A Selective Literature Review: Immigration, Acculturation & Substance Abuse

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BACKGROUND

Increasing attention is devoted to the booming immigrant population and the critical role this group will play in the United States economy in the next two decades. However, little is said about the health status of this group and the potential impact of ill health on the productivity of this critical emerging workforce. Further, immigrant children and youth remain an invisible population in public discourse about immigrants, their impact on labor markets, and how they contribute to the changing ethnic makeup of the United States. To address these issues, social scientists, including public health experts, are beginning to pay attention to acculturative and generational trends in the health status of immigrant children and families in the U.S. In 1996, National Research Council (NRC) and the Institute of Medicine (IOM) established the Committee on the Health and Adjustment of Immigrant Children and Families to increase our knowledge about the physical and mental health statuses, risk behaviors, and educational experiences and outcomes of first- and second-generation immigrant children and their families (National Research Council, 1998).

Additionally, there is growing consensus within the social science community about some of the causes and implications of health deterioration among immigrants. For instance, research is conclusive that substance abuse and affective disorders are more likely to occur after immigrants have migrated to the United States. On the other hand, there is little consensus about the mechanism or processes by which these changes in health take place. Nonetheless, a growing body of research on immigrant health provides an important foundation that can direct the efforts of policymakers, researchers, educators, health and health care workers to protect the health of this critical workforce. This report will focus on what is known about the impact of immigration and acculturation on substance abuse and addiction among immigrants, especially immigrant youth.

OVERVIEW

The following report is the product of a selective review of the literature on immigration, acculturation, and substance abuse among immigrants and refugees in the United States. Although adolescents were the primary focus of our review, we included literature on children and adult immigrant/refugee populations in our analysis. This research is part of a larger investigation, which will leverage the expertise of state funding agencies and local service providers of substance abuse services for immigrants and refugees. Drawing on their expertise and insight, we hope to pave the way for the development of more comprehensive, accessible, and culturally competent programs for the rapidly growing immigrant/refugee populations in the United States. Our work is supported by a Career Development grant from the Robert Wood Johnson Foundation, Developing Leadership in Reducing Substance Abuse (DLRSA).

Our literature review was guided by the following four research questions: Who are today's immigrants? What challenges are commonly faced by immigrants? How do immigration and acculturation impact substance abuse among adolescent immigrant populations? What types of interventions and services are needed to help youth and their families deal with substance abuse and addiction? Literature included in our research spanned various disciplines, including public health, mental health, sociology, and psychology. We began by combing through 10 years of relevant research presented in the following research journals: American Journal of Public Health, Social Science and Medicine, Prevention Science, Adolescent Health, School Health, Health & Social Work, Substance Use & Misuse, Journal of Drug Issues, and Journal of Community Psychology. This initial review provided us with a foundational understanding of relevant issues, as well as led us to papers, books, and other key sources of information. Since much of the foundational inquiry relating to immigration and acculturation dates back to the 1930's, we also reviewed seminal work on acculturation and issues relating to uprooting and resettlement. Please see Appendix 1 for a detailed presentation of the publications that informed our literature review.

Due to the shifting demographics of immigrant populations, the evolving challenges faced by newcomers, the need for continued migration, and the changing

policies affecting immigrants living in the United States, this report is not intended to be timeless or conclusive. Rather, it is intended to be a work-in-progress that can help current workers and decision-makers in the substance abuse and addiction field to develop a better understanding about immigrant sub-groups they will increasingly confront in their work. With this enhanced understanding, providers, funders, policy-makers, and researchers may be able to more effectively address the diverse and ever-changing needs of immigrants and refugees. In light of the continued growth and influx of immigrant populations into the United States and the growing dependence of the U.S. economy on this labor force, the future physical, mental and economic health of our nation depends on the ability of public health workers to acknowledge and address the health needs of newcomers.

FINDINGS

Who are today's immigrants?

Immigrants and refugees are an increasingly substantial subset of the US population. During the 1990s, more than 13 million people immigrated to the US., averaging well over a million immigrants per year. This number includes 700,000 to 900,000 legal immigrants, 70,000 to 125,000 refugees and asylees, and at least 300,000 to 500,000 undocumented immigrants arriving each year (Capps et al., 2003). According to the US Census, the foreign-born population in 2003 was 33.5 million people or 11.7% of the population. Projections suggest that the numbers of first- and second-generation U.S. residents will continue to rapidly expand. By 2050, US Census estimates indicate that the foreign-born population will top 15%, a historic high that has not been reached since the immigration boom of the early 1900s (Capps et al., 2003). The growth rate of young immigrant populations is particularly marked; the population of children in immigrant families has grown nearly seven times faster than the population of children of US-born parents (National Academy Press, 1997).

