) can limit opportunity to provide a complex account of cultural processes and their relation to behaviour.

[15] For instance Nghe, Mahalik & Lowe (2003) highlight the need to consider the wave of migration and its context (e.g., vocational skills of the migrants).

address daily practical issues, whereby the parents become more reliant on their children on everyday matters. Parents, perhaps by virtue of their older age, are less rapid at picking up the new country's culture. Hence, changes in power relationships may be common in Vietnamese immigrant families and these changes may be a source of family conflict and distress (Kegler et al., 2005).

Kegler et al. (2005) reviewed different forms of identity conflict experienced by American Vietnamese youth. For instance, a tension may be experienced between acting as an American and satisfying one's parents. Overall, Vietnamese youth need to connect with both homeland traditional and the new culture (Kegler et al., 2005), although the means to do so are probably multiple.

Nghe, Mahalik and Lowe (2003), as part of an integration of literature on Vietnamese migration, describe what may also be a typical family dynamic in Vietnamese Australian families: Vietnamese men hold high expectations of better serving their role in the family through anticipation of more opportunities in the US. The inevitable disappointment with actual opportunities, coupled with the lowered success at meeting the role, signified (among other developments) as the wife taking up employment to help make ends meet, in turn leads to a threatening of the patriarchal and hierarchical makeup of the family. These dynamics create tension between the couple, the children and the couple's parents with potential for both benefits and harms. However, a common outcome is that these tensions create distress among family members, which when added to the usual excessive pressures experienced as part of adaptation to a new place creates substantial challenges (Nghe, Mahalik & Lowe, 2003) that are important to understand in relation to alcohol.

Cao and Pham (2002) found quite high consumption per drinking session for young women questioned (ages 15 to 35), elucidated by the Management Committee for the current project to be:

> "….indicative of a cultural divide within the Vietnamese community between generations, particularly in regard to gender around those who migrated as adults from Vietnam and those who grew up in Australia." (p.14).

The US literature touches on the issue of generational distance; children may encounter value conflict, most notably finding appeal in certain elements of US mainstream culture (e.g., less perceived constraints on behaviour) and potential distancing from parents' which the parents would like the child(ren) to sustain commitment to. Child abandonment of the homeland culture then may serve to accentuate the perceptions of failure of the father who is expected in the culture (more so than the mother) to confirm the culture in the children.

Acculturation Measures

Numerous measures of acculturation have been developed (e.g., Ward & Rana-Deuba, 1999), including measures tailored for American (e.g., Nguyen & von Eye, 2002) and Australian

Vietnamese (Marino, Stuart & Minas, 2000).[16] Studies suggest that the self-perceived mode changes developmentally and is ongoing (Unger et al., 2004). Overall, at least for studies of adolescents, there is a consistent relationship between level of acculturation to US culture and drug use (Unger et al., 2004).

Independent and Interactive Effects of Socio-Demographics and Other Factors with Acculturation

Other important factors associated with acculturation were discussed in the literature. These are summarized below:

Ali et al. (2000) suggest that unemployment may be a risk factor for drug use; unemployment in Vietnamese communities is higher than in the wider population. Unemployment was a major concern among Vietnamese-speakers in Sydney (Bertram, Flaherty & Everingham, 1996).

Makimoto (1998) urges caution in attributing drinking patterns in an immigrant Asian group to acculturation processes; socio-demographic confounds, including age, education level and SES are likely and are difficult to examine for small samples found in this research area.

Ryder (2003) found a consistent pattern in the literature; namely, the longer migrants resided in the new country, the more the causes of mortality reflected the pattern witnessed in that country. Ryder (2003) argued that a possible pathway was behavioural; in this case, the "convergence" of migrant alcohol and cigarette use with the host country and associated matching of mortality outcomes with these lifestyle factors. The convergence prediction for alcohol and cigarette consumption was supported for male migrants, but not for female migrants.

Australian studies suggested that examination of drug use in Vietnamese migrants required consideration of experiences with racism and marginalisation (Ali et al., 2000; see Higgs et al., 2001; also Mellor, 2004). In relation to drugs, was the highly questionable stereotype (delivered, for instance, through mainstream media) the use of heroin and associated crimes of young Vietnamese (Ali et al., 2000).

The reasons for alcohol use may be separate from any acculturation process and be about dealing with experiences in the host country. For instance, Morgan et al. (1984, cited in Makimoto, 1998) reported that South East Asian youth who are relatively new to the US used alcohol and other drugs as a means to "forget their past".

ALCOHOL USE AS SYMBOLIC BEHAVIOUR: IMPLICATIONS FOR ACCEPTABILITY

Room (2005) suggests other developmental trajectories take place that need to be viewed from a theoretical framework where the symbolic significance of alcohol intake and other behaviours is considered. Abstinence or further endorsement of alcohol intake is dependent on the cultural significance of this behavioural domain relative to other cultures (minority and mainstream) operating in the host country (Room, 2005). These expressions, whether conscious or not, are exhibits to various audiences (such as the host culture) of difference or similarity, where

[16] The study by Nguyen and von Eye (2002) on Vietnamese American adolescents, using Cofirmatory Factor Analysis found Berry's (more complex) bi-dimenional model was more valid than the traditional acculturation model.

behaviours such as alcohol intake are tools marking levels of power (in the case of possession and use of a substance) and group identity. Depending on the context, the process of ethnic identity expression may result in either strengthening of alcohol consumption habits or even cessation. What is important is that attention is given to the symbolism of a domain of behaviours (as indicator of social activity, power etc.) that is separate from influences on behaviour that represent a giving in to or vulnerability to pressures associated with adapting to a new culture and place, and acculturation processes (Room, 2005).

A noteworthy process by which alcohol use can be exacerbated is when the social group has alcohol use as part of its assigned identity, but due to their marginalization (such as in terms of power) seek to enhance that mark of identity as an expression of difference. "Expressive power" (Room, 2005, p.326) is all the group may have in such situations and will therefore use that cultural resource fully. Overall, whether a given social group sees alcohol consumption (such as intoxication) as a problem – both at the individual and the community level – is affected by the symbolic function of the behaviour relative to the other cultures operating in the host country (Room, 2005).

GENDER, CULTURE AND ALCOHOL

The following are observations of cultural dimensions for males and females in the context of Vietnamese who have moved to the US. However, there is no reason why the points that follow would not apply to Australian Vietnamese communities. In Vietnam, Australia and the US it appears that men drink alcohol more than women do.

Males: the bonding ritual of nhau

A ritual among social gatherings of Vietnamese men that is "indigenous" and unique to Vietnamese is the practice of "nhau", the behavioural essence of which is binge drinking (Nghe, Mahalik & Lowe, 2003). Nhau is argued to serve a number of functions for males including an opportunity to express masculinity through the act of drinking and exhibiting tolerance to alcohol, as well as an opportunity to share experiences and be more emotional than would usually be the case with other men or in any other social context (Nghe, Mahalik & Lowe, 2003). Nhau transcends socioeconomic status and is (traditionally) seen to be accepted by women, however, only men participate (Nghe, Mahalik & Lowe, 2003). Women are expected to tolerate nhau as it is a form of reward for men for meeting his role as the family provider (Nghe, Mahalik & Lowe, 2003). Nhau provides one of few traditional opportunities for men to attain emotional and practical support from other men (Nghe, Mahalik & Lowe, 2003). They are not likely, traditionally, to seek support, such as on private matters, on a regular basis with their wife or other women (Nghe, Mahalik & Lowe, 2003).

There are various aspects of nhau that makes it a promoter of excessive drinking. Not only is it socially accepted, including drinking to the point of drunkenness, but there is the potential for losing face among women if men do not consume alcohol or are sensitive to it (Nghe, Mahalik & Lowe, 2003). Nhau demonstrates the impossibility of refraining from drink in certain social contexts shaped by collectivist (Vietnamese) values, where one is obliged to fill other's glasses as one's own is always filled, and men must take turn at hosting nhau (Nghe, Mahalik & Lowe, 2003). Furthermore, there are no negative connotations tied with nhau – or initiated drunkenness (Nghe, Mahalik & Lowe, 2003).

In terms of these, nhau illustrates well the challenges of trying to untangle benefits from costs of problem behaviour when it is embedded in a particular socio-cultural practice. Thus, a dilemma posed is that reducing the practice in order to decrease alcohol-related risks to health would arguably undermine this source of male support. However, alternative forms of male support may be provided through community services.

Nghe, Mahalik and Lowe (2003) argue that nhau can become problematic when outside Vietnam. While alcohol and its variants (such as rice wine or rieu chat) is always affordable in the homeland (cheap beer or bia hoi), it is more financially sapping in other countries, with the potential to financially affect the wider family. In addition, the stress of acculturation and other stressors associated with adapting to the new country proximal to arrival can lead to a potential over-reliance on nhau as a coping strategy in men (Nghe, Mahalik & Lowe, 2003).

The higher prevalence of alcohol consumption of men compared to women in Australia may partly be explained by the traditional (gender-exclusive) role of nhau for males. More research is needed as it is not apparent from research if nhau is practiced in Australia, or some hybrid practice among Vietnamese Australian males. Important in this respect, Makimoto (1998) notes that Asians who have immigrated may not be the same in cultural practices and corresponding drinking patterns as those who remain in the homeland. Further research may explore whether the acculturation process to mainstream Australian culture, which is characteristically pro-alcohol[17], sustains such drinking habits as found in nhau (or may well even enhance them), or whether acculturation may help break down the practice of nhau. For instance, as far as drinking is an expression of ethnic difference from the mainstream culture, Vietnamese Australian men may have an underlying motivation to abstain from alcohol (Room, 2005). Research is needed on how males negotiate challenges to self-identity and traditional roles in the Australian context, and how men may be supported in coming up with decisions that promote family wellbeing. Tallying the range of problems that may arise when nhau is practiced outside Vietnam, there is the possibility that it may significantly affect Vietnamese Australian families and communities.

