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For “Them”, Not Us: A Qualitative Study Of Asian American Pacific Islander Perceptions Of Substance Use And Harm Reduction

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For "Them", Not Us: A Qualitative Study of Asian American Pacific Islander Perceptions of Substance Use and Harm Reduction

Master of Public Health Thesis

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Abstract:

Background: Asian American Pacific Islander (AAPI) substance use data is typically aggregated in a way that not only produces overly generalized results, but also potentially perpetuates stereotypes created by the Model Minority Myth (MMM). This has mutually reinforced a lack of representation and understanding of AAPI substance use experiences and needs. This presents a public health concern that is both excluding them from consideration by the field of harm reduction, but also themselves from considering harm reduction. Disaggregated data shows rising rates of substance use and associated harms that are often hidden or not taken as seriously as a public health issue, raising concerns that the lack of problem recognition of AAPI substance use issues will preclude them from being meaningfully and intentionally engaged by harm reduction organizations. This exploratory qualitative study examines the perceptions and relationships that AAPIs have with substance use and harm reduction by having them explore the question: “Who is harm reduction is for?”

Methods: 15 qualitative interviews with adult AAPIs living in the U.S., with personal and/or professional experience with substance use or substance use topics were conducted in English over Zoom. Interview data was analyzed using thematic analysis.

Results: Three overarching themes were identified: that substance use was a contributing factor in how AAPIs defined their social positionality; that problem recognition of substance use was doubly erased by both AAPIs and non-AAPIs; and that harm reduction was something AAPIs did not see as expressly inclusive of their community, but rather for ‘others’: white people, people who used opioids, and people who injected drugs.

Conclusions: Harm reduction and public health organizations need to make more efforts to better integrate minoritized communities, like AAPIs, not just to ensure the availability of culturally responsive substance use resources, but also to challenge deeply held stigmas and stereotypes.

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Background:

Challenging the Monolith: Asian American Pacific Islanders

Asian American Pacific Islanders (AAPIs) are commonly reported as having some of the lowest rates of substance use, when compared to other racial/ethnic groups[1]. Distinctions like this – in addition to generalized perceptions of high educational attainment, wealth, and quiet but hard working natures – often constructs the AAPI community as a "model minority": a successful minority that not only reaped the spoils of the American Dream, but also as a model of what other minorities could achieve as well[2]. This phenomenon is often referred to as the Model Minority Myth (MMM)[3]. However, many within the AAPI community have long raised strong concerns with how data from one of the U.S.'s most diverse and fasted growing diasporic communities is collected[4,5], pointing to vast differences in experiences between communities that fell under the 1975 federally constructed definition of '*Asian or Pacific Islander'* [6]. As of 2000, the U.S. Census retained most of the 1975 definition, but split it into two: defining "Asian American" as people having ancestral origins in the "Far East, Southeast Asia, or the Indian subcontinent" and "Native Hawaiian and Other Pacific Islander" as including "Native Hawaiian, Samoan, Guamanian or Chamorro, Fijian, Tongan, or Marshallese peoples", in addition to the people of Melanesia, Micronesia, and Polynesia[7]. These are populations with markedly different historical, social, economic, and political experiences, both in their countries of ancestral origin and here in the U.S. AAPI data that has been disaggregated by ethnicity have revealed stark contrasts in poverty levels[8] and educational attainment[9].

The gross aggregation of AAPI data complicates our ability to accurately understand health issues within the community and also critically, has the potential to obscure and perpetuate health disparities[5]. For example, despite deep contention over the definition of the AAPI community, the 1985 "Heckler Report", one of the first comprehensive studies on health disparities amongst U.S. minority groups, misstated that "[t]he Asian/Pacific Island minority, in

aggregate, is healthier than all racial/ethnic groups in the United States, including Whites."[10] "Data-driven" findings like these are further compounded and perpetuated by the stereotype promise of the MMM, creating a gray area for public health research to accurately assess health needs and issues. The movement to disaggregate AAPI data and reconsider our understanding of AAPI health issues has no intent of claiming that what the AAPI community goes through is better or worse than other minority groups, but rather uplifts the urgency of not repeating a "mutually reinforced cycle" of poorly constructed data and racial stereotypes that could threaten to leave our communities behind[11]. As Dr. Megan Shen of Weill Cornell Medical College writes, "[O]ften it is difficult to understand and address the disparities present among these populations, because Asians are rarely prioritized as underserved, and consequently, are not the focus of research or added resources, such as special clinical services or outreach programs designed to deliver needed care within communities."[5]