What are countries-of-origin for immigrants?

The foreign-born residents of the US hail from over 100 different countries according to the 2000 US Census. An Urban Institute survey of immigrants found 75

countries of origin among foreign born residents in Los Angeles County and 109 for New York City alone (Capps et al., 2002). Within this vast diversity, Mexico stands out as the most common country of origin, accounting for 30% (9 million) of the foreign-born living in the US in 2000. The entire continent of Asia accounts for the next largest share (26% or 8 million), followed by the cluster of other countries in Latin America including the Caribbean islands (22% or 7 million). Europe and Canada, the primary origin of immigrants from 100 years ago, now account for 18 percent (6 million). Africa and other countries (including Australia, New Zealand, and the Pacific islands) account for only 3 percent (about 1 million), though the number of foreign-born from Africa has been on the rise in recent years.

Where are immigrants settling?

While it would be challenging to find an area of the United States that is unaffected by this most recent wave of immigration, there are several regions in which immigrants most often settle. According to the US Center for Immigration Statistics (2002) sixty-five percent of legal immigrants upon arrival declare intention to reside in just six states: California, New York, Florida, Texas, Illinois, and New Jersey (Immigration and Naturalization Service, 2002). Having experienced substantial immigration influx during the past few decades, these six states have well established immigrant communities as well as state and local government initiatives that support newcomers including health programs, English as a second language courses, and interpreter/ translation services. However, while these major destination states continue to draw the largest numbers of immigrants, 22 other states with relatively low immigrant levels before 1990 have experienced faster growth rates in their foreign-born populations between 1990 and 2000. Due to both direct immigration and secondary migration from traditionally high receiving states like California, the majority of these "new growth" states have more than doubled their foreign-born population. The 10 states with the fastest growing immigrant populations in 2002 were North Carolina (274%), Georgia (233%), Nevada (202%), Arkansas (196%), Utah (171%), Tennessee (169%), Nebraska (165%), Colorado (160%), Arizona (136%), and Kentucky (135%) As a consequence of this rapid growth, new growth state and local leaders are now faced with new issues regarding immigration populations related to their countries of origin, English

proficiency, legal status, as well as where newcomers are settling within the state: urban centers, suburbs, rural agricultural areas (Capps et al., 2002).

What is the residency status of immigrants?

The large majority of immigrants arrive in the US legally, however a substantial number of newcomers are undocumented. Since 1990, about 350,000 undocumented immigrants per year have entered the US, bringing the total estimate of undocumented people living in the US to nine million. The magnitude of the undocumented population tends to differ by region of origin. The countries of origin accounting for the largest undocumented immigrant populations are Mexico, El Salvador, Guatemala, Columbia, Honduras, China and Ecuador. Representing the largest number, Mexico (4.8 million in 2000) accounts for 69 percent of the total undocumented population in the US. Upon arrival, almost one-third (32%) of undocumented immigrants choose to settle in California. Other states with large percentages of undocumented newcomers are Texas (15%), New York (7%), Illinois (6%) and Florida (5%). In total, these five states account for 64 percent of the total undocumented population (Migration Policy Institute, 2003).

What is the Age Distribution of Immigrants?

While people migrate from their county-of-origin for various reasons, the most common impetus for immigrating to the US continues to be the search for a better life, and an improved standard of living. Therefore, the largest majority of people immigrating is those seeking employment and are of working age. The US Census Bureau Current Population Survey in 2003 found that 80 percent of the foreign-born population living in the US is between the ages of 18 and 64 years, compared to 60 percent of the native-born population. Under 10 percent of the foreign born are under 18 years old, indicating that few newcomers are arriving with young children. However, it is estimated that one in five children in the US today under the age of 18 is a child of an immigrant (Migration Immigration Source, 2002).

What key challenges do immigrants face?

Demographic characteristics alone reveal nothing about the experience of new arrivals after they migrate to the United States. Individuals typically come to the United States in search of better standards of living, improved socioeconomic opportunities, to

escape political persecution or to reunite with family members. For many immigrants, their vision of a better future may lead them to underestimate the intense stressors they will face in their new environment. Although each immigrant/refugee's experience is unique, there is a common set of challenges that newcomers typically confront. These challenges often impact physical, behavioral, and psychological well-being.