Females

The reasons for lower consumption of alcohol in females (Bertram, Flaherty & Everingham, 1996; Rissel, McLellan & Bauman, 2000) are yet to be ascertained. Potential explanations include: (a) a faster pace of acculturation by females (Kaplan et al., 2003), (b) female avoidance of alcohol initiated by aversive biological responses, such as facial flushing and headaches (Caetano, Clark & Tam, 1998, described below), and (c) engagement in nhau by males alone (Nghe, Mahalik & Lowe, 2003). Collins and McNair (2002) noted other vulnerability factors (for Vietnamese and other women) including more regular experience of negative affect, risk of sexual abuse and other aversive events, and protective factors including alcohol avoidance during pregnancy and domestic demands limiting opportunities to drink.

Cao and Pham (2002) found that younger females may be an at risk group, similar to other Australian young women. There was no other age-gender data reported in the literature or discussion of why this subgroup may consume more drinks per session. The Cao and Pham

[17] For instance, a national Australian survey found 81.4% of males and 68% of females approved of personal regular use of alcohol; over-50% proportions were evident for all age groupings within each sex (AIHW, 2002).

(2002) data (see summary tables) may suggest that higher drinking per bout is associated with the perception in females between 15 and 35, that they are not encountering "problem drinking".

Facial Flushing and Alcohol Avoidance

Research has found a good proportion of Asian American women experience facial flushing and a cascade of other bodily responses, such as headaches and sweating, all attributed to the expression of inactive aldehyde dehydrogenase (ALDH2-2; Collins & McNair, 2002; also, see Makimoto, 1998, p.274). ALDH2-2 is found in roughly a quarter to one half of Asians (Lieber, 2001, cited in Collins & McNair, 2002). Severity of the flush response varies among females. While males also can display flushing, women are more likely to react adversely to it, as it may be a source of embarrassment (Collins & McNair, 2002). Nevertheless, this genetic factor may play a protective role for both sexes. Alcohol consumption has been found to increase as a function of ALDH2-2 salience (one, two or three copies per person; Wall & Ehlers, 1995, cited in Makimoto, 1998). The claimed moderative effect of sex may be due to embarrassment of flushing for females (and subsequent avoidance of alcohol), but not for males (Parrish et al., 1990, cited in Collins & McNair, 2002).

HELP SEEKING BEHAVIOUR AND PARTICIPATION IN RESEARCH

Support is valued within socialisation for Vietnamese, including through extended family (Nghe, Mahalik & Lowe, 2003), however this may be conditional on the form of support and type of problem[18]. Vietnamese seem to display a reluctance to approach service providers and preference for family and more informal networks. Unrestrained use of drugs is one type of problem that Vietnamese families are likely to prefer to deal with internally in order to avoid attention that "brings shame on the family name" (Ali et al., 2000, p.viii). Seeking services, at least in the context of illicit drug use, could even be interpreted as betrayal by the victim's family/community (see DHS, 2002).

Vietnamese cultures differ from western cultures broadly in terms of being less prevention focused. For example, Vietnamese tend only to focus on alcohol/drug intake as an issue, upon the onset of aversive symptoms for health-related or other problems (See Bertram, Flaherty & Everingham, 1996; DHS, 2002). This is consistent with people of non-mainstream cultures more generally and help may not be sought until the drug-related problem has reached a crisis (DHS, 2002). Similarly, harm minimisation is a concept foreign to traditional Vietnamese culture. Ali et al. (2000) found that those of Vietnamese background residing in Adelaide struggle with the concept of harm minimisation, both in relation to drugs and as a more general life orientation. This was echoed in Melbourne (Manning, 2003), although community leaders and professionals had greater understanding and support of harm minimisation.

Unwillingness may be even higher for use of counselling (Ali et al., 2000). It is unclear whether western models of drug-related counselling are effective for people from non-western cultures. For instance, assertion of personal problems and ways to deal with them may not be a behavioural and cognitive repertoire that clients may be familiar with or use (DHS, 2002).

[18] Again, major sources of support may involve social activities that include a high consumption of alcohol (Nghe, Mahalik & Lowe, 2003).

In a Melbourne study of the support needs of parents of five ethnic communities in the City of Greater Dandenong, Manning (2003) found that Vietnamese parents typically struggle in isolation when a child has a drug problem. She argues that the notion of seeking help can be foreign for extended family affected by the drug use of a loved one in Vietnamese communities. Fear of exposure and a lack of trust around confidentiality maintain this stance, and people are sceptical about the effectiveness of services.

The following is a statement from an American Vietnamese community youth program Leader, who was asked to provide advice (through a research interview) for future program designers:

> Be persistent and…..Vietnamese people are very reserved and if they have problems or if they're sick, they are not going to come out and tell you. They're not going to run for help. You have to come and approach them and just be available when they need you (Kegler et al., 2005, S77).

Ali et al. (2000) investigated the use of opium and heroin in those with Vietnamese background in Adelaide, and touched on the need for access of research through community members:

> The Vietnamese community is not an easy community for researchers or service providers to gain access to, particularly if they try to approach the community without a sufficient understanding of cultural issues unique to the community. Considerable time is needed to establish credibility and develop trust. Drug users in the Vietnamese community do tend to be wary of researchers and service providers, as they value their anonymity and privacy. For drug user interviews conducted for this project, it was found that injecting drug users were reluctant to come forward for interview, except in cases where there was a pre-existing relationship with someone from within the community (p. vii).

There may be a lack of efficacy not just in drug users but more broadly. Ali et al. (2000, p.viii) report that:

> The interviews showed that members of the Vietnamese community, both in general and within health and welfare agencies, do not feel confident of their ability to deal with alcohol and other drug issues.

Confidentiality Issues

The language barrier can play a role in misunderstandings regarding confidentiality (DHS, 2002). Anxiousness regarding other's awareness of one's drug use was also found to be highly salient in Vietnamese interviewed in Adelaide (see Ali et al., 2000). As Vietnamese communities were relatively small and more closely knit in Adelaide, there were heightened concerns regarding loss of anonymity when opening up about one's drug use to one's peers and to services (Ali et al., 2000). A community worker also noted the need for anonymity as a motivation including avoidance of contact with those of a Vietnamese background.

> One worker supported the view that the use of mainstream services provided a greater feeling of security among Vietnamese patients - there was less risk of the

patient running into the counsellor, doctor, nurse or receptionist when walking down the street. It was felt that many Vietnamese people would prefer not to see a Vietnamese counsellor for drug-related problems. This feeling was reinforced by a young person who said 'I feel uncomfortable talking about drugs to an Asian person' (p.41).

EFFECTS OF PLACE: EXPOSURE TO FACILITIES AND ALCOHOL ADVERTISING

A limited number of studies demonstrate place effects that may operate independently of other factors examined in this literature review. These independent effects are important to understand as they challenge views that alcohol is due to ethnicity associated 'weaknesses' (cf. Alaniz, 1998). Any behaviour patterns tied to a particular ethnic group needs to be demonstrated to operate at least independently from co-relating factors (e.g., a significant predictor after controlling for place). Alcohol outlet density, the number of bars and other facilities where alcohol can be purchased, seems to vary systematically with ethnicity makeup of an area (Alaniz, 1998). Density is likewise associated with exposure to advertisements for alcohol and opportunities to drink 'on site'. This is important as alcohol outlet density is associated with increased alcohol consumption prevalence[19] and problems such as alcohol-related violence. Alaniz (1998) reviewed the limited literature available to show a common trend of alcohol outlet density maximising in communities characterised by low income levels and composed of ethnic minorities (e.g., Vietnamese). It may be that particular disadvantaged sub-groups of the American population are targeted by the alcohol industry.

DISCUSSION AND CONCLUSIONS

Implicit in the peer-reviewed literature, most notably in Bertram, Flaherty & Everingham (1996), is the notion that excessive alcohol use is not a major problem in Vietnamese Australian communities.[20] This is challenged by the local study (Cao & Pham, 2002), anecdotal evidence from community leaders in Melbourne, the potential presence of traditional Vietnamese practices such as nhau (or acculturated variants of this practice), and assertions that men with a Vietnamese background engage in more binge drinking than the general population in other countries (e.g., the US; Amodeo et al., 1997, cited in Makimoto, 1998).

The most definitive prevalence study in Australia was that conducted by Steel et al. (2004) who found DSM-IV Alcohol Use Disorder to be significantly lower among Vietnamese refugees in NSW than in the general NSW population.

Some consistent findings and views arise out of the literature review. These are:

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[19] In line with research on automaticity - alcohol use following exposure to cues may be direct, that is, bypassing any conscious-choice making by the individual (Bargh & Chartrand, 1999). Instead, the cue may activate cognitive representations (e.g., self-concept that include alcohol use as an attribute) that in turn lead to alcohol seeking.

[20] Bertram, Flaherty & Everingham (1996) do acknowledge that their findings can only be generalised to the Vietnamese communities in Sydney. Another issue is that this study is of course outdated- community level prevalence levels can change over time.

