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Exploring Substance Use Among Asian Americans: Seven Themes from Interviews with Service Providers and Community Residents

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Exploring Substance Use Among Asian Americans:

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This report describes the aims, approaches, and findings of an exploratory research study that researchers in the Institute for Asian American Studies at the University of Massachusetts Boston conducted in collaboration with the Bureau of Substance Addiction Services in the Massachusetts Department of Public Health. The study aimed to shed light on substance use and its associated harms among Asian Americans in Massachusetts. The researchers used focus group and individual interviews to learn about the participants' perceptions, observations, and opinions about substance use in Asian American communities. Recruitment targeted participants in two categories: health and social service providers serving Asian American populations and residents of one Boston neighborhood. The study began in fall 2022 and was concluded in spring 2024.

The researchers developed the study design, wrote interview protocols, recruited participants, facilitated focus groups and individual interviews, and analyzed the data. The participants (N = 31), included 17 Massachusetts-based providers, eight neighborhood residents of Boston's Chinatown, and six out-of-state providers from New York City and Los Angeles County. The providers from Massachusetts were selected for their professional experience serving Cambodian, Chinese, Korean, and Vietnamese clients, and they practice in three cities: Boston (Chinatown and East Boston neighborhoods), Lowell, and Worcester. The out-of-state providers were selected because they have experience counseling Asian Americans with substance use problems. Appendix C includes information on the participants. Appendix A includes information on the participants.

Four reviewers were asked to provide feedback on an earlier draft of this report. Each reviewer (identified only by number in this report) was also a focus group participant or individual interviewee. They were selected for their extensive professional experience working as mental health clinicians or as public health, social service, or community health providers in Asian American communities. We requested their review both to validate our findings and elaborate on observations and opinions. This report includes direct quotes from these reviewers to add detail and context to the comments made by the wider focus group and interviewees also quoted in this report (Appendix B).

***Aim and Approach*:** Our aim was to learn from participants' descriptions of their experiences and observations related to substance use by Asian Americans and to gather their recommendations for improving services. The participants were asked questions that focused on use of substances, including prescription and illicit opioid drugs, stimulants, nicotine, and marijuana. The list of questions we asked participants is included in Appendix C. All focus group and individual interviews were conducted in the language participants preferred to speak. Each session was transcribed; if participants spoke in an Asian language, their answers were professionally translated into English.

To recruit participants, we solicited recommendations or referrals from academic, public health, and community experts. Our recruitment focused on Asian American ethnic groups and

an immigrant neighborhood because it has a concentration of low-income residents, many of whom, for a variety of reasons discussed in this report, do not seek assistance with substance use. The eight community residents responded to a flyer posted in a residential building or were found by referral from community agencies.

***Limitations*:** The total sample size ($N = 31$) of participants is limited because the number of providers with in-depth professional experience working with the study's targeted ethnic groups—Cambodian, Chinese, Korean, and Vietnamese—is small. We could not include a representative from every Asian ethnic group because of resource limitations. When we began our study, there was no available published or private list of healthcare professionals in Massachusetts with expertise in substance use among Asian Americans. As a result, we used purposive convenience sampling to create a list of prospective participants to invite. We first created a preliminary list by consulting professional contacts and directories. We sought referrals and then asked study participants for recommendations during the course of the study.

Further research is needed to validate and assess the generalizability of our findings. By asking probing questions that have received little to no attention in previous research on substance use among Asian Americans, we have laid the groundwork for future studies with larger and more diverse samples of Asian American participants. It will be possible to refine methods used in this study to collect qualitative data on Asian Americans disaggregated by ethnicity while also accounting for demographic heterogeneity within each ethnic group. It will also be important to study ethnic groups not included in this research, such as Asian Indians, Bangladeshi, Pakistani, and other South Asians.

Background: Asian Americans comprise a racial category inclusive of more than 20 Asian ethnicities as counted by the U.S. Census. They are the fastest-growing group in the United States. In this report, we use the term "Asian" to refer to a person's origin or ancestry in East Asia, Southeast Asia, or South Asia. However, we realize that different regions and nations across Asia have varied concepts of health and wellness as well as diverse health practices and habits. We use the term "Asian American" to describe research participants of Asian descent and who reside in the U.S. regardless of citizenship or residency status. We also use the term "immigrant" as all participants are either first- or later-generation immigrants.

In health and social research, collecting accurate data at the community or individual level requires differentiating participants by demographic factors associated with life stressors that increase risk for substance use problems. For Asian Americans, such factors may include low income, occupation, gender, social or linguistic isolation, or recency of immigration. Some of these factors also affect processes of acculturation and enculturation, which entail learning about a culture of immigrant heritage and adapting to a new culture.

Our study examined how generational status influences thinking about substance use problems. According to the U.S. Census Bureau definitions of generational status,[1] a person born in the United States with at least one or more parents born abroad is a second-generation

[1] https://www.census.gov/topics/population/foreign-born/about/faq.html

immigrant; if both parents are born in the U.S. but at least one grandparent is born abroad, this person is a third-generation immigrant. The impact of some life stressors, such as language and social isolation, tend to change across immigrant generations. In addition, a person's age at the time of immigration influences educational experiences and cultural outlook. For example, if an immigrant comes to the U.S. as a child with adult family members and attends U.S. schools from an early age, the process of acculturation and enculturation differs from an immigrant who settled in the U.S. as an adult. Adding to this complexity is whether a person came to the U.S. as a refugee, to unite with family members, or for an educational or economic opportunity. The reason and circumstances for immigration may make settling and adapting to a new country more or less difficult.

Accordingly, we designed our research to explore the possible interplay of factors that may increase risk for problematic substance use, as well as concepts of health and well-being that can influence whether a substance use disorder is recognized as well as attitudes about seeking treatment. We were interested in how a person's affinity with some aspects of heritage cultures and/or U.S. culture shape understandings of and coping with substance use problems.

Asian Americans have experienced significant racial prejudice since the mid-nineteenth century. In 2020, dangerous U.S. political rhetoric blamed the Covid-19 pandemic on China by calling the virus "China virus" or "kung flu." Asian Americans across ethnic backgrounds were targeted and faced racial backlash across the United States. Fears about physical attacks, verbal taunting, and others acts of discrimination exacerbated mental health distress among Asian Americans across the U.S. Our interviews took place from fall 2022 to spring 2024, after a preparatory phase of the research. We undertook the research to understand the twofold health crises of anti-Asian racism and Covid-19 illness, both of which increased substance usage among Asian Americans. This coincides with survey data collected on Asian Americans but not disaggregated by ethnicity (Spencer et al., 2023; Wu et al., 2023; Yan et al., 2023; see Appendix D for a listing of references by type of substance use). Yan and colleagues (2023) found significant increases over time in the incidence rate ratio (IRR) of Asian Americans' past-month use of alcohol, cocaine, or tranquilizers. For these substances, respectively, IRR was 1.3 times, 3.0 times, and 17.2 times greater in 2020 than between 2016 and 2019; in contrast, there was no change in the IRR among whites between these two periods.

This report is broken into the following seven sections:

1. Barriers to Accessing Prevention Education and Treatment
2. Understanding and Treating Alcohol Use Disorders
3. Leveraging Support in Families and Communities
4. Prioritizing Services for Population Sectors at Greatest Risk
5. Training Programs for Culturally Competent Health Professionals
6. Providing Interdisciplinary Clinical Care
7. Learning from Treatment Providers in Other States

It concludes with Recommendations: Priority Goals and First Steps.

Please note that some quotes have been edited for clarity.

Barriers to Accessing Prevention Education and Treatment

Culturally Responsive and Bilingual Services for Treatment and Prevention Are Unavailable

There was strong agreement among our focus group and interview participants that there is a lack of substance use prevention and treatment programs suitable for delivery of services to Asian Americans. For example, standard approaches to preventative education do not address cultural beliefs about substances and treatment.

A provider serving Vietnamese Americans in Worcester commented:

> So what we have been seeing over the past is that treatment is close to very inaccessible for the community we serve. First of all, I think because the population we serve, most of them are what we call new immigrants. So they moved to the United States within 10 years. So the whole medical system itself, it's very confusing for them. And I think most of the service treatment and a lot of things are not really [made] be accessible to folks who don't really speak fluent English.

A social worker who serves Vietnamese in Worcester added:

> I think most of the client(s) that we work with and we are talking to them about substance abuse, they have this belief that they will be able to manage this under control by themselves or with some … I don't know how to call this, folk treatment like just herb(s) or like acupuncture . … So they believe they can get help from them … because that's something they know.