Economic Disadvantage and Poverty

Due to the meager financial conditions of many immigrants (the U.S. Census found that 31.1% of foreign-born, full-time workers earned less than $20,000 in 2001), many are often forced to reside in low-cost neighborhoods, which are often dangerous, poverty-stricken, and offer poor living conditions. According to the U.S. Census, 43.3% of immigrants live in urban areas, compared to 27% of the native-born population. Newcomers with low levels of education often have difficulty accessing high income jobs. In his study of Mexican immigrant adults, Vega, Sribney, and Achara-Abrahams (2003) reported that only 49% of immigrants in his study received more than six years of education. In many cases, low educational attainment relative to the US-born population leads to low paying jobs and long work hours for immigrants. On the other hand, highly skilled and well-educated immigrants who may have been teachers, lawyers, or engineers in their countries of origin, often initially find themselves confined to low paying jobs outside of their discipline. Immigrants who are skilled in areas such as nursing for which there is a labor shortage in the US fair better.

Resettlement & Affordable Housing

Traditional immigration hubs such as New York City and Los Angeles remain central points of entry and resettlement for newcomers. Due to urban renewal in many urban centers, there is increasingly less affordable housing in these areas. As a result, it is increasingly common for immigrants to migrate directly to small towns and cities on the outskirts of major urban areas. Here, affordable housing and employment opportunities in industries such as farming or meatpacking may be easier to find. Examples of these changing resettlement trends include the growing Indo-Guyanese community in suburban Schenectady, New York, as well as the Hmong community in Lowell, Massachusetts. Overall, the 2000 U.S. Census revealed that ethnic and racial diversity has risen substantially in small cities and suburbs outside of major urban centers

(Frey, 2001). According to the Lewis Mumford Center for Comparative Urban and Regional Research, Hispanics and Asians live in these non-urban areas with people of the same ethnicity in higher proportions than a decade ago.

Social Networks and Social Capital

As can be seen in resettlement patterns, many immigrant subgroups attempt to recreate the strong social support systems, tight-knit communities, and extended family systems left behind in their countries of origin. Such social networks with high social capital can become a protective mechanism against social isolation, offering better education, community life and safety (Woolcock, 1998). On the other hand, social networks that are fragile and create excessive demand on individuals within the network can become detrimental to health and well-being of its members. Immigrants who find themselves outside of these established immigrant communities and who are not fully integrated into their non-immigrant community of residence, often experience social isolation. Social isolation is among the strongest predictors of poor health and is shown to be a risk factor for substance abuse and mental disorders such as depression. Among other factors, the lack of social support is a contributing factor to the higher rates of depression and alienation among immigrant youth of all racial and ethnic groups as compared to their native-born counter-parts (Yu, Huang, Schwalberg, Overpeck, & Kogan, 2003, citing Kao, 2000).

Language and Linguistic Diversity

Language barriers impede adjustment to living in the US. For adults, the inability to communicate often induces feelings of frustration and helplessness. Language minority students are the fastest growing population in US public schools, comprising 350 language groups spoken in schools (Escamilla, 2000). Eight languages including Spanish, Vietnamese, Hmong, Cantonese, Cambodian, Korean, Laotian, and Navajo, comprise 85% of the linguistic diversity in U.S. public schools (Escamilla, 1999). Youth often respond to the language barrier by remaining silent, appearing withdrawn, moody, and fearful. According to James (1997), this common response can last one to two years.

Adjustment to Social Norms

Many new immigrants also experience tension between the cultural norms from their home country and popular cultural norms in the United States. They find that traditional values and behaviors are often undermined or not sanctioned in the US. Immigrant children tend to internalize a new set of cultural norms, a new language, and a new value system more quickly than their parents. These differing rates of acculturation frequently become a source of conflict in immigrant families. As Velez and Ungemack (1995) explain, exposure to new norms weakens the social controls of the society of origin. The child's quicker adjustment often leads to feelings of alienation between parent and child. Often exacerbating familial conflicts is the need for an immigrant child to begin serving as a translator for his/her parents. This results in a reversal in dependence that can threaten parental authority (Baptiste, 1993). James (1997) explains that, as immigrant adolescents begin to think and behave more independently, they increasingly depend and seek advice from non-kin, such as teachers, friends, and school counselors.