- Vietnamese Australian males tend to drink more alcohol than Vietnamese Australian females (Rissel, McLellan & Bauman, 2000) and these sex differences are also observed in the US (Kaplan et al., 2003).
- General practitioners are reported to be a source of information and persuasion to change among Vietnamese Australians (Ali et al., 2000; Bertram, Flaherty & Everingham, 1996). It is unclear, however, whether this only applies to GPs situated within Vietnamese communities.
- On the basis of disparate sources, it can be claimed that Vietnamese prefer informal networks for assistance with alcohol-related problems instead of accessing drug services (Drug and Alcohol Multicultural Education Centre, 1992-1997; Bertram, Flaherty & Everingham, 1996), where a lack of trust is one issue (Ali et al., 2000; p.7). For instance, "Vietnamese and other Indo-Chinese community groups appear to share a reluctance to discuss issues such as drug use or mental health problems with people outside the family structure or the network of traditional healers."

These issues are part of a wider position in the literature for which there is generally consensus: the ultimate ability to approach, connect (e.g., gain trust) and assist Vietnamese and other "ethnic" groups essentially requires an understanding of their socio-cultural context and interventionists who are themselves members of that community (Ali et al., 2000; Kegler et al., 2005; Nghe, Mahalik & Lowe, 2003; Unger et al., 2004). Furthemore, the philosophy and concerns of the current project resonate with the perspective and findings of previous projects focusing on Vietnamese in South Australia (Ali et al., 2000) and NSW. The findings of this study are likely to be informative to service providers in the other states.

Nevertheless, there are large gaps in understanding of the needs of Vietnamese communities in respect to alcohol, limiting the health care system and the more immediate community's capacity to intervene effectively. Salient concerns with other's in one's own community being aware of one's drug-related problems is clearly an issue, although the preference reported for non-Asian health workers was for issues of heroin dependence (Ali et al., 2000). It is unclear whether this would also apply to alcohol (does this count as a drug to Vietnamese Australians?) and in this way the background of interviewers in the current project.

In relation to alcohol, there appears to be an absence of dialogue on methodology, such as the cultural appropriateness of the questions and what researcher/interviewer-community relationships are most likely to collect valid data. Clearly, meticulous care is needed in the wording of questions regarding alcohol and its use (e.g., drunkenness). Without the development of sound (culturally-tailored) measures through the kind of study to be proposed, the true prevalence of alcohol dependence and subsequent harms to individuals and communities will never be known and evidence-based responses never implemented.

It is not well understood what acculturation trajectories Australian Vietnamese take. Whether acculturation of Vietnamese Australians leads to increase or decrease of risk is highly conditional, with need for consideration of the culture and risk profile changes over time. There are numerous intra-individual and interpersonal factors (Unger et al., 2004). These dynamics may be difficult to unpack through statistical analyses alone. Findings from Ali et al. (2000) suggest it may be fruitful to include in the project, an assessment of Vietnamese community

worker needs, competencies and concerns in relation to alcohol-related problems in Vietnamese clients.

In terms of the volume of peer-reviewed research on alcohol patterns in Vietnamese communities, Australia is unjustifiably far behind the US. The current project includes program attributes, such as use of Vietnamese speaking interviewers, qualitative design towards development of a survey and a deeper understanding of the problem, and interpretation of results (Kegler et al.,2005) - that arguably represent best practice in this area.

Consequently, the literature review firmly establishes that there is an urgent need for a multi-method study targeting older youth and adults of Vietnamese background who reside in Melbourne and that the current project will provide the first substantive data base on alcohol-related variables for this population.

STAGE ONE

Stage One of the project involved focus groups and individual interviews with twelve members of the Vietnamese community (aged 16 years and older). The aims of Stage One of the investigation included identifying typical rates of alcohol consumption across different age groups, obtaining a formative understanding of the types of problems associated with alcohol and drug use and identifying the social and cultural context of drinking within the Vietnamese community. Data from interviews informed the development of the questionnaire used in Stage Two, and also provided more detailed and personal examples of the issues related to alcohol use within the Vietnamese community.

Recruitment for the focus groups occurred at a range of locations to ensure a diverse range of participants, including those who did not identify as having problematic alcohol and other drug use, and those who were accessing treatment services due to their consumption patterns or related problems. Interviews and focus groups took up to one hour each and a thematic analysis of the data was conducted.

Interviews and focus groups were completed and coded with a view to developing categories of responses concerning perceptions of alcohol use in the Vietnamese community, cultural issues and help seeking behaviours. Five main themes were found:

- Drinking alcohol is a common social activity or in social context such as celebrations and Asian drinking parties.
- Participants held the perception that 'clubbing' and getting drunk go hand in hand. Going to the pub seems to be generally encouraged by Australian friends.
- Cultural issues were raised such as:
    - Vietnamese males drink more than females, and older women do not drink.
    - Domestic violence or verbal abuse due to drinking was mentioned several times, especially if a wife tries to limit her husband's alcohol intake.
    - Flushing seems to be more associated with the older generation (e.g. "Usually, the older crowd stop drinking when they are very red in the face").
- Asking for help is not usual in the Vietnamese cultural because consuming alcohol is seen as 'normal'. It's not in line with the image that Vietnamese people try to portray (i.e., proud, upholding reputations, respecting others and "sharing family problems is taboo"). Participants also raised the issue of the lack of language specific services.
- Cultural values were also raised such as the importance of:
    - Maintaining a good reputation
    - Don't drink and drive
    - Importance of maintaining control over actions and degree of drinking
    - Importance of not speaking 'nonsense' (e.g. "Drinkers waste time talking nonsense" and " … make nonsensical points")

STAGE TWO

Stage Two of the project involved developing and administering a survey to over 1000 people (men and women aged 16 and older) within the Vietnamese community using a number of paid Vietnamese Research Assistants (men and women of various ages).

Participants

The sample consisted of 1080 male and female Vietnamese participants aged 16 years and older. There is research evidence plus clear community concern to suggest that people as young as 16 years of age exhibit alcohol problems. However, the research ethics committee was strongly against involving those under 18 years of age in the research. In the 2004 National Drug Strategy Household Survey, data were collected on Australians aged 14 years and older and many school surveys collect information on school children aged 12 years and older. In order for us to balance the need to explore early drinking behaviour, with the ethics of asking young people about potentially sensitive topics, it was felt that participants 16 years of age and older were of interest in order to capture some information from youth at an age when alcohol experimentation may begin.

For the purposes of this study, a person of Vietnamese origin is first or second generation Vietnamese, or who, beyond that, identifies as Vietnamese because they have either been exposed to Vietnamese culture through living in the country or they have a biological relative who was born in Vietnam.

The participants were 1080 Vietnamese people (49.5% male, 50.5% female) with a mean age of 39 years (*SD* = 15 years). Almost half of the participants lived in areas with the postcodes 3171 (Springvale, Sandown Village, 10.3%), 3023 (Burside, Cairnlea, Caroline Springs, Deer Park, 8.7%), 3011 (Footscray, Seddon, Seddon West, 7.3%), 3021 (Albanvale, Kealba, Kings Park, St Albans, 7.3%), 3019 (Braybrook, Robinson, 5.7%), 3020 (Albion, Sunshine, 5.5%). Over half the participants were either married (46%) or living in de facto relationships (18%). In regards to employment status, 49% had full time work, 16% had part time work, 12% were students, and 10% were either retired or receiving pensions. There were approximately equal percentages of participants who reported that their gross combined household annual income fell into the $60,000-$99,999 (13%), $40,000-$59,999 (16%), $20,000-$39,999 (13%), $1-$19,999, and *no income* (11%) bands; 31% of participants did not wish to disclose their annual income. Two-thirds of participants had children (68%). They had a mean of 2.3 children each (*SD* = 1.8), with the average ages of the oldest and youngest children being 17 years (*SD* = 14.5) and 16 years (*SD* = 12.4), respectively. A substantial percentage of participants had completed high school (79%), with many having a trade diploma or certificate (26%) or a university degree (20%). Most participants (86%) were born in Vietnam; 12% were Australian born. With regard to the participants born overseas, large amounts of migration occurred around 1980 (1979 – 4%, 1980 – 6%, 1981 – 4%) and 1990 (1989 – 5%, 1990 – 10%, 1991 – 4%, 1992 – 4%). Most participants who migrated to Australia were either refugees (53%), family migrants, or relative sponsored (40%). Almost all of the participants' mothers (96%) and fathers (96%) were born in Vietnam. The participants mainly spoke and read Vietnamese (58% of the time) and English (39% of the time). They identified more strongly with Vietnamese culture (65%) than Australian culture

(33%). The participants affiliated mostly with the Buddhist (39%) and Christian (30%) religions; 30% of participants did not have any religious affiliations.

DESIGN

Undertaking research in communities of a non-English speaking background requires a comprehensive understanding of the cultural influences that have an impact on the research method and research findings. For this reason, the research project had an Advisory Committee which consisted of respected members of the Vietnamese community. The Committee provided advice on the project including:

- Input into the development of the questionnaire content, length and style of questions.
- The recruitment of project assistants and research participants.
- The interpretation of the project's findings.
- The creation and maintenance of links with key policy and service sectors to inform the project's recommendations and their implementation.

Within the Vietnamese culture, for example, women are often regarded as subservient to men (Nghe, Mahalik & Lowe, 2003), and family members are often reluctant to speak with strangers (without credibility or endorsement) about personal matters (Ali et al., 2000). They also place great emphasis on "saving face" by not speaking about family problems (Ali, et al., 2000). These issues pose a number of barriers and require sensitivity in research methodology and design. For example, results may be affected if a female interviewer were to interview a male, or if a young interviewer were to interview an older person, given that respect is accorded to adults as they age. The likelihood of obtaining valid data is therefore increased by using age and gender appropriate interviewers and by aligning the research with credible and respected organisations.