An Issue of Substance: Understanding AAPI Substance Use

Considerable efforts have been made to address the implications that data aggregation and MMM have had on AAPI public and population health concerns, across a myriad of health concerns including cancer, diabetes, maternal and infant health, and cardiovascular disease[12]. A little less attention has been paid towards assessing and addressing Asian American substance use, especially through a harm reduction lens. The moralization of substance use as a 'bad' attribute, also plays neatly into pre-existing stereotypes about the AAPI model minority, presenting a challenge for understanding the true extent of its epidemiology and potential issues. The concern with constant, unnuanced, and sometimes unquestioned reporting of low substance use prevalent rates amongst AAPIs, is that it plays straight into a stereotype that threatens to not only halt further questioning, but also can generalize the perception of the lack of substance use issues and needs across the entire AAPI community.

A number of papers have been challenged for their “premature” and methodologically questionable conclusion that AAPIs use substances at less frequent rates compared to non-AAPI peers, pointing out low sample sizes, over-sampling more populous east Asian demographics to generalize the experiences of smaller AAPI communities, and total lack of distinction between the many different ethnic groups under the AAPI umbrella[13]. However, a disaggregated AAPI substance use study found highly variable rates of substance use among AAPI youth in California and Hawaii, with some rates, especially from Filipino and Native Hawaiians, matching or even exceeding rates of substance use amongst white peers[14]. Another disaggregated substance use study, revealed that Japanese-Americans and mixed-heritage AAPIs had rates of substance use higher than their AAPI peers[15]. These findings help provide insight into the uneven landscape of AAPI substance use, challenging the generalizations and stereotypes imparted on this community.

Finally, even with lower overall substance use prevalence rates, there are findings that those rates are rapidly changing and sometimes in ways that are not expected. For one, amongst the AAPI adults that made up 1.3% of adult clients entering drug treatment for the first time in 2005, stimulants accounted for 57.3% of listed primary drugs for treatment admission, increasing from 45.3% just 4 years prior, a much higher increase than white or Black clients[16]. Another recently published study found that between 2016-2020, there was a significant increase of alcohol, cocaine, and tranquilizer use amongst AAPIs, at rates 1.3x, 3.0x, and 17.2x the rate among whites[17]. These findings were in line the 2018 SAMHSA report of a 220% spike in stimulant use reported by AAPIs from 34 to 110 per 100,000, far outpacing other racial and ethnic groups[18]. Critically, in 2020, overamping (typically caused by stimulants) and overdose-driven fatalities have been shown to be increasingly more rapidly amongst AAPIs in the western U.S. than white counterparts[19]. These are all alarming trends that have often been buried by data aggregation and the MMM.

This lack of reliable data and attention towards these substance use disparities may also likely worsen health outcomes for AAPIs who use drugs. The same study of AAPI youth in California and Hawaii revealed a drastic disparity between youths' self-perceived need for substance use treatment and the level of treatment need indicated by DSM criteria[14]. The authors suggested the lack of recognition of substance use problems as an underlying reason, despite findings that show AAPIs do have similar treatment needs, experiences, and outcomes for substance use treatment[20]. This was referred to as "problem recognition"[21]. Studies have shown that AAPIs already tend to underutilize and under-access mental health services in part due to the pressure of model minority stereotypes[22,23], and in particular, AAPIs who needed substance use treatment, were less likely than white patients to report past-year treatment for substance use[24]. The concern is that this underutilization of substance use services, is also being taken to represent an absence of lack of demand[25], which has concerning consequences for funding and policy prioritization, especially for this rapidly growing community.

While there are a significant number of barriers towards accessing substance use support that are not specific to just AAPIs[26], the lack of specific inclusion and focus on AAPI substance use needs will likely compound the disparities and prevent further recognition of community needs[27]. However, studies on AAPI substance use treatment been largely focused around forms of substance use treatment and care that traditionally emphasize abstinence, and not necessarily around their access to and adoption of harm reduction strategies to mitigate drug-use related harms and risks. Indeed, almost no research exists on AAPI relationships and perceptions of harm reduction, representing a vast area of opportunity to explore additional strategies to address AAPI substance use.