Refugees Status

Compared to the anxiety experienced by immigrants, the stresses confronting refugees are often even more intense. Unlike voluntary immigrants, refugees are often forced to come to the United States to flea political persecution that results from their ethnicity, nationality, religion, or political opinions. As a result of persecution in their homeland, refugees are often severely traumatized. Many suffer from Post Traumatic Stress Disorder as a result of the violence and torture previously experienced.

Refugees also tend to have weaker social networks than immigrants, fewer financial resources, less formal schooling, and more psychiatric illness. Westermeyer (1997) writes that conditions that have been associated with refugee children are depression, somatic complaints, sleep disturbances, social withdrawal, violence, and antisocial behavior. Refugees also more often have to deal with family separation than other immigrants. Separated from families, many refugees are placed with American families rather than with members of their own ethnic group. If they are accompanied by family, those family members are often absent or unavailable (Westermeyer, 1997).

Immigrants' legal status is a key factor for their well-being. Undocumented immigrants constantly appear to do worse in many health and social indicators than their legal counterparts. Unemployment rates among undocumented immigrants are higher than those for legal immigrants. One third of unemployed undocumented immigrants believe that the main barrier to get a job is their lack of legal status. (Metha, 2004) Furthermore, legal status directly affects immigrants' wages and work conditions. Undocumented families have an average income of 40% less than documented and US families. (Passel, 2005) Unauthorized immigrants also report significantly higher rates of working in unsafe conditions and of wage and hour violations. (Metha, 2004) Compare to US-born adults, undocumented immigrants are twice as likely to live in poverty; and their children suffer higher risks of poverty and poor health. (Passel, 2005)

Undocumented immigration also has a toll on immigrants' mental health. Experiences from crossing the border illegally added to the constant fear of deportation and legal uncertainty can lead to severe problems such as depression and post traumatic stress syndrome. These and other health problems often remain undiagnosed and without treatment due to undocumented immigrants underutilization of health services. More than half of undocumented immigrants are uninsured (59%) compared to only 25% of legal immigrants. (Passel 2005) Furthermore, despite the fact that they also contribute to economy by paying taxes, undocumented immigrants rarely utilize government safety-net programs, even when they are eligible for them due to fear of legal consequences.

How do immigration and acculturation impact substance use?

Changes in Substance Use Patterns

Research consistently shows that foreign-born individuals initially demonstrate better health indicators than their native-born counterparts and this is consistent across socioeconomic status and educational attainment. However, with increased time in the United States, the health status of foreign-born individuals tends to deteriorate. Rumbaut (2004) found that, the longer the time and exposure to the United States, the poorer are the physical health outcomes of immigrants and the greater their propensity to engage in a variety of risk behaviors. While newcomers were found to be less likely to engage in

substance use than the US-born population, those who had been in the United States for 10 years or longer reported drug use that was not significantly different from that of the US-born population (SAMHSA, 2004).

Relocation to the United States is also associated with changes in drinking patterns. Vega et al (2003) relay evidence of these changes in Mexican males. In a study by Caetano and Mora (1988), Mexican men in their native country were found to drink less often but more per occasion than men in the United States. As they adjusted to their new environment, this occasion drinking combined with the more frequent drinking characteristic of the US culture, "creating a new pattern of regular drinking at higher consumption levels" (Vega et al., 2003).

Peer Influence

For many immigrant youth, the gradual weakening of parental control and changes in family structure are often accompanied by increasing peer influences. For adolescents, social learning can contribute to the onset of substance abuse behaviors. According to Velez and Ungemack (1995), peer modeling was found to be the strongest predictor of Puerto Rican youth's drug involvement. Research shows that immigrant youth are particularly vulnerable to peer pressure. Blake, Ledsky, Goodenow, and O'Donnell (2001b) found that recent immigrant youth reported lower alcohol and marijuana use compared with youth who are lifetime residents of the US. However, these new comer youth were likely to have less parental support to avoid risk behavior and most likely to experience peer pressures to engage in risk behavior. Recent immigrant youth also report lack of confidence to refuse substances (Blake et al, 2001b). This increasing influence may accelerate their adoption of what they perceive as mainstream behaviors and cultural norms.