For this reason, Vietnamese peer interviewers (men and women of various ages) were employed to recruit research respondents and were trained to interview a number of their age and gender matched peers using a purposed developed questionnaire. Each interviewer was employed on the recommendation of community groups such as the Quang Minh Temple, and will require a character reference. Peer interviewers were trained using the National Health and Medical Research Council guidelines for the ethical conduct of research with humans. Specifically, the topics that will be covered include the principles of ethical conduct (such as integrity, respect for persons, beneficence and justice, consent, research merit and safety and the ethical review and conduct of research), research involving children and young people, and research involving persons in dependent or unequal relationships.

Peer interviewers were paid $20 for each completed survey. We acknowledge that providing peer interviewers with financial incentives may lead them to unduly influence participants to complete questionnaires; however such risks will be minimised with adequate ethical training and supervision. To ensure that such a relationship will not compromise a participant's ability to give consent which is free from any form of pressure and to ensure participant anonymity and confidentiality, interviewers did not interview within their own networks but swapped with another interviewer. The importance of confidentiality and anonymity was emphasised in

training and supervision so that interviewers were clear about their ethical responsibility in relation to this matter.

MEASURES

The questionnaire aimed to examine the use of alcohol in contemporary Vietnamese society. Specifically, the sections of the questionnaire include: Demographics, Alcohol consumption patterns, Context of alcohol use, Effects of alcohol use, Other drug use, Alcohol related knowledge and cultural values, Current health and wellbeing, and Service usage and help seeking behaviours. Where possible and appropriate, a number of questions have been drawn from standardised measures, such as, Alcohol Use Disorders Identification Test (AUDIT World Health Organisation, 1993), Short Index of Problems (SIP; Miller, Tonigan & Longabaugh, 1995), Addiction Severity Index – Drug and alcohol use subscale and Psychiatric symptom subscale (ASI; McLellan, Luborsky, Woody & O'Brien, 1980), and the Personal Wellbeing Index (PWI; International Wellbeing Group, 2005) or directly from the National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2004) to enable broader comparison. We were granted permission use the questions of the 2004 National Drug Strategy Household Survey. Pilot testing of the questionnaire was conducted during its development and it is available in both Vietnamese and English. The pilot testing involved the Advisory committee testing it for useability. The questionnaire is attached.

PROCEDURE

A recruitment campaign using local Vietnamese media (radio and print) was used to recruit research respondents, in addition to recruitment through large Vietnamese community organisations and major shopping centres and shopping precincts. Participants within the peer interviewers' networks were also recruited. However, to ensure anonymity, interviewers did not interview participants from within their own networks. Those interested in participating were referred to other peer interviewers. This was important in increasing the likelihood of obtaining valid data.

During recruitment, it was made clear to participants by interviewers that participation was voluntary and that participants could withdraw at any time prior to their data being analysed. Participants were assured of the confidentiality of the material they provide, and that the peer Interviewers had received training around this.

Our Advisory Committee members strongly recommended that we did not seek written consent from participants, as Vietnamese people are likely to be distrustful of participating if they have to sign their name. One Advisory Committee member, Professor Giuong Phan from Victoria University, explained that signed consent had been a barrier to participation on a number of his research projects. Therefore, consent was established either by verbal agreement, or by returning the questionnaire anonymously.

The Australian Psychological Society Ethical Guidelines (5th Ed) also states on pg17 that "common law regards minors as being capable of giving voluntary informed consent if they have sufficient maturity". According to these guidelines, maturity usually occurs around 14 or 15

years of age. Consequently, we believe those aged 16 or above should be able to provide their own voluntary consent to participate in this research, given the likely benefit to the Vietnamese community of having their honest responses about alcohol use and issues.

As an additional check of maturity peer interviewers were trained to ask participants under 18 years of age if they had understood the key principles of the research process, such as its voluntary and confidential nature, that participants can withdraw at any time, etc. Interviewers made a judgement about whether the participant understood the process and could cease participation if they were not happy with their level of understanding.

Participation information forms and the questionnaire were available in both English and Vietnamese. The questionnaire took approximately 30 minutes to complete.

All respondents had the option of completing the questionnaire alone and returning it in the reply paid envelope provided or by completing the questionnaire with the assistance of an interviewer in face-to-face meetings or telephone interviews. The interviewer could also return the questionnaire on the participant's behalf. These were coded appropriately and analysed to determine if the method of administration influences the results, given the sensitivity of the subject matter and the potential reluctance of respondents to answer truthfully

ANALYSIS

The sample was stratified to match community population demographics. Stratification occurred by age and gender, and we aimed to ensure that there was a spread across residential locations within metropolitan Melbourne. A sample size of approximately 1000 participants allowed sufficient power (0.90) to carry out a number of statistical tests of difference and relationships at a two-tailed significance level of α=0.01.

Table 3 shows the stratification across age and gender which we aimed to achieve, and the stratification of the current sample. As can be seen, the present sample was close to the stratification targets.

Table 3. Stratification across age and gender: Targets and current count

Stratification targets

Age by gender		15-19	20-29	30-39	40-49	50-59	60-69	70+	Total
	Males	75	100	100	75	75	50	25	500
	Females	75	100	100	15	15	50	25	500
	Total	150	200	200	150	150	100	50	1000

Current count

Age by gender		15-19	20-29	30-39	40-49	50-59	60-69	70+	Total
	Males	50	97	114	113	86	40	21	521
	Females	41	149	147	76	61	36	23	533
	Total	91	253	267	197	149	76	37	1070

Table 4 shows stratification across residential locations in Melbourne, and the present spread of the sample across residential locations and religion. As can be seen, the present sample was close to the stratification targets across residential locations. There was also a good spread across religion.

Table 4. Stratification across residential locations and religion: Targets and current count

	Min. required	Current count
Areas		
Whitehorse	32	32
Maribyrnong	123	228
Greater Dandenong	186	187
Brimbank City Council	236	168
Braybrook	24	61
Richmond	27	51
Religion		
None		324
Buddhism		415
Christianity		324
Other		3

RESULTS

ALCOHOL CONSUMPTION PATTERNS

Of the 1080 participants, 76% had tried alcohol during their lives. The average age when these people first tried alcohol was 18 years (SD = 5). Three quarters of participants had consumed alcohol in the previous 12 months (n = 753). The remaining results reported in this section relate to these participants. There was a broad spread in how often the participants consumed alcohol: every day (15.5%), 5-6 days per week (8.6%), 3-4 days per week (19.9%), 1-2 days per week (19.5%), 2-3 days per month (11.2%), 1 day per month (7.6%), less often (15.7%), and no longer drinking (2.0%). On a typical day during which participants drank alcohol, they consumed, on average, 2.74 standard drinks (SD = 2.35). Recalling the day during which they consumed the most number of standard drinks, there was a large spread in the maximum number of drinks: 1-2 standard drinks (22.7%), 3-4 drinks (21.6%), 5-6 (21.1%), 7-10 (16.5%), 11-12 (3.9%), and 13 or more (11.2%). A large percentage of people (40.2%) never consumed 6 or more standard drinks on a single occasion, with 25.9% consuming 6 or more drinks on one occasion on a monthly basis, and 15.1% consuming this many drinks on a single occasion during a week. Two-thirds of participants never found it difficult to get thoughts of alcohol out of their minds (66.4%); a quarter of participants, however, found it difficult on a weekly (12.1%) or monthly (12.0%) basis. Two thirds of participants did not find it difficult to stop drinking once they had started (67.6%), whereas others found it hard on a weekly (11.8%) or monthly (10.5%) basis. Similar percentages of participants found it difficult to remember what happened the previous night because of their drinking (never had difficulties, 68.1%; weekly difficulties, 12.1%; monthly difficulties, 9.7%) and felt guilt or remorse after drinking (never, 62.4%; weekly, 17.4%; monthly, 7.3%). Most participants never drank alcohol in the morning (88.8%), but some did so monthly (4.2%). A quarter of participants reported that someone else had been injured as a result of their drinking, with 16.3% of injuries occurring within the last year and 7.8% of injuries

occurring more than a year ago. Three quarters of participants (73.0%) reported that no significant others in their lives (relative, friend, doctor, health worker) had been concerned about their drinking or had asked them to reduce their consumption of alcohol; 16.3% indicated that someone had been concerned within the last year and a further 7.8% recalled that someone had been concerned over a year ago. In the past 30 days, participants had used alcohol on an average of 11.2 days (*SD* = 10.9) and become intoxicated using alcohol on 2.3 days (*SD* = 10.7). On average, participants spent $112.50 (*SD* = $154.63) on alcohol during the prior 30 days. In the previous 30 days, participants experienced alcohol-related problems infrequently (*M* = 0.75 days, *SD* = 1.54). Half the participants (49.5%) reported that their levels of alcohol consumption were somewhat harmful to them, and a further 25.0% of participants indicated that their alcohol consumption was neither harmful nor beneficial.

Table 5 shows the AUDIT and Personal Wellbeing Index scores across sex and age for the present sample. Regarding the AUDIT, scores above eight indicate hazardous or dependent drinking (Babor, Higgins-Biddle, Saunders & Monteiro, 2001). Table 5 shows that young men and women report that they engage in risky drinking practices. On the Personal Wellbeing Index, the normative range for Australia is 73.4 – 76.7 (International Wellbeing Group, 2006). The table below shows that young men and women report lower personal wellbeing scores compared to the Australian population.

Table 5. AUDIT and Personal Wellbeing Index Scores for sex and age.

