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Investigating Socio-Cultural Factors Influencing the Attitude, Behaviour and Experiences of Asian New Zealanders Towards Alcohol and Drug Use

Final Report

Asian Family Services
for Te Whatu Ora Health New Zealand

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Executive Summary

This qualitative study provides critical insights into the experiences and perceptions of alcohol and drug (AoD) use in Aotearoa New Zealand's (NZ) diverse Asian communities. Building on previous quantitative research (Asian Family Services (AFS) et al., 2023), findings indicated higher-than-expected substance use rates among certain Asian subgroups in NZ. This study delved deeper to investigate the cultural and social dynamics shaping AoD behaviours, as well as participants' experiences accessing support.

Drawing on in-depth interviews with 24 Asian participants representing a range of demographics - age, ethnicity, gender, sexual orientation, time spent in NZ, marital status, highest education level, employment status, and AoD – several primary causes were identified as contributing to AoD use. These included family rituals, peer influence, curiosity, and coping with emotional distress. Younger participants and second-generation migrants often described alcohol initiation as part of social integration into NZ culture, while first-generation participants emphasised the use of alcohol as a tool for professional networking or adapting to perceived cultural expectations.

During periods of peak consumption, participants often perceived positive outcomes and noted that AoD enhanced social confidence, professional networking skills, academic performance, and sexual pleasure. LGBTQ+ respondents emphasised that substances facilitated the exploration and acceptance of their sexual orientations, despite the inherent risks.

The study also uncovered adverse impacts, including deteriorating mental health, strained relationships, and physical health concerns. For some, tolerance built up and withdrawal symptoms were frequent, particularly among older people who use alcohol and younger people who use drugs. Reduction efforts were at times triggered by external events such as medical diagnoses, legal issues, or self-reflections.

This study stresses the need for culturally informed health promotion, early intervention strategies, and peer support programmes that resonate with Asian communities. Services should integrate culturally appropriate education, stigma reduction strategies, bilingual counselling, a holistic peer support system, and LGBTQ+-friendly spaces to effectively meet the diverse needs highlighted by this research.

In conclusion, AoD use among Asian communities in NZ is influenced considerably by a combination of Asian and NZ cultural dynamics, identity factors, social pressures, and mental health needs. Directing these complexities through culturally responsive policies and community-driven interventions will be essential for ensuring safe AoD consumption within this rapidly growing demographic.

1 Introduction

This research intends to explore the social and cultural factors that form patterns observed in Asian people residing in Aotearoa New Zealand (NZ). Specifically, it seeks to understand how this population experiences alcohol and other drugs (AoD) as well as their cultural perceptions surrounding them. Lastly, the research aims to identify how support services can better equip themselves to cater to this population.

1.1 Background and context

NZ is undergoing substantial demographic change. According to the 2023 Census, 861,576 people (17.3%) identified as Asian, marking a 21.8% increase since 2018 (Stats NZ, 2023). Projections indicate that by 2043, the Asian population will comprise more than 33% of the total population (Stats NZ, 2023). This rapid expansion combined with the Asian community's rich cultural, linguistic and migrant diversity, emphasises the urgent need for responsive services designed to address current and future health and social needs. Recognising and deepening our understanding of Asian New Zealanders today is essential. It will help protect policies, health, community services and resources, to ensure a thriving and flourishing society as this group becomes an increasingly significant portion of NZ's population.

1.2 Asian population and AoD

The 2024 Health Survey Report identified drug use as the fourth and alcohol use as the sixth most significant health problems people are currently facing in the country (Ipsos, 2024). The 2023/24 New Zealand Health Survey reported that 76% of adults had consumed alcohol in the previous year, of which 57% Asian people recalled consuming alcohol in that same year. Cannabis use in the past year, was recorded at 15.6% among the adult population (Ministry of Health (MoH), 2024). A closer examination of earlier survey data reveals that in 2021/22, cannabis use among self-identified Asian people had approximately doubled to tripled over the past decade, increasing from around 1.9% in 2011 to approximately 4.4% in 2023/24 (MoH, 2024).

In response to these trends, Asian Family Services (AFS) and the New Zealand Drug Foundation (NZDF) (2023) were commissioned to conduct a nationwide survey exploring AoD use within the Asian population living in NZ. They collaborated with Synergia and Trace Research to conduct this survey. Findings showed that AoD use in some subgroups exceeded the national average. This quantitative study with 1,052 Asian New Zealanders confirmed cannabis use in the past year was 7.6%, with notably higher rates among Indian and Filipino participants. Further, nearly 50% of those who reported current drug use

reported experiencing more benefits than harm from drug use. Alcohol use was reported at twice the rate among NZ-born Asian people compared to their overseas-born counterparts (AFS et al., 2023).

These overlapping data points emphasise critical gaps in understanding the cultural and social drivers of AoD use within diverse Asian communities. To unpack these dynamics, this current qualitative study involves in-depth interviews with 24 Asian New Zealanders, providing direct insights into their lived experiences.

1.3 Research Aims and Objectives

AFS, as a leading provider of culturally responsive counselling and community support for Asian New Zealanders, has observed a rise in AoD concerns reported in various nationwide surveys. In response, AFS has championed this qualitative inquiry to surface the social, cultural, political, and identity-driven factors that contribute to the use of AoD in Asian communities.

By listening directly to the voices of diverse Asian New Zealanders across a range of age groups, migration histories, and sexual orientations, this research will guide service providers and community stakeholders in developing equitable strategies, family-centred education, and peer-led support models that resonate with the lived realities of Asian communities now and in the future. The term Asian people in NZ is more inclusive and refers to individuals of Asian descent who reside in NZ, including those who may be recent immigrants, foreign nationals, with temporary visas, NZ citizens, or have dual citizenship.

1.4 Research Questions

The purpose of this research is to explore the social and cultural factors behind patterns observed in the NZ Asian Alcohol and Drug Survey. Specifically, it seeks to understand how Asian New Zealanders perceive and experience AoD use. Guided by the quantitative survey's findings, this study aims to answer the following questions:

Research Question 1: What are the perceptions and experiences of Asian people who report AoD use?

Research Question 2: What are the perceptions and experiences of Asian people relating to the access of AoD information and/or help services?

1.5 Value of the study

This qualitative study delivers three key impacts that collectively enhance our insights of AoD use within NZ's Asian populations.

First, by centring the lived experiences of Asian New Zealanders, the study addresses a critical gap left by purely quantitative surveys. While large-scale data outline the use and patterns of harm, in-depth interviews reveal why and how social and cultural norms, family expectations and acculturation shape the initiation, escalation, and reduction of AoD use.

Second, the study further develops recommendations for culturally responsive practices. A recent scoping review noted the limitations of disaggregated health data and highlighted the need for Asian-specific service design (Chiang et al., 2021). Our findings reinforce this need, supporting the vision for interventions grounded in multilingual outreach, peer-led support, and family-centred education.

Third, this research strengthens mixed-methods evidence on minority health by integrating qualitative depth with existing quantitative trends. In doing so, it proposes actionable recommendations for policymakers and funders to develop AoD services that are both evidence-based and culturally compatible, ensuring the system is well-positioned to meet the needs of NZ's growing and evolving Asian demographic.

2 Methodology

2.1 Ethics Approval and advisory group

The research project was submitted for approval by the Aotearoa Research Ethics Committee (AREC) in November 2024 while their approval was obtained in early February 2025, prior to conducting interviews.

As part of the approval process, AFS collaborated with a research institute from the University of Auckland (UoA) - the Centre for Arts and Social Transformation (CAST) to draft the research plan. Their expertise with socially sensitive topics was instrumental in producing a high-quality application, which included the research recruitment advertisement, interview guide containing semi-structured interview questions, participant consent form, and participant information sheet (PIS), attached in Appendices 1 to 3.

These components were further refined for accuracy and to ensure alignment with the AREC's requirements, drawing on guidance from the AoD advisory group established by AFS. This group comprised subject matter experts from the NZDF, UoA, CAST, Trace Research, migrant non-governmental organisations (NGOs), and counsellors, who provided input on research processes and content at each milestone.

2.2 Interview methodology

2.2.1 Participant selection criteria and recruitment process

The participant sample was to comprise individuals who had experienced alcohol and/or other drug-related harm in NZ. Specifically, eligibility criteria required participants to be aged 18 years or older, self-identify as Asian, currently reside in NZ, and have consumed alcohol and/or other drugs in the past or present, with self-reported experiences of harm or challenges associated with the use.

Participant recruitment was carried out through a comprehensive approach that combined targeted outreach, community engagement, and partnerships. Recruitment advertisements were distributed via email to AFS staff, including members from the Public Health and Clinical teams – the latter comprising counsellors, who were well-positioned to identify potential participants and connect them with the researchers for pre-screening. In addition, AFS and CAST disseminated recruitment information to a variety of external organisations, such as anonymous AoD support groups, Community Alcohol and Drug Services (CADS), the NZDF, Needle Exchange Programme and the Salvation Army,

leveraging existing sector networks to broaden the study's reach. AFS also engaged with Trace Research, a market research agency with expertise in Asian participant panels, to recruit 10 eligible participants. Social media platforms, including WeChat and Facebook, were utilised to enhance visibility and accessibility, particularly among hard-to-reach communities. Finally, snowball referrals, and word of mouth also played a valuable role in extending recruitment beyond formal channels.

This multi-faceted recruitment approach was designed to engage a diverse range of Asian ethnicities particularly those identified as being at higher risk, including Chinese, South Asian, Filipino, and Korean populations as well as individuals from the LGBTQ+ community.

Interested participants were pre-screened either verbally or via a Microsoft Form to ensure they met the study's eligibility criteria. Eligible individuals were then briefed about the purpose and scope of the research, had the opportunity to ask questions, and were invited to indicate their preferred language for the interview. They were provided with the PIS and were required to return a signed consent form prior to an interview if they wished to participate.

Following the initial round of recruitment and interviews, the research team observed that the sample did not sufficiently capture the diversity of perspectives sought. Notably, no participants reported experiences with intravenous drug use – a route of administration that is under-reported, insufficiently explored, and highly stigmatised within Asian communities (Deryabina & El-Sadr, 2019; Lan et al., 2018; Lee et al., 2021; Patel et al., 2021). Additionally, the representation of participants who identified as LGBTQ+ was limited. This intersectional identity, being both Asian and LGBTQ+, remains critically underexplored in the existing literature on AoD use (Gatanaga et al., 2024; Homma et al., 2012).

To address these gaps, a second round of recruitment was undertaken to engage additional participants who had experienced harm related to intravenous drug use and/or identified as LGBTQ+ Asian New Zealanders. The support of the NZ Needle Exchange Programme (NZNEP) was helpful in facilitating this targeted recruitment.

2.2.2 Sample demographics

A total of 24 participants were interviewed, reflecting diversity across a range of demographic variables, including age group, ethnicity, time spent in NZ, marital status, gender, sexual orientation, highest education level, and employment status. Participants also varied in their experiences with AoD use, including self-reported harm or challenges. The sample included 1.5 generation, referring to those who migrated to NZ as children or adolescents, and second-generation individuals, referring to those who were born in NZ to migrants.