This same provider noted that community-based organizations are an optimal space for the delivery of culturally responsive education because community members feel comfortable there, and they have rapport with the staff members who speak their preferred language and share their cultural background. The staff should be trained to deliver education tailored to the cultural ways of thinking and communication of clients:

> I would love to have people come in and teach some teams how to talk about mental health and substance use, right? Like peer teaching, and how do you provide some space for these teams to be able to talk about all the issues they have, right? So like this is a perfect space ….

Continuing to speak about treatment and recovery, this provider noted:

> But we imagine something like some kind of supported housing, some kind of a peer-run type of recovery place where people can come in, socialize, feel safe and get the kind of the support and counseling they need. Sometimes also areas where they can stay and maybe live for a while and develop social support, simply because a lot of folks with substance use tend to be very much alone. So having natural supports [like] having support to work. I think a lot of it is things

> that I think we all do naturally, and how do you get that at the front door for folks? And hav[ing] support that speak their language is something that's always needed everywhere. …

Reviewer 4 explained why a standard U.S. treatment model is culturally inappropriate for many Asian immigrants. Generally, the model uses a one-to-one interaction between a professional provider and a client, or a provider talking with a prescribed group of strangers who share a common problem or ailment.

As Reviewer 4 elaborated:

> [E]specially [for] Asian immigrants/refugees who rely on family/social relationships, this treatment model feels alien to them, therefore [it] hinders those who have severe substance use problems from seeking help.

No single approach will be suitable for leveraging family support systems to help individuals seek and continue treatment after it begins. There is great diversity of cultural belief systems and immigrant experiences among different Asian ethnic communities. Moreover, each ethnic group is complex within itself. Well-managed partnerships among health professionals, social service providers, community organizations, and researchers are required to fill the void by creating innovative prevention and treatment that is culturally tailored for targeted communities. Details and suggestions are described in subsequent sections of this report.

Lack of Education About Mental Health and Substance Use

Significantly, many older Cambodian, Chinese, and Vietnamese people living in low-income communities can neither read nor write in their native language or in English. To break down communication barriers and deliver comprehensible and usable education, health educators and service providers need resources, including culturally responsive training and materials, to deliver information in understandable formats, such as through oral messaging, pictures, and multimedia presentations.

A resident who lives in Boston's Chinatown brought up a suggestion about community education:

> More publicity can be done, such as holding symposiums, like today's meeting. Or hand out flyers on the street to let more people know about it. Or hold special lectures in public places. Some people like to attend events in public places.

A retired administrator of public health programs in Massachusetts described the need for education tailored to the linguistic ability and educational level of many community members:

> One more thing we had always talked about is that if you're developing resource materials, especially in writing, do it at the third-grade level because that's a level most of the people are probably able to understand. Now, there are

> educated people, don't get me wrong. But I think the important thing is to really get the word out to the people, those who are not able to access the information through others [ways].

Reviewer 2 described misunderstandings about alcohol abuse stemming from low levels of formal education among some community members.

> [Some Vietnamese] don't see alcohol abuse as a problem, [and they] don't recognize using alcohol for sleep or to relax is a problem. They think the need to use alcohol daily is a habit, not an addiction.

Reviewer 3 added this comment on the limited understanding of mental health among some Chinese immigrants:

> When many people encounter mental health problems, they mostly hide at home. They only think they are sick, but they do not realize that it is a mental health issue and there is no way/resources to communicate with and even seek help.

Lack of Services in Multiple Asian Languages

Accessing culturally tailored services for substance use problems starts with accurate language translation. The websites of most public health agencies commonly offer a "select language" menu, but it is driven by Google Translate. Although these tools help widen potential readership and offer multiple language options, professional translation services are required to avoid misunderstanding or perceived cultural disrespect stemming from poor artificial intelligence (AI) translations. Our research team found that on health agency websites, the translation of English words or phrases into Chinese is too often inaccurate, hard to understand, or inappropriate. Automated mobile interpretation tools have similar shortcomings to other AI options.

In clinical settings, professional in-person interpretation is vitally important for communication on sensitive topics and to ensure accuracy and comprehension of medical information, such as instructions on medications—from how to take them to possible side effects. Some literal translations of English phrases or health-related concepts are confusing. For example, in some Asian cultures, people describe emotional or psychological distress in terms of bodily discomfort or disharmony; the "mental health" terminology used in U.S. healthcare provider situations is traditionally associated with stigma in Asian cultures. When translated literally, moreover, some medical terms such as "substance" have no translation, making the information incomprehensible.

A community health worker in Boston's Chinatown described the lack of language access for Chinese patients:

> When the patients don't speak English, they didn't know how to ask questions regarding about their health problems and how to get the healthcare. … So,

> furthermore, if they get into the care, in the facility, an in-person interpreter will be helpful. Otherwise now they're using a lot of video and phone interpreters, [and] for some of the patients [it] is [a] challenge because some of them speak a dialect like Toisanese, Fujianese. It's so hard to find the interpreter, but also through the video or phone many of them they are not fully understanding the conversation … [with] the provider. And then they didn't know how [to read] the instruction for the clinical visit and then after the clinic. … [W]hen they have … medication questions, they don't know how to call, who to call, and how to address the problem. And they just stop the medication and give up for all the refills. … [F]or the non-English-speaking patient, because all the drugs, the name[s] are only in English, there is not any translation [to Chinese] … . [P]eople didn't really understand which ones [medications] are which. They even don't know how to read the … instructions that [are] labeled on the bottle.

Delivery of services with the use of certified bilingual interpreters is required in all clinical settings, even though it is common practice for immigrants to bring an English-speaking relative to a doctor's appointment. Not only does this insert possible confidentiality issues but many providers also expressed that a family member may interject information or opinions that can alter the course of the consultation with the patient. A diagnosis can be compromised, or even wrong, because the accuracy of interpretations provided by non-healthcare professionals cannot be verified by the provider. Other detrimental effects of this process have been widely studied, including parent–child role-reversal (Hua and Costigan, 2012; Trickett and Jones, 2007).

Even so, relatives can sometimes play a helpful role by integrating recommended treatment into family routines. Family members may competently serve as language resources in these situations, yet professional interpreters are still needed, as are bilingual materials such as flyers, pamphlets, and web-based information. As noted earlier, among older immigrants from Cambodia, China, Vietnam, and other Asian countries, many cannot read in their native language or in English. This makes narrative-style instructions and storytelling videos important vehicles for delivering health information to these individuals.

A service provider in Worcester commented:

> And I think it's very, very hard that even for hospitals saying that they have an interpreter in the hospital, but you will have to be able to call the hospital to make an appointment to get the interpreters. So the step before that, there's no interpreters or anything like that. You have to figure out somehow yourself … like to look for support around people, like to your friend, to your neighbor, to your family, in saying that I need help because I have this addiction, it's very, very hard for folks. So I just think that it's really not that, I guess, accessible.

Reviewer 2 underscored the unavailability of prevention programs linguistically tailored to Vietnamese Americans:

> There is no substance prevention treatment in [the] Vietnamese language in Metro Boston. … No AA [Alcoholics Anonymous] meeting in [the] Vietnamese language. AA materials [do] not really apply to [the] Vietnamese population.

Denial, Stigma, and Shame

In traditional Asian cultures, strong stigma and shame are attached to seeking help for emotional or mental health problems, let alone substance use problems. In such deeply embedded ways of thinking, admitting to mental health problems or addiction suggests weakness of character and reflects poorly on the family. Someone seeking mental health counseling may be labeled as "crazy." For this reason, the percentage of Asian Americans seeking treatment for mental health problems and/or substance use is markedly lower than for other racial groups (Alegría et al., 2022; Choi et al., 2024).

A college health counselor and substance use professional remarked:

> [O]ne thing too that always bothers me a little bit is a lot of times the providers will say, "Oh, well, the reason why they don't come forward is because this is a stigma in Asian culture not to seek mental health." And I'm kind of like, yes and no. I mean, that also sounds like a justification for why we're not reaching out to the Asian population, because there's this stigma and they won't come forth. If anything, it means then, okay, let's say that is true. That means we need to work harder … reaching out and understanding. But sometimes that's always the piece, like, "Sorry, can't help them because there's a stigma and they won't come forward."
>
> [J]ust because we aren't really seeing this happening or we don't have a lot of numbers about this challenge among the Asian American community, it doesn't mean the problem isn't there. It's associated with stigma or with perceived stigma about coming out and saying that "I have … mental health challenges, I need services." … And also the mental health crisis among the API [Asian Pacific Islander] population is high, high, high.

Asian Americans often feel it is more acceptable and useful to seek help from family members than from a clinic or healthcare provider. Many will often wait until an untreated mental health problem worsens to a crisis point, forcing admission to a hospital.

