Published in final edited form as:

J Ethn Subst Abuse. 2020 ; 19(3): 345–357. doi:10.1080/15332640.2018.1532855.

TREATMENT OF ALCOHOL USE DISORDER AMONG PEOPLE OF SOUTH ASIAN ANCESTRY IN CANADA AND THE UNITED STATES: A NARRATIVE REVIEW

Nitasha Puri, Kirsten Allen, Launette Rieb

University of British Columbia, Vancouver, BC, Canada

Abstract

To explore access and treatment for alcohol use disorders (AUDs) among people of South Asian ancestry living in Canada or the United State, EQUATOR guidelines were applied to 34 manuscripts identified through an English language literature search (1946–2017) for this narrative review. The population studied has poor access to and engagement with treatment for AUD. Early evidence suggests benefit from adopting language-specific materials, offering South Asian–specific therapy groups, and incorporating traditional healers. Specific engagement and therapy considerations may increase AUD treatment access and effectiveness among South Asians living in Canada or the United States.

Keywords

South Asian; alcohol use disorder; treatment; immigrant

INTRODUCTION

Alcohol use disorder (AUD) is a growing chronic disease with multiple sequelae including liver toxicity, cardiovascular disease, injury, mental illness, and death (Alcohol, 2015; Officer, 2016). Overall, 5.1% of the global burden of disease and injury is attributable to alcohol (Alcohol, 2015; Officer, 2016). Although strides have been made to further study and address alcohol use issues, there is a paucity of research that explores the alcohol use patterns and related health needs of a diversifying North American population (Mackenzie et al., 2016). In particular, Canada and the United States have experienced significant demographic shifts in recent years, with immigrant, racialized, ethnocultural, and refugee (IRER) groups composing approximately 20% of the population (Mackenzie et al., 2016; Fong & Tsuangng, 2007).

Individuals of South Asian ancestry constitute the largest racialized group living in Canada and are growing rapidly in numbers in the United States (Mackenzie et al., 2016). South

Corresponding Author: Nitasha Puri, MD CCFP, nitasha.puri@alumni.ubc.ca, Department of Family Practice, University of British Columbia, 3rd Floor David Strangway Building, 5950 University Blvd., Vancouver, BC, Canada, V6T1Z3.

Disclosure statement

No financial interest or benefit has arisen from the direct applications of this research.

Asians may be particularly vulnerable to the negative health effects of alcohol use, especially liver disease (Bayley & Hurcombe, 2011; Wickramasinghe, Corridan, Izaguirre, Hasan, & Marjot, 1995). Bayley and Hurcombe (2011) noted that South Asian men in the United Kingdom have a higher alcohol-related death rate than the national average and are overrepresented in alcohol-related liver cirrhosis patient populations (Bayley & Hurcombe, 2011). Cochrane and Bal found that Sikh Punjabi males consumed greater levels of alcohol and experienced more alcohol-related problems compared to other South Asian and white men (Cochrane & Bal, 1990; Sandhu & Malik, 2001). In addition to health effects, problematic alcohol use is linked with increased family violence and disruption, financial problems, drinking and driving, and legal problems (Agic, Mann, & Kobus-Matthews, 2011).

Although alcohol is seen as a fortifying and bonding drink among Punjabi males, which likely leads to increased consumption, scholars believe that the development of AUD in this population is due to a mixture of genetics, family tensions, migratory trauma (including partition and attacks on Sikhs), and acculturative stress related to racialization (Agic et al., 2011; Kunz & Giesbrecht, 1999; Lee, Law, & Eo, 2004; Legge & Sherlock, 1991; Sandhu & Malik, 2001). Gender and generational differences exist, with immigrant and first-generation females consuming less alcohol among immigrant populations than more-acculturated second- and third-generation males or females (Agic et al., 2015; Khera & Nakamura, 2016; Thandi, Chahal & Cheema, 2005).