Table 1. *Participant demographics*

	Total	Alcohol	Drugs	Both
Ethnicity				
Chinese (Mainland and Malaysian)	7	2	2	3
Filipino	3	2	0	1
Indian	3	1	0	2
Korean	6	4	0	2
Thai	1	0	0	1
Vietnamese	1	1	0	0
Cambodian	1	0	0	1
Multi-ethnic	2	1	0	2
Total	**24**	**11**	**2**	**11**

	Total	Alcohol	Drugs	Both
Gender				
Female	6	2	0	4
Male	18	9	2	7
Age Groups				
18-24	4	1	0	3
25-34	7	3	1	3
35-44	8	3	1	4
45-54	2	1	0	1
55-64	1	1	0	0
65-74	2	2	0	0
Time Spent in NZ				
1 to 5 years	1	0	1	0
6 to 10 years	4	2	0	2
11 to 15 years	3	1	0	2
More than 15 years	5	4	0	1
1.5/2nd Generation	11	4	1	6
Marital Status				
Single	10	2	1	7
Married	8	7	0	1
Divorced/Separated	1	0	0	1
In a Relationship	5	2	1	2

	Total	Alcohol	Drugs	Both
Sexual Orientation				
Straight	21	11	1	9
Gay	3	0	1	2
Employment Status				
Full-time	13	7	1	5
Part-time	3	0	1	2
Self-employed	4	2	0	2
Student	2	0	0	2
Retired	2	2	0	0
Highest Education Level				
Secondary School	2	2	0	0
Certificate/ Diploma	5	1	1	3
Bachelor's Degree	14	6	1	7
Post-graduate Degree	3	2	0	1

Table 2. *Participant Information*

Participant	Age	Gender	Ethnicity	Residence	Education	Employment	Marital Status	Sexual Orientation	AoD Use
P01	18-24	Male	Indian	6 to 10 years	Post graduate degree	Full time	Single	Straight	Alcohol only
P02	35-44	Male	Korean	15+ years	Bachelors degree	Full time	Single	Straight	Alcohol only
P03	45–54	Male	Korean	15+ years	Secondary school	Full time	Married	Straight	Alcohol only
P04	25–34	Male	Chinese	1 to 5 years	Bachelors degree	Full time	In a relationship	Gay	Drug
P05	35–44	Male	Chinese, Indian, Burmese	1.5/2 Gen	Certificate/ Diploma	Self employed	Married	Straight	Alcohol only
P06	18–24	Male	Chinese	1.5/2 Gen	Bachelors degree	Student	Single	Straight	Both
P07	35–44	Female	Korean	1.5/2 Gen	Bachelors degree	Self employed	Married	Straight	Alcohol only
P08	35–44	Male	Korean	1.5/2 Gen	Bachelors degree	Self employed	Single	Straight	Both
P09	65–74	Male	Malaysian Chinese	15+ years	Post graduate degree	Retired	Married	Straight	Alcohol only
P10	25-34	Male	Vietnamese	11 to 15 years	Bachelors degree	Full time	Married	Straight	Alcohol only
P11	18–24	Female	Chinese	1.5/2 Gen	Bachelors degree	Part time	Single	Straight	Both
P12	25–34	Female	Korean	1.5/2 Gen	Bachelors degree	Student	Single	Straight	Both
P13	25–34	Female	Cambodian	6 to 10 years	Bachelors degree	Part time	Divorced/Seperated	Straight	Both
P14	25–34	Male	Filipino	1.5/2 Gen	Bachelors degree	Full time	In a relationship	Straight	Alcohol only
P15	35-44	Male	Thai	1.5/2 Gen	Bachelors degree	Full time	In a relationship	Straight	Both
P16	25–34	Female	Filipino	1.5/2 Gen	Bachelors degree	Full time	In a relationship	Straight	Alcohol only
P17	35-44	Male	Indian Kiwi	6 to 10 years	Post graduate degree	Full time	Single	Gay	Both
P18	65-74	Male	Chinese	6 to 10 years	Secondary school	Retired	Married	Straight	Alcohol only
P19	35-44	Male	Chinese	1.5/2 Gen	Certificate/ Diploma	Part time	Single	Straight	Drug
P20	35-44	Male	Chinese	15+ years	Certificate/ Diploma	Full time	Married	Straight	Both
P21	25-34	Male	Filipino	11 to 15 years	Certificate/ Diploma	Full time	Single	Straight	Both
P22	55-64	Male	Korean	15+ years	Bachelors degree	Full time	Married	Straight	Alcohol only
P23	18-24	Female	Japanese and NZ	1.5/2 Gen	Certificate/ Diploma	Full time	In a relationship	Gay	Both
P24	45-54	Female	Indian	11 to 15 years	Bachelors degree	Self employed	Single	Straight	Both

2.2.3 Interview design and protocol

Qualitative, semi-structured interviews lasting between 60 and 90 minutes were conducted to explore participants' experiences and perspectives of AoD use, as well as their perspectives on accessing information, support, and services available in NZ when help-seeking and recovering.

Prior to each interview, participants were informed that their involvement in the research was voluntary and confidential, and that they could pause or withdraw from the study at any time - including up to two weeks post-interview – should they feel uncomfortable.

Participants observed to be partaking in AoD use during the interview were provided with information about relevant local support services, including counselling and community-based programs. Those that expressed immediate distress regarding their AoD use were given contact details for support services such as CADS and AFS, both of which are equipped to deliver culturally appropriate support.

The interview guide, PIS, and consent form are provided in Appendices 1 to 3.

2.2.4 Data collection procedures

Interviews were conducted either in person or online, with participants being offered the option to have their cameras on or off. All interviews were carried out by members of the AFS and CAST research team. To uphold ethical considerations, care was taken to ensure that participants were not interviewed by someone with whom they had a prior counselling relationship.

Further, only 20.8% (5/24) of these interviews were conducted in a language associated with participants' ethnicity, reflecting participant preferences. The predominant preference for English in this sample suggests the influence of multiple, nuanced factors. As noted in numerous empirical studies and review articles, stigmatisation, and fear of losing face can pose a significant barrier to help-seeking amongst Asian communities in western nations (Goh et al., 2021; Leong et al., 2011; Shah et al., 2019; Sue et al, 2012). Consequently, engaging in open dialogue with someone from the same ethnic background may have been perceived as risking the exposure of personal experiences, as well as increasing the risk of privacy concerns within a small community. Participants could have felt that it would place implicit pressure to conform to perceived cultural norms and expectations, which could inhibit candid discussion of their experiences with AoD. These broader cultural concerns were also reflected in participants' emphasis on preserving anonymity throughout the research process when discussing potential project involvement with the research team.

2.2.5 Interview Guide

The research team facilitated interviews in participants' preferred languages by pairing them with interviewers who were fluent in those languages. Interviewers were provided with a semi-structured interview guide, designed to offer a structured yet flexible framework; it is included in Appendix 1. This guide facilitated consistent coverage of key research objectives and questions while allowing for open-ended, in-depth conversation. Each component of the guide aligned with areas of inquiry relevant to the study's focus on socio-cultural factors influencing the attitudes, behaviours, and experiences of Asian communities in relation to AoD use in NZ.

These aspects included:

- **Background** (migration, time spent in NZ, time spent receiving support if any)
- **AoD journey** (perceptions and experience of first time AoD use, changes in use over time, positive and negative impacts of use, experience of accessing support services if any, and motivations and barriers to seeking help)
- **Personal characteristics** (demographics, life stage, personality characteristics, and risk preferences)
- **Ideas and values** (looking back at own upbringing: cultural beliefs about AoD, and values that influence behaviour)
- **Macro-environment** (NZ cultural ideas about AoD, policy, regulations, and changes in types of available AoD)
- **Experience in NZ** (acculturation, employment, life stage, financial, social, and significant events)
- **Community influences** (influences and perceptions observed amongst family, friends, community contacts, and recommendations for service provision improvements to support Asian people with experience of AoD use)
- **Immediate environment influences** (physical environment, marketing, opportunities to consume AoD and access support services, stressors in the environment, policies, and rules)

2.2.6 Qualitative analysis approach

For interviews conducted in Asian languages, audio recordings were securely transferred to professional translators – each of whom had signed confidentiality agreements prior to receiving the files. These translators transcribed and translated the interviews into English to ensure accuracy and fidelity of participants' narratives. The resulting transcripts were then read multiple times to develop a deep understanding of participant accounts and emerging patterns.

A thematic analysis was conducted to identify recurring patterns and themes across the dataset. Transcripts were systematically coded, with all excerpts collected and labelled according to participant characteristics, and quotes tagged using themed codes. An idiographic approach was adopted to retain the distinctiveness of each participant's experience, enabling a detailed exploration of how participants' narratives evolved over time and the contextual factors influencing AoD use at different points in life.

3 Results

Following the coding and iterative review of transcripts from the 24 participants, recurrent codes were developed into overarching themes. The themes were shared with the internal research team and with CAST from UoA to allow inter-coder reliability checks. These themes were presented to the NZDF and advisory group for sense-making.

Thematic analysis initially began using ATLAS.ti to support systematic coding and organisation of qualitative data. The software was effective for managing large volumes of text and identifying early patterns across transcripts. As the analysis progressed, a manual approach was adopted to allow for closer, more interpretive engagement with the data. This shift enabled greater flexibility and a deeper understanding of meanings. The manual process facilitated a more reflective analysis.

The themes have arrived through the typical path of AoD use, namely, initiation, escalation, and reduction. The subthemes provide further insight into participants' experiences. Where relevant, contrasts are drawn between first-generation migrants, 1.5- and second-generation migrants. Intersections with gender and sexual orientation are also highlighted. Lastly, the results shed light on participants' preferred support services and include their recommendations for a more effective and culturally compatible support system/systems of care.

3.1 Stage 1: Initiation of AoD Use

Initiation refers to the initial point at which a person first engages in AoD use. While the goal was to understand the participants' experience with AoD in New Zealand, some participants had used AoD in their home countries and continued to use AoD in New Zealand. Others had used AoD for the first time in New Zealand. By examining this stage, we identified the early points of influence, particularly where cultural traditions, familial expectations, or community norms may shape apprehension or openness toward AoD use.

3.1.1 Peer Influence

20 of 24 participants mentioned receiving explicit encouragement to try alcohol or other substances, but the description of that pressure varied by generation and environment surroundings. First-generation migrants often encountered pressure in workplace contexts in their home country. These accounts reveal a culture of obligation within migrant work settings.

"After graduation, I went to (a different city in China) for my first job. Every evening my coworkers insisted that I drink with them, even when I said no, they poured me a glass." P04 (male, Chinese, age 25–34)

Similarly, a Korean participant recalled,

"At the office once a month we had sponsored nights out. You could not refuse the boss's toast without risking ridicule." P22 (male, Korean, age 55–64)

By contrast, 1.5 and second generation, and NZ-born participants described peer influence and socialisation as a reoccurring theme.