A psychiatrist working with Asian immigrant patients in a Boston hospital said:

> So on one hand, [there is often] really a reluctance to take medicines, and then a reluctance to get care. But then when they do present for care, they are quite acute and progressed in whatever it is that they're presenting with, be it a physical health or mental health challenge. And so I think that's also ironically a set-up for misuse because then once you're sort of more advanced in whatever illness or disease process you're presenting with, then it can be hard

> to get that pain under control. It can be hard to really manage things well. And so that's also a set-up for [substance] misuse.

Cycles of Marginalization

Reflecting the stigma attached to self-reporting, health datasets do not represent true rates of substance use by Asian Americans because there is substantial underreporting. These data inaccuracies are worsened when health surveys are not professionally translated in home languages, use terms and concepts culturally incomprehensible to immigrants, and fail to disaggregate data on Asian Americans by ethnicity, nativity, or immigration status. In turn, underreporting reinforces widespread racial stereotypes that wrongly portray Asian Americans as uniformly "successful" and as the so-called model minority group, unaffected by financial, social, and mental health challenges. In reality, the rates of poverty and social–linguistic isolation are disproportionately high among Asian American residents of Boston and other major metropolitan areas.

According to the National Center for Health Statistics, the misclassification of Asian Americans among drug-overdose deaths is greater in the Midwest, Northeast, and South than in the West (Arias et al., 2016). No matter the region, the false perception that Asian Americans do not need mental health services, including prevention education and care for substance use problems, fuels a cycle of marginalization and invisibility in systems of addiction prevention and treatment. The negative cycle of marginalization is perpetuated when providers justify inattention to service needs of Asian Americans by pointing to their reluctance to seek treatment because of the cultural stigma. As a result, little is known about the true numbers of people in the Asian American population who suffer from substance use problems.

Understanding and Treating Alcohol Use Disorders

Alcohol Use

Participants in our focus groups shared the observation that binge drinking and otherwise heavy drinking in Asian American communities are more common than many health providers realize. It is often customary to consume alcohol to relieve stress. When the head of a household is a heavy drinker, this negatively affects the dynamic of the family as a whole and its members individually. What is noteworthy is that family members generally perceive the person's heavy drinking as culturally appropriate behavior.

Research participants pointed out the risk for substance use from social–economic stressors, including difficult and low-wage work, language and social isolation, poverty, and trauma.

A health provider in Lowell described how some Cambodian refugees use alcohol to cope with firsthand memories of the genocide of the Pol Pot era:

> Some are still stuck there, you know, their body might be here, but they're like … [they] can't leave or they've refused to leave or they just don't want to leave

> … and the only way to let the body [be] here and the soul stay there is [through] the transition into alcohol. Make yourself smile, make yourself happy, make yourself alive.

Reviewer 1 commented on the implications for treatment in existing public health systems:

> There's no long-term commitment to assisting the clients in sustainable recovery through support and stabilization services, educational support, job training, housing, and employment. So, very often, they return to the environment where they came from before the treatment. It is very important to have the support and stabilization services as part of the recovery investment.

Reviewer 1 added that risk for alcohol dependency is increased in neighborhoods with high rates of poverty, and he noted that there are more liquor stores in these areas than in more affluent communities.

As related to receiving education on the risks of substance use, residents value in-person educational workshops. Chinese community residents in Boston noted reductions in funding for grassroots education efforts. They felt this was a loss for the community because sitting and talking together enhances community partnership in the prevention and treatment of substance use. These community partnerships are crucial for shared decision making on improving both community health and individual health. Online webinars can be useful to reach people who cannot physically attend in-person meetings, but they should not replace face-to-face conversations.

A Chinatown resident noted about using an online platform to hold meetings:

> Because many people are using the internet, like people who live in Malden, Quincy, or Braintree, they might not be able to come/drive to Chinatown for a meeting. It is better to use the internet to hold regular lectures to teach people how to be better parents, teach people how to read labels, and how to translate and read Chinese and English. In fact, I think this is very important. You can use online resources.

No one-size-fits-all approach can meet the wide needs of the diverse cultural, educational, religious, spiritual, and gender backgrounds of Asian American community members. As a result, it will be necessary to develop and pilot-test a variety of approaches to see which best reach Asian Americans communities and individuals. For example, younger Asian Americans who have studied some science in school may be open to learning about medical and biological factors that influence addiction. Many Asian Americans from traditional Asian cultures are more receptive to religious or spiritual approaches to healing. For example, 12-step recovery programs have been successfully adapted for some Asian American communities, including among Korean Americans. For others, recovery approaches may include popular practices of Buddhist meditation, tai chi exercise, or traditional Asian medicine. To overcome resistance to talking therapies about substance use and using Western

evidence-based medical practices will require integration of wellness practices familiar in Asian cultures.

Reviewer 2 commented that most of her clients with alcohol problems practice Buddhism and believe "cold turkey" is the best method to stop drinking.

> [They see] no need for detox/rehabilitation but use isolation and being 'locked away' to stop drinking.

She did note that 12-step programs are more accessible to people who practice Christian religions.

Co-occurring Gambling Disorder

Compulsive gambling is another form of addiction and often co-occurs with other substance use, including alcohol. Gambling is a serious problem because of the devastating effects on the well-being of the gambler and their family. In one interview, a social worker described in particular the lure of casino incentives for Vietnamese immigrants, and the ease of free or low-cost bus transportation to casinos. In one focus group, a nurse practitioner with expertise in treating substance use among Asian Americans described how patients relieve the stress of demanding low-wage jobs and social isolation through gambling. Because gambling, consuming alcohol, and smoking cigarettes are legally and socially acceptable behaviors, unlike illegal substance use, it is difficult for people to give up these stress-relieving behaviors.

A social worker who counsels Vietnamese Americans in Boston noted:

> [Gambling is] one of the big problems in the Vietnamese community. I remember go[ing] … to post up our flyers [for] support group for [a] substance or addictions program. And next to it there's like [an ad for] $30 and a free trip to the casino. When I do walks around my local community, I see the shuttle, the bus. I do see Asian people waiting for those buses to get on. … You get on, you get money to play.

Leveraging Support in Families and Communities

Understanding Families, Supportive Systems, and Complexity

In general, participants agreed that family members are an important source of support for many Asian Americans struggling with substance use and mental health problems. However, involving family members in identifying and helping providers to treat their loved one's problematic substance use requires understanding Asian American family dynamics and roles within the family.

Providers will often look for ways to gain the trust of family members. In some cases, providers found that family-based or couple's counseling was effective. Yet not all clients or patients have a family member willing or able to help. Some family members may try to hide,

or at least not discuss, substance use problems in the family unit. Parents, teenage children, or spousal partners may not want to attend counseling for their family member's substance use problems for a variety of reasons. Even so, providers said that some family members want to actively participate. For example, one study found that Asian Americans as compared to other racial and ethnic groups are far more likely to make proxy calls to quitlines (that is, help hotlines) on behalf of a family member who smokes (Zhu et al., 2006). A Korean religious worker in Los Angeles noted in an interview that in Korean immigrant families, it is the parents who seek substance use treatment on behalf of their children, even for adult children. However, many parents seek treatment help only after spending years struggling to manage the issue on their own. Considering how family units differ, it will be important to identify and tailor appropriate methods to meet family dynamics and relationships.

A Korean religious worker noted:

> Many Koreans couldn't get help from [an American-run center] … because of language barriers. Family is the treatment seeker, not the person who uses a drug. So, in most cases, parents are the ones initiating treatment. Yet, most of them, even if they are conversational in English, have difficulty understanding addiction treatment in English. … [T]hey want to get involved in the treatment, but they can't at an American-run center.

Community Education, Bilingual Presentations, Multimedia Storytelling, and Workshops

Participants described the need for multiple approaches to educating clients and patients. One psychiatrist who works in a Boston hospital described a messaging strategy for successful community educational workshops. If aid for depression or mental health was advertised as such, then few people would attend. If it was advertised as helping families with stress or helping children do well in school, the room was filled with attendees.

As this psychiatrist told us:

> In past partnerships between medical professionals and community organizations, important lessons were drawn. You talk about depression or mental health [but] you'll have nobody show up. … But if you talk about, like, well-being and health and helping your family manage stress and helping your kids to do well educationally, sort of focusing on those educational and other kind of community values, then suddenly it's a packed house.

A social worker Long Beach, California reported that in a particular Cambodian community, there has been gradual progress in opening up intergenerational conversations in small groups at a health center. In established community organizations, where youth, parent, and senior groups already exist, these can be natural places to introduce conversations on substance use, but only if the topic fits with the established program and everyday concerns of the group.

A leader of a community organization serving Cambodian Americans in Lowell noted the importance of multimedia formats for education, particularly videos in the Khmer language with English subtitles.

> When you … talk about community but you don't see that community represented in the visual … there needs to be some educational workshops, webinars in Khmer and in English to talk about that. So it's almost like a campaign if you will. … So we're hitting the young population and the older population.