South Asians may struggle to receive care for their AUD despite increased morbidity. In general, IRER populations have a lower participation in health promotion, prevention, and use of health services compared to their non-IRER counterparts (Mackenzie et al., 2016; Mulia, Tam, & Schmidt, 2014; Schmidt, Greenfield, & Mulia, 2006). Barriers to care exist at the individual, community, and structural levels and are multifold (Canada, 2016; Schmidt et al., 2006). Those listed in the comprehensive report by Mackenzie et al. include service accessibility, patient-provider interaction, circumstantial challenges, language, stigma, and fear (Mackenzie et al., 2016). That said, there is growing evidence to suggest that in addition to structural changes around health systems and social determinants, culturally tailored psychosocial and health promotion interventions can also improve outcomes for target groups (Bedi, 2018; Mackenzie et al., 2016; Griner & Smith, 2006). These approaches maintain core components of an evidence-based treatment but translate it to be more relevant and consistent with the ideas, values, beliefs, norms, attitudes, and knowledge of the target group (Bedi, 2018; Mackenzie et al., 2016; Griner & Smith, 2006). In Griner and Smith's (2006) broad meta-analysis of American IRER populations, interventions targeted to a specific cultural group were four times as effective as interventions provided to groups consisting of clients from a variety of backgrounds. In addition, interventions conducted in clients' native language (if other than English) were twice as effective as interventions conducted in English (Mackenzie et al., 2016; Griner & Smith, 2006). In addition to these targeted treatment modalities, heterogeneous evidence from multiple countries suggests traditional healers may offer some value and efficacy in treating mental illness, a finding that may be loosely applied to substance use issues as well (Nortje, Oladeji, Gureje, & Seedat, 2016).

Currently, the evidence around treatment access and interventions for AUD among IRER populations is diverse and scoping. Given the uniquely high risk of alcohol use issues and morbidity among South Asians, it is clear that a more focused and nuanced understanding of AUD treatment in this IRER population is necessary. Thus, this narrative review explores the following question: What is currently known about the access to and treatment of alcohol use disorder among the South Asian population in Canada and the United States?

METHODS

Narrative reviews seek to summarize previously published literature and identify new study areas not yet understood (Ferrari, 2015). Unlike systematic reviews, no acknowledged guidelines are available for narrative reviews in order to shape the methodology (Ferrari, 2015). For this manuscript, a literature search was conducted using Medline, CINAHL, Psychinfo, Embase, and Cochrane Database of Systematic Reviews (1946–January 2017), evaluating alcohol use patterns, motivations, and treatment access. Search keywords included cultur*/ethnic*; (southasian* or “south asian” or “southeast asian” or indian or india or Punjab* or fiji* or Pakistan* or Bangladesh* or “Sri Lanka*” or sikh*); alcohol*/addict*; and clinic*/treatment*/outpatient*. The inclusion criteria for the initial search were as follows:

- Any type of study methodology, including meta-analyses, scoping reviews, reports and gray literature, randomized control trials, cohort and/or case-control studies, and case reports
- Studies focused on South Asian people in the United States, United Kingdom, and Canada who use alcohol, with South Asian being defined as those who self-reported having Indian (including Punjabi), Pakistani, Sri-Lankan, or Bangladeshi origin/ancestry but living outside of these countries
- Adults over 18 years old, all genders, all religions
- Studies describing treatment defined as outpatient clinics, peer support programs such as 12-step, psychosocial interventions, and health care delivery models
- English language

Exclusion criteria were:

- Studies that focus on polysubstance use or are not specific to alcohol use
- Studies that focus exclusively on youth or adolescent populations

From 495 abstracts reviewed, 24 publications met the inclusion criteria as decided by one researcher. A citation search was conducted on the relevant manuscripts, but no further sources were identified. A secondary search was conducted in key journal search engines, including the Journal of Ethnicity in Substance Abuse and Transcultural Psychiatry, using the words “South Asian,” “Punjabi,” and “Alcohol,” from which approximately four articles were identified. Gray literature searches through community partnerships and research meetings revealed four additional manuscripts, and citation searches were completed on these manuscripts, revealing an additional two citations. Overall, 34 manuscripts were

critically assessed for key results, limitations, suitability of methods used, quality of results obtained, and interpretation of the results. When able, EQUATOR guide-lines were applied to study evaluation. The most relevant and rigorous conclusions were woven into the narrative results, with some studies being excluded for content redundancy or limited methodology. Some less rigorous studies were included for their relevance despite their methodological shortcomings. The bulk of included manuscripts were narrative reviews, as opposed to higher quality interventional or cohort studies.

RESULTS

No data exist on the efficacy (i.e., outcomes around reduced amount/frequency of alcohol use, reduced morbidity, quality of life indicators, etc.) of treatment for AUD in South Asians. Like other populations, South Asians in Canada and the United States are theoretically able to access private and publicly funded inpatient treatment facilities, acute tertiary and emergency care, detoxification sites, sobering centers, outpatient day programs, out-patient psychosocial and medical management, peer support, and online recovery resources.