"Most of the time, I drink for social reasons. I'm not really the kind of person who just feels like drinking and then does it." P20 (male, Chinese, age 35–40)

"I was looking forward to experimenting. And for a longer duration of time, I wanted to socialise rather than being alone and lose my friends." P16 (female, Filipino, age 25–34)

Participants were asked if they were pressured into AoD use, most declined and instead described it as a form of encouragement or invitation to participate rather than something imposed upon them. It is important to note that peer pressure differs from peer-driven acts. Peer pressure involves deliberate persuasion, whereas peer-driven acts would mean participants would collectively behave a certain way without deliberate force.

3.1.2 Family Rituals

Many participants first encountered alcohol at family gatherings, where it was frequently presented as a gentle activity, typically without any guidance on safe consumption. 14 participants discussed their first sip or taste of alcohol during birthday banquets, weddings, or other celebrations in their hometown.

"At Lunar New Year my siblings made a toast with baijiu. They laughed and said, 'Don't you dare refuse your elder.' I took the shot although it burned my throat." P18 (male, Chinese, age 65–74)

"But in China, drinking often feels like completing a task, you know? When you go out to eat or attend something, drinking becomes a mandatory part of it." P20 (male, Korean, age 35–44)

"At Diwali, my uncles poured Johnny Walker and said, 'Be a man, have a sip.' I swallowed even though it burned." P17 (male, Chinese, age 35-44)

"Tết starts with a cup of rice wine for good fortune. No one talks about how many cups are safe." P10 (male, Vietnamese, age 25-34).

With second-generation participants it was noted that family rituals lacked discussion of lower-risk limits. Even where parents who consumed alcohol, they did not discuss safe limits with their child or teenager.

> *"My mom says she just gets really bad, like hangover, so she just prefers not to drink. They wanted to raise me as like a good kid. So I guess it was, it wasn't really talked about like the effects of alcohol."* P23 (female, Japanese-NZ, age 18–24)

An Indian participant described a wedding where men and women ended up sitting separately, and the men's area would turn into whiskey rooms,

> *"My mother would frown if I got drunk. My father would encourage me. It felt confusing."* P24 (male, Indian, age 45–54)

Family rituals allowed access to and societal acceptance of AoD use throughout generations, but they did not teach harm-reduction skills, which set the stage for further experimentation.

3.1.3 Curiosity and rite of passage

Among the 1.5-generation and second-generation participants, who straddle the divide between Kiwi youth (i.e., age 18-24) culture and parental expectations, curiosity proved to be a compelling initiator of AoD use. Participants depicted their first use as a small act of rebelliousness, a symbolic entry into maturity, or symbolic step toward adulthood. Intentional planning was reported by several participants. Since alcohol was readily available, socially acceptable, and visible in family environments, it was usually the initial experiment. Other substances such as cannabis, 3,4-methylenedioxymethamphetamine (MDMA), and nitrous oxide, frequently appeared later, often in the context of festivals or night-time social gatherings. Notably, rite-of-passage language was also reflected in drug-curiosity narratives:

> *"We bought Vodka Cruisers for the party because it felt like a grown-up thing to do."* P14 (male, Filipino, age 25-34)

> *"My mental health was quite bad. And then my friend group had access to alcohol and drugs, so. And it was like quite normalised in that friend group because they do it like all the time. So I guess I ended up falling into that."* P23 (female, Japanese-NZ, age 18-24)

> *"At a rave party everyone tries drugs. I didn't want to be the only sober one."* P20 (male, Chinese, 18-24)

Alcohol initiation was influenced by cultural acceptability and social gatherings with peers, whereas drug initiation was more commonly linked to curiosity and a desire to be part of

a sub-culture. Participants who first experimented with alcohol did not begin experimenting with drugs until months or years later.

Patterns of initiation also reflected differences in time spent in NZ. First-generation migrants used alcohol or drugs within the context of collectivist values or cultural rituals with the intention of consuming in moderation. In contrast, NZ-born and 1.5 generation participants initiated alcohol or drug use, driven by social gatherings with peers to fit in or due to efforts in asserting personal autonomy.

3.1.4 Coping with stressors: emotional or physical

Participants who initiated AoD use for coping reasons often described a "tipping point," such as anxiety in social situations, a recent breakup, family violence, or a longstanding sense of being "different."

P01 reflected on using alcohol to manage social anxiety as a young adult. They recounted entering university and feeling out of place in group settings, particularly as a migrant who had not fully acclimatised to NZ's social scene. Alcohol provided a socially acceptable avenue to overcome shyness and blend in: *"I was always very shy in school, but at my first flat party everyone had drinks in their hands. I felt like I could actually talk to people after a few sips, like I became a new version of myself."* P01 (male, Indian, age 18-24)

For P07, initiation coincided with a period of stress and family conflict. They linked their first use of alcohol to feelings of isolation at home:

> *"It was so lonely, everyone was fighting at home, so when friends asked me out for drinks I said 'yes.' It was the first time I forgot about home problems and just laughed."* P07 (female, Korean, age 35-44)

Several participants specifically mentioned using AoD to cope with the aftermath of relationship loss or emotional hurt.

P21 described starting to drink after the end of a long-term relationship, expressing how alcohol temporarily softened the pain and allowed them to re-engage with social life,

> *"After my girlfriend broke up with me, I could not stop thinking about it. My mate said, just come out for a drink. At first, I said no, but later I saw it helped me just forget for a bit."* P21 (male, Filipino, age 25–34)

These narratives highlight how stress stemming from family rejection, cultural expectations, or gendered norms, influences the initiation of AoD use. For many participants, it functioned as a form of self-soothing or emotional escape in response to these emotional and psychosocial stressors.

3.2 Stage 2: Escalation

Escalation denotes the shift from infrequent or experimental use to more frequent, heavier patterns of consumption. This became a recurring theme as nearly (18 participants) 75% of the participants described a turning point when “one drink” evolved into nightly consumption, or when drugs initially used for sleep or socialisation gradually became sources of daily dependence. Experimentation emerged as a distinct phase, typically occurring in mid- to late-adolescence.

3.2.1 Self-medication

During the escalation phase, the purpose of coping shifted from short-term relief to regular self-medication. Participants described a development from using substances “sometimes” for nerves or sadness, to using them habitually whenever such feelings appeared. Rather than an occasional tool, alcohol or drugs became a routine response to negative emotions, with many stating that “it just became what I [they] did every night,” or that “after work, I[they] couldn’t relax without a drink.”

> *“It started with just a few drinks after work to take the edge off. But soon, every day, I needed it just to get through.”* P01 (male, Indian, age 24–25)

Chronic loneliness, ongoing workplace or academic pressure, persistent anxiety, and family conflict emerged as entrenched drivers of substance use during the escalation phase. For some participants, particularly those identifying as LGBTQ+ or second-generation migrants, unresolved trauma or ongoing discrimination made harmful substance use a relied on strategy for emotional regulation as they could control their feelings in a predictable way.

Participants who had started drinking or using to "feel confident at parties" found themselves drinking alone to cope with intrusive thoughts, despair, or sleep issues. For those with anxiety, depression, or trauma histories, AoD were frequently used in the escalation phase to replace or enhance other forms of assistance such as seeking counselling, confiding in friends, or engaging in cultural or religious coping strategies, AoD use became the default means of self-soothing.

> *“Whenever I felt the stress building up at work, instead of talking to anyone or going for a walk, I’d just open a beer. It was automatic.”* P21 (male, Filipino, age 25–34)

From the interviews, it was noted that increased use of AoD was at times intentional and used to suppress factors such as stress, fatigue, self-esteem or even with emotional support.

For, first-generation migrants, long hours in physically demanding jobs, irregular shift work, and the sleep disruption that accompanies both were recurring themes. Several participants explained that a glass of strong beverage or a joint had become the quickest, cheapest sleep aid in a country where they felt time-poor and linguistically isolated from primary-care services. P04 (male, Chinese, age 25–34) described leaving a kiwifruit packing shed at midnight and smoking cannabis in the hostel car park because "my [their] brain kept buzzing, and I [they] just wanted everything to go quiet."

By contrast, **second-generation and NZ-born participants** focused on feeling anxiety related to academic performance, body image, peer relationships, and future career prospects. Alcohol often emerged as the coping mechanism, with weekend binges having "turned the volume down" on spiralling thoughts. Some participants eventually incorporated prescription medications, obtained informally from family members or flatmates. P21 (male, Philippines, age 25-34) "I have a social group I engage with often, and I think that was probably one of the main reasons as to why I was drinking a lot as well".

An additional layer appeared among **LGBTQ+ participants and those who experienced racism**. Here, self-medication meant reducing the psychological barriers. P17 (male, Indian, age 35–44) described methamphetamine as "a potion that let me[them] be gay without fear for one night".

The prescription status made little difference to the underlying pattern of use. Most coping agents were not formally prescribed, such as cannabis shared in hostels (P04), spirits taken from the family cupboard (P03), or passed on by friends P12). Yet the rationale for self-medication remains strikingly similar, whether the substance came from a General Practitioner (GP), or a local dairy. In each case, the substance was treated as a functional tool for immediate symptom relief, particularly in contexts were speaking only about distress felt impossible, impractical or, too shameful.

These accounts emphasise that escalation through substance use as a coping strategy is not simply a matter of individual choice, but often a response to unmet support needs shaped by migration history, cultural norms, and social identity. Addressing those root pressures, rather than focusing solely on the substances alone, is therefore an imperative for developing effective harm-reduction, treatment planning, and related delivery services.

3.2.2 Functional Enhancement

During periods of peak consumption, many participants described experiencing perceived advantages from AoD use. Although this phase is characterised by escalation, risk, and in some cases, harm, participants emphasised the real and meaningful sense of relief or enhancement that they derived, which helps explain the continuation or intensification of use. Several overlapping subthemes were prominent: increased social

confidence, enhanced sexual pleasure or connection, improved work or study performance, and the ability to temporarily mask or move beyond personal pain or trauma.

Social confidence and fitting in

Many participants described how substances helped them break through shyness, manage anxiety, or feel accepted by peers and colleagues. For some, alcohol enabled them to adopt a different persona - someone more confident, relaxed, or humorous.

> *"When I drank, I could talk to anyone, even people I didn't know. I felt like I was actually funny."* P23 (female, Japanese-NZ, age 18-24)

> *"It helped me stop worrying if people liked me or if I was saying the right thing."* P01 (male, Indian, age 24–25)

> *"alcohol helps me feel more relaxed. I'm naturally a very reserved person, so sometimes at gatherings I don't feel very open. But if I have a bit of alcohol, I feel more at ease and it's easier for me to talk to people."* P07 (male, Chinese, age 35-44)

For younger participants and those who had migrated to NZ more recently, AoD use at parties, flat gatherings, or bars was frequently described as a clear pathway to social integration and a means of mitigating feelings of exclusion or cultural difference. Traditions such as, pre-loading on alcohol in private spaces before socialising in public venues or drinking a crate of beer (typically 12 bottles) between midday and midnight remain deeply embedded in Kiwi youth drinking culture (McCreanor et al., 2016; Soysa et al., 2023). Participation in such activities is typically viewed as a means to bond with and be accepted by peers.