Males				Females				Total			
Age		**Audit**	**Personal Wellbeing**	**Age**		**Audit**	**Personal Wellbeing**	**Age**		**Audit**	**Personal Wellbeing**
15-19	Mean	7.18	74.49	15-19	Mean	5.33	71.28	15-19	Mean	6.42	73.07
	N	39.00	48.00		N	27.00	38.00		N	66.00	86.00
	SD	4.90	16.77		SD	4.25	15.59		SD	4.70	16.24
20-29	Mean	8.78	69.88	20-29	Mean	7.62	63.84	20-29	Mean	8.10	66.19
	N	81.00	92.00		N	115.00	144.00		N	196.00	236.00
	SD	6.71	11.86		SD	5.02	15.90		SD	5.79	14.73
30-39	Mean	13.33	67.90	30-39	Mean	7.94	61.45	30-39	Mean	10.56	64.22
	N	94.00	108.00		N	99.00	143.00		N	193.00	251.00
	SD	7.53	14.34		SD	5.66	16.54		SD	7.15	15.93
40-49	Mean	12.66	67.03	40-49	Mean	5.85	66.80	40-49	Mean	10.55	66.94
	N	91.00	104.00		N	41.00	70.00		N	132.00	174.00
	SD	7.57	16.03		SD	5.02	17.00		SD	7.56	16.38
50-59	Mean	7.22	74.55	50-59	Mean	4.25	67.04	50-59	Mean	6.72	71.50
	N	59.00	82.00		N	12.00	56.00		N	71.00	138.00
	SD	5.06	14.10		SD	4.11	16.34		SD	5.01	15.44
60-69	Mean	5.57	70.90	60-69	Mean	8.00	74.54	60-69	Mean	5.96	72.62
	N	21.00	38.00		N	4.00	34.00		N	25.00	72.00
	SD	5.15	14.68		SD	6.48	13.11		SD	5.31	13.98
70+	Mean	4.22	78.78	70+	Mean	4.33	74.47	70+	Mean	4.27	76.53
	N	9.00	21.00		N	6.00	23.00		N	15.00	44.00
	SD	1.56	14.42		SD	2.73	13.17		SD	2.02	13.79
Total	Mean	10.09	70.53	Total	Mean	7.09	65.68	Total	Mean	8.79	68.07
	N	394.00	493.00		N	304.00	508.00		N	698.00	1001.00
	SD	7.18	14.84		SD	5.21	16.44		SD	6.57	15.85

Note: SD=Standard deviation

Problem drinking (measured by the AUDIT) was associated with: experiencing recent Psychiatric Symptoms - Addiction Severity Index ($r=.57$, $p<0.001$); spending less time speaking

English (r=0.21, p<0.001); and lower personal wellbeing (measured by Personal Wellbeing Index) (r=0.37, p<0.001).

Table 6 shows percentages of alcohol and other drug use of the present sample and the Australian population taken from the Australian Institute of Health and Welfare's (2008) 2007 National Drug Strategy Household Survey.

Table 6. Alcohol and other use: Comparing the present sample and the Australian population.

Alcohol and Other Drug Use	Vietnamese in Melbourne	Australian Population
Ever used an illicit drug (%)	22.3	38.1
Use tobacco regularly (%)	48.1	17.9
Ever consumed alcohol (%)	76	89.9
Age of first use	18 years	17 years
Consumed alcohol in previous 12 months (%)	66.3	82.9
Daily (%)	10.7	8.1
Weekly	26.1	41.3
Less than weekly	39.2	33.5

CONTEXT OF ALCOHOL USE

The results in this section are those of the participants who had consumed alcohol in the previous 12 months (n = 753). Beer was the beverage that participants most usually drank (80.9% of participants), followed by wine (57.4%) and spirits (47.1%). The participants consumed alcohol at home or at friends' houses (83.9%), at parties at other people's houses (74.8%), at licensed premises (54.8%), at schools, universities, and workplaces (16.9%), and in public places (28.7%). They usually drunk alcohol with friends (86.1%), family (40.0%), partners (25.1%), work or school colleagues (13.8%), and strangers (9.7%); 21.9% reported that they drunk alone. Most participants bought their own alcohol (69.5%). Other means of obtaining alcohol were through family members (21.6%), friends and acquaintances (19.4%), steeling or taking it (0.3%), and strangers (0.3%). Most alcohol consumption occurred in the evening (87.3%), but participants also drunk in the morning (15.7%), at lunchtime (23.8%), and in the afternoon (57.0%). In the last 12 months, participants undertook the following activities while under the influence of alcohol: attended school, university, or work (39.8%), went swimming (16.1%), drove a motor vehicle (17.8%), operated hazardous machinery (2.5%), created public disturbances or were public nuisances (2.4%), caused damage to property (2.0%), verbally abused people (30.0%), and physically abused people (12.4%). Participants reported having a range of experiences in the last 12 months due to their drinking, including being unhappy (36.9%), not eating properly (42.9%), failing to do what was expected of them (35.5%), feeling guilty or ashamed (33.3%), taking foolish risks when drinking (35.1%), acting impulsively while drinking and regretting it later (35.3%), harming their physical health (41.6%), having problems with money (27.2%), harming their physical appearance (40.1%), hurting their families (34.1%), damaging friendships and close relationships (27.9%), impeding their personal growth (21.0%), damaging their social lives, popularity, and reputations (20.3%), spending or losing a lot of money (25.0%), having car accidents while drinking or intoxicated (26.3%), and stopping family

members from seeing other people to prevent them from talking about the participants' drinking (5.6%).

EFFECTS OF ALCOHOL USE

The results reported in this section were calculated from the data of all participants ($N = 1080$). In the prior 12 months, 28.0% of participants reduced the amount of alcohol they consumed at one time, 23.7% reduced the number of times they drunk, 16.6% switched to drinking more low-alcohol drinks, and 8.1% stopped drinking alcohol. Several participants made several of these changes. Half of the participants (51.7%), however, did not make any of these changes in alcohol use. The main reasons for participants changing the ways in which they consumed alcohol were: health reasons (40.9%), safety reasons (30.7%), and lifestyle or personal reasons (16.8%). The participants reported that many of the possible consequences of drinking had occurred for them or other people in their lives (see Table 7).

In the last 12 months, persons affected by alcohol verbally abused 29.0% of participants, physically abused 23.9% of participants, made 27.5% fearful, and exerted inappropriate control over 11.0% of participants. On these occasions, the persons affected by alcohol were family members (43.7%), friends (40.2%), current or former boyfriends or girlfriends (8.2%), other persons they knew (1.6%), or other persons they did not know (6.3%). Only 1.1% of participants reported all incidents to the police; 11.2% of participants reported some incidents to police and 87.7% reported no incidents. Reasons indicated for not reporting incidents to police were that they were too trivial (10.7%), were private matters (88.7%), and were such that the police could not or would not do anything (5.9%). Other reasons offered were that the participants did not the offenders punished (79.0%), were too confused or upset by the incidents (62.5%), were afraid of reprisal or revenge (12.8%), and did not want to bring shame on their families (38.5%).

Table 7. Percentage of present sample reporting consequences of drinking for themselves, friends and family members.

	To them	To friends/ family members	To them and friends/ family members	No
Had a hangover	7.8%	15.1%	34.3%	38.7%
Got nauseated & vomited from drinking	7.3%	15.0%	32.6%	41.2%
Were caught drink driving by the police	2.6%	21.2%	19.5%	52.9%
Had driven a car after drinking too much	2.2%	18.4%	18.4%	58.8%
Gambled too much because of drinking	1.3%	25.1%	6.7%	62.4%
Had trouble with the law because of drinking	1.9%	29.9%	3.2%	60.9%
Lost a job because of drinking	1.2%	26.4%	4.4%	64.2%
Missed work or a class because of hangover	2.7%	14.6%	16.4%	62.5%
Got a lower grade or performed badly because of drinking	1.9%	15.7%	10.3%	68.1%
Got into a fight after drinking	1.0%	23.8%	11.0%	60.1%
Had family conflicts or problems because of drinking	2.9%	15.7%	20.7%	56.6%
Had conflicts with friends because of drinking	2.2%	14.1%	22.9%	56.8%
Engaged in regretful behaviours because of drinking	2.6%	13.9%	20.3%	59.3%
Had unwanted sex because of drinking	2.5%	10.3%	24.8%	58.5%
Drunk more heavily in response to family problems	2.0%	13.1%	18.6%	62.1%
Were restricted from visiting others by someone who drinks	1.4%	13.1%	4.7%	76.6%
Were not given your share of money by someone who drinks	1.5%	7.2%	0.3%	86.8%

Table 8 shows percentages of the present sample compared to the Australian population who undertook activities while under influence of alcohol in the past 12 months. The Australian norms were taken from the Australian Institute of Health and Welfare's (2008) 2007 National Drug Strategy Household Survey.

Table 8. Percentage of current sample compared to the Australian population undertaking activities under the influence of alcohol in the last 12 months.