The existing data revealed three key concepts around treatment for AUD among South Asians: (a) Asian Pacific Islanders (APIs), a focused IRER group that encompasses South Asians, are less engaged in treatment due to various social and structural factors; (b) there is early evidence for tailored psychotherapy in the population; and (c) there is early evidence for the inclusion of traditional and/or religious principles in treatment approaches for some South Asians.

Poor engagement in treatment

North American studies that focus specifically on South Asians in AUD treatment settings do not exist, yet a collection of American manuscripts did detail engagement in treatment among the Asian Pacific Islander (API) population, which is a racial category that refers to a heterogeneous group of people with origins in East, Southeast, and South Asia as well as the Pacific Islands (Chang et al., 2017). API is a broad term with almost 50 countries and cultures represented. Fong and Tsuang's narrative review summarized evidence that API are greatly underrepresented in addiction treatment across the different settings, from residential to outpatient to hospital-based admissions (Fong & Tsuang, 2007). Mulia et al. demonstrated that Asians have one third less odds of receiving an alcohol intervention during a four-year period and are approximately four times as likely to receive alcohol counseling from clergy ($p < .5$) rather than other health care professionals (Mulia et al., 2014). The same research team demonstrated earlier in their narrative review that there is a lack of "culturally appropriate" treatment programs geared toward APIs (Schmidt et al., 2006).

Treatment access issues are multifactorial, and this may be due to a variety of institutional, cultural, social, and structural barriers, including stigma and shame, degree of acculturation, family dynamics, cost, language, and health literacy (Agic et al., 2011; Chang et al., 2017; Masson et al., 2013; Smith, Dawson, Goldstein, & Grant, 2010).

Stigma and shame

Within the South Asian community there is negative stigma associated with AUD; this is most pervasive for immigrant and first-generation South Asians, women more than men (Agic et al., 2011; Smith et al., 2010; Thandi et al., 2005). No studies directly describe the effect of stigma on treatment for South Asians, but if we extrapolate data on the stigma effect for other communities, we might conclude that it is also a barrier to access and treatment completion for South Asians, especially in treatment modalities that require group disclosure of alcohol issues (Lee et al., 2004). In many communities, stigma may affect readiness for change, as well as course of recovery, and cause some to keep their alcohol use disorder a secret from family members and friends to avoid embarrassment and shame (Agic et al., 2011; Chang et al., 2017; Fong & Tsuang, 2007). In the data analysis of the American National Epidemiologic Survey on Alcohol and Related Conditions, Smith and colleagues concluded that stigma may also underlie the barriers to initiation, attitudes toward recovery and self- management, and completion of treatment – a conclusion which Fong and Tsuang also allude to in their narrative review (Fong & Tsuang, 2007; Smith et al., 2010).

Degree of acculturation

A few Canadian studies have explored the association between acculturation and alcohol use patterns among South Asians. Although somewhat dated, Weber's 1996 survey of Punjabis in Brampton, Ontario, revealed that increased levels of acculturation were associated with more liberal attitudes toward the use of alcohol, as well as increased lifetime use of alcohol (Weber, 1996). Despite this, those who had lower levels of acculturation experienced more alcohol-related problems. This finding may be explained further by Sue and colleagues' report on the compounded experience of stigmatizing microaggressions (that less-acculturated people may be more susceptible to), which can lead to negative mental health (Lufkin, 2018; Sue et al., 2007).

Acculturation also affects communication, a key element in AUD treatment and access and the development of individualized treatment plans. Thandi et al. conducted semistructured one-on-one interviews with Canadian health care practitioners who provided services for Punjabi clients struggling with AUD. They concluded that there is variance in communication styles among first-, second-, and third-generational South Asians due to the level of acculturation (Thandi, Chahal & Cheema, 2005). This is echoed in Nayar and Sandhu's postdoctoral thesis exploring counseling nuances among the same community (Nayar & Sandhu, 2006). Elders, or immigrants who spent most of their lives in India before immigrating, usually have English as a learned language, and most of their knowledge is based on personal experiences. Second and third generations are generally literate in English, and their knowledge is based on personal experiences and written language, as well as deductive reasoning and Western thought (Nayar & Sandhu, 2006; Thandi, Chahal & Cheema, 2005). Language also affects communication and access; Chang and colleagues' qualitative study of care providers' perspectives on treatment barriers for APIs suggests that a common language between staff and clients was needed to experience therapeutic nuances such as acceptance, connection, and openness. Speaking a common language enabled the expression of cultural meanings and helped clients build better relationships with treatment providers (Bedi & Shergill, 2017; Chang et al., 2017).