Enhancement of sexual pleasure and intimacy

AoD use in sexual contexts was not solely associated with "partying"; participants often described as a means to overcome shyness, experiment with new versions of the self, foster connection, and soften the edges of internal or social conflicts. Among a few of the heterosexual female participants who were comfortable sharing their experience with sex and alcohol consumption, AoD use did not amplify their sexual experiences; on the contrary, it was linked to moments of discomfort. Some recounted situations where friends made unwanted advances under the influence, or where they felt pressured to meet their boyfriend/partner's sexual expectations despite their own lack of interest. A male participant who was open to discussing the effect AoD had on their sexual experiences mentioned that while alcohol modestly increased their sexual pleasure, they did not enjoy the combination of drugs and sex. For LGBTQ+ participants, however, drugs were more frequently described as tools to enhance sexual pleasure and created a sense of safety or comfort.

"Yeah. And I think that's the beginning that I combined marijuana and sex, and then I began to get kind of addicted to that because I found, like, this is like such a good experience. Like it just enhanced the feeling and the sex was like, so good." P04 (male, Chinese, age 25–34)

Work and Study Enhancement

A smaller, yet significant, group of participants reported that moderate use of alcohol, stimulants, or cannabis at peak times was associated with perceived improvements in their capacity to manage work or academic responsibilities. This pattern was particularly evident when participants experienced heightened stress, excessive workload, or heavy cultural expectations.

"I only smoked after exams, but it made me stop obsessing about grades and sleep for once." P11 (female, Chinese, age 18–24)

"A drink before networking helped me actually go up and talk to people." P09 (male, Chinese, age 65–74)

"It was easier to focus on work after a drink at lunch. It was just the way the office worked." P22 (male, Korean, age 55–64)

Coping with Trauma or Emotional Pain

Several participants, across a range of age groups and generations, reported that their peak substance use coincided with periods of significant personal distress such as, family violence, relationship breakdowns with significant others, unresolved trauma, or struggles with cultural identity. In these contexts, substances were considered tools to temporarily mask the suppressed emotional pain, enabling individuals to appear composed and functional in public or social settings.

"'Cause I was going through quite a lot. And my depression was like peaking. And at that time. So, I decided to drop down to part time schooling. With my dropping down to part time, it gave me a lot more time and opportunity to actually go and drink and do drugs." P21 (male, Filipino, age 25–34)

"When I drank, I didn't feel like I had to worry about being different, I just felt like part of the group." P23 (female, Japanese-NZ-European, 18–24)

"Drugs made it easier to deal with the breakup and my mental health. For a while, I just didn't care about the pain." P01 (male, Indian, age 18-24)

Participants who were recruited for this study had experienced different levels of issues with AoD use; therefore, escalation was part of their journey. Most acknowledged the short-term benefits that AoD use provided. The aftereffects of increased use did include

regret or introduction to new risks due. Reported motivations extended beyond individual needs such as alleviating anxiety or pain, encompassing powerful broader social drivers, including the desire to belong, to succeed, to connect, or to heal. Understanding these reported benefits is critical to developing interventions that are empathetic, non-judgmental, and culturally compatible for Asian NZ communities.

3.2.3 Identity Tension

Across all of these participant groupings, identity tension led to escalated substance use since AoD were often framed as tools for fulfilling desired social, professional, sexual, or peer-related roles, while also simultaneously remaining hidden from family scrutiny. First generation migrants described AoD use as a way to reconcile workplace expectations with cultural obligations; second generation youth used alcohol to integrate with Kiwi peers without overtly compromising family values. LGBTQ+ participants reported using drugs to access aspects of a liberated identity that had to be concealed in numerous settings. Gender and age introduced further complexity: women feared reputational damage, while older men feared seeming irresponsible. In each case, substances provided a temporary solution to conflicting identities but often reinforced continued and escalated use. These findings highlight the need for programs that assist Asian New Zealanders in navigating identity-based pressures without reliance on AoD.

> *"My family think I never touch alcohol; my workmates think I am always up for another round. Both stories are true and neither is."* P22 (male, Korean, age 55–64)

> *"One glass makes me social, three glasses let me laugh at the gay jokes without worrying they are about me."* P17(male, Indian-NZ-European, age 35–44)

> *"...but under the influence of alcohol I didn't need to deal with my problems and my sister would often say you behave like dad when you drink."*
> P05 (male, Multi-ethnic, age 25–34)

3.2.4 Secrecy and Stigma

Secrecy diffused participants' justifications, driven by family shame, fear of legal consequences, and the fear of damaging the "high achieving student" stereotype. Several participants explicitly hid their use from at least one close relative.

> *"...this kind of idea that like if I showed who I was on the weekends to my parents, then they would not accept me for me."* P21 (male, Filipino, age 25–34)

> *"I would go to my exams and think because I'm doing this (drugs), I need to study harder to make sure it doesn't like impact. You know, my life and my studies."*
> P12 (female, Korean, age 25–34)

"I was so ashamed I discussed sleep issues with my GP but never mentioned my nightly wine habit." P18 (male, Chinese, age 65–74) The concealment of use reinforced isolation and prevented access to both informal (family) and formal (healthcare) supports. Stigma also led to avoidance of community services.

> *"AFS ads felt focused on gambling [not AoD]. I felt judged, so I did not call even when I needed help."* P04 (male, Chinese, age 25–34)

3.2.5 Increased Tolerance and Withdrawal

During the times of heavy AoD use, participants observed an emotional reliance on, and physiological and psychological demand for, increasingly larger doses, alongside a growing difficulty in reducing or controlling their intake.

One participant noted how their tolerance had outpaced normal sleep patterns,

> *"It was like this thing that night is approaching and I need to just get really drunk and then take myself out essentially. And so it was like the most intense escapism. And so I think that's what I was like chasing constantly."* P12 (female, Korean, age 25-34)

When another tried to reduce their intake, they discovered how withdrawal amplified discomfort.

> *"I'm just afraid I will not be able to sleep without it (marijuana)."*
> P04 (male, Chinese, age 25–34)

Several described needing repeated or escalated sessions to achieve the original high,

> *"I think that's the beginning that I combined marijuana and sex, and then I began to get kind of addicted to that."* P04 (male, Chinese, age 25–34)

> *"I needed more pills each trip to feel high."* P23 (female, Japanese-NZ, age 18–24)

Participants during this phase consumed higher amounts because the tolerance level increased, which meant more quantities were needed to have similar effects. Another reason for increased use of substances was when they tried to reduce their intake or missed a session, which led a few participants to experience withdrawal symptoms, which needed to be curbed by a session to cover for the missed session.

3.3 Stage 3: Reduction in AoD Use

Participants described multiple catalysts for reducing or stopping use: health scares (hypertension, fatty liver), legal consequences (Driving Under the Influence (DUI) suspensions), and family or friends mentioned their concerns or worry with the participants AoD use.

One participant explained,

> *"After my DUI, I never drove after drinking again."* P22 (male, Korean, age 55-64)

Another participant recalled,

> *"My brother told me, 'I need you around.' That got me to cut back more than therapy."* P19 (male, Chinese, age 35-44)

Family and friends played a pivotal role: eight participants credited relatives or peers for encouraging a decrease in AoD use. Only six mentioned formal counselling as primary support. This suggests that strengthening informal support networks may be as crucial as expanding clinical services.

The variety of experiences and influencing factors recounted by participants demonstrate that the term "Asian encompasses diverse ethnicities, cultures, and migration journeys; it cannot be treated monolithically. Subgroup-specific approaches are essential to address differing cultural norms, stigma levels, and patterns of AoD use.

Our in-depth thematic analysis reveals how peer and family influences, cultural tensions, and emotional drivers intertwine across phases of AoD use. The results underscore the necessity of culturally attuned interventions such as integrated mental-health and sexual-health support to meet the diverse needs of Asian New Zealanders.

3.3.1 Health and Legal Wake-Up Calls

A few participants did not begin to reconsider their consumption until they had a serious reflection on the issue. These concerns fell into three main categories: medical warnings, encounters with the justice system, or accidents. Moments or realisations such as these, led to immediate stops to their consumption.

P18 described the moment their long-time GP switched from English to Cantonese to underscore the gravity of an ultrasound result,

> *"He pointed at the scan and said, 'fatty liver.' Hearing it in my own language made it feel serious."* P18 (male, Mainland Chinese, age 65–74)

In the week that followed they reduced their nightly wine from two glasses to one and volunteered for a liver-health monitoring programme.

3.3.2 Legal consequences

For others the wake-up call arrived in the form of legal sanction. A participant recalled being stopped at a roadside checkpoint after what they considered a "moderate" client dinner,

> *"The officer said, 'You're twice the limit.' They took my licence on the spot."* P22 (male, Korean, age 55–64)

Because their job required driving prospective buyers to building sites, the six-month suspension created an immediate threat to their livelihood. In response, they stopped lunchtime soju entirely and now decline second rounds at corporate dinners.

3.3.3 Self-realisations

A handful of participants described avoiding serious harm to themselves or others. One participant recounted collapsing in a factory toilet after a double "bong session" during a lunch break,

> *"I sat on the cubicle floor for almost an hour, couldn't even stand up, one step away from the manager seeing me."* P04 (male, Chinese, age 25–34)

Although no formal disciplinary action followed, the incident scared them enough to limit cannabis to after-work hours.

3.3.4 Limited staying power

A participant admitted that a paramedic's warning after an alcohol-induced blackout *"felt dramatic in the ambulance,"* but by the following weekend they *"was [were] back on the RTDs, telling the story like a joke."* P20 (male, Chinese, age 18-24)

When an event occurs, it can temporarily motivate people to stop a habit, but without extra help, they often go back to it later. Change often begins when a person experiences a crisis that challenges their sense of identity, such as a medical diagnosis, license suspension, or near-miss accident. These events can act as powerful wake-up calls, especially when someone in a position of authority frames the risk as personal loss. In these moments, people may feel motivated to make immediate changes, like cutting back on substance use. However, lasting transformation doesn't come from the crisis alone, it depends on whether the person has the support and safe environment needed to reflect, connect with others, and try something different. Without this ongoing support or culturally appropriate guidance, even the strongest wake-up call can lose its impact, and the person may return to old patterns. Ultimately, meaningful change is shaped not just by critical moments but by the context that surrounds them.

Self-Reflection

Once the external alarms had faded, many participants described experiencing a quieter but equally powerful reckoning - a moment of personal reflection triggered by an episode of harm that prompted them, at least temporarily, to consider change. This "mirror phase" was rarely dramatic; rather, it unfolded in the early hours of the morning, in the stillness of a hangover, or while mentally replaying a troubling memory. Although just over half

our sample reported such turning-points, their outcomes diverged sharply – some participants transformed regret into sustained reduction in use, others acknowledged the damage but kept using, and a few participants oscillated between resolve and relapse.

3.4 Cultural Nuances

It is important to understand that while "Asian" is a broad term encompassing a diverse range of ethnicities, closer examination reveals significant variations in cultural norms across different subgroups. Below is an understanding behind the perceptions of AoD in various Asian societies.