	Vietnamese in Melbourne			Australian Population		
Activities under influence of Alcohol (%) in past 12 mths	**Males**	**Females**	**All**	**Males**	**Females**	**All**
Drove a motor vehicle	19.3	4.3	11.9	16.2	8.0	12.1
Operated hazardous machinery	3.1	0.4	1.8	1.4	0.1	0.8
Verbally abused someone	14.8	25.3	20.9	7.4	4.1	5.7
Physically abused someone	9.2	7.5	8.6	1.7	0.5	1.1
Caused damage to property	1.5	0.9	1.4	2.7	0.7	1.7
Stole money, goods or property	0.8	0.6	0.6	0.7	0.2	0.4
Went swimming	4.6	16.5	11.2	7.1	3.3	5.2
Went to work / education	23.9	29.6	27.8	6.0	2.1	4.0

	Vietnamese in Melbourne			Australian Population		
Victims of Alcohol Related Incidents (%) in past 12 mths	**Males**	**Females**	**All**	**Males**	**Females**	**All**
Verbal abuse	19.2	39.4	30.3	29.3	21.5	25.4
Physical abuse	14.7	33.1	25.0	5.9	3.1	4.5
Put in fear	18.7	36.4	28.6	12.0	14.1	13.1

OTHER DRUG USE

About half of the participants (53.9%) had smoked tobacco cigarettes. Of these people who smoked, 48.1% did so regularly. Almost one quarter of the participants (22.3%) had tried an illegal drug.

BELIEFS, VALUES, AND CULTURAL PRACTICES

The participants reported that they believed that (a) an adult male could drink, on average, 2.15 standard drinks per day (*SD* = 2.17) for many years without negatively affecting his health, (b) an adult female could drink, on average, 1.58 standard drinks per day (*SD* = 1.98) for many years without negatively affecting her health, (c) an adult male could drink 2.55 standard drinks in a 6 hour period (*SD* = 4.27) before he puts his health at risk, (d) an adult female could drink 1.76 standard drinks in a 6 hour period (*SD* = 2.25) before she puts her health at risk, (e) a person could consume 1.04 standard drinks in one hour (*SD* = 0.83) and still remain under the legal limit (0.05) for driving a motor vehicle. Two-thirds of participants (63.5%) had heard of a "standard drink" of alcohol before they completed the questionnaire. Half the participants (53.2%) reported that the number of "standard drinks" appears on cans and bottles of alcoholic beverages; 12.9% indicated that this information was not provided on bottles and cans, and 29.3% did not know the answer to this question. If participants needed information about alcohol, they reported that they would go to the phone book (55.7%), drug and alcohol services (63.6%), counselling services (47.7%), community health centres (55.3%), hospitals, doctors, and medical clinics (65.6%), chemists (40.6%), government departments or services (35.6%), priests, churches, and temples (35.7%), teachers, schools, and universities (32.0%), media (39.0%), internet (50.9%), and family or friends (58.6%). Participants' responses to 10 "True" or "False" statements are given in the Table 9.

The participants reported that their bodies could process approximately 1.37 standard drinks per hour (*SD* = 1.25). When asked to nominate 3 of 10 values that they considered most important, when thinking about drinking alcohol, participants selected the following values: moderation (36.5%), endurance of hardships (2.5%), tolerance (23.8%), adhering to family roles (8.6%), upholding a good reputation (14.4%), upholding a family reputation (11.2%), pride in oneself (14.9%), maintaining control of one's behaviour (23.1%), intelligence and level headedness (23.2%), harmony (24.7%), and protecting the families privacy (21.5%).

Table 9. Percentage of the present sample responding to true/false statements regarding the effects of alcohol.

Statement	True	False
If pregnant, women should drink less than normal.	79.1%	16.6%
There is no risk to a baby if a woman has only a few drinks during pregnancy.	54.6%	40.8%
Drinking alcohol during breastfeeding will not affect the baby.	23.0%	72.4%
Drinking alcohol together with other drugs can be life threatening.	86.8%	8.4%
A person with hepatitis C should drink should drink less than normal.	81.3%	13.4%
A person with hepatitis C and poor liver function should not drink any alcohol.	85.9%	9.4%
The effect of a depressant such as sedatives, heroin or benzodiazepines becomes three or four times more powerful when combined with alcohol.	85.9%	8.3%
Prolonged heavy intake of alcohol may result in brain diseases, including brain damage.	86.4%	8.8%
Prolonged heavy intake of alcohol may result in an increased risk of cancer.	86.0%	9.2%
Prolonged heavy intake of alcohol may result in liver diseases, such as cirrhosis and hepatitis.	88.2%	6.9%

HEALTH AND WELLBEING

In general, participants rated their health as excellent (5.7%), very good (18.7%), good (50.5%), fair (19.0%), or poor (1.8%). Asked about the past 30 days, (a) 32% of participants reported that they experienced serious depression; (b) 32% experienced serious anxiety and tension; (c) 18.2% experienced hallucinations; (d) 31.8% experienced trouble understanding, concentrating, or remembering; (e) 25.9% experienced trouble controlling violent behaviour, including episodes of rage or violence; (f) 8.2% experienced serious thoughts of suicide; and (g) 1.7% attempted suicide. In the same 30-day period, some participants (13.1%) had been prescribed medications for psychological or emotional problems. When participants were asked to rate how satisfied they were with various aspects of their lives, on a 0 to 10 scale, they responded with average scores of 6.83 (*SD* = 1.71) for standard of living, 6.85 (*SD* = 1.70) for health, 6.53 (*SD* = 1.94) for what they were achieving in life, 6.68 (*SD* = 1.89) for personal relationships, 6.95 (*SD* = 1.83) for how safe they feel, 6.97 (*SD* = 1.79) for feeling part of their communities, and 6.62 (*SD* = 1.93) for their future security. The participants who had migrated to Australia (*n* = 937) indicated that they had experienced the following problems: legal status issues (18.8%); language difficulties (79.3%); academic and work performance difficulties (57.4%); financial difficulties (56.8%); perceived prejudice, racial and ethnic discrimination, and socio-political

influence (9.7%); culture shock (55.5%); homesickness (64.8%); social isolation and alienation (4.7%); and loss of social support (2.9%).

Service Usage, Help Seeking, and Barriers

Asked if they would seek help if they believed that they, or someone in their families, had an alcohol problem, 71.9% responded "yes", 20.3% "possibly", and 3.8% "no". Of those who answered "yes" or "possibly" (n = 995), they would get help from doctors (77.3%), telephone helplines (59.4%), community services or counsellors (61.4%), family members or friends (62.3%), and churches or temples (35.8%). Although 21.6% of participants would not mind the nationality of the helper, 44.6% indicated they preferred Vietnamese nationals as helpers 11.4% preferred Australians.

Referring to the whole sample (N = 1080), initiatives that would make it easier for participants to seek help are: access to language specific services (35.9%), places where that could go where nobody recognised them or new their names (17.1%), confidentiality (62.9%), access to a helper who understands the Vietnamese culture (32.4%), and having people visit them in their homes (22.6%). Things that make it difficult for the participants to seek help include help seeking behaviours are not in line with their cultural values (39.2%), no language specific services (6.7%), worries that their families will find out (37.0%), and worries that others will find out (48.4%). In regard to listening to Vietnamese radio programmes, 29.6% of participants listened to them often, 52.1% sometimes listened to them, and 14.6% did not listen to them. Similarly, 27.7% of participants often read Vietnamese newspapers, 51.6% read them sometimes, and 17.1% did not read them. With respect to Vietnamese television programmes, 13.5% watched them often, 53.3% watched them sometimes, and 30.0% did not watch them.

Sex and Age as Independent Variables

Sex

On the whole, there were minimal differences between males and females across all variables studied. Small differences were found, however, for some variables.

- More males (85.9%) than females (67.1%) had tried alcohol (φ = .22, p = .000000).
- Males consumed alcohol more frequently than did females (V = .36, p = .000000). Males tended to drink everyday (23.6%), 5 to 6 days per week (9.5%), 3 to 4 days per week (12.6%), or 1 to 2 days per week (15.3%). Females mainly drunk 3 to 4 days per week (24.4%), 1 to 2 days per week (21.3%), or less often than 1 day per month (19.6%)
- On a typical day when participants drunk alcohol, males consumed one standard drink (M = 3.19, SD = 2.10) more than females (M = 2.20, SD = 2.59, d = 0.43, p = .000000).
- On the day when participants drunk the most number of alcoholic drinks, males drunk more than females (V = .31, p = .000000). Males were spread across the categories: 1 to 2 standard drinks (20.2%), 3 to 4 drinks (18.0%), 5 to 6 drinks (17.2%), 7 to 10 drinks (20.9%), and 13 or more drinks (17.5%). Females were towards the lower end of the categories: 1 to 2 standard drinks (28.4%), 3 to 4 drinks (28.4%), 5 to 6 drinks (26.4%), and 7 to 10 drinks (12.2%).
- Males consumed six or more drinks on one occasion more frequently over the last 12 months than females (V = .32, p = .000000). Although 31.7% of males and 54.9% of females reported never having six or more drinks on one occasion, 24.3% of males consumed six or more drinks on a single occasion each month, and 23.5% did so each week; 28.2% females consumed six or more drinks on one occasion on a monthly basis.