A "Gentler" War on Drugs[28]: The Disparate Response

After decades of drug war disproportionately waged against Black and Brown communities, emergent calls for a more empathetic harm reduction response to the opioid overdose crisis, more commonly associated with white communities[28], have rightfully raised critical questions about racial bias in public health and drug policy response[29,30]. Harm reduction philosophy is centered around the mitigation of risk and harms from drug use, rather than necessitating full abstinence from substance use[31]. Harm reduction strategies, across a diverse range of substances and modes of substance use, have been shown to be effective at reducing risks from substance use[32]. Harm reduction is also a social movement that embraces that drug use is a part of human society for a variety of reasons, and that punitive, prohibition-style policies typically escalate harm, not prevent it. The history of harm reduction in the U.S. can be traced back to the early 1980s with the rise of the HIV/AIDS epidemic and the application of syringe exchange programs to stem HIV transmission amongst injection drug users[33], but has only very recently become a more major component of public health policy and response across the U.S. under the Biden-Harris Administration[34].

While this more recent uptake has been applauded as a long overdue step in the right direction, the disparate response to the real or perceived drug issues amongst different racial and ethnic communities threatens to perpetuate existing disparities. In particular, the "whitewashing" of the opioid overdose crisis that has obscured rising death rates amongst Black, Indigenous and Latinx communities[35], continues to be cited as primary driver of the current more public health-oriented response to drug problems[36,37]. This selective move towards harm reduction has the potential to be disproportionately applied, creating "a less punitive, clinical realm for Whites where their drug use is decriminalized, treated primarily as a biomedical disease, and where their whiteness is preserved, leaving intact more punitive systems that govern drug use of people of color"[29]. We see this selective application of empathy across changing drug policy approaches, with one study finding that racial resentment,

especially among white respondents, was strongly associated with opposing measure that would decriminalize drug possession[38]. The efforts to dismantle the damages of the drug war and build in its place, harm reduction approaches, must prioritize the Black and Brown communities that bore the brunt of the harshest drug war policies. It is also critical that as the U.S. grapples a paradigm shift that seeks to treat instead of punish, that harm reduction is applied and made accessible to people of all backgrounds that use drugs – *including* groups that have historically flown under the radar like AAPIs. Finally, increasing the inclusivity and diversity of harm reduction will strongly benefit minoritized communities of color. While harm reduction *is for everyone*, tailoring harm reduction programs to be culturally responsive and focused, can not only make it even more effective for minoritized groups[39], but be a strong signal that everyone is deserving of empathetic, compassionate care.

Harm Reduction for Asian American Pacific Islanders

There is relatively limited research, writing, and resources about AAPI experiences and relationships with harm reduction. Despite some growing recognition of the under-representation of AAPIs in harm reduction, there are significant gaps in access and understanding. A literature review found only one book chapter dedicated to harm reduction considerations for AAPIs, which emphasized the issue of "problem recognition" as a barrier to seeking treatment and help, and that harm reduction could be an effective tactic to manage and mitigate substance use-related harms and risks[21]. While most harm reduction organizations are already resource limited due to limited funding and an uphill battle for political and social support, this makes the challenge of bridging service gaps to underserved populations within harm reduction even more difficult. For example, the Lower East Side Harm Reduction Center in Manhattan's Chinatown, provides bilingual services to AAPI clientele in Mandarin and English, but lack further funding and capacity to support a wider range of clientele: for example, being able to recruit and retain a Cantonese-speaking peer worker[40]. Other issues, may lie in having

AAPI patients in need of harm reduction services accept that they need it. The San Francisco Community Health Center, reported that many of their HIV-positive AAPI patients rarely discuss their substance use, and despite serving a patient population that is at least 30% AAPI, only one AAPI client used their syringe services exchange in a four year period of operation[40]. These stories mirror the primary concern surrounding the underrepresentation of AAPIs in harm reduction: both that harm reduction services will continue to not reach them, and that AAPIs will not see themselves as a part of harm reduction.