3.4.1 Indian Culture

Within the Indian communities represented in our sample, alcohol is generally accepted in specific social rites such as weddings, Diwali celebrations, and graduations, but remains tightly governed by familial and religious norms. Men typically drink discreetly among close friends or at after-work gatherings, whereas women encounter more pronounced social taboos.

As one participant explained,

> *"At Diwali gatherings the men clink whisky glasses in the back room; women do not join."* P24 (male, Indian, age 45–54)

Drug use is even more heavily condemned, illustrating the fear of familial ostracism,

> *"If my parents knew about my drug use, they would have cut me off."*
> P17 (male, Indian, age 35–44)

3.4.2 Chinese Culture

Among our Chinese-heritage participants, baijiu and rice wine play central roles in New Year and wedding rituals, where refusal can be seen as rude.

> *"They passed me a small glass of baijiu; refusing felt disrespectful."*
> P18 (Male, Mainland Chinese, age 65–74)

But in everyday social settings, many prefer red wine for its lower alcohol content and perceived style. Illicit drug use remains criminalised in China and highly stigmatised here.

A younger Chinese participant noted,

> *"Back home it was easy to find weed in Xinjiang, but here I keep it secret because of the law."* P04 (male, Chinese, age 25–34)

Gendered expectations persist, with men generally permitted to drink publicly in business or peer contexts, while women risk judgment if seen intoxicated. First-generation migrants emphasised alcohol use being framed as a ritual obligation. Meanwhile, 1.5-generation and second-generation, and NZ-born Chinese participants described drinking as a peer-driven norm.

3.4.3 Korean Culture

In Korean culture, alcohol, primarily soju and beer, are woven into corporate and social life.

> *"At every company dinner we had a round of soju to prove loyalty."*
> P22 (male, Korean, age 55–64)

Declining a boss' toast can jeopardise workplace relationships, while overindulgent drinking carries its own social stigma. Drug use is virtually unheard of; Korean-heritage participants uniformly described illicit substances as a criminal matter,

> *"In Korea drug users are seen as outcasts or worse."*
> P12 (female, Korean, age 25–34)

Among women, modest alcohol consumption such as sipping soju during celebratory meals seems to be more socially acceptable, while high-volume drinking remains discouraged. One female participant described excusing herself after one small taste to preserve their reputation. Further, younger Korean New Zealanders report shifting towards moderate wine consumption with meals.

3.4.4 Filipino Culture

Alcohol occupies a central place in Filipino "fiesta" traditions, with beer or rum flowing at family gatherings and community events.

P14 (male, Filipino, age 25–34) described Sunday barbecues ending with San Miguel beer toasts: *"It was how we bonded."*

By contrast, illicit drug use carries profound stigma linked to the Philippines' recent "war on drugs."

P21 (male, Filipino, age 25–34) expressed fear of violent consequences: *"Back home they killed drug users; that terrified me."*

Gender norms allow both men and women to drink socially, though women often step away before heavy drinking begins. Second generation Filipinos balance inherited celebratory drinking customs with awareness of Kiwi moderation norms and legal restrictions.

3.4.5 Vietnamese Culture

Vietnamese-heritage participants described rice wine and light lagers as staples of Tet and family meals. Drug use in Vietnam is tightly policed, and participants reported hearing of extrajudicial killings in the early 2000s underscoring the profound deterrent effect of state violence on drug experimentation.

In NZ, casual beer drinking has become more common, but heavy intoxication remains frowned upon. Women may join men for toasts but rarely consume large quantities of alcohol. The legacy of fear around drugs persists across generations.

3.4.6 Japanese-NZ-European Culture

Participants of Japanese heritage blend traditional and NZ-European practices. Japan-born respondents spoke of sake tastings and shochu with family meals.

> *"Omakase dinners included small sake samples, never to excess."*
> P23 (female, Japanese-NZ-European, age 18–24)

Meanwhile, drug use is taboo and the participant had not seen drug use in Japan,

> *"In our culture we simply do not discuss drugs."*
> P23 (female, Japanese-NZ, age 18-24)

NZ-raised Japanese report adopting wine culture in social gatherings, valuing mindful consumption, and culinary pairings, distinguishing it from the binge drinking associated with NZ's wet culture. While gender roles are relatively balanced, they are overt.

4 Discussion

Perceptions and Experiences of AoD Use, and Related Harm among Asian People in New Zealand

Following the collection of rich data from participants with lived experience, and the subsequent coding and generation of themes, we are now well-positioned to answer our first research question.

> ***Research Question 1:*** *What are the perceptions and experiences of Asian people who report AoD use and related harm?*

This qualitative research highlights that the views and experiences regarding AoD usage among Asian individuals in NZ are significantly influenced by cultural backgrounds, generational factors, gender, and the characteristics of their social surroundings. Although personal experiences differ, the stories collectively emphasise several shared themes and distinctions that are essential for comprehending and addressing AoD-related harm within these communities.

Cultural Framing and Norms

Participants' perspectives on AoD consumption were greatly shaped by their countries of origin and the cultural attitudes toward substance use within those contexts. For instance, first-generation migrants from Korea and China frequently emphasised the key role of alcohol in social and professional customs. Drinking is typically linked with business interactions, respect for social hierarchies, and traditional notions of masculinity, thereby creating social pressures that complicate abstinence from alcohol in social gatherings. On the other hand, drug use, particularly cannabis and stimulants, carries significant stigma and is sometimes associated with serious legal repercussions or perceived moral failing. Participants from Vietnam and the Philippines recounted experiences from their countries of origin involving severe penalties, such as capital punishment for drug-related crimes, which fostered a deep sense of fear and shame regarding drug consumption, even after migration.

Participants of Indian, Filipino, and Malaysian Chinese heritage shared similar cultural anecdotes. Alcohol intake was at times permissible within limits, especially for men, whereas illicit drug use remained taboo across generations. For women, visible intoxication from AoD was linked to negative stereotypes related to propriety, with female participants detailing more controlled and disciplined patterns of use.

Generational Differences and Bicultural Tension

The study highlights clear contrasts between first-generation migrants, and 1.5 and second-generation Asian New Zealanders. First-generation migrants often viewed their substance use as a tool for navigating unfamiliar professional or social environments, a means to "fit in" or relieve the stress of migration and acculturation. They were more likely to hide AoD use from family members, especially older relatives, due to fear for reputation and eagerness to save face.

By contrast, 1.5 and second-generation participants felt the pressure of balancing their identities between conservative values of their families and the more lenient, individualist culture in NZ. This tension played out in several ways. Young people described drinking as a route to social acceptance, sometimes experimenting with drugs as a form of rebellion, or self-discovery. However, they also reported feeling judged by both worlds - "boring" among Kiwi peers if they did not use and "disrespectful" among family if they did use.

Gender and Sexuality

Gender differences in AoD experiences were noticeable. Men, especially those from Korean, Chinese, or Vietnamese backgrounds, often felt explicit or implicit pressure to drink heavily in male-dominated spaces as proof of toughness, sociability or leadership. Women's stories revealed stricter boundaries. Their use was more likely to be managed in ways that minimised reputational risk. Female participants described feeling caught between NZ norms of gender equality, which tend to normalise social drinking among women, and the stricter gendered expectations of their cultural communities.

Participants from the LGBTQ+ community had a difference perspective. For some, AoD use was a pathway to social belonging, granting confidence, and removing barriers of being "different" or hiding one's identity. Others described escalating use to manage mental health distress, loneliness, especially when family support was lacking or cultural taboos made open discussions feel impossible. For these participants, safe spaces that recognised both their cultural background and sexual orientation were vital, though often lacking even at a GP or counsellor visit.

Harm, Coping and Help-Seeking

First-generation participants were more likely to describe physical health problems (such as liver issues, sleep disturbance, or withdrawal symptoms) as triggers for reduction or cessation. Some experienced legal consequences (for example, drink-driving) or "wake-up calls" from medical professionals, which prompted immediate but sometimes temporary reductions in use.

Younger, NZ-born participants, and 1.5 and second-generation migrants were more likely to highlight social or psychological harms: losing friendships, academic difficulties, anxiety,

or regret after risky behaviour. Coping motivations shifted across stages of use. Initially, substances helped with social anxiety or identity tension; during periods of heavy use, participants reported that AoD sometimes offered a sense of comfort, emotional detachment or self-confidence they perceived to be otherwise unattainable.

Barriers to Support and Preferences for Help

Across the sample, participants emphasised cultural and structural barriers to help-seeking. Fear of stigma within family, religious communities, or ethnic groups meant that most participants tried to manage on their own or sought help only when problems became intense. For some, mainstream services were perceived as irrelevant, linguistically inaccessible, or culturally inexperienced. In contrast, others found peer-led support, online support, or even assistance from outside their cultural communities to be a partial substitute.

Participants kept circling back to options they felt would be nonjudgemental and respect their cultural background. Bilingual or bicultural counsellors, peer groups comprising Asian migrants, and LGBTQ+ community circles were considered indispensable. 1.5 and second-generation students mentioned that campus mental-health offices provided generic support. Further, family support was described as a "double-edged sword" for some, encouraging relatives helped initiate change, but for the majority, the fear of disappointing parents (or causing shame) kept issues concealed.

Alcohol Versus Drug Experiences

Perceptions and experiences of alcohol and drugs differed substantially. Alcohol was frequently normalised, integrated into workplace and social rituals, and its harms often minimised until serious health or legal issues arose. In contrast, illicit drugs were surrounded by far greater stigma and secrecy. Even occasional use provoked significant anxiety about family reputation or legal risk. Several participants described using drugs to explore self-expression but did so in carefully concealed settings or among trusted peers. For most, the distinction between alcohol and drugs was beyond legal or chemical – it was deeply rooted in perceived social and cultural norms with alcohol being explained away as "just being social," while drug use felt more taboo.

4.1 Accessing AoD Information and Help: Cultural and Demographic Considerations

We also sought to explore the existing support services, including their accessibility and the barriers faced by participants in utilising them.

> ***Research Question 2:*** *What is the perception and experience of Asian people relating to the access of AoD information and/or help services?*

Among the varied Asian communities that were interviewed, the views and experiences related to obtaining information and support services for AoD were influenced by a complex mixture of cultural standards, migration backgrounds, generational differences, and social identities. Most participants noted a significant disconnect between their needs and the cultural relevance of current mainstream services, with differences in both the kinds of support they preferred and the sources they trusted.

A prevalent theme was the need for cultural and linguistic relevance in the provision of information and services. Many first-generation migrants, especially those from Chinese, Korean, and Vietnamese backgrounds, conveyed that assistance and information were significant only when offered in their native language or by individuals who were attuned to their cultural context. Some indicated that information in English, even if it was linguistically accessible, often did not resonate with the specific values, familial obligations, and concepts of shame or “face” that influenced their experiences with substance use. For instance, older men noted that they dismissed typical pamphlets or public outreach efforts as being “for New Zealanders, not for us [them],” while several female participants emphasized the necessity of service providers who recognised the challenges posed by filial piety, societal gender expectations, and the stigma related to women's substance use within their communities.