- Males more often had difficulties getting thoughts of alcohol out of their heads than females ($V = .27$, $p = .000000$). Although 59.0% of males never found it difficult to get thoughts of alcohol out of their minds, some had trouble on monthly (13.2%) or weekly (18.4%) bases. Most females (81.0%) never had a problem with getting thoughts of alcohol out of their heads.
- Males more often found that they were not able to stop drinking once they had started than females ($V = .30$, $p = .000000$). Although 58.5% of males never found that they were not able to stop drinking, some had trouble on monthly (11.4%) or weekly (18.5%) bases. Most females (83.1%) never had a problem with stopping drinking once they had started.
- When asked about the previous 30 days, males had consumed alcohol on more days ($M = 13.02$, $SD = 11.87$) than females ($M = 8.57$, $SD = 8.99$, $d = 0.41$, $p = .000000$).
- A higher percentage of females (70.4%) consumed wine than males (48.98%, $\varphi = .22$, $p = .000000$).
- Females reported that they usually drank with their partners (43.3%) more often than did males (11.2%, $\varphi = .37$, $p = .000000$).
- Females also reported that they usually drank alone (32.9%) more often than did males (12.7%, $\varphi = .24$, $p = .000000$).
- A higher percentage of males (81.0%) obtained alcohol through purchasing it themselves than females (58.5%, $\varphi = .25$, $p = .000000$).
- With regard to activities performed while under the influence of alcohol in the last 12 months, more females went swimming (28.8%) than males (6.1%, $\varphi = .31$, $p = .000000$), and more females verbally abused others (44.1%) than did males (19.4%, $\varphi = .27$, $p = .000000$); more males (25.4%) drove motor vehicles while under the influence of alcohol than females (7.5%, $\varphi = .23$, $p = .000000$).
- More females (55.6%) than males (34.0%) reported that they had not eaten properly, on occasions, during the last 12 months because of their drinking ($\varphi = .22$, $p = .000000$).
- More females (40.0%) than males (18.3%) reported that friendships and close relationships had been damaged during the last 12 months because of their drinking ($\varphi = .24$, $p = .000000$).
- More females (40.9%) than males (20.0%) reported that friends and family members had trouble with the law because of their drinking ($V = .25$, $p = .000000$).
- More females (36.6%) than males (17.1%) reported that friends and family members had lost their jobs because of their drinking ($V = .23$, $p = .000000$).
- More females (35.5%) than males (13.1%) reported that friends and family members had got into fights after their drinking ($V = .26$, $p = .000000$).
- In the last 12 months, more females than males reported that they had been verbally abused (39.4% vs. 19.2%, $\varphi = .22$, $p = .000000$), physically abused (33.1% vs. 14.7%, $\varphi = .22$, $p = .000000$), or inappropriately controlled (18.8% vs. 3.8% $\varphi = .24$, $p = .000000$) by persons affected by alcohol.
- There was a large difference between males and females in the relationship between them and the person affected by alcohol who verbally abused them, physically abused them, put fear into them, and exerted inappropriate control over them ($V = .54$, $p = .000000$). For males, the persons were friends (71.3%), family members (16.1%), and others not known to them (9.1%). For females, the persons were family members (60.0%), friends (20.9%), and current or former boyfriends or girlfriends (12.3%).

- More males (66.9%) than females (42.7%) had smoked tobacco cigarettes during their lives (φ = .24, p = .000000).
- More males (51.1%) than females (19.8%) were regular smokers (φ = .32, p = .000000).
- If the participants needed information about alcohol, more females than males would go to priests, churches, or temples (48.2% vs. 24.9%, φ = .24, p = .000000); teachers, schools, or universities (44.1% vs. 21.3%, φ = .24, p = .000000); and the media (52.6% vs. 27.5%, φ = .26, p = .000000).
- When thinking about drinking alcohol, tolerance was a value that more females (45.7%) than males (15.9%) indicated was important to them (φ = .32, p = .000000).
- If participants believed that they or someone in their family had alcohol problems, more females (45.3%) than males (23.3%) would seek help from churches or temples (φ = .23, p = .000000).

Age

On the whole, age was associated with few of the variables studied and, when effects were found, the effects were mainly small to medium in magnitude.

- The participants who had tried alcohol were, on average, 10 years younger (M = 37 years, SD = 14) than those who had not tried alcohol (M = 47 years, SD = 16, d = 0.68, p = .000000).
- There was an association between participants' ages and their ages when they first tried alcohol (r = .43, p = .000000). Younger participants tended to have tried alcohol at younger ages than older participants.
- The participants who usually drank spirits were, on average, 8 years younger (M = 32 years, SD = 11) than other participants (M = 40 years, SD = 15, d = 0.57, p = .000000).
- The participants who usually consumed alcohol at house parties were, on average, 9 years younger (M = 34 years, SD = 12) than other participants (M = 43 years, SD = 17, d = 0.65, p = .000000).
- The participants who usually consumed alcohol at licensed premises were, on average, 7 years younger (M = 33 years, SD = 11) than other participants (M = 40 years, SD = 16, d = 0.48, p = .000000).
- The participants who usually consumed alcohol in public places were, on average, 6 years younger (M = 32 years, SD = 9) than other participants (M = 38 years, SD = 15, d = 0.45, p = .000000).
- The participants who usually consumed alcohol with their friends were, on average, 11 years younger (M = 35 years, SD = 12) than other participants (M = 46 years, SD = 18, d = 0.87, p = .000000).
- The participants who usually obtained alcohol from friends or acquaintances were, on average, 9 years younger (M = 29 years, SD = 12) than other participants (M = 38 years, SD = 13, d = 0.64, p = .000000).
- The participants who usually consumed alcohol in the evening were, on average, 11 years younger (M = 35 years, SD = 13) than other participants (M = 46 years, SD = 17, d = 0.84, p = .000000).
- The participants who went swimming in the last 12 months while under the influence of alcohol were, on average, 9 years younger (M = 29 years, SD = 7) than other participants (M = 38 years, SD = 14, d = 0.67, p = .000000).

- The participants who had been physically abused in the last 12 months by someone affected by alcohol were, on average, 8 years younger (M = 33 years, SD = 10) than other participants (M = 41 years, SD = 16, d = 0.58, p = .000000).
- The participants who had been put in fear in the last 12 months by someone affected by alcohol were, on average, 7 years younger (M = 34 years, SD = 10) than other participants (M = 41 years, SD = 16, d = 0.47, p = .000000).
- There ages of participants was associated with the type of person affected by alcohol who abused them, made them afraid, or inappropriately controlled them (η^2 = .07, p = .000000). Participants affected by family members (M = 36 years, SD = 11) were 11 years older than those affected by current and former partners (M = 25 years, SD = 5, p < .01) and 3 years older than those affected by friends (M = 33 years, SD = 10, p < .05). Participants affected by friends (M = 33 years, SD = 10) were 8 years older than those affected by current and former partners (M = 25 years, SD = 5, p < .01).
- The participants who had tried illegal drugs were, on average, 12 years younger (M = 30 years, SD = 10) than other participants (M = 42 years, SD = 16, d = 0.85, p = .000000).
- There was a negative association between participants ages and the number of standard drinks they perceived an adult female could drink in a 6 hour period without putting her health at risk (r = -.24, p = .000000).
- The participants who would go to their teachers, schools, and universities if they needed information about alcohol were, on average, 9 years younger (M = 33 years, SD = 12) than other participants (M = 42 years, SD = 16, d = 0.35, p = .000000).
- The participants who would use the internet if they needed information about alcohol were, on average, 11 years younger (M = 34 years, SD = 12) than other participants (M = 45 years, SD = 16, d = 0.79, p = .000000).
- The participants who indicated that the statement, “If pregnant, women should drink less than normal,” was true were, on average, 10 years younger (M = 37 years, SD = 14) than those who marked it as false (M = 47 years, SD = 18, d = 0.67, p = .000000).
- There was a negative association between participants ages and the number of standard drinks of alcohol they perceived their bodies could process in an hour (r = -.26, p = .000000).
- When thinking about drinking alcohol, participants who indicated that tolerance was a value important to them were, on average, 9 years younger (M = 33 years, SD = 11) than other participants (M = 42 years, SD = 16, d = 0.63, p = .000000). HERE
- When thinking about drinking alcohol, participants who indicated that adhering to family roles was a value important to them were, on average, 9 years older (M = 47 years, SD = 19) than other participants (M = 38 years, SD = 14, d = 0.64, p = .000000).
- When thinking about drinking alcohol, participants who indicated that upholding their families’ reputations was a value important to them were, on average, 8 years older (M = 46 years, SD = 17) than other participants (M = 38 years, SD = 15, d = 0.57, p = .000000).
- There was a negative association between age and perceptions of health (r = -.29, p = .000000).
- The participants who indicated that they had experienced serious depression for a significant period in the past 30 days were, on average, 7 years younger (M = 34 years, SD = 12) than other participants (M = 42 years, SD = 17, d = 0.47, p = .000000).

- The participants who indicated that they had experienced serious anxiety for a significant period in the past 30 days were, on average, 7 years younger (M = 34 years, SD = 12) than other participants (M = 45 years, SD = 17, d = 0.47, p = .000000).
- The participants who indicated that they had experienced trouble controlling violent behaviour, including episodes of rage or violence, for a significant period in the past 30 days were, on average, 7 years younger (M = 34 years, SD = 10) than other participants (M = 41 years, SD = 17, d = 0.50, p = .000000).
- Of the participants who migrated to Australia, those who experienced language difficulties were, on average, 11 years older (M = 43 years, SD = 15) than other participants (M = 32 years, SD = 13, d = 0.75, p = .000000).
- Of the participants who migrated to Australia, those who experienced homesickness were, on average, 7 years older (M = 43 years, SD = 15) than other participants (M = 36 years, SD = 14, d = 0.46, p = .000000).
- The participants who indicated that access to language specific services would make it easier for them to seek help were, on average, 13 years older (M = 47 years, SD = 15) than other participants (M = 34 years, SD = 13, d = 0.93, p = .000000).
- The participants who indicated that confidentiality would make it easier for them to seek help were, on average, 10 years younger (M = 36 years, SD = 14) than other participants (M = 46 years, SD = 16, d = 0.68, p = .000000).
- The participants who indicated that seeking help is not in line with their cultural values and made it difficult for them to seek help were, on average, 6 years older (M = 42 years, SD = 14) than other participants (M = 36 years, SD = 15, d = 0.42, p = .000000).
- There were large differences between the ages of participants and the frequency with which they listened to Vietnamese radio programs (η^2 = .26, p = .000000). The participants who did not listen to Vietnamese radio were 13 years younger (M = 25 years, SD = 10) than participants who sometimes listened (M = 38 years, SD = 13), who were, themselves, 11 years younger than those who listened often (M = 49 years, SD = 15).
- There were large differences between the ages of participants and the frequency with which they read Vietnamese newspapers (η^2 = .28, p = .000000). The participants who did not read Vietnamese newspapers were 15 years younger (M = 24 years, SD = 9) than participants who sometimes read (M = 39 years, SD = 13), who were, themselves, 10 years younger than those who read often (M = 49 years, SD = 15).
- There were large differences between the ages of participants and the frequency with which they watched Vietnamese programmes on television (η^2 = .17, p = .000000). The participants who did not watch Vietnamese programs were 10 years younger (M = 31 years, SD = 13) than participants who sometimes watched (M = 41 years, SD = 14), who were, themselves, 9 years younger than those who watched often (M = 50 years, SD = 16).