Collaborations with Community Organizations to Provide Care

Over recent decades, Asian American leaders and residents in large- and medium-sized cities have created sophisticated networks of community-based social service organizations and health clinics. For example, many are member organizations of the National Council of Asian Pacific Americans.[2] More locally, the Massachusetts Asian American and Pacific Islanders Commission also provides lists of health and social service organizations.[3] However, as noted earlier, lists of specialists trained in treating substance use among Asian Americans are not available.

Some of the local organizations play a critical role in reaching out to clients for whom family services and mental or behavioral health counseling is unavailable, inaccessible, or culturally inappropriate. Several nonprofit service agencies, religious organizations, and social programs already offer family-based and individual counseling services.

A former public health administrator with experience treating substance use problems in Lowell recommended that public health agencies use a codevelopment strategy for developing prevention and treatment programs. One component would be developing training for providers to screen and counsel individuals at risk for substance use problems. He commented:

> So it's very important that the Department of Public Health or business work in collaboration with the organization that is in the trenches, who deals with them on a regular basis in developing the training tools and training modules …

Reviewer 1 described how community-based organizations can encourage families to seek counseling when outside intervention is stigmatized:

> The mutual aid and social service organizations plays an important role in bridging this gap. Mental health and substance use providers need to develop partnerships with these agencies as well as faith-based organizations to address the community needs.

[2] https://www.ncapaonline.org/member-organizations/
[3] https://aapicommission.org/resources/asian-american-community-resources/

Prioritizing Services for Population Sectors at Greatest Risk

Participants described social determinants of substance use disorders, highlighting several factors that place some community members at higher risk than others.

Immigrants of Refugee Background

The Cambodian genocide and Vietnam War brought Southeast Asian American refugees to Massachusetts beginning in the 1970s.

Vietnamese American Residents in Boston

A social worker who treats Vietnamese clients in Boston described mental health problems among older Vietnamese refugees:

> [T]hey still have nightmares about [feeling] they're still in the war, still in Vietnam. … So they use substance[s] to [deal with] that. But there's great denial. You know, for Vietnamese, [there's a] stigma about going out and get[ting help for] mental health… . They don't see using alcohol as a problem. … It's just, "Oh, it just helped me to sleep, it's just to help me to relax." … But at the beginning, they talk about, "I have [a] headache, I have body ache[s]," more of [the] near-symptoms than family problems [or] nightmares.

Reviewer 4 added insights on how life experiences have led many Vietnamese immigrants to use substances to relieve distress from war and trauma:

> Some escaped on fishing boats and met pirates en route to America. Many escaped through the jungles and endured hunger, disease, and near-death experiences. Immersing themselves in alcohol and other substances is described by many as a way of "easing a tortured soul" or as a way of "relieving sadness."

In addition, Reviewer 4 observed that alcohol is not seen as a bad thing:

> [T]he use of [alcohol] is encouraged in certain families and communities, [and it is] difficult [for] someone whose alcohol use has become problematic to seek help. Additionally, many traditional herb treatments use heavy rice liquor, vodka, and/or rum to soak these herbs. It is also a belief that alcohol when combined with herbs enhances the "heat/hot" energy, which doubles healing power.

The professional counselors we spoke with in Boston and Worcester have experience in serving Vietnamese Americans with substance use problems. One provider in Boston described how memories of past trauma persist and are transmitted in Vietnamese immigrant communities and families; the long-term effects interact with present-day life difficulties, including illness, economic disadvantage, and discrimination.

Cambodian American Residents of Lowell

Lowell is the city of residence of the second-largest Cambodian community in the U.S. Our interviews included several providers from a well-established network of Cambodian American social service and health professionals in Lowell. Several interviewees recommended prioritizing treatment of alcohol use disorder among men and women. As noted in an earlier quote, problematic alcohol use is both a serious and hidden problem among adults who are at least 50 years old because many came to the U.S. as children, found jobs, and supported their families. But as their children grow up, these adults are no longer the center of the household and so have time to reflect on their strenuous life to survive in this new homeland. This generation's mental health problems have received relatively little attention by service providers.

A community health professional in Lowell offered observations from his experience working with clients who are Cambodian refugees, mostly men in their mid-50s or older, who survived the 1975–1979 Cambodian genocide, noting that the substance use was mostly alcohol or marijuana:

> [T]hey are trying to not let the next generation, or you know, their family members know. I mean, I guess that you know … [in] our Asian culture. ... I can say that most men my age don't talk about a lot of things. … There is both the guilt of survival, you know the guilt of being here, and also the loss they have taken. … You use your body, you know, you use your physical strength to support your family. Now your kids are older. Now your kids are getting to this new generation and adapting to a new culture. They're not using alcohol … they [may] be all using these vaping and all other things there are more updated. But for [some] people [it is] like, alcohol, cigarettes, marijuana, especially [the freedom to use] marijuana.

One family counselor in Lowell, who was not of Asian descent, described his experience as a social worker among a sector of young Cambodian Americans who turned to gang membership and street life to provide a sense of belonging and protection. For many of these young people, substance use problems are persistent and recurrent.

This counselor told a story about a Cambodian mother and father. He described how their very difficult work life negatively affected their children:

> So they [a]re working 10, 12 hours, you know… and they [the kids] basically raised themselves [through no] fault of their parents because their parents were doing the best that they could … to make a better life for them … and some folks … make it out okay and other folks don't. … [W]hen you're that young, you get involved in the wrong situations with the wrong people, and … your brains [are] not fully developed until you're about 25 years old anyway, [as] some of the studies that have been done now, so [being] 15, 16 … .

> [T]he love the kids weren't getting at home … they were trying to find it in other places … . So, … having to … band up with your friends to … keep yourself safe, … and then … these other folks … come in and [are] like, "Oh this looks great." … "I can get that love from these folks," and then they get wrapped up into that lifestyle … and it's not that their parents don't love them, it's more that the parents aren't there because they're working so hard … to build a life for their family.

This counselor described the outcome for some gangs in Lowell:

> [A] lot of people, they're, you know, selling serious amounts of drugs, pushing heavy weight. Just a couple months ago … 21 arrests [were] made. There was a task force that was formed. It was like [the] Lowell Police, FBI, I think some folks from the DOJ [Department of Justice]. They picked up like 21 kids from Asian Boyz.

It is important that providers collaborate with nonprofit community organizations and community clinics to codesign and implement substance use prevention and treatment programs. It is in local community organizations where the requisite community expertise can be found. A number of established community organizations in Massachusetts have developed successive cohorts of leadership, staff, and social programs with tested models and delivery approaches for family-based counseling and therapy, youth programs, and health education for parents. These programs provide an avenue for integrated education and screening for substance use problems. Sustainable recovery requires investment in programs that provide addiction treatment as well as underlying social problems, such as lack of job opportunity, culturally responsive mentoring, and social and recreational programs.

Vietnamese American Residents in Worcester

Asian American providers interviewed in Boston seemed to know little about substance use problems among the Vietnamese community in Worcester. In cities of refugee settlements across the United States, one population subgroup of Vietnamese refugees are known as AmerAsians: they were born in Vietnam in the war years to U.S. military personnel and Vietnamese women. They are now adults, but they endured ethnic-based discrimination in Vietnam and are now at risk for health problems in the U.S. Many of them still have limited proficiency in English. Among the Vietnamese Americans in Worcester, a disproportionate number of AmerAsians are in treatment for substance use disorder.

A service provider in Worcester described his work in an acute treatment program:

> [I]n my work, I have a very high chance to engage with those population that they're using opioids, [either] prescription or painkiller. And the group that I know in Worcester area, they are called Amerasian. So that is a group of men, some woman too. … I think that they are around from 30 to 50 years old. They are [mostly] male and they are first generation. That means they come in they don't speak good English. … And usually with that group, … they deal with a

> lot of stuff like [the] language barrier, they lost all documentation. … [A]nd they have a lot of severe illness[es], like Hep[atitis] C.

Although there are some residential treatment facilities in Worcester, very few Vietnamese or other Asian Americans willingly enter residential treatment programs because the environment feels culturally foreign and unwelcoming, and services are too often perceived as poor in quality. Our interviewees described the need for substance use education and counseling to be integrated with services provided at community centers, where Vietnamese and other Southeast Asian cultural themes are knitted into everyday activities, including recreational, educational, and counseling programs for adults and youth.