Use of Services

Immigrants and refugees utilize substance abuse services less than native-born populations due to cultural and sociopolitical barriers. First, immigrants may not seek substance abuse services because they are unfamiliar with the system, do not know how to access the services, or are simply unaware that the services exist. Secondly, stigma is a powerful deterrent to help seeking in many cultures. The cultural stigma attached to substance abuse problems may prevent immigrants and refugees from seeking services.

In many cultures, emotional problems and substance abuse are cause for dishonor.
Among traditional Asian-Indians, for example, substance use is perceived as a moral
problem contributing to family shame (Bhattacharya, 2002). This perception differs
greatly from that of some Latino cultures, in which the initiation of alcohol use is
considered part of a boy's initiation into adulthood (Mental Health Center of Dada
County, Inc. 2003). Research suggests that, partially due to the stigmatization of
substance abuse, Asian American and Pacific Islanders underutilize mental health
services far more than other populations. Finally, fear is another deterrent to accessing
services. Immigrants who are illegally in the United States may fear discovery and
deportation and, as a result, do not seek any health or social services.

Window-of-Opportunity

Despite the common barriers to accessing substance abuse services, research
suggests there is a window of opportunity in which newcomers are quite receptive to
learning about substance abuse. This has been particularly apparent with adolescents.
According to research with newly arrived immigrant youth, recent immigrants had higher
perceptions of the utility and importance of health education (Blake, Ledsky, &
Goodenow, 2001a). Their study revealed that, compared to other students, recent
immigrants were also more concerned about drinking, teen pregnancy, STDs, and mental
health issues such as depression. In light of these findings, there is an urgent need for
early intervention to prevent the onset of substance abuse behaviors among immigrants
and refugees.

***How can substance abuse and addiction workers attend to the cultural needs of
immigrant youth and their families?***

A great deal of research has identified features, methods, and strategies that are
necessary for substance abuse prevention/intervention approaches that address the needs
of youth and their families. Recent literature on substance abuse is marked by an
increasing support for the use of evidence-based practices. These practices have been
evaluated and found to be consistently effective at decreasing substance abuse risks and
behaviors, while increasing protective factors. For service agencies, evidence-based
programs are intended to make implementation and evaluation processes more concrete,

organized, and systematic. Furthermore, the demonstrated effectiveness of evidence-based programs can permit increased confidence among providers that the services they offer will be successful.

Awareness of Cultural Bias

Unfortunately, most evidence-based programs were not designed specifically for immigrant/refugee populations. Therefore, these programs may be inappropriate in light of the unique challenges and needs of immigrants/refugees. The messages and strategies used in many substance abuse prevention programs were designed for a White, middle-class recipient population (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Kumpfer et al. assert, "The theoretical constructs, definitions of protective or risk factors, appropriate interventions of strategies, and research evaluation strategies have all been influenced by mainstream American values" (Kumpfer et al., p.242, citing Turner, 2000). According to Castro and Alarcon (2002), most programs have superficial coverage of cultural variables and are culturally blind to the needs of racial/ethnic minority recipients. Research suggests that, for this reason, traditional prevention/intervention programs may be ineffective with culturally diverse groups (Terrell, 1993).

Cultural Tailoring of Services

To encourage participation or use of services, programs must be culturally tailored to reflect the needs and perspectives of the target audience. Kumpfer and colleagues found that recruitment and retention was significantly improved by changes made to the content of program to reflect the cultural needs and values of the target audience without compromising the core components of the program (Kumpfer 2004). According to Pasick, D'Onofrio, and Otero-Sabogal (1996), cultural tailoring is, "The process of creating culturally sensitive interventions, often involving the adaptation of existing materials and programs for racial/ethnic populations." Without cultural tailoring, Castro and Alarcon write, the messages of a prevention program may be ineffective for diverse groups of learners (Castro & Alarcon, 2002). Cultural tailoring must be reflected in the surface structure of a program, in which interventions are matched to observable social and behavioral characteristics. Surface structure increases receptivity, comprehension, and acceptance of messages (Rensnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000, citing Simons-Morton, Donohew, & Crump, 1997). Although Hansen

and colleagues were not looking specifically at immigrants and refugees, they found that proven prevention programs that were developmentally and culturally appropriate have larger effect size than those that are not (Hansen et al, 2004).