In order to dig deeper into this issue, this qualitative study was conducted to better understand AAPIs' relationship with substance use, their perception of substance use related needs and issues within the community, and finally, their perceptions of and relationship to current harm reduction practice. This study represents one of the first efforts to gauge how AAPIs believe harm reduction sees them, and how they see themselves within harm reduction practice. These findings could be used to better inform harm reduction interventions and outreach efforts to a population that has persistently faced the threat of erasure from national consideration.

Methods:

Patient Recruitment

AAPIs with personal and/or professional experience with substance use-related issues and topics were recruited from across the U.S. for the study to comprise as diverse a sample as possible. Recruitment materials were shared through social media networks including Facebook, Instagram, Twitter, and LinkedIn, as well as through Yale School of Public Health's and personal social networks. Some snowball sampling also occurred from interested participants alerting their colleagues and peers to the study. Study participants completed a registration survey on Qualtrics that asked them for demographic details and elaboration on

their personal and/or professional experiences, and were subsequently assigned participant numbers. Participants were not compensated for their participation in interviews. Participants were informed of and consented to the fact that they would be identified throughout the study by the information they provided upon registration: gender identity, age-range, ethnicity, U.S. region of residence, and characterization of personal and/or professional experience with substance use.

Data Collection

The interview guide [Appendix 1] was developed in consultation with thesis advisors and with the support of Dr. Katie Wang, an expert on the impact of stigma on health outcomes. The questions were divided into two portions: the first part specifically focusing on AAPI perceptions and attitudes towards substance use, and the second part on questions regarding harm reduction and how participants perceived their own and their community's potential relationship with harm reduction practice.

One-on-one interviews were virtually conducted over Zoom by the investigator, and digitally recorded onto the investigator's laptop. Unfortunately, translation services were not available for this study, restricting the interviews to being conducted only in English. Interviews lasted from 45 minutes to 3 hours. Zoom's automatically produced transcripts were reviewed against the audio recordings for accuracy. Both the transcript and audio recordings were identified only by participants' study numbers and stored on a secure server, Yale Box, with access available only to the research team. Personal identifiers of individuals mentioned by participants during the course of the interview were removed for privacy, given the sensitivity of the information shared. This study was exempted from IRB review by the Yale University Institutional Review Board (#2000034364).

Data Analysis

Thematic analysis was used to identify key themes and patterns found in participants' responses around three key areas: the relationship that AAPIs described having with substance use of their own or within their own communities; the extent to which they described substance use being an issue of concern within the AAPI community; and finally, their perception of harm reduction practice and who these services were for. Thematic analysis allows for the identification and interpretation of broad patterns within data, which is particularly useful for exploring a topic that is at once both under-researched and mostly informed by potentially misrepresented data. The goal of thematic analysis is not to merely summarize participant responses and organize it by question, but to analyze beyond the semantic and surface level responses, and dive into latent ideas and assumptions held by participants[41].

The Zoom-produced transcripts were cleaned and reviewed against the mp3 audio recordings for accuracy, and entirely read through before analysis was initiated. Notes were taken from each interview to summarize key points and answers to two Likert scale questions. Comparing these notes allowed for the creation of themes and sub-themes to help organize participant responses. Participant identifiers are included with their responses (and in Appendix 2), to help better contextualize their own experiences and to avoid complete aggregation of responses. Given the small sample size, results should not be taken to be a complete generalization of experiences across the entire AAPI community, but as an exploration.

Results:

Participant Demographics

A summary of the 15 participants' demographic information is shown in Table 1. A table that describes individual participants can be found in Appendix 2, and specific quotes are designated by [Study Participant #] throughout the text. All participants were at least 18 years of

age, self-identified as part of the AAPI community, currently lived in the U.S., and self-identified as having personal and/or professional experience with substance use-related issues or topics. 26.7% of participants reported only personal experience, 46.7% reported only professional experience, and 26.7% of participants reported both personal and professional experience with substance use. The terms “personal” and “professional” to describe experiences were not tightly defined to allow for a wider range of interpretation, though participants were asked to elaborate on their self-reported designation during registration. There was no threshold to qualify as having “personal” experience with substance use, nor was there a requirement for participants to have personal experience specifically with illicit substances to qualify (i.e. alcohol, marijuana, tobacco, e-cigarette use all included). Participants who reported any personal use, reported everything from recreational use to disordered substance use with a range of both licit and illicit substances. Participants who reported any professional experience were mostly healthcare or social services professionals, healthcare students, and researchers, with some reporting involvement with community-based harm reduction organizations. Participants were not explicitly asked about current or ongoing substance use during the interview or registration.