Family dynamics

Studies suggest that the South Asian family unit both enables and prevents individuals from seeking treatment and attaining their recovery goals (Chang et al., 2017). These phenomena are heavily intertwined with acculturation, stigma, and communication, as described in the preceding (Lee et al., 2004). In some cases, stigma is so severe that South Asian women (particularly first generation) are more willing to endure abuse from intoxicated husbands than encourage them to seek treatment and discuss substance use, for fear of bringing shame to the family (Agic et al., 2011; Thandi et al., 2005). Lee et al., a group that conducted a broader questionnaire among 495 Asian Americans in 2004, offered similar findings of interest in containing issues within the family unit. In their study, 53.2% of South Asians preferred abstaining from alcohol use on their own or talking to friends or family members (16.1% and 11.3%, respectively) (Lee et al., 2004). Very few would consider seeking counseling, AA, or detox and out-patient medical services (Lee et al., 2004).

The role the family plays in encouraging treatment is important and necessary to successful engagement in seeking treatment programs. This may involve working with the families separately in education to promote an awareness of the difficulties surrounding addictions and reduce harmful perceptions and co-dependencies that enable a mistrust of seeking professional help (Bedi & Shergill, 2017; Fong & Tsuang, 2007).

Intersecting structural barriers

As mentioned earlier, South Asians are a group that contains racialized or discriminated individuals as well as those who have migrated. These factors represent historical, political, economic, and social dynamics or inequalities that are largely outside the control of individuals but do affect them significantly (Masson et al., 2013; Rastogi & Wadhwana, 2006; Sue et al., 2007). These broader structural phenomena inform how health systems are created or accessed and translate into barriers such as cost of treatment, limitations in mobility, court-mandated treatment without individual matching or choice, and generally fewer treatment facilities that offer culturally tailored approaches to care (Chang et al., 2017; Fong & Tsuang, 2007; Masson et al., 2013). Most studies currently draw these conclusions from narrative literature reviews; however, no longitudinal cohort correlating factors have been examined with these theories in the South Asian population.

Health literacy and messaging

A seminal Canadian study by Agic et al. conducted focus group interviews with members of seven different IRER communities, including individuals who identified as Punjabi. Among other findings, Agic et al. observed resistance to current health messaging due to cultural and language insensitivity, both of which affect engagement in treatment and prevention of alcohol use disorder (Agic et al., 2011). For example, Punjabi respondents felt that awareness messages were found to focus too closely on the individual choice, which did not resonate with their community-oriented world-view. In addition, focus group findings consistently stressed the need for health messages to be made in native tongues; however, a direct translation of English messages does not account for cultural concepts (Agic et al., 2011). Messages might also be better received if they are conveyed by respected members of

the community, such as religious and community leaders, counselors, and local physicians (Agić et al., 2011).

Tailored psychotherapy and traditional treatment

Several reports described the efficacy of culturally tailored therapy. In Mackenzie and colleagues' report to the Mental Health Commission of Canada, it is clear from eight systematic reviews and meta-analyses that therapies adapted for a specific cultural group are more likely to be effective than those targeting a culturally mixed group of participants (Mackenzie et al., 2016). The impact of cultural adaptation on outcomes is greater in adults than in children and youth. Matching therapists by language was twice as effective as not matching especially among Asian Americans when effect sizes were compared (Mackenzie et al., 2016). None of the more specific studies included by Mackenzie et al. in their review were focused up South Asians; however, these conclusions may be applied to South Asians.