Develop Ways-of-Knowing

Surface tailoring also mandates that program designers and implementers understand recipients' daily lives, the way they interact, and their typical patterns of behavior. For substance abuse prevention and intervention, this requires understanding the types of alcohol or drugs typically used by the population. Resnicow et al. (2000) emphasize that it is important for prevention educators to speak to students using their own terminology. In additional to this, the authors assert that incorporating images of people, places, food, and other cultural elements into informational materials enhances surface sensitivity. Another critical component of making a program culturally competent at the surface level is to provide instruction and information in a language that recipients understand. Translations of text-based information, native speakers, and interpreter services are necessary to make a prevention program accessible to service recipients who are not fluent in English.

Using Participatory Approaches

Service agencies can also be more culturally sensitive in terms of surface structure by recruiting members of the target immigrant group to participate in program planning, development, and service delivery. Though Hecht, Marsiglia, Elek, Wagstaff, Kulus, and Dustman (2003) were not looking exclusively at immigrants, the researchers found that minority youth responded more favorably to programs in which teachers or characters were members of their own group.

Hire Competent Service Providers

Prevention and treatment programs for immigrants must assure that all their staff possesses the attitudes, knowledge and skills necessaries to work with culturally diverse populations. A cultural competent team is an essential component of accessible and responsive programs. It allows establishing positive relationships between providers and clients and to improve the quality of services provided. Cultural competence starts with providers' recognition of their own cultural beliefs and practices, and acceptance that they may not be share by people from other cultures.

The Institute of Medicine report *Unequal Treatment,* released in 2002, highlights education as the best strategy to develop cultural competence among providers. Cross-cultural training and education for providers should be provided in an ongoing basis. It should focus on improving three spheres: knowledge, attitudes and skills to work with multicultural clients. Providers should be aware of the ethnic and cultural differences in the causal factors of substance use. They need to understand the effects that acculturation and biculturalism have over trends and consumption patterns among different populations; and how health care is influenced by culture and social factors. Understanding culture also allows providers to be aware of how biases, prejudices and stereotypes undermined their efforts. It promotes providers' appreciation of the positive characteristics of each culture and the value of cultural differences.

Address Cultural Nuances

Cultural tailoring must also be reflected in the deep structure of a program. Resnicow et al (2000) explain that deep structure program adaptations reflect how cultural, social, psychological, environmental, and historical factors influence an individual's health behaviors. The authors suggest that it is the deep structure (e.g. values, attitudes, behavioral norms, etc.) of a program that often determines the impact that program will have on targeted attitudes and behaviors. As with surface structure, there are several ways in which substance abuse programs can be culturally sensitive in terms of deep structure.

Reflect cultural themes: First, health promotion messages and strategies should reflect cultural themes that have been identified across racial/ethnic groups. After conducting interviews with Vietnamese, Cambodian, and Hmong refugees, for example, Frye found that kinship solidarity and the search for equilibrium emerged as dominant cultural themes that could be effective carriers of health messages (Frye, 1995). Gloria and Peregoy (1996) found that predominant Latino values include simpatia, personalismo, familismo, machismo and hembrismo, verguenza, and espiritismo. Additionally, Wong and Piran found that, while Western culture emphasizes the development of the individual, independence, and an internal locus of control, Chinese culture stresses interdependence, collectivity, and an external locus (Wong, & Piran, 1995). Based on these differences, a prevention/intervention program that embraces only

one of these perspectives may be ineffective when used with certain immigrant populations. A program that reflects recognition of an immigrant group's cultural values, on the other hand, could increase their receptivity to its underlying prevention/ intervention messages.

Address differential attitudes: Another way to culturally tailor a program in terms of deep structure is to acknowledge differences in cultural attitudes relating to alcohol and drugs. According to Orlandi (1992), "An ethnic or racial group's shared norms, beliefs, and expectations regarding alcohol and its effects shape the group members' drinking habits, the ways in which the members behave while drinking, and their perceptions of personal and collective responsibility for the outcomes of drinking." Research has identified consistent correlations between one's cultural identification and his/her beliefs about health issues, responses to messages, and substance use behaviors. For example, while some cultures perceive alcohol as sacred and essential, others view it as destructive (Amodeo, Robb, Peou, & Tran, 1997, citing Mandelbaum, 1965). Amodeo et al. (1997) explain that in some cultures, drinking with family members is a social event, and refusal to drink is viewed as a rejection of the other family members.