Low-Income and Job-Related Stress in Working-Class Communities

In many Asian immigrant enclaves, a large percentage of residents work in low-income occupations. In Lowell, for example, a relatively large proportion of Cambodian immigrants work as low-wage assemblers in manufacturing plants or in services. Throughout Massachusetts, many Asian American immigrants work in the food industry as chefs or waiters in restaurants, retail sales, and delivery. Many live in multigenerational households, and elderly parents may live in rent-subsidized housing in Boston's Chinatown. However, the high rents there make it impossible for working-age adult offspring to live nearby. As occurs in other low-income and working-class communities, it is common for Asian American workers and family members to turn to substance use to relieve the stress from the demands of working long shifts in low-paying occupations and with few days off. In addition, the isolation caused by language barriers and the discrimination faced by many Asian immigrants significantly increases the risks for using and then becoming addicted to substances.

The family counselor from Lowell, quoted earlier, commented on this problem:

> It's like a lot of people need to cope, right? It's [substance use] a coping mechanism for, you know, not having any other avenues … . I think [it's] at a higher rate in places that have higher poverty rates as well … you know, you can't go on a $10 thousand vacation to Florida. So you're coming home and drinking every day because you can't kill the pain any other way … and I think it's across the board … it's not just in Asian American culture. It's in every culture.

Teens and Young Adults: School-Related Problems

Increasingly, young people of all ethnic backgrounds are using stimulants (sometimes mixed with other dangerous drugs such as fentanyl) and/or marijuana and nicotine vaping to try to cope with feelings of isolation, racial prejudice, and academic pressure. Binge drinking is also common among college and teenage Asian American students. In the years preceding the Covid-19 pandemic, young Asian Americans in the Boston Public School system reported that they were more likely to report feeling overlooked and invisible, and were less likely to seek help compared with students of other racial or ethnic backgrounds (Rondo et al., 2023). With the surge of anti-Asian racism caused by politics and other factors during the pandemic, young

Asian Americans faced heightened risk for substance and alcohol use to cope with the direct experience of discrimination, including threats, bullying, aggression in schools as well as fear for their family members' safety because Asian seniors and women were often targeted in public places.

A counselor in the Boston Public Schools system commented:

> I did see a lot of students that suffered from severe mental health issues tend to utilize THC in their cartridges when they vape. They don't necessarily have little doobies or little blunts compared to other ethnic groups and how they consume cannabis. But at least for the Asian students that I've seen and that I know are using, they use the vape cartridges as a medium to consume cannabis. So, for me, I can't say that it's been a drastic increase, but I only see what I can see only because, most of the time for the past year and a half, we were on remote. And so, a lot of those consumption habits probably occurred at home, out of sight compared to them coming in bloodshot and seeing all the cues. So that's just been my experience.

Reviewer 1 noted that Asian American youth face mental health issues:

> Teens and youth in these [Asian American] communities are faced with high rate[s] of depression and other mental health disorders, and it has been exasperated during the pandemic. Lack of culturally and linguistically appropriate services, along with lack of learning during the pandemic, has increased the mental issues facing this group; and they often turn to substance use or other forms of drugs to address their needs.

Training Programs for Culturally Responsive Health Professionals

Presently in Massachusetts (and in other states), there is a glaring shortage of bilingual and culturally knowledgeable healthcare professionals who can competently treat substance use disorders in Asian American communities. Expansion of culturally accessible treatment programs cannot be achieved unless staffing needs are first met. Training programs should be offered in academic institutions, including clinical training for physicians, nurses, and psychologists, and in programs training social workers and family and school counselors.

A leader of an Asian American drug treatment program in Los Angeles County pointed to the acute shortage of professionals who can treat substance use problems among Asian Americans, saying:

> [We've] got to pay people better in this field. But I think the universities could do a better job in specifying some classes around addiction medicine and encouraging students to take on this field. So they['ve] got to pay them and incentivize them to do this field, but the schools got to create the curriculum around it.

Reviewer 3 recommended developing avenues for young people who live in immigrant Asian American communities to join training programs and service delivery teams because they are a significant community resource, and their involvement "injects vitality into community services and brings strong influence on families" while also laying a foundation for decreased substance use problems among younger generations. To encourage and enable young people's engagement, this study finds that targeted funding is needed for community internships, practicums, and scholarships directed for training in working with Asian American communities.

Providing Interdisciplinary Clinical Care

When an individual or family seeks information or considers treatment for substance use, their first point of contact with a provider will depend on factors such as language ability, cultural and community norms, and knowledge about available services. For example, initial contact may take place through a social worker; a nurse, psychologist, or other medical professional; or in a hospital, clinic, or nonmedical setting, such as a local social agency, church, or school. In medical settings, typically, the combined expertise of several specialists is required (e.g., family physician, pediatrician, psychologist, psychiatrist with training in addiction medicine, nurse, and social worker). In larger hospitals, there are generally no systems in place for efficient coordination of such interdisciplinary care. In small community clinics, few staff are available.

A nurse with extensive experience in health leadership positions and delivery of clinical care in hospitals and community clinics explained:

> [There is this] whole idea [to use] the interdisciplinary approach to treatment of a patient, in theory. But if you've ever seen the interdisciplinary team [at] work, it's not the best. The reason being is, for example, on a medical floor, they would ask for a psych consult. The psychiatrist comes … and does the interview and then the evaluation and writes a report. "Here's the medication that I recommend." And then the doctor on the medical side goes, "Well, how does that medicine interact with the medicine that I'm prescribing?" And the psychiatrist says, "I have no idea, but this is my recommendation," right? And the medical doctor would say, "Thank you very much, but no thank you," right? Because he doesn't want to be responsible for chemical interaction because he's not aware, he doesn't have the training and knowledge about psychiatric medication, possible implications. So this is kind of where the divides are, right? And so, where does therapy come in, right? And so even though we have models that we should use, often time it's a challenge to use them. So this is in a hospital that's well-equipped but all the specialists are not interacting well.
>
> In these community hospitals, these small community hospitals, clinics, they don't even have very many specialists, and people may be going to, you know, the family services at the community agency, social agencies, not even a hospital, and the person they're talking to is a social worker, and she may not

> even recognize what's going on. She knows they have problems, but she can't identify that, or [if] there's a substance use problem.

To provide the appropriate care in contemporary medical settings, better interdisciplinary care requires better training and resources.

Learning From Treatment Providers in Other States

Two health professionals in New York City and Los Angeles County shared their experiences with treating young Korean Americans. These two cities each have large populations of Korean Americans. A Korean American social worker in NYC pointed out that demographic changes among Asian Americans are leading to hopeful signs that stigmatization of mental healthcare is lessening.

A family and youth counselor in New York City remarked:

> I know Koreans have a preconceived idea about mental illness. So, the Korean community has a strong stigma associated with it. Yet, I know the stigma nowadays is not as strong as it used to be. What I am trying to do now as a mental health first-aid instructor is to debunk the stigma by educating Korean people. Also, many mental health screening tools have been developed. There are many Korean behavioral health centers as well. Within the KCS [Korean Community Services of Metropolitan New York], there is also a mental health clinic. There is a New York Child Health Center. I know many Asian American families are using the service. Flushing [in New York City] has many mental health clinics treating Koreans. Because of these many treatment centers, Koreans now realize that getting professional help is better for managing their problems. Many Koreans experienced the benefits of the treatment. So, the stigma associated with mental illness has substantially decreased.

Many Asian Americans are using mental health treatment centers and centers that are better at treating clients from diverse racial–ethnic backgrounds. As the family and youth counselor noted, mental health screening tools have been updated to be more appropriate for Asian Americans.

Treatment approaches and their efficacy are often shaped by religious or spiritual perspectives. A Christian religious worker in Los Angeles, for example, explained why treatment centers run by Korean staff will increase accessibility and receptivity. In this person's experience, many Korean Americans seek help for substance use from churches because of the high costs of treatment at residential treatment centers.

This Korean religious worker said:

> A … drug rehabilitation program costs almost $30,000 if you don't have health insurance. It's too expensive for a Korean family to handle. That's why Korean parents try to seek treatment from a church.

In addition, families want treatment in centers staffed by Korean Americans, where they can communicate in the Korean language. In these situations, parents initiate and are actively involved in treatment.

For example, a nurse practitioner commented:

> It will be important to investigate how the diversity of religious and spiritual practices among Asian Americans shape treatment models in Massachusetts and other states.

Recommendations: Priority Goals and First Steps

This section summarizes recommendations on Goals and First Steps that should be taken to develop and deliver linguistically and culturally accessible education and treatment services for Asian Americans in Massachusetts. First, we describe priority goals. Second, we highlight first steps toward meeting these goals.

Priority Goals

Language Accessibility

(a) Develop and provide bilingual and culturally responsive health promotion materials.
(b) Fund a sizable expansion of the pool of certified interpreters and translators qualified to serve Asian American clients seeking support and help for substance use.