A small body of evidence also suggests that it is important to investigate the overlay of religious, spiritual, and traditional frameworks with South Asian clients' therapeutic concerns, particularly for those of the Sikh religious tradition. (Bedi & Shergill, 2017; Sandhu, 2009; Thandi, Chahal & Cheema, 2005). For example, in Bedi and Shergill's summary of psychology literature, specific communication styles and counseling frameworks that incorporate elements of the Punjabi-Sikh immigrant and Canadian-born view are described (Bedi & Shergill, 2017). They reference several principles such as collectivism in the society balanced with North American individualism, the way that knowledge is perceived, as well as the inclusion of God's will in the life and disease process. Their research also shows that in times of distress, many Punjabi Sikh individuals turn to their religion, and so recommending that a person consult a Sikh elder, visit a Sikh Gurdwara (temple), do seva (volunteering), or practice meditation may be warranted. The authors also highlighted the tensions surrounding racialization of Sikhs compared to other folks of South Asian ancestry and referenced the need to tread carefully around assumptions of religious worldviews as some Punjabi Sikh individuals can react with suspicion or feel judged by those who focus too much on religion too soon in the therapeutic process (Bedi & Shergill, 2017).

In addition to adopting religious and cultural worldviews in therapy, members of the South Asian community regularly seek assistance from home remedies and traditional healers such as hakims, homeopathic doctors, and Ayurvedic practitioners to help with mental distress, which has, in some studies, been shown to be efficacious from a psychosocial perspective (Dein & Sembhihi, 2001; Nortje et al., 2016).

DISCUSSION

This narrative review explored what is currently known about the treatment of AUD among the South Asian population in Canada and the United States. Given the uniquely high morbidity and risk of alcohol use issues among South Asians, it is clear that a more focused and nuanced understanding of AUD treatment in this IRER population is necessary. The existing data revealed three key concepts around treatment: (a) APIs (including South Asians) are less engaged in treatment due to various social and structural factors, (b) there is

early evidence for tailored psychotherapy treatment, and (c) there is early evidence for the inclusion of traditional and/or religious principles in treatment approaches for some South Asians.

Overall, the heterogeneous and nonspecific evidence presented difficulties in creating a narrative about the vulnerable South Asian population. The complex intersections among stigma, family dynamics, cultural factors, and structural factors that affect treatment, all of which are influenced by racialization and migration issues that are present among all IRER populations, can be further understood and applied to the development of more-tailored approaches to treatment for AUD.

Implications for treatment

Despite the limited information available, some considerations can be suggested for structuring prevention, outreach, access, early intervention, and treatment of AUD in the South Asian Community in Canada and the United States. First, target all educational material in the oral and written language of the specific group to be reached and, if possible, liaise with respected members of the community to respectfully distribute advice. Second, work to address stigma and fear within communities. Third, ensure any group therapy or education sessions contain people of similar South Asian background whenever possible and incorporate elements of an individual's worldview as well as their family. Finally, offer access to traditional South Asian healers when building treatment programs.

Limitations

Recently, scholars have critiqued the process of studying ethnocultural groups. Social scientists acknowledge that ethnicity is not static and discrete, instead highlighting the fluid and context-dependent nature of multiple identities. Despite these ideas, researchers continue to assess ethnic group categories in ways that lack critical reflection around the validity measurements as well as the social, bureaucratic, and political decisions shaping ethnicity (Hunt, Kolind, & Antin, 2018). Nevertheless, Hunt et al. agree that there is still a role for ethnic categorizations in documenting health inequities and social injustices, requiring a new way of measuring ethnocultural nuances that are “justified beyond simplified explanations of social convention and that ‘do no harm’ in terms of perpetuating racism and obscuring the root causes of social and health problems related to alcohol and drugs” (Hunt et al., 2018, page 195). It may be said that rather than delineating groups by ethnicity, we ought to do so by social factors affecting their lived experience (i.e., racialization, migration, or other factors).

In addition to this foundational limitation of studying South Asians, many of the studies that were included in this narrative review were lower quality evidence as per the EQUATOR guidelines. The majority were completed with small sample sizes and neglected to include South Asians diagnosed with AUD as the major focus. In approximately half of the cited studies, the South Asian population was only a small subset of the groups studied. For this reason, many of the conclusions were drawn from a group that may not be representative of the South Asian alcohol-using community. Finally, a limitation often cited in the articles reviewed arose from the personal nature of the subjects discussed. It is possible that

responses from focus groups may not be wholly encompassing of the depth and breadth of the problem or its solution.