Throughout most Western cultures, however, adolescent substance use is considered to be deviant (Swaim, Bates, & Chavez, 1998). Similar correlations exist with regard to cultural attitudes towards illicit drugs. In Indian culture, drug use is considered a moral problem that brings dishonor to one's community, often causing the family to lose prestige and pride (Bhattacharya, 2002). In Haiti and Cambodia, however, narcotics are often used as medicine (Amodeo et al., 1997), perhaps resulting in different perceptions of drugs among immigrants of those cultural groups in the United States. The effectiveness of a prevention/intervention program may largely depend on the extent to which its messages agree or conflict with recipients' attitudes towards substance use and abuse.

Examine family structure: Interventions must also respond to the family structure embraced by the service recipients. In doing so, they must recognize cultural differences in parenting characteristics, parenting strategies, parent-child expectations, and strategies for parental monitoring and discipline. Providing an example, Kumpfer et al. (2002) explain that, since Asian and American Indian adolescents expect elders to

provide wisdom and suggestions, family interventions asking them to reflect and share personal feelings may be culturally inappropriate (Kumpfer et al., 2002).

Involve parents: Parents must be involved in substance abuse prevention/intervention efforts for immigrant youth. According to Velez and Ungemack (1995), family controls can provide a protective buffer against stresses associated with migration and discourage child from adopting deviant behaviors modeled in the new society. Since parental control often becomes threatened with time in the United States, parents should monitor their child's behavior from the outset and establish the standards of acceptable behavior within the new environment. With a cultural understanding, service providers will be better able to encourage students to talk to their parents about substance use, cultural norms, and personal risks. Bhattacharya (2002) found that adolescents who placed importance on their parents' drug abuse prevention messages tended not to use drugs. Substance abuse programs that help strengthen family bonds and facilitate communication can counteract the weakening of parental control that often occurs during acculturation.

Go where they are: Since school systems have direct access to many immigrant youth during the period in which they are likely to initiate substance use, schools are the logical venue for the delivery of prevention services. Furthermore, immigrant parents may also be more accepting of help from schools than from community agencies or other service organizations. Since the cultural values of many immigrants stress reliance on family support, many are resistant to community-based counseling. Parents are more likely to accept counseling for children in a school context (James, 1997). Therefore, prevention program developers must make programs that can be easily integrated into the school setting and curricula, and they must provide necessary tools, technical assistance, and training for teachers and school administrators (Kaftarian, Robertson, Compton, Davis, & Volkow, 2004).

There are various ways that schools can help prevent substance abuse problems. First, interpersonal bonding and school adjustment should be promoted within a school context. Attachment to school represents bonding to pro-social norms and helps prevent deviance. Among Mexican-American dropouts, lack of school bonding was associated with attachment to drug-using peers, while adjusted peers were less likely to attach to

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drug-using peers (Swaim et al., 1998). Schools can also provide more robust education about different health issues. In light of findings that recent immigrants had higher perceptions of the utility of health education and worried more often about related health issues (Blake et al., 2001a), interventions should be more accessible; as immigrants become more acculturated, they may be less receptive to prevention efforts and at increased risk of initiating high-risk behaviors.

       Identify children at risk: Effective prevention and intervention approaches must also identify at-risk youth. According to Britto, Klostermann, Bonny, Altum, and Hornung (2001), students must be questioned early on about their health status. The authors assert that access to health services is likely to improve health habits, modify risky behavior, and improve overall adolescent health (Britto et al, 2001). Providers must identify linguistic and culturally sensitive assessments that will identify immigrant children at risk for psychosocial problems and risk-taking behaviors. Since substance abuse often emerges in response to the stresses of immigration, these assessments must be able to identify symptoms of culture shock, emotional distress, adjustment problems, fear, and identity confusion (James, 1997).

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6. Acculturation issues: factors, stages. Acculturation was discussed in the beginning of the 20th century by American cultural anthropologists R.Redfield, R.Linton and M.Herskovits. At the first stage, they considered acculturation to be the exchange of cultural features that results when groups of individuals having different cultures come into continuous first hand contact. Gradually, scholars refused to see acculturation as a group phenomenon and started to treat it on the level of individual psychology. According to the new interpretation, acculturation has come to be viewed as changes in This article provides a review of the literature on the acculturation of Latino and African-American adolescents to traditional European-American cultural values, and the effect on their substance abusing behaviors. The review includes a critical analysis of studies that examine the effects of acculturation on the mental health and well-being of Latino adolescents. Recent findings documenting the association between acculturation and substance abuse among Latino adolescents are discussed. The article also examines the dearth of research on the role of acculturation in the substance-abusing beh