FURTHER ASSESSMENT OF ALCOHOL CONSUMPTION PATTERNS

Of the 1080 participants:

- 360 had consumed no alcohol in the last 12 months
- 720 had consumed alcohol in the last 12 months … of these:
    - 670 had exceeded alcohol guidelines (>6 standard drinks for men, >4 standard drinks for women) on the day they consumed the most alcohol
    - 117 consumed alcohol everyday, contradictory to the guidelines

    - 44 had exceeded the guidelines for alcohol consumption on a typical day in which they consumed alcohol
    - 7 exceeded the guidelines for alcohol consumption, and drank every day

DISCUSSION

- Results appear consistent with previous research which shows that fewer Vietnamese Australians drink alcohol, and those that do drink, do so at somewhat lower levels than the wider Australian population.
- Furthermore, those that do drink appear to experience more serious problems as a consequence.
- Middle age men and young adult women were most likely to drink, smoke tobacco regularly, and experience problems with alcohol.
- Vietnamese in Melbourne prefer to keep their problems within their families and are unlikely to report alcohol related violence to the Police.
- Help seeking would be made easier if there were confidential, language specific services, which understand Vietnamese culture. While doctors were the preferred helpers, other services would also be accessed by Vietnamese in Melbourne, with half (typically older) preferring Vietnamese specific services.

RECOMMENDATIONS AND DISSEMINATION PLAN

- Government will be engaged to examine current practice in Vietnamese general practitioners and to ensure that training is available for them to screen for alcohol abuse.
- Results will be presented to various stakeholders to examine system responses to areas of most need identified by this study and to target responses. See Dissemination plan below.
- State government funding will be sought to increase the presence of Vietnamese specific counsellors in community settings.
- In December 2008, a press release will be circulated with the most important key findings, plus a list of services (both in Vietnamese and English) which the public can access if they, or someone they know needs help with an alcohol problem.
- In February 2009, radio interviews with be sought with SBS radio and 97.4 FM.
- In early 2009, a public forum is also planned to discuss alcohol issues. A panel of experts will be bought together including a member of the police force, a Vietnamese general practitioner, a Vietnamese family violence counsellor, and an academic with expertise in drug and alcohol related research. Members of the community will be invited to ask questions and discuss the use of alcohol in the Vietnamese community and alcohol related problems, plus the key findings of the research.
- In early 2009, we will explore the feasibility of producing a documentary, telling stories of Vietnamese families who have alcohol related problems, how the culture may prevent help-seeking, and how families have sought help. The aim is for the documentary to be aired on SBS television.
- In early to mid 2009, current and former staff members the Centre for Psychiatric Nursing Research, University of Melbourne, will take the lead in writing 1 to 2 further articles for publication in peer-reviewed journals regarding the rates of alcohol consumption and alcohol abuse in the sample compared to the Australian norms, and help seeking behaviours in the Vietnamese community in relation to alcohol problems.
- One publication is currently in press: Happell, B., Gruenert, S., & Platania-Phung, C. (in press) Rates of alcohol usage among Vietnamese Australian communities: A literature review. *Journal of Substance Use*. We are awaiting feedback and will send through a copy of the published article when it occurs.
- One presentation has been made: Polimeni, A.M., Phat Cao, T., Gaskin, C., Gruenert, S. & Happell, B. (November, 2008). They drink less but the harms are greater: Patterns and consequences of alcohol use in Melbourne's Vietnamese community. Poster presented at Australasian Professional Society on Alcohol and Other Drugs Conference.
- The results will continue to be presented at conferences as appropriate.

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APPENDICES

APPENDIX A: GEOGRAPHY OF VIETNAMESE COMMUNITIES IN AUSTRALIA

There were 150,839 Vietnamese-born people in Australia according to the 1996 census (Viviani, 1997).

Vietnamese immigrant residential patterns in city areas are characteristically highly concentrated, rather than dispersed. A number of theories for this have been proposed (see Glavac & Waldorf, 1998, p. 346-7).

Concentrations of Vietnamese reside in Footscray, Broadmeadows, Coburg, Thomastown, Preston, Reservoir, Epping, Lalor, Box Hill, Richmond and Springvale. According to census data there were 54,518 Vietnamese-born people in Melbourne in 1996, up from 43,677 in 1991 (Healy, 1997). Of the Vietnamese-born 1996 population in Melbourne, 45.8% arrived in Australia prior to 1986, 27.3% arrived between 1986 and 1990 and 24.2% between 1991 and 1996.

According to ABS 2001 Census data, 6,760 Vietnamese-born resided in the Maribynong area, 13% of the Maribynong population spoke Vietnamese and around 41% of Vietnamese demonstrate "low English proficiency". Furthermore, 29.6% of Maribynong residents born in Vietnam were unemployed.

In the City of Greater Dandenong (2005), which includes Springvale, Vietnamese-born residents represent the largest ethnic sub-group (estimated at 11,641). Of interest, 94% of newly arrived from Vietnam established themselves between 1991 and 1995 in the then City of Springvale (Greater Dandenong, 1996, cited in Mudaly, 1997). According to Mudaly (1997), the age distribution of Vietnamese in this region is younger overall.

In the City of Whitehorse, which includes Box Hill, Vietnamese-born residents comprise 1.4% of the population (2,006 people), of which 1,641 speak Vietnamese at home (ABS, 2001, cited in City of Whitehorse, 2006).

In the City of Melbourne, which includes Richmond, 742 residents spoke Vietnamese at home (1.5% of the population). Of these, 245 spoke English very well, 231 spoke English well, 187 did not speak English well and 61 did not speak English at all.

APPENDIX B: INTERVENTIONS AND PROGRAMS FOCUSED ON VIETNAMESE COMMUNITIES IN AUSTRALIA AND THE US

A secondary aim of this literature review was to examine some community-based programs that have focused on Vietnamese populations and to identify any lessons and prevailing questions that were found.

The literature review identified only one targeted Vietnamese program in Melbourne for alcohol issues. Described by Mudaly (1997), it was conducted by the City of Greater Dandenong (funded by the National Drug Strategy, DHS) and aimed to increase Vietnamese family and youth access to drug-related services. A peer-education approach was adopted; a series of steps similar to the current project were taken, with a particular focus on information design to get a clear message across to the target families. Underlying this approach was recognition that an individual behaviour-only approach is not likely to be as effective as a more ecological approach that aims to increase community awareness or drug-related issues and strengthen more general ties between youth and their families. A follow-up program evaluation also took place, including forums that involved Vietnamese families.

In South Australia, Drug and Alcohol Services Council has worked in collaboration with the Vietnamese Community in Australia on a range of community projects including drug-related issues for Vietnamese youth. The major project, called *Hoi Sinh* (regeneration) is being conducted with a number of other organizations and includes the aims of increasing awareness of alcohol, improving referral services and encouraging community participation in tackling drug-related problems (for details of the project, see Tesoriero, 2002).

Kegler et al. (2005) reviewed four youth development programs in the US. Common across them was endorsement of a holistic approach called "positive youth development" of which several "assets" can be found and that demonstrate efficacy in reducing risk-behaviours in Vietnamese youth (Kegler et al. 2005). In particular, community interventions for Vietnamese in the US emphasize cultural appropriateness (e.g., part ownership of the intervention by the Vietnamese-speaking community) and the related issue of information/education design (Kegler et al, 2005).

The proposed project will meet the first criterion through partnership with a body that has close ties to the Vietnamese community (Quang Minh Temple) and through the use of Vietnamese speaking interviewers. The second criterion is met through attaining a better understanding of knowledge and attitudes of Vietnamese Australians to alcohol through the qualitative study as a precursor to improved survey design, and follow up interviews in order to assist data interpretation.

Previous initiatives for Vietnamese communities to tackle drug-related issues have witnessed high community responsiveness and participation (Higgs et al., 2001; Kegler et al., 2005; Mudaly, 1997), reflecting the untapped strengths of this sub-group of the Australian population.
Conclusions

Vietnamese communities overall appear to be positively responsive to community-based initiatives. More recent initiatives have involved shaping environments surrounding individuals

rather than an all out attempt to change risk behaviour. This approach values overall prevention as a life strategy, rather than just issues pertaining to drinking. However, as discussed earlier, there are Vietnamese cultural tensions regarding the predominantly western life philosophy of prevention.

APPENDIX C: PARTICIPANT INFORMATION SHEET, LIST OF SERVICES, AND QUESTIONNAIRE

See attached.

1. Participant Information for Patterns & Consequences of Alcohol Abuse: Vietnamese Alcohol Survey

2. Alcohol Survey

3. Alcohol Information and Support – Fact Sheet