Gaps and further areas of research

There is a clear need for rigorous development and evaluation of health literacy and treatment interventions for the population. In addition, more in-depth study into the correlates of the risk for developing AUD and related morbidity might inform preventive treatment options. Questions regarding specific treatment outcomes such as withdrawal scores, toxicity levels, number of drinks consumed, number of days heavy drinking, and quality-of-life indicators may offer more-specific findings about which pharmacologic and psychotherapeutic interventions are most effective. Similarly, the role of family dynamics in seeking treatment and in creating treatment plans requires further research, as does an approach to stigma and effects of racialization and migration. Gender-based analyses as well as intergenerational analyses would contribute greatly to developing further treatment options for the South Asian community.

CONCLUSION

Overall, AUD is a growing issue among the diversifying populations in Canada and the United States. South Asians are at increased risk for AUD- related morbidity yet have reduced engagement with effective treatment options. Specific outreach targeting this group that acknowledges structural effects of racialization and that is language and culturally specific is warranted. Further research is needed to support this vulnerable population.

Funding details

This study is not supported by any grant. The corresponding author receives a research training salary through the University of British Columbia Clinical Scholars Program.

REFERENCES

- Agic B, Mann RE, & Kobus-Matthews M (2011). Alcohol use in seven ethnic communities in Ontario: A qualitative investigation. *Drugs: education, Prevention and Policy*, 18(2), 116–123.
- Agic B, Mann RE, Tuck A, Ialomiteanu AR, Bondy SJ, & Simich L (2015). Gender differences in alcohol use and risk drinking in Ontario ethnic groups. *Journal of Ethnicity in Substance Abuse*, 14(4), 379–391. [PubMed: 26307906]
- Alcohol (2015). <http://www.who.int/mediacentre/factsheets/fs349/en/>
- Bayley M, & Hurcombe R (2011). Drinking patterns and alcohol service provision for different ethnic groups in the UK: A review of the literature. *Ethnicity and Inequalities in Health and Social Care*, 3(4), 6–17.
- Bedi R (2018). *Culturally-Adapted Counselling and Psychotherapy*. Vancouver, Canada: BC Psychology, 13–15.
- Bedi RS, & Shergill A (2017). *Counselling and Psychotherapy with Punjabi Sikhs: Socio-Cultural Considerations*. Vancouver, Canada: BC Psychology.
- Canada M. H. C. o. (2016). *The Case for Diversity: Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations*. Ottawa, Ontario: Mental Health Commission of Canada.
- Chang JS, Sorensen JL, Masson CL, Shopshire MS, Hoffman K, McCarty D, & Iguchi M (2017). Structural factors affecting Asians and Pacific Islanders in community-based substance use