Culturally Responsive Treatment Programs

(a) Create ongoing, sustainable, and accessible programs available in healthcare institutions.
(b) Codesign and coordinate the promotion of culturally responsive services with community service organizations.

Training for Medical and Social Work Professionals

Support academic institutions in providing college- and graduate-level training on substance use prevention and treatment in Asian American communities. Understand and then meet the pressing need for creating culturally responsive training curriculum and resources for students in medical and nursing programs, clinical mental health counseling, and social work programs. Develop substance use internships, practicums, and scholarships for training providers working with Asian American communities.

(a) Collaborate with secondary school systems and community organizations to encourage students who live in or have ties with residents of immigrant Asian American neighborhoods to enter preprofessional and professional training programs.
(b) Develop training programs (or increase opportunities) to improve coordinated interdisciplinary clinical care for Asian Americans in hospitals and community clinics.

Three First Steps to Meet Priority Goals

Codevelop Pilot Approaches to Treatment and Prevention

(a) Establish and facilitate **community–provider dialogues with the assistance of academic researchers and the Bureau of Substance Addiction and Services** (BSAS) to solicit recommendations for new treatment and prevention approaches for treating substance use addictions in Asian American communities in Massachusetts.
(b) Develop channels for community organizations to **meet with the BSAS Office of Community Health and Equity** to share knowledge.
(c) Develop a **workshop series** to propose innovative design of pilot tools for culturally tailored screening, prevention education, and treatment.

Conduct Follow-up Research and Develop Research Capacity

(a) Develop **research** on how Asian Americans with lived experience cope with substance use and seek help in Massachusetts. Collect data and feedback on the use of alcohol, tobacco and other drugs, including emerging trends in stimulant use.
(b) Conduct **interviews and focus groups** to find out where and how Asian Americans with lived experience seek help**.** Is it from relatives, friends, religious counselors, health providers, community organizations, or others?
(c) Formulate recommendations to expand research capacity for collecting **valid and reliable data** on mental health and substance use among Asian Americans in Massachusetts, including social determinants of risk disaggregated by ethnicity.

Develop Pilot Training

(a) Develop **workshops** to create training materials and pilot educational sessions for providers, including social workers, counselors, and medical professionals. Workshops will train providers working in community organizations on the subject of substance use so they can integrate culturally responsive education and treatment into their services. Selected modules will then be adapted for trainings in cultural responsiveness for staff in BSAS-affiliated programs.
(b) **Solicit recommendations on training materials from representatives** from healthcare institutions, professional training programs, and social service agencies that work in Asian American communities.

Appendix A. List of participants interviewed

Location/Date	Participants	No. of Participants	Language	Type of Meeting	Type of Interview
2023					
Boston, MA/ Apr. 24, 2023	Service providers	5	English	Online	Focus group
Boston & Worcester, MA/ May 3, 2023	Service providers	3	English	Online	Focus group
Boston, MA/ May 19, 2023	Community residents	8	Cantonese	In-person	Focus group
Boston, MA/ Jun. 6, 2023	Service providers	2	English	Online	Group interview
Los Angeles, CA/ Nov. 6, 2023	Religious worker	1	Korean	Telephone	Individual interview
New York, NY/ Nov. 11, 2023	Service provider	1	Korean	Online	Individual interview
Lowell, MA/ Nov. 17, 2023	Service providers	2	English	Online	Group interview
Boston MA/ Nov. 28, 2024	Service provider	1	English	Online	Individual interview
Los Angeles, CA Dec. 5, 2024	Service provider	1	English	Online	Individual interview
Los Angeles, CA/ Dec. 6, 2024	Service provider	1	English	Online	Individual interview
Boston, MA Dec. 7, 2023	Service provider	1	English	Online	Individual interview
2024					
Los Angeles, CA/ Jan. 8, 2024	Service provider	1	English	Online	Individual interview
Long Beach, CA/ Jan. 8, 2024	Service provider	1	English	Online	Individual interview
Boston, MA/ Jan. 10, 2024	Service provider	1	English	Online	Individual interview
Lowell, MA/ Jan. 16, 2024	Service providers	2	English	Online	Group interview
	Total	**31**			

Appendix B: Selected Comments by Research Participants

These are additional selected quotes from the transcriptions of the interviews and focus groups. As with quotes in the report, these have been edited for clarity. These are submitted to expand on the themes in the report.

Barriers to Accessing Prevention and Treatment Services

A service provider in Worcester described the difficulties of a client at both work and home that influenced his substance use problems. Having a Vietnamese speaking counselor made it possible for the client to open up and talk about sensitive topics and hardships

> [S]o that they can open up and more easily talk about difficult subjects. One patient, for example, said he worked in a factory and became ill from exposure to toxic chemicals at work. He lost his job and had to move in with a relative, and [he] used alcohol to relieve the stress.

Further describing this client's experience, this professional added:

> [A]nd then the family cannot accept or help him anymore. He had to go to the shelter. He needs a place like a cultural residential [facility]. …There's a lot of programs to help, but he doesn't fit with any situation like that. But the big question is: Where [is it that] they can live?

And:

> [T]he percentage of the Asians who come to get the detox is very, very … small. However, it looks like a tip of the iceberg. …[T]hey don't want to go to detox. First, they're confused, [there is the] language barrier … nobody understands [them]. And when people get high, they don't … have the patience to follow with a lot of the rules, regulations of the program. And usually … they have a case manager and a nurse and they [can be] very disorganized. The people come there … overdosed or because of a court order. That's why they come in, because … they feel like [they're] trapped in their life. … [But] they don't want to go.

Immigrants with mental health and substance use problems often need social assistance beyond counseling. They may need help in obtaining secure and affordable housing, medical care, and other types of financial assistance. A Vietnamese social worker in Boston described the multiple and integrated services typically needed by clients.

> One clinic works with a behavioral health community program [that] is … helping clients get to their appointments, helping clients to obtain their housing, getting medical rights for clients, taking clients to SSI [Social Security offices for Supplemental Security Income] for interviews.

Alcohol Use

A retired administrator of public health programs in Massachusetts commented from his former experience as a substance use counselor:

> [I]in most of the Asian communities … hard liquor is the major issue. So that's the area we need to focus on probably, and I tell you, the communities will [unintelligible] deny we have a problem because there's a social norm for each community as well. Doesn't matter which ethnic group it is. That's something which is universal and active. So I think breaking through that barrier is an important part, and we need to really work with the organizations that are in the frontline to deliver that message.

Alcohol Use, Cooccurring Gambling Disorder

A nurse practitioner described her experiences treating substance use among Asian Americans and other patients:

> [P]eople are smoking with that nicotine to relieve stress. They may drink to do the same thing. … Gambling, it's a way of getting your dopamine receptors to light up again because there's nothing else great in your life. You have substandard housing; you're working 18 hours a day. You don't know the language. It's really hard to make ends meet. And so I think if we're asking people to decrease some of these activities that are helping them escape their current reality, how can we make their current reality better? You can't take everything away, because for a lot of individuals, they'll say, "With the trauma that I'm enduring right now, what's the point? I have nothing to look forward to if you take all this away." So really looking at building [programs], what do we want the lowest common denominator to experience in our society? And how can we support them? Because I think, when especially with the legalized electronic gambling, with cigarettes being legal, e-tobacco being legal, alcohol being legal, people will always say to me, "It's legal, so it can't be that bad … do you want me to go out and shoot up fentanyl instead? No? I'm going to go to a liquor store and buy some nips." And so, in that way, with the patients that I work with, quitting smoking and quitting drinking is the most challenging only because of accessibility, availability, and acceptability.

Training Programs for Culturally Competent Health Professionals

A counselor with experience as a street worker in Lowell suggested using indirect methods of communication and embedding education about substance in recreational and social programs:

> [W]hy don't we create like a social center? Like that you can go in [and] walk around like [in] a gym … you walk around and stretch it out. People [are] not

> gonna buy membership. I'd rather take the membership money and buy a six-pack of beer. You know, it's like if I can walk into a place that people don't ask a lot of question, walk around, and then if I want to talk to somebody, I can talk to somebody. I mean if I have money [to fund this program] that's what I would do. I would have, you know, a social service program … [with] street workers working in there … [and] community health workers. … I would provide indirect education.

Teens and Young Adults: School-Related Problems

A counselor in the Boston Public Schools system commented:

> Yeah, I think what I would only add again, just from the high school perspective, is that I think I do see a lot of female students utilizing the vaping apparatus as a way to smoke without really being perceived as a smoker. So, I think, yeah, maybe the five years I've seen, maybe at least for those that [are] refer[red] to me, and this is not the ones that are in the general population, but only the ones that [are] refer[red] to me for student support and for counseling. I have about seven female students out of maybe oh, gosh, 50 students that I've seen through the course of my five years.