Participants who were second-generation and born in NZ typically showed more comfort with English-language resources and mainstream health promotion initiatives. However, they also expressed a desire for services that recognised the blended nature of their identity and the unique cultural norms that continued to influence their families or social circles. Some individuals explained that they felt "caught between worlds” for services targeted at specific ethnicities yet concerned that mainstream providers might overlook the subtle aspects of cultural shame, model minority expectations, or family norms about "not talking about it" that impacted their willingness to seek assistance. This issue was especially relevant for young adults navigating transitions in university or early career stages, who indicated a preference for peer-led or youth-focused services that facilitated non-judgemental discussions about AoD use.

LGBTQ+ participants indicated that support was perceived as accessible only when it was inclusive of not only their cultural identity but their sexual or gender identity as well. Those who participated in group support or harm-reduction programs specifically designed for queer Asian communities expressed positive experiences about being able to “show up as a whole person” - a relief from the labelling many faced within their ethnic and mainstream social environments. Conversely, some noted that mainstream addiction services felt “straight by default,” resulting in discomfort or reluctance to disclose situations and risks unique to their communities.

Trust and confidentiality emerged as significant issues, particularly for individuals within small, close-knit diaspora groups. Several participants expressed concern that utilizing ethnic-specific services could lead to exposure and damage to their reputation within the

community, while seeking assistance from mainstream providers caused worries about potential misunderstandings, stereotypes, or lack of discretion regarding issues such as migration status, sexual orientation, or mental health. This conflict sometimes resulted in a complete avoidance of formal services, with a tendency to prefer anonymous online resources, peer networks, or reliable professionals known for their cultural sensitivity.

Peer support, whether informal or structured, was greatly appreciated, especially among younger and second-generation migrants. Many indicated that discussions with friends, classmates, or colleagues who experienced similar cultural challenges, or a similar migration journey were more effective in validating their experiences and encouraging them to seek help than any formal intervention. However, several participants shared instances of receiving unhelpful or even damaging advice from peers who normalised high-risk behaviour or dismissed their worries as overreactions.

Ultimately, the influence of family has a twofold nature. For certain individuals, particularly those from more collectivist cultures or who maintain strong connections across generations, family can serve as a valuable source of support, provided discussions occur without blame or fear of losing face or status. Conversely, for others, family represents the primary obstacle to openness and help-seeking, with the concern of shame, disappointment, or social rejection. The findings emphasise that for interventions to be genuinely effective, they must explore family dynamics and community values, rather than focusing solely on individuals.

Barriers to Culturally Responsive Support Systems

The results of this research highlight the interactions among cultural and individual elements that influence the AoD experiences of Asian New Zealanders.

The stigma associated with substance use was deeply embedded for many first-generation immigrants, influenced by their ethnic communities' fears of "losing face," religious or spiritual beliefs, and familial values. This frequently made them less inclined to seek help and in certain cases, led them to stop using services they thought were either too culturally appropriate for NZ or not discreet enough. Second-generation participants, on the other hand, expressed discontent with universal, "one-size-fits-all" tactics and interventions, calling for assistance that acknowledged both their NZ upbringing and the ongoing impact of cultural expectations from their families.

Several participants who tried to control their use or abstinence relapsed when they returned to social situations where drugs or alcohol were used frequently, or when they were confronted with stressors such as loneliness, relationship problems, or academic stress. Many indicated a strong preference for support structures that combined emotional or identity-reinforcing components (e.g., peer support groups where experiences related to cultural or LGBTQ+ identities could be shared openly without fear)

with practical strategies (e.g., managing triggers, improving social skills, or finding alternatives.

The effectiveness of support was closely tied to how well it aligned with participants' identities and experiences. For older migrants, services provided in their native language by staff familiar with cultural norms and migration-related challenges felt more secure and accessible. When services that could "navigate both worlds" recognising the balance between family obligations and individual autonomy participants expressed higher levels of trust. Younger individuals and those born in NZ, including members of the 1.5-generation or LGBTQ+ communities, preferred groups or online platforms where they didn't have to choose between their ethnic and sexual orientations. The extent to which participants felt "fully seen" and understood frequently determined whether they remained engaged with support or quietly disengaged.

For some, anonymous digital resources or helplines offered a crucial first step where embarrassment or fear of community exposure was a concern. The presence of culturally relevant frameworks, such as acknowledging the impact of migration, generational gaps, or gendered expectations, enhanced the perceived legitimacy and effectiveness of these resources.

Relapse is a common part of the process when people are trying to change their substance use. But because of the stigma around drug use, these experiences are not often discussed openly; this affects how people are supported. In our research, the key difference was in how people were treated when they relapsed. When families, peers, or services understood relapse as a normal part of recovery rather than a personal or cultural failure, people felt more supported and were more likely to keep trying. On the other hand, when they felt judged or shamed, they were more likely to hide their struggles or stop seeking help altogether, which undermined progress. This highlights the importance of responding to relapse with empathy and support, rather than judgement or blame.

When considered together, these insights indicate that enhancements to AFS and similar services depend on a thorough understanding of the overlapping cultural, generational, and social identities that influence AoD experiences. The most effective interventions, as noted by participants, were those that recognised the diversity within Asian communities, offered options and safety in engagement methods, and approached support as a long-term relational process as opposed to a set of isolated interventions. Incorporating these insights into the design and delivery of services will be essential for effectively addressing the needs of Asian New Zealanders dealing with AoD issues and for enabling individuals to break free from patterns of adverse outcomes and relapse.

4.2 Bridging the Quantitative Trends and Qualitative Experiences

There is a strong alignment between the quantitative study findings conducted by Synergia and Trace Research in 2023 and the themes identified in this qualitative study that relate to stigma, cultural barriers, and motivations for AoD use. Both studies confirm that when it comes to seeking help amongst Asian people in NZ, there is a hesitancy due to stigma, losing face, or disappointing close family, with 46% of drug users and 33% alcohol users highlighting these concerns (AFS et al., 2023). This study further supports this finding through the experiences participants mentioned around social judgement and family expectations. For example, a participant continued to perform well in university, which they believed would provide a cover for the AoD use. Another participant decided to stay at their friend's house as they did not want their parents to see them in an intoxicated state. This articulates the fears entrenched in their culture. A recent study by Adams et al., (2022) reinforces these findings, highlighting the deep-rooted cultural expectations among young Asian people living in NZ that create a barrier in seeking support.

There is also consistency in the motivations for AoD use across both studies. Results from the quantitative study indicated relaxation (52%), socialisation (43%), feeling included (27%), obligated to drink in social settings (20%), and lastly, stress or mood coping (18%) were the key motivators for AoD use. This closely aligns with the themes that emerged in the initiation stage as well. Participants explained AoD use as a means to manage anxiety, mitigate social awkwardness, and cope with interpersonal difficulties. One participant described alcohol was needed to combat shyness and engage in social settings with confidence, while another recounted using cannabis to numb feelings of discomfort in their personal life or when dealing with emotional pain. The qualitative study allowed us to gain deeper insight into the motives behind consumption, revealing that substances were sometimes used as tools to navigate new social environments and establish social networks as first and second-generation migrants. Other motivations included managing high-stress situations, coping with relationship challenges, or temporarily enhancing a social persona through intoxication.

It is also worth highlighting notable differences in both studies when it came to the emerging nuances around ethnic groups, especially with drug use. Quantitative findings explicitly identified considerable variations among ethnic groups; notably, Filipinos (27%), Indian (19%), Korean (17%), and Chinese (12%) had disproportionately higher cannabis use (AFS et al., 2023) compared to the general NZ Asian average (15%) (MoH, 2024). Qualitative findings cannot point towards ethnic groups facing more harm; however, they have allowed a better understanding of the perceptions different ethnicities have of drug use. For example, Filipino communities have been affected by mass drug-related killings in the Philippines, which has amplified stigma and secrecy around drugs. However, the

quantitative data shows that more Filipinos are using or facing harm due to drug use in NZ. The Indian participants showed more openness towards the consumption of alcohol and drugs. This finding aligns with Hara et al. (2024), who observed that Indians seemed to associate alcohol with enjoyment. Their study also suggests a rising trend in drug use in India, alongside mixed levels of awareness and ambivalence regarding the associated risks and harms.

There is a strong connection between the quantitative and qualitative findings regarding the heightened vulnerability of LGBTQ+ Asian individuals. Survey data indicated higher rates of amphetamine use among LGBTQ+ participants (AFS et al., 2023), which was echoed in interview responses that explored the deeper emotional and social drivers behind substance use. Participants spoke of the toll of constant discrimination, with one describing drug use as a way to cope with being different.

Both datasets strongly advocate for targeted initiatives to reduce stigma, enhance service visibility, and provide culturally sensitive outreach. Additionally, recognising variations across ethnic subgroups and specific vulnerabilities within migrants and LGBTQ+ Asian populations must inform tailored, responsive intervention strategies.

5 Recommendations

After a thorough understanding of the cause and effects with AoD use among Asian people living in NZ, we would like to propose the following recommendations:

5.1 Participants' Advice to Others Who Use AoD

5.1.1 People Who Use Alcohol

- **Listen to your body and stop when you notice symptoms:** Several participants expressed regret about ignoring early physical symptoms and pushing boundaries beyond safe limits. Their advice to others included tuning into signs such as blackouts, emotional outbursts, and disrupted sleep.
- **Reflect honestly and frequently on why you drink and your experiences of it:** For some, alcohol was used to mask anxiety, loneliness, or social discomfort. Participants encouraged others to proactively reflect on their motivations rather than waiting for a crisis point to reassess behaviour.
- **Know your limits and create boundaries:** Those who were able to use moderately recommended setting rules such as "never drink alone" or "avoid spirits" and upholding those boundaries, socially and personally.
- **Talk to someone early:** Many wished they had sought culturally safe support sooner. They urged others to find someone they trust, particularly professionals who understand their language or background.

5.1.2 People Who Use Drugs

- **Know what you are taking, what to expect from it, and how to use it as safely as possible:** Participants cautioned against experimentation without understanding dosage, especially with substances such as Gamma Hydroxybutyrate (GHB), methamphetamine, or synthetic cannabis. They advised others to educate themselves before use.
- **Do not use alone:** Several overdose or near-miss stories underscored the danger of independent use. They urged people that are using to stay around peers who could notice signs of distress.
- **Reflect on why you are using drugs:** A few shared that while drugs initially offered a sense of confidence or connection, reliance often led to increased isolation and emotional challenges. They recommended seeking therapy or creative outlets to explore self-worth.

- **Seek support from people who understand your experience:** Participants highlighted the importance of speaking with trusted providers or others who shared similar cultural or LGBTQ+ backgrounds, noting that these connections reduced feelings of judgement or dismissal of experiences. They emphasised the value of seeking supporting from wherever felt most safe and affirming.