Participants were recruited from all over the country. 73.3% of participants self-identified as female, 60% of participants were between the ages of 26 to 35, 66.7% of participants reported a bachelor’s degree as their highest level of education, and 73.3% of participants were from the Northeast region (New England or Mid-Atlantic division). Participants represented various parts of the Asian-American community, including Filipino-Americans (33.3%), Indian-Americans (20.0%), and Korean-Americans (20.0%).

Table 1. Demographics and Backgrounds of Study Participants (n=15)

	Frequency	**Percent***

Gender Identity	**Female**	11	73.3%
	Male	4	26.7%
Ethnic Identity	**Chinese-American**	1	6.67%
	Filipino-American	4	26.7%
	Indian-American	3	20.0%
	Korean-American	3	20.0%
	Lao-American	1	6.67%
	Taiwanese-American	1	6.67%
	Mixed Japanese-White	1	6.67%
	Mixed Filipino-White	1	6.67%
Age	**18-25**	5	33.3%
	26-35	9	60.0%
	36-45	1	6.67%
Highest Attained Level of Education	**Bachelor's**	10	66.7%
	Master's	2	13.3%
	Professional or Doctorate Degree	3	20.0%
	Northeast: New England	6	40.0%

U.S. Residence by Census Regions[42]	**Northeast: Middle Atlantic**	5	33.3%
	Midwest: East North Central	1	6.67%
	West: Pacific	2	13.3%
	West: Mountain	1	6.67%
Personal and/or Professional Experience with Substance Use	**Personal Experience Only**	4	26.7%
	Professional Experience Only	7	46.7%
	Both Personal and Professional Experience	4	26.7%

*****Not all percentages may round to 100% because of rounding.

Thematic Analysis Results

Ultimately, three major themes emerged from the data: (1) that AAPIs saw substance use as a factor that influenced their positionality both within the AAPI community and outside of it; (2) that model minority stereotypes and lack of representative data doubly erased AAPI substance use issues; and (3) that while participants broadly agreed harm reduction could be applied to everyone – including AAPIs – they ultimately reported the perception of harm reduction as existing primarily for others. These themes and sub-themes, illustrate a deeper tension found in existing not just as racialized minority in America, but as an otherized model minority, and how substance use was a component of defining these in-group and out-group identities.

This fundamental tension of defining "*them vs. us"* is echoed across participants' responses, underscoring the inconsistent and confusing ways in which AAPIs see themselves

represented in the discourse around substance use. Amidst the myriad of personal and interpersonal stories of substance use shared by participants, they unanimously reported that there was a prevailing sense that substance use was not an issue in the AAPI community[40]. While these findings lean sociological in nature, they highlight a challenge for public health and harm reduction organizations of ensuring the "problem recognition"[21] of AAPI substance use by not just themselves, as the gatekeepers and providers of services, but also by the AAPI community. Above all, the findings posit*: if you don't see that others truly include you in the "problem", how and why would you believe that you'll be included in the "solution"?*

Theme 1: Navigating the Model Minority Myth: "We're the 'Good Ones', Right?"

"I think to an extent, they're still having to perform and posture, particularly to white communities, kind of trying to solidify our place as within proximity to whiteness right. That we're not like the other communities of color, that we're the "good ones", right?"

- (Male, 26-35, Filipino-American, New England, Professional Experience)

Numerous studies have already touched on the impact of MMM on AAPI health[3,5,21,23]; however this section provides some additional context in how AAPIs see substance use as a factor in their social positionality in their families, amongst their peers, and as compared to other racialized minorities in the U.S. Positionality is defined by "how differences in social position and power shape identities and access in society"[43], and helps inform our sense of membership and belonging across different communities. Participants shared how the stigma and moralization of substance use intersected with their identities and positions within their communities, often in heavy contrasts and comparisons: whether it was between generations, between peers who used drugs and those who didn't, or as an unwilling pawn in a racial hierarchy defined by their status as part of the "model minority".