Community Education, Bilingual Presentations, Multimedia Storytelling, and Workshops

A health worker in Boston's Chinatown described one outcome for an intergenerational educational program:

> [T]o reduce the gap between the parents who don't speak English, but they have more life experience … and then [help them] transfer those things to the children. But also let the children know those kinds of [experiences that] the people [parents have] is a gift. They have a lot of experience … just they don't use the English [language] to tell you their story.

A social worker in Worcester described an innovative Air We Breathe Program that included education on tobacco cessation and vaping:

> They brought in a firefighter, a lieutenant, a medical doctor, a pediatrician, and a public health person. And they just talk in general [about] air and they went through different types of air. So the firefighter was talking about carbon monoxide and then smoke and then they talked about tobacco. So I was like, wow, that's really good. So what we did was we brought in, I think it was like 50 or 60 people and it was older adults, youth, and children. And they did the whole gamut of all that, just explaining it from those perspectives. So it was really well done and well received because it wasn't just about tobacco cessation and "vaping is inhaling all this poison into your system and it's worse than smoke." But it was just like about what kind of air you want [to] breathe, and then what happens when there's a fire and there is smoke and it's coming?

> And then what happens to a child's lungs around inhaling that air, inhaling this air, and what does carbon monoxide look like? So I just thought that was brilliantly done and that's sort of like the perspective of how do you deliver on information without sounding like you're actually preaching, right? And that's always the creative aspect of … even like years ago when we had this one day of [a] conference, but we divided everything up into a challenge around how do you act out different scenarios? So we would have scenarios like, so here's a family, the child, whoever wants to play, the teenager comes home and says, "I am pregnant." What do you do? And you get 15 minutes to act this out and how do you want to respond to the same thing? They're on drugs. What do you do? So a lot of it is really from the community perspective or from the cultural perspective is how do you figure out a way to get people to learn things and to participate in sort of conversations that's about wellness and recovery without shoving it down their throats, if you will.

This social worker added that young people could effectively learn about substance use in community organization settings:

> [J]ust opening the door for afterschool, for the kids to come in and to find a safe space and then to provide sports and tutoring and all that. … I would love to have people come in and teach some teams how to talk about mental health and substance use, right? Like peer teaching, and how do you provide some space for these teams to be able to talk about all the issues they have, right? So like [there are community] space[s] to do this, but you have to have the money to bring in the right people to help.

Providing Interdisciplinary Clinical Care

The retired public health administrator and former substance use counselor in Lowell suggested:

> I think the first step would be [for] … the key staff from the substance abuse, basically Cambodian [unintelligible] and begin to engage in a dialogue. … Engage in the dialogue between … Cambodian [unintelligible], as well as the Substance Abuse Bureau [Bureau of Substance Addiction and Services]. … I think that dialogue is going to really … it's a mutual education. … We can educate staff at the Substance Abuse Bureau [on] some of the needs and issues … but they can say how we can really begin to look at developing these programs and expertise in our organizers. Now, I'm not saying that we are going to be experts in such a way that we'll be able to deliver —because the next step, once you finish the initial stage of educating, then you need to begin to look at it who is providing the service, because this is something we read in with the tobacco control program in '93. When we started that it was all about educating, and I always said education is great, but where do they go? Because if someone needs the service, there has to be a place for them to go. So, that would be the sequential order of things to happen.

He added about educating a professional workforce that can meet the changing demands of this population:

> [S]o many institutions [are] preparing the students who go out and meet the [healthcare] needs. But I think … what is lacking is that we are not responding to the demographic changes that are taking place in [the] Commonwealth in preparing the new graduates [for] what they're going to be facing in their workforce. So I think that's a piece we need to really begin to look at. The shifting demographic changes that have taken place over the last two, three, four decades has really steered things very differently than what we are providing services in the '80s and '90s. … So the training has to be also kind of [adapting] to those kind of situations. How do we prepare the new workforce to face the reality when they get out to the work environment? Yes, I think that's a piece the academic institutions can definitely embrace and begin to implement, I think.

Appendix C. Interview Questions

On the impact of misuse and abuse of opioids:

(1) What are your observations, perceptions, and/or thoughts about the extent and impact of opioid misuse and abuse in Asian American populations?
(2) How serious is the problem?
(3) Who may be affected, and why?

Note: we will clarify terminology as needed, such as the meaning of the term "opioids," including differentiating between "misuse" of prescription drugs and "abuse" of non-prescription drugs.

On the impact of misuse and abuse of other types of substances:

(1) What are your observations, perceptions, and/or thoughts about the misuse and abuse of other types of substances in Asian American populations; for example, what about alcohol and tobacco?
(2) How serious are the problems?
(3) What forms do the problems take?
(4) Who is affected, how, and/or why?

On accessibility of prevention and treatment services:

(1) How accessible to Asian Americans are existing prevention and treatment services for substance misuse and abuse?
(2) How can accessibility to the services be improved?
(3) Are services effectively tailored for the language and culture of ethnic groups of Asian Americans?
(4) If not, what are your suggestions for improvement?
(5) What other types of barriers need to be understood and addressed?

For healthcare providers only:

(1) What is your experience of treating or assisting Asian Americans with a substance use disorder?
(2) How did you come into contact with them?
(3) What are the outcomes of the treatment/assistance?
(4) What lessons did you learn from the experience?

Appendix D: References

Sources	Ethnic Groups	Substance	Summary **The following are extracts with minor editing from article abstracts if published in journals.**
Mid- and Post-Pandemic			
Hai,. A. H, Lee, C. S., John, R., Vaugn, M. G., Bo, A., Lai, P. H. L., and Salas-Wright, C. P. (Nov. 2021). "Debunking the Myth of Low Behavioral Risk Among Asian Americans: The Case of Alcohol Use." *Drug and Alcohol Dependence* 1;228:109059. PMID: 34600252.	Asian Americans	Alcohol	Older Asian American adolescents (ages 15–17) had a higher prevalence of past-month drinking (8.0%), binge drinking (4.3%), and alcohol use disorder (AUD) (1.8%), compared to younger Asian American adolescents (ages 12-14). Among Asian American adults, higher rates of binge drinking (23.0%) and AUD (7.2%) were observed among young adults ages 18–25, compared to Asian American adults ages 26 and older. Comparing rates of binge drinking among Asian American adults by country of origin and nativity, the highest rates of binge drinking and AUD were observed among US-born Korean Americans (prevalence of binge drinking: 26.9%, AUD: 13.1%) and US-born Filipino Americans (prevalence of binge drinking: 25.9%, AUD: 6.2%).
Wu, T. Y., Hsieh, H. F., Resnicow, K., Carter, P. M., Chow, C M., and Zimmerman, M. (Dec. 2023). "Understanding the Intersectionality of COVID-19 Racism, Mental Distress, Alcohol Use, and Firearm Purchase Behavior Among Asian Americans." *Journal of Racial Ethnic Health Disparities*; PMID: 38062320	Asian Americans	Alcohol	The study results showed that the racism Asian Americans experience is directly related to their increased mental distress, substance abuse (alcohol), and firearm purchases.
Yan, Y., Yoshihama, M., Hong, J. S., and Jia, F. (June 2023). "Substance Use Among Asian American Adults in 2016–2020: A Difference-in-Difference Analysis of a National Survey on Drug Use and Health Data." *American Journal of Public Health*, 113(6):671–79.	Asian Americans	Alcohol, Cocaine, Tranquilizers	The incidence rate ratio (IRR) among Asian Americans' past-month alcohol use, cocaine use, and tranquilizer misuse in 2020 versus in 2016 to 2019 was 1.3 times, 3.0 times, and 17.2 times, respectively, the same IRR among Whites.
Alegría, M., Falgas-Bague, I., Fukuda, M., Zhen-Duan, J., Weaver, C., O'Malley, I., Layton, T., Wallace, J., Zhang, L., Markle, S., Lincourt, P., Hussain, S., Lewis-Fernández, R., John, D. A., and McGuire, T. (2022). "Racial/Ethnic Disparities in Substance Use Treatment in Medicaid Managed Care in New York City: The Role of Plan and Geography." *Medical Care*, 1;60 (11):806–12. PMCID: PMC9588705	Asian Americans in New York State	All substances	Asian Americans continue treatment less frequently than Whites and other racial or ethnic groups. Asian Americans face barriers in substance use treatment, engagement, and follow-up after withdrawal.