- treatment: Treatment provider perspectives. *Journal of Ethnicity in Substance Abuse*, 16(4), 479–494. doi:10.1080/15332640.2017.1395384 [PubMed: 29236627]
- Cochrane R, & Bal S (1990). The drinking habits of Sikh, Hindu, Muslim and white men in the West Midlands: a community survey. *Br J Addict*, 85(6), pp. 759–769. [PubMed: 2378993]
- Dein S, & Sembhi S (2001). The use of traditional healing in South Asian psychiatric patients in the UK: Interactions between professional and folk psychiatries. *Transcultural Psychiatry*, 38(2), 243–257.
- Ferrari R (2015). Writing narrative style literature reviews. *Medical Writing*, 24(4), 230–235. doi:10.1179/2047480615Z.000000000329 Retrieved from 10.1179/2047480615Z.000000000329https://doi.org/10.1179/2047480615Z.000000000329 Retrieved from https://doi.org/10.1179/2047480615Z.000000000329
- Fong TW, & Tsuang J (2007). Asian-Americans, addictions, and barriers to treatment. *Psychiatry (Edmont)*, 4(11), 51
- Griner D, & Smith TB (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy (Chic)*, 43(4), 531–548. doi:10.1037/0033-3204.43.4.531 [PubMed: 22122142]
- Hunt G, Kolind T, & Antin T (2018). Conceptualizing ethnicity in alcohol and drug research: Epidemiology meets social theory. *Journal of Ethnicity in Substance Abuse*, 17(2), 187–198. doi:10.1080/15332640.2017.1316223 [PubMed: 28511029]
- Khera GS, & Nakamura N (2016). Substance use, gender, and generation status among Asian Indians in the United States. *Journal of Ethnicity in Substance Abuse*, 17(3), 291–302. doi:10.1080/15332640.2016.1201715 [PubMed: 27436588]
- Kunz JL, & Giesbrecht N (1999). Gender, perceptions of harm, and other social predictors of alcohol use in a punjabi community in the Toronto area. *Subst Use Misuse*, 34(3), 403–419. doi:10.3109/10826089909035653 [PubMed: 10082064]
- Lee MY, Law PF, & Eo E (2004). Perception of substance use problems in Asian American communities by Chinese, Indian, Korean, and Vietnamese populations. *Journal of Ethnicity in Substance Abuse*, 2(3), 1–29.
- Legge C, & Sherlock L (1991). Perception of alcohol use and misuse in three ethnic communities: Implications for prevention programming. *International Journal of the Addictions*, 25(suppl 5), 629–653.
- Lufkin B (2018). The tiny ways prejudice seeps into the workplace. *BBC Capital*.
- Mackenzie K, Agic B, Tuck A, Antwi M, & Canada M. H. C. o. (2016). *The Case for Diversity: Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations*. Ottawa, Ontario.
- Masson CL, Shopshire MS, Sen S, Hoffman KA, Hengl NS, Bartolome J, Iguchi MY (2013). Possible barriers to enrollment in substance abuse treatment among a diverse sample of Asian Americans and Pacific Islanders: Opinions of treatment clients. *Journal of Substance Abuse Treatment*, 44(3), 309–315. [PubMed: 22985677]
- Mulia N, Tam TW, & Schmidt LA (2014). Disparities in the use and quality of alcohol treatment services and some proposed solutions to narrow the gap. *Psychiatric Services*, 65(5), 626–633. doi:10.1176/appi.ps.201300188 [PubMed: 24487667]
- Nayar KE, & Sandhu JS (2006). Intergenerational communication in immigrant Punjabi families: Implications for helping professionals. *International Journal for the Advancement of Counselling*, 28(2), 139–152.
- Nortje G, Oladeji B, Gureje O, & Seedat S (2016). Effectiveness of traditional healers in treating mental disorders: A systematic review. *The Lancet Psychiatry*, 3(2), 154–170. [PubMed: 26851329]
- Officer, C. P. H. (2016). *The Chief Public Health Officer's Report on the State of Public Health in Canada 2015: ALCOHOL CONSUMPTION IN CANADA*. Ottawa, Canada
- Rastogi M, & Wadhwa S (2006). Substance abuse among Asian Indians in the United States: A consideration of cultural factors in etiology and treatment. *Subst Use Misuse*, 41(9), 1239–1249. doi:10.1080/10826080600754470 [PubMed: 16861175]
- Sandhu DS, & Malik R (2001). Ethnocultural background and substance abuse treatment of Asian Indian Americans. *Ethnocultural Factors in Substance Abuse Treatment*, 368–392.

- Sandhu JS (2009). A sikh perspective on alcohol and drugs: Implications for the treatment of punjabi-sikh patients. *Sikh Formations*, 5(1), 23–37. doi:10.1080/17448720902935037
- Schmidt L, Greenfield T, & Mulia N (2006). Unequal treatment: racial and ethnic disparities in alcoholism treatment services. *Alcohol Research and Health*, 29(1), 49. [PubMed: 16767854]
- Smith SM, Dawson DA, Goldstein RB, & Grant BF (2010). Examining perceived alcoholism stigma effect on racial-ethnic disparities in treatment and quality of life among alcoholics. *Journal of Studies on Alcohol and Drugs*, 71(2), 231–236. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2841733/> [PubMed: 20230720]
- Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder A, Nadal KL, & Esquilin M (2007). Racial microaggressions in everyday life: implications for clinical practice. *American Psychologist*, 62(4), 271. [PubMed: 17516773]
- Thandi G, Chahal S, & Cheema M (2005). A Review of Substance Abuse Services for South Asian Punjabi Sikh Communities in Surrey and Surrounding Areas. Surrey, BC
- Weber TR (1996). The influence of acculturation on attitudes toward alcohol and alcohol use within the Punjabi community: an exploratory analysis. *Subst Use Misuse*, 31(11–12), pp. 1715–1732. [PubMed: 8908713]
- Wickramasinghe SN, Corridan B, Izaguirre J, Hasan R, & Marjot DH (1995). Ethnic differences in the biological consequences of alcohol abuse: A comparison between south Asian and European males. *Alcohol and Alcoholism*, 30(5), 675–680.(0735–0414 (Print)) [PubMed: 8554653]