5.2 Recommendation for the Support Services Sector

5.2.1 Short-Term

- **Deliver culturally tailored services**: Services must go beyond language translation to reflect Asian worldviews, family structures, values (e.g., filial piety, saving face), and religious or spiritual beliefs. Staff should be trained to work effectively with collectivist, high-context cultures. To ensure these efforts are impactful and sustainable, culturally appropriate services must be thoughtfully co-produced with Asian voices, thoughtfully developed, adequately resourced, and sufficiently funded. This can help meet a strong need for services where Asian individuals engaging in AoD use can be seen, heard, and understood as their authentic selves.
- **Offer anonymous, low-barrier early intervention**: Many participants expressed reluctance to approach official services due to fear of judgement or social repercussions. Offering discreet drop-in sessions, peer-led support, or anonymous digital consultations may increase early help-seeking.
- **Create safe spaces for LGBTQ+ Asian people**: Several LGBTQ+ participants described using substances to cope with family rejection or cultural silence around sexuality. Services must offer trauma-informed, queer-affirming care that includes cultural safety.
- **Integrate AoD services into familiar settings**: Embed education and counselling options into GP clinics, international student services, religious institutions, and cultural festivals to reach communities in spaces they already trust.
- **Normalise moderation**: Develop campaigns that show what healthy drinking looks like in Asian cultural contexts, rather than focusing solely on abstinence or addiction. Raising awareness of healthy drinking is especially important given the longstanding and current absence of a national campaign specifically targeting Asian populations.
- **Scale up harm-reduction information**: Many participants using drugs learned about harm-reduction only after incidents. Services should distribute multilingual, accessible drug safety resources tailored for people using AoD that are younger migrants or identify as LGBTQ+.

- **Develop culturally appropriate peer-led support**: High value was placed on peer support from lived and living experience. Funding should support the development of new, and growth of preexisting culturally diverse and culturally safe networks of peer-support workers, including LGBTQ+ and gender-diverse representatives.
- **Provide flexible and accessible services**: Students and working migrants frequently described challenges accessing care during standard business hours. To address such barriers, services should offer a range of flexible options, including support groups, after-hours appointments, online platforms, and telehealth. Equally important is the availability of low-threshold services that allow anonymous access, i.e., not requiring a National Health Index (NHI) number; this is especially vital for individuals concerned about the impact of seeking help on their visa status. These approaches are crucial for providing discreet, timely support.

5.2.2 Long-Term

- **Build an Asian AoD workforce pipeline**: Participants were more willing to open up when speaking to someone "who gets it." Services must invest in training and hiring Asian clinicians, community navigators, and peer-support workers.
- **Support research and data equity**: Lack of data continues to render Asian AoD issues invisible. There is an urgent need to commission research that provides a robust, up-to-date longitudinal understanding of use patterns, harm, and effective interventions across subgroups.
- **Respond to motivations behind substance use**: Different substances were used for different reasons, shaped by personal, social, and environmental factors. Specifically, alcohol was often linked to social integration and family life, while drugs were more often associated with escape or trauma. Effective support must focus on understanding these underlying motivations and designing education, messaging, and service pathways that reflect the diverse realities behind substance use.
- **Develop culturally appropriate youth communication resources**: The study identified curiosity, social anxiety, and peer pressure in early use. It is vital to fund the development of youth-centred resources that help young Asian New Zealanders to reflect on their shared experiences and learn about AoD within culturally meaningful contexts. Partnering with secondary schools and tertiary institution can support the delivery of these resources.
- **Integrate cultural safety into mainstream services**: AoD services must advance beyond cultural awareness and embed structural responsiveness. This includes providing interpreter services, developing culture-specific intake forms, and implementing family engagement strategies that acknowledge stigma and shame prevalent in some communities. Crucially, it involves training mainstream clinicians not only to be culturally competent but to practice cultural safety, ensuring respectful, empowering, and responsive care for Asian clients.

- **Provide LGBTQ+ culturally safe spaces**: Given the role of AoD in navigating sexual orientation and emotional pain for LGBTQ+ participants, services should strengthen their provision of support for the LGBTQ+ community. This can allow individuals to feel comfortable being their authentic selves when seeking support.

5.3 Government-Level Recommendations

5.3.1 Short-Term

- **Address data invisibility**: AoD and public health surveillance tools must collect and disaggregate data by detailed ethnic categories rather than homogenising categorisation such as "Asian," and include questions about gender, sexuality, and migration history to inform better services.
- **Fund culturally specific AoD services**: Mainstream, one-size-fits-all models are ineffective in addressing the needs of minority groups, including Asian communities. To ensure equitable access, dedicated funding is needed for services led by and for Asian communities, especially in areas with high Asian migrant density. These services must target Asian sub-groups by being linguistically responsive and using trusted and culturally relevant channels to reach Asian communities that may otherwise not engage with services.

5.3.2 Long-Term

- **Make AoD policy multicultural by design**: AoD harm and help-seeking are shaped by culture, generation, and migration status. Future policy must integrate diverse perspectives from the start, rather than retrofit inclusivity later.
- **Embed cultural responsiveness into health policy and strategy**: AoD policy should reflect the multicultural realities of NZ and centre equity. This includes requiring Te Whatu Ora Health NZ services, Primary Health Organisations (PHOs), and NGOs to demonstrate how they engage with and support Asian communities as a vulnerable, diverse group.

This research is not solely about documenting problems; it is a call to action. Asian people living in Aotearoa deserve services that recognise their unique experiences, values, and struggles. Many participants bravely shared their most vulnerable stories in the hope of helping others feel less alone. Their voices challenge us to build a system where no one must choose between their culture and healing.

6 Limitations of the study

There were a few limitations worth noting in this study:

- Only 24 participants were interviewed; therefore, the generalisability of findings across all Asian people living in NZ is limited.
- Participants either contacted the researcher or were referred by a counsellor, indicating a level of comfort with the topic. However, those who find discussions about AoD use stigmatising or are not yet ready to participate were not represented. This suggests that there may be deeper layers of experience within the Asian community that remain unexplored.
- Most participants preferred to conduct the interview in English. This allowed them to feel more comfortable sharing their experiences with someone from a different cultural background, which helped reduce barriers around discussing a sensitive topic. However, it may also have limited the depth of the conversation, as participants might have been able to express more complex cultural and emotional experiences in their first or heritage language.
- This study was not longitudinal and did not follow participants through their journeys over time. Instead, it relied on participants recalling and reflecting on past experiences at a single point in time. As a result, their responses may have been shaped by memory rather than the emotions felt during those significant moments.

7 Future Research Directions

Future research directions can explore several key areas:

- Specific demographic groups, such as a particular ethnicity, sexual orientation, or first- or second-generation migrants. This would allow for more in-depth and culturally nuanced insights.
- Intentional research to examine intersectionality, for example how sexual orientation and migration history influences AoD use. This approach would help generate rich data from groups that are consistently underrepresented or more vulnerable.
- In the context of service sector research, collaborating with Asian communities to co-design or co-produce targeted intervention strategies could help build trust and improve understanding of stigma, accessibility, and cultural nuances. This could be achieved through focus groups, community-led activities, or pilot testing as a starting point.
- Studies involving current service providers and their clients could offer valuable feedback on the cultural responsiveness and effectiveness of existing services. Listening directly to clients' experiences can help identify barriers and guide improvements based on the themes identified in this study.

In conclusion, this study provided valuable insights into participants' perceptions of AoD use in NZ. It highlighted key barriers faced by Asian participants, including stigma, identity challenges, and socialisation conflicts. These findings reinforce the need for culturally sensitive and tailored support systems. A one-size-fits-all approach remains a significant barrier to effectively supporting those in need. To address these challenges, greater collaboration is needed between communities, service providers, and policymakers. Reducing AoD-related harm and promoting education and safe environments requires informed, collective action. Through this approach, positive and lasting change can be achieved within NZ's Asian communities.

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Appendices

A. **Interview guide**

B. **Participant information sheet**

C. **Consent form**

Appendix A: Interview guide

Interview Guide: Investigating social-cultural factors influencing the attitude, behaviour and experience of Asian New Zealanders toward alcohol and drug (AoD) use

Thank you for agreeing to take part in this study. I appreciate you taking the time to share your experiences, which will be valuable in helping us understand how alcohol and drug use affects individuals in the Asian community in New Zealand.

Before we begin, I'd like to remind you that everything you share will be kept confidential, and you won't be identified in any reports or publications. This interview is semi-structured, which means I have a set of questions to guide us, but we're free to follow up on any experiences or thoughts that come up along the way. Please feel comfortable sharing as much or as little as you're comfortable with and let me know if you need a break at any time.

With your permission, the interview will be audio-recorded and transcribed. You can ask me to pause or stop the audio recording at any time. You also have the right to withdraw from study up to two weeks after the interview without giving a reason.

Discuss the Participant information sheet and consent form, to clarify any questions they might have.

Can I ask a few questions about your background?

Demographics:

- **Age**: Can you please tell me which age group you fall into?

  ☐ 18 – 24 years ☐ 25 – 34 years ☐ 35 – 44 years
  ☐ 45 – 54 years ☐ 55 – 64 years ☐ 65 – 74 years
  ☐ 75 years or over

- **Gender**: How do you identify in terms of gender?

  ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer
  ☐ A gender identity not listed here (Please specify): _____

- **City in New Zealand**

  Name of City you reside in New Zealand: _____

- **Ethnic Background**: Which Asian ethnicities do you most identify with?

  ☐ Chinese ☐ Indian ☐ Korean
  ☐ Filipino ☐ Japanese ☐ Vietnamese
  ☐ New Zealander Other (please specify): _____

- **Length of Residence**: How long have you lived in New Zealand?

  ☐ Less than 1 year ☐ 1 to 5 years ☐ 6 to 10 years
  ☐ 11 to 15 years ☐ 15+ years ☐ NZ born
  ☐ 1.5/2nd generation migrant

- **Education Level**: What is the highest level of education you've completed?

  ☐ No formal education ☐ Primary school ☐ Secondary school
  ☐ Certificate or diploma ☐ Bachelor's degree
  ☐ Postgraduate degree (Master's, Ph.D.)

- **Employment Status**: Are you currently employed, and if so, what is your role?

  ☐ Employed full-time ☐ Employed part-time ☐ Self-employed
  ☐ Student ☐ Unemployed ☐ Retired
  ☐ Other (please specify): _____ (govt benefit)

- **Living Situation**: Who do you currently live with? Partner- male

  ☐ Alone ☐ With family /partner/ spouse ☐ With roommates/friends
  ☐ Other (please specify): _____ (govt housing)

- **Access to Support Services**: Have you previously accessed or are you currently using any health or support services related to alcohol or drug use? (e.g. GP, specialist, AoD support, online support- website searches, anonymous chatting/groups, counselling, mental health support)

  ☐ Yes, currently Add service provider name, if possible
  ☐ Yes, in the past Add service provider name, if possible
  ☐ No

(Remind about the helpline support mentioned on the participant information sheet)

SECTION 2:

1. Can you walk me through the first time you consumed **alcohol**?
    a. Explore further age/year, if consumed alone or with friends, what was the motivation or happening in life around that time? How did it make you feel?

2. Can you walk me through the first time you consumed **drugs**?
    a. Explore further age/year, if consumed alone or with friends, what was the motivation or happening in life around that time? How did it make you feel?