Asian vs. American: Between Oceans and Generations

"All of the Asian elders I have in my life, I don't think I have had any conversations with any of them about my work in harm reduction where I didn't feel like we were at odds about how people who use substances deserve to be treated."

- (Female, 26-35, Mixed Japanese-White, West Mountain Region, Personal and Professional)

When asked about the overall perceptions and attitudes towards substance use within the AAPI community, a majority of participants immediately contrasted their (younger) generation's relative acceptance of substance use against the relative disapproval of their parents' (older) generations. Many specifically ascribed their "open-mindedness" towards drugs to being more "American" or "Americanized", directly in comparison to what they saw as the "Asian" traditional and conservative values of their parents that condemned substance use. Only one participant, who was mixed Filipino-American, described her experiences with substance use as something that allowed her to connect more deeply with her Asian heritage through accessing more traditional forms of knowledge and spirituality [SP #11].

While participants weren't asked about their generational status as part of the study registration, most described themselves during the interview as part of the 1.5 or 2nd generation. Some participants attributed generational differences in substance use attitudes to their parents growing up in countries having stricter cultural norms or laws around substance use, referencing examples ranging from the Philippine Drug War under President Duterte and strict cultural taboos against marijuana use in South Korea. A few also referenced generational and migrational trauma as an influence on substance use views, that there were generational differences to addressing and coping with pain. Other participants mentioned the influence of religion where they learned to associate substance use with "sin" [Study Participant #7], and how this was a factor in wanting to differentiate from their parents' generation. Additionally, one

participant contrasted the upbringing by her immigrant parents that was described as "*education driven, and you know, not using drugs, not having sex, you know those forbidden things weren't really permitted growing up"* to how she saw the upbringing of her subsequent generations: *"I feel as my children, and my children's children become more 'Americanized', so to speak, we'll be more liberal in our values" [SP #2].*

Many participants who identified as 1.5 or 2nd generation AAPIs, pointed to the aspirations that their Asian immigrant parents laid out for them, referencing high educational achievement and successful careers, and how drugs posed a specific threat to model minority status. One shared: *"[I]f you're doing drugs, that means you're not doing the things you're supposed to be doing, like school, having a career, and having a family, and all that stuff right? So then it's just considered like this very insidious thing that will stop us from living out our perfect American dream." [SP#3].* The loss of model minority status and deviation from the American dream was noted to not be just of an individual consequence, but also a blow to the family's reputation [SP #8]. Multiple participants alluded to stories of growing up in church or community center centers with other members of their community, hearing disapproving gossip among parents about another parents' kid who had been caught using drugs, as a formative experience in their views on substance use. One participant recounted how the loss of a Filipino-American friend to drug overdose, was followed by persistent gossip in the community that his mother hadn't "raised him right", with little context or respect for the decedent *[SP #12]*. Another participant shared that hearing these stories since he was young had reinforced that not only should substances be avoided, but that if substances were used, that all efforts needed to be taken to avoid it being known *[SP #8]*.

Substance use or even the association of substance use was often positioned in the familial context as a rebuke of the privileges conferred to children through parental sacrifices.

One participant referenced his mother crying when she learned about his substance use, describing this as an emotional response to him *"throwing away everything that we [parents] did for [him]" [SP #9].* An Indian-American participant *[SP #6]* who had professional goals of working with people living with substance use issues, reflected on the tension she felt from her family's disapproval of using her burgeoning medical career to focus on a patient population they found harder to sympathize with. She referenced a perception from her family that substance use was a *"personal choice"*, a mentality that she believed could have been informed by the extreme poverty conditions her parents witnessed many people experiencing in India as: *"why would you do this [substance use] to yourself, if you are fortunate enough to escape all these things that other people can't?" [SP #6].*

"Good Asian, Bad Asian": The Moralization of Substance Use and AAPI Identity

"They might have stigma towards someone that doesn't use substances, and says like 'Oh, that person is like a FOB [Fresh off the Boat] or a nerd because they just wanna study all the time'. But, like someone who doesn't use substances, might be like oh that person [who uses drugs] is a fucking crackhead. … And like, how that fits in with their view of what a 'good' Asian person is supposed to be, is gonna change depending on whether or not they personally use substances or are okay with other people using substances."