Choi, S., Hong, S., Gatanaga, O. S., Yum, A. J., Lim, S., Neighbors C.J., and Yi, S. S. (2024). "Substance Use and Treatment Disparities among Asian Americans, Native Hawaiians, and Pacific Islanders: A Systematic Review." *Drug and Alcohol Dependence*, 1(256):111088. PMCID: PMC10922506	Asian American Pacific Islanders (AAPIs)	All substances	Asian Americans have lower rates of substance use and substance abuse disorders (SUDs) as compared with both Whites and other racial and ethnic minorities. This is a systematic review of 37 studies and 11 disaggregated reports. Despite increased treatment admissions over the past two decades, AAPIs remain underrepresented in treatment facilities and underutilize SUD care services. Treatment quality and completion rates are also lower among AAPIs than other groups.
Godinet M. T., McGlinn, L., Nelson, D., and Vakalahi, H. O. (2020). "Factors Contributing to Substance Misuse Treatment Completion among Native Hawaiians, Other Pacific Islanders, and Asian Americans." *Substance Use Misuse*, 55(1):133–146. PMID: 31846599	AAPIs	All substances	AAPIs who use methamphetamines were less likely to complete treatment than Whites. AAPIs in treatment for alcohol use have higher odds of completing treatment than AAPIs in treatment for other substances.
Hua J. M., and Costigan C. L. (Jul 2012). "The Familial Context of Adolescent Language Brokering Within Immigrant Chinese Families in Canada." *Journal of Youth Adolescence*, 41(7):894–906. doi: 10.1007/s10964-011-9682-2. Epub 2011 Jun 17. PMID: 21681583.	Chinese Canadians	All substances	Language brokering, whereby children of immigrants provide informal translation and interpretation for others, is considered commonplace. More frequent language brokering was associated with poorer psychological health for adolescents who held strong family obligation values or who perceived parents as highly psychologically controlling. More frequent language brokering was also associated with more parent–child conflict. Contrary to some past findings, language brokering frequency was not significantly positively associated with self-esteem or with parent–child congruence (i.e., levels of understanding and satisfaction with parent–child relationships)
Sahker, E., Park, S., Garrison, Y. L., Yeung, C. W., Luo, Y., Arndt, S., and Furukawa, T. A. (Oct. 2022). "State Population Indices Predict Asian American and Pacific Islander Successful Substance Use Treatment Completion: An Exploratory Observational Study." *Journal of Ethnicity in Substance Abuse*, 2 1 (4):1485–1500.	AAPIs	All substances	AAPI were more likely to successfully complete treatment in states where AAPI population as a percentage of the state population was high (greater than 3.99%), compared to low 3.99% or less); the completion rates were 48.22% and 40.86%, respectively). The difference was clinically meaningful (RD ¼ 7.36, 95% CI ¼ 7.96, 6.77). Findings suggest treatment agencies in areas with low AAPI densities may improve outcomes by supporting AAPI community and cultural social networks.
Spencer, S. D., Pokhrel, P., Helm, S., Wilczek, K., Galimov A., and Sussman, S. (Mar 2023). "Emerging Adulthood Attributes, Discrimination, Mental Health, and Substance Use in a Sample of Asian, Native Hawaiian/Pacific Islander, and White College Students." *Asian American Journal of Psycholo*gy, 14(1):51–62. PMCID: PMC10289252	Asian American, Native Hawaiian/ Pacific Islander, White college students	All substances	NHOPI ethnicity had a significant indirect effect on higher substance use via discrimination and poorer mental health (indirect effect = 0.01, standard error (SE) = 0.002, p = .03). Asian ethnicity had a significant indirect effect on higher substance use via poor mental health (indirect effect = .01, SE = .006, p = .04). In addition, Asian ethnicity had a significant protective effect on substance use via lower prevalence of social network substance use (indirect effect = −.11, SE = .04, p = .004).

Wang, C. L., Kanamori, M., Moreland-Capuia, A., Greenfield, S. F., and Sugarman, D. E. (2023). "Substance Use Disorders and Treatment in Asian American and Pacific Islander Women: A Scoping Review." *American Journal on Addictions*, 32(3):231–243.	AAPIs	All substances	The prevalence of substance use disorders (SUD) among AAPI women increased overall but the literature on SUD treatment for AAPI women is very limited.
Trickett, E. J., and Jones, C. J. (Apr. 2007). "Adolescent Culture Brokering and Family Functioning: A Study of Families From Vietnam." *Cultural Diversity and Ethnic Minority Psychology*, 13(2):143–50. doi: 10.1037/1099-9809.13.2.143. PMID: 17500603.	Vietnamese Americans	All substances	In immigrant families, culture brokering (CB) refers to the ways in which children and adolescents serve as mediator between their family and aspects of the new culture. Greater amounts of adolescent CB were indeed related to higher adolescent reports of family conflict, but also to greater family adaptability. In addition, the amount of CB was unrelated to family satisfaction and family cohesion.
Shearer, R.D., Segel, J. E., Howell, B. A., Jones,. A. A., Khatri,. U G., Teixeira Da Silva, D., Vest, N., and Winkelman, T. N. A. (Mar 2024). "Racial and Ethnic Differences in Heroin, Methamphetamine, and Cocaine Use, Treatment, and Mortality Trends in 3 National Data Sources—United States, 2010-2019." *Medical Care* 62(3):151–160.	All Americans	Heroin, Methamphetamine, and Cocaine	The largest percent increases in heroin-involved overdose deaths between 2010 and 2019 were among Asian/Pacific Islanders and Black groups.
Rondon, Y., Sasaki, G., Tung R., Piazza, P., Carey, A.J. (Feb 2023). "Truth from Youth: The Asian American Experience in Boston Public High Schools." Massachusetts Asian American Educators Association.	Asian Americans	Not applicable	Asian American students at Boston public schools report feeling less safe, more undervalued.
Townsend, T., Kline, D., Rivera-Aguirre, A., Bunting, A. M., Mauro, P. M., Marshall, B. D. L., Martins, S.S., and Cerdá, M. (Mar 2022). "Racial/Ethnic and Geographic Trends in Combined Stimulant/Opioid Overdoses, 2007–2019." *American Journal of Epidemiology* 24;191(4):599–612. PMCID: PMC9077116	AAPI	Opioid and Stimulant	Cocaine/opioid overdose mortality rose sharply among Hispanic and Asian Americans between 2007 and 2019. Stimulant use in AAPIs increased faster than among Whites, primarily along the West and Northeast US.
Zhu, S. H., Nguyen, Q. B., Cummins, S., Wong, S,, and Wightman, V. (Apr. 2006). Non-smokers seeking help for smokers: a preliminary study. *Tobacco Control*, 15(2):107-13. doi: 10.1136/tc.2005.012401.	Asian Americans	Tobacco/Nicotine	Over 22, 000 non-smoking proxies called. Proportions differed dramatically across language/ethnic groups, from mean (+/-95% confidence interval) 2.7 (0.3%) among English-speaking American Indians through 9.3 (0.0%) among English-speaking Hispanics to 35.3 (0.7%) among Asian-speaking Asians. Beyond the differences in proportion, however, remarkable similarities emerged across all groups. Proxies were primarily women (79.2, 1.7%), living in the same household as the smokers (65.0, 2.1%)), and having either explicit or implicit understandings with the smokers that calling on their behalf was acceptable (90.0, 1.3%).

Pre-Pandemic .			
Fang L, Barnes-Ceeney K., Lee R.A., and Tao J. (2011). "Substance Use Among Asian-Americ.an Adolescents: Perceptions of Use and Preferences for Prevention p\Programming." *Social Work Health Care* 50(8):606-24. doi: 10.1080/00981389.2011.588115. PMID: 21919640; PMCID: PMC3221611.	Asian Americans	All substances	Factors influencing SUD rates among Asian Americans included stress, depression, low self-esteem, and disapproval of close peers and family members.
Sahker E., Yeung C.W., Garrison Y.L., Park S., and Arndt S. (Feb 2017). "Asian American and Pacific Islander Substance Use Treatment Admission Trends." *Drug and Alcohol Dependence* 171:1-8. doi: 10.1016/j.drugalcdep.2016.11.022.	AAPIs	All substances	For AAPI compared to non-AAPI, there was a greater increase in admissions to public or private treatment facilities receiving public funds from 2000 to 2012 ($p < 0.0001$; OR = 1.02, 95% CI = 1.019–1.022). Large percentage increases were seen in multiple demographic and treatment characteristics, most notably in prescription opioids as a problem substance, age of first use for the oldest and youngest groups, and homelessness. The largest change was in the oldest group, with a 425% increase in admissions for those beginning to use their drug of choice at age 55 years and older.
Arias, E., Heron, M., National Center for Health Statistics, Hakes J., and US Census Bureau. (Aug. 2016). The Validity of Race and Hispanic-Origin Reporting on Death Certificates in the United States: An Update." *Vital Health Statistics* 1;(172):1–21. PMID: 28436642	All Americans	Death Certificates	In the US, misclassification of AAPI identity in vital statistics data is greater in the Midwest, Northeast, and South than in the West.