3. How has your alcohol or drug use changed over time? Explore if they are using the same substances, are the reasons to use the same or have they changed?

4. Can you tell me examples or times when using AoD use made it **easier** for you in your daily life, such as **work or studies?**
    a. health (mental, stress and physical)?
    b. relationships (friends, family)?

5. Have there been times when AoD use has caused **difficulties** in your daily life? (examples)
    a. health (mental, stress and physical)?
    b. relationships (friends, family)?

6. In your experience, how do you think your community views people who use alcohol or drugs? Examples?
        a. How has this perception affected how you feel about **your own** use? Example.

7. What types of types of support services or information related to drinking or using drugs that **you have** found **helpful** and how did they help? (examples of support: yourself, family, friends, counselling, community programs, or online resources)?
    a. How did you find this support or information?
    b. If they didn't find the services or access them, what were the barriers?

8. Have there been any types of support that you **found were not too helpful**? example.
    a. What do you feel was missing or didn't work?
    b. What changes could be made to existing services to make them more helpful?

9. **Building Trust with Asian Community:** What things can be done by organisations or people around you that can better support people who are facing harm by using alcohol or drugs.

10. **Advice for others:** What advice would you give to others in the Asian community who might be going through similar struggles?

Closing the interview

Thank you very much for taking the time to share with me about your experiences. Do you want to add anything else to what we have covered in this interview?

(Remind about the helpline support mentioned on the participant information sheet)

(Stop recording. Provide incentive)

Appendix B: Participant information sheet

Investigators: Dr Wardah Ali, Dr Ying Wang, Professor Peter O'Connor, Ms. Kelly Feng

Funder: Health New Zealand

This Participant Information Sheet will help you decide if you want to participate. It sets out what your participation would involve, possible benefits and risks to you, and what would happen after the study ends. Please make sure you have read and understood all the pages. If you agree to participate in this research, you will be asked to sign the Consent Form. You will be given a copy of the Participant Information Sheet and the Consent Form to keep.

What's it all about?

We are seeking individuals willing to share their personal experiences and perspectives on alcohol and drug use, and how they navigated the information, support, and services available to them. The interview focuses on your experience with alcohol and drug as an Asian person living in New Zealand, as well as how you managed the process of help-seeking and recovery. If you have encountered similar experiences, we would like to hear your insights on how we can support and encourage early help-seeking among those affected by alcohol and drug use.

The information we gather during this research will be invaluable for developing more cultural appropriate services to prevent or reduce alcohol and drug harm in Asian communities. This research is being conducted by a team of researchers from Asian Family Services and the University of Auckland, with funding from Health New Zealand. We are particularly interested in exploring personal, cultural and environmental factors that impact people's experiences with alcohol and drug consumption.

Who Will Be Invited to Take Part?

You are invited to participate because we want to talk to people from Asian cultures about their own experiences with alcohol and drug harm while residing in New Zealand. We are looking for individuals who meet the below criteria:

- Aged 18 or older
- Self-identifies as Asian
- Currently resides in New Zealand

- Have consumed alcohol and/or drugs, with self-reported experiences of harm or challenges related to their use (e.g., health impacts, social or family issues, or legal difficulties)

What Will My Participation in the Study Involve?

During the interview, you will be asked a few questions to help us understand your socio-demographic background and information around your alcohol or drug use (e.g., years of consumption, types of consumption, whether you have accessed any support services).

If you agree to take part, your participation and identity will remain confidential. You will be invited to participate in an individual semi-structured interview. The interview session is expected to take about 1 to 1.5 hours, allowing for any breaks in between. The session's date/time and location (Zoom/MS Teams or in-person) will be arranged between you and the researcher. For interviews conducted in person, this will be held at the University of Auckland campus or at the Asian Family Services premises. Your participation will not incur any cost.

With your permission, the conversation during the interview will be audio-recorded, and the researcher will take notes where appropriate. You can ask to pause or stop the audio recording at any time during the interview. In the case of Zoom/MS Team interviews, only audio recording will be used. Video recordings will be immediately deleted after the interview. The audio recording will be translated and/or transcribed by a third party who will have signed a confidentiality agreement. Upon request, you may receive a copy of the translated interview to review and provide feedback to the research team within two weeks of receiving the document.

Interviews can be conducted in your preferred languages. If the interviewee cannot provide an interview in your preferred language, we can provide a translator at any point during the study. Please let the researcher know should it be required.

As a token of appreciation for the time and effort you have provided, you will receive a $80 gift voucher at the end of the interview.

What are the possible benefits and risks of participating in this research?

The findings from this research will inform the development of more culturally appropriate support, initiatives on alcohol and drug use. The results of the study can help service providers to develop more targeted, culturally appropriate interventions and recovery support for Asian people with alcohol and drug issues.

As the topics explored in the interviews include discussing personal experiences, there is a possibility that you may experience some emotional discomfort when discussing sensitive issues during the interviews. If you feel uncomfortable with topics discussed in

the interviews, you may ask for the interview to be terminated at any time. If you do not want to answer any particular question, just let us know. You can also request that the recorder be turned off at any time during the discussion.

Discussing your experiences may cause emotional discomfort. If you feel uncomfortable, you may withdraw from participation at any time. You are encouraged to seek support if needed; a list of counselling or support services is provided at the end of this Participant Information Sheet.

What are your rights?

Your participation in this study is entirely voluntary. You can decline to participate without giving a reason. If you choose to participate, you may decline to answer any individual questions or request that the recorder be turned off at any time during the discussion. If you want to participate now but change your mind later, we can remove your data from the study up to two weeks after the interview. Your identity will be kept confidential. Your name and other information which can identify you personally will not be used in any publications arising from this study. Your identity will not be disclosed to a third party unless disclosure to information that suggests that there is a threat to your own safety or the safety of others. In such events, the researcher has a duty to disclose the information to a third party, such as the police and mental health services.

What will happen to your information?

Participation in this study is not anonymous for in-person interviews, as the researcher will meet you for the interview. During the interview, the researcher will record information about you and your participation. Only the research team will have access to your identifiable information, which will be kept separately from the research data. This personally identifiable information will be removed from the substantive data collected in the study. In all interview recordings, transcripts, and notes, you will be identified by a code name only known to the researcher. It will not be possible for you to be individually identified in any report or publication arising from the study.

Quotes from the interview recordings may be used in publications arising from this research. Care will be taken in choosing quotes or altering them such that specific information that could compromise confidentiality will be replaced.

Security and storage of study data

All data collected in this research will be securely stored on a secured research drive or in a locked cabinet within AFS premises. Access to the data will be restricted to the researchers of this project. The data will be kept for six years. After this time, all data will be destroyed or deleted.

Rights to access the study results

Publications summarising the findings of the research will be prepared after the analysis stage of this study. You can indicate on the consent form if you want to request the summary of this research to be sent to you. Other conference papers and journal articles may be prepared. A summary of the findings will also be available on the Asian Family Services website

Contact details:

If you wish to take part in this study, you can contact the research team to answer your questions regarding the project or your participation. You will be required to sign the Consent Form, and then the date/time and location of the interview will be arranged between you and the researcher.

Dr Wardah Ali
Research and Innovations Lead
Asian Family Services
Email: **[CONTACT DETAILS REDACTED]**

Dr. Ying Wang
Research Fellow
Centre for Arts and Social Transformation
Waipapa Taumata Rau, The University of Auckland
Email: **[CONTACT DETAILS REDACTED]**

If you feel we have not kept to what we promised in this participation sheet or have concerns about this project, you can contact our supervisors:

Kelly Feng
Chief Executive Officer
Asian Family Services
Email: **[CONTACT DETAILS REDACTED]**

Professor Peter O'Connor
Director
Centre for Arts and Social Transformation
Waipapa Taumata Rau, The University of Auckland
Email: **[CONTACT DETAILS REDACTED]**

Chair contact details: For concerns of an ethical nature, you can contact Manager of Aotearoa Research Ethics Committee, Dr Keely Blanch, on **[CONTACT DETAILS REDACTED]**

Information on Support Services

Below is a list of support agencies that provide free, professional and confidential telephone and/or face-to-face counselling and support services:

Asian Helpline: 0800 862 342 (Cantonese, Hindi, Japanese, Korean, Mandarin, Thai, Vietnamese, English) Monday to Friday 9:00 am to 8:00 pm Telephone counselling: Appointment for face-to-face counselling

Lifeline Aotearoa: (mental health) 0800 543 354 (English) 24 hours or free text 4357

Helpline number to speak to a trained counsellor: (mental health) 1737

Depression Helpline: (mental health) 0800 111 757 or free text 4202

Safe to Talk: (sexual harm) 0800 044 334 or free text 4334

Alcohol and drug helpline: 0800 787 797

Healthline number: (free health advice) 0800 611 116

Appendix C: Consent form

Investigators: Dr Wardah Ali, Dr Ying Wang, Professor Peter O'Connor, Kelly Feng

Funder: Health New Zealand

I have read the Participant Information Sheet. I have understood the nature of the research and why I have been invited to participate.

I am satisfied with the answers I have been given regarding the study, and I have a copy of this Consent Form and Participant Information Sheet.

I understand that my participation is voluntary, and I have been given sufficient time to discuss this study with family/whānau or a friend and decide whether or not I wish to participate.

I understand that participation in this study will involve in an individual semi-structured interview session (1 to 1.5 hours), allowing for any breaks in between.

I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports or publications on this study.

I understand that the interview will be audio-recorded. The recording can be paused or stopped at any time during the session. The audio recording will be translated and transcribed by a researcher or third party bound by a confidentiality agreement.

I understand I can request for a copy of the translation to review. I understand that provide my feedback within 2 weeks. After 2 weeks, changes to the translation will not be made.

I understand that I may remove my data from the study up to two weeks after the interview without giving a reason.

I understand that quotes from my interview might be used in publications of this study, and care will be taken in altering them such that specific information that could compromise confidentiality will be replaced.

I understand that the topics discussed in the interview may cause emotional distress and I can terminate the interview at any time.

I understand there are helplines available if I need them, and I understand whom to contact for culturally and language-appropriate services for the Asian community.

I know whom to contact if I have any questions about the study in general.

I understand that I will receive a gift voucher as a token of appreciation at the end of the interview, in recognition of the time and effort I have contributed to this research.

I agree to my interview being audio-recorded.	Yes ☐	No ☐
I would like to be provided with a copy of my translated interview. I understand that I will need to provide my feedback within 2 weeks.	Yes ☐	No ☐
I request the summary of this research to be sent to me. If ***yes***, please provide your email address:	Yes ☐	No ☐

Declaration by participant:

I hereby consent to take part in this study.

Participants signature: _____

Participants name: _____ Date: _____

Declaration by the member of the research team:

I have given a verbal explanation of the research project to the participant and answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researchers signature: _____

Researchers name: _____ Date: _____

Asian Family Services
Together enriching lives

Te Puna
Whakaiti Pāmamae
Kai Whakapiri

New Zealand
Drug Foundation

Health New Zealand
Te Whatu Ora