- (Female, 18-25, Indian-American, Mid-Atlantic Region, Personal/Professional)

The moralization of substance use played a role in how some AAPIs reported navigating the restrictive nature of the MMM stereotypes. Substance use is broadly stigmatized across society, not just amongst AAPIs[37,44]. However, multiple participants discussed how substance use set up dichotomies that framed AAPIs, particularly young AAPIs, as being 'good' or 'bad' representatives of the community as seen by their peers, and their motivations for deviating and resisting the norm. Participants established that the norm typically was of not using substances,

with one participating sharing: *"I feel like the stereotype of Asian Americans in general, is not one that's normally associated with substance use." [SP#4].* She went on to suggest that substance use was sometimes seen as a distinguishing factor of those who went with the "*goody two-shoes*" stereotype, and those who were willing to rebel against it *[SP#4].* One participant elaborated on some of these factors she believed influenced substance use amongst younger AAPIs: *"I think maybe the need to overcompensate, perhaps against like stereotypes about Asian Americans…those stereotypes being that like you're nerdy, or that you don't know how to have a good time. … I think growing up around those stereotypes can make it so that sometimes, you really try hard to push back against it, and not associate with it at all." [SP #10].*

However, while some participants addressed their substance use as a way to challenge model minority, other participants referenced stories where perceived or known substance use was used as a way to challenge a peer's position within the AAPI community. One participant shared an anecdote from a circle of other undergraduate Indian-American peers, where the topic of cocaine use was brought up. Someone then referenced an absent Indian-American peer, who was part of Greek life on campus, as possibly having used cocaine: *"Everyone just started laughing, it was a mean kind of laughter. Like people were like very clearly putting her down [by] saying 'she probably does drugs', which in that circle is considered a very bad thing. Because she chooses to be part of a sorority, which in that circle was very uncommon, it was like [she] was less a part of the Indian community on campus. …She was starting to get these labels of like, 'Oh, she's not a part of our community [as Indians], and like she probably just goes and does drugs all the time" [SP #3]*.

Two participants also specifically alluded to the "Asian Glow" or "Asian Flush" phenomenon, as a distinctive marker of perceived willingness to break model minority norms. "Asian glow" refers to facial flush, or reddening of the face, reaction due to the body's inability to

process alcohol, that is more commonly found amongst east Asians[45]. One participant specifically linked this very visible reaction to consuming alcohol to *"Asian Americans being lightweight, and it being very evident when you're on a substance"*, and how this contributed further to stereotypes that *"you like, either can't hang, or that you get fucked up really easily because of those factors" [SP #10].* Another participant expanded on the ways "Asian glow" served as a marker of racial identity, in two very different settings. In what he described as a *"very racially diverse undergraduate program"*, he recalled that Asian glow was seen almost as a *"badge of honor"* for AAPIs: "*It was kind of like showing that, I engage in stuff, like I drank, I'm cool, even though I'm underage" [SP #13].* But the same participant also reflected of hearing from friends who had gone to predominantly white institutions, where "*there was a lot of shame associated with Asian glow, because it wasn't a normalized thing"* as a reaction to what is considered a common rite of passage for young college students to engage in drinking culture *[SP #13].*

"Contamination" of the Model Minority and The Imposition of Racial Hierarchy

"I grew up hearing, 'don't do drugs, don't do drugs'. And yet, so who gets to do drugs? Well, it's not us. … I think [drug use in the AAPI community] is treated like a contagion, to prevent contamination within our community. But if one Black person uses [drugs], then like, they say that the whole of them, all Black people use [drugs]. … But it's us, we don't. We're the "model minority". We don't wanna be them. We're not one of them."

- (Female, 26-35, Filipino-American, New England Region, Professional)

The existence of a "model" minority, ultimately requires the positioning of other minorities within a hierarchy. Participants touched upon the tension of not only being pressured to uphold the model minority, but also specifically addressed the unconsciously communicated instruction to avoid drugs to avoid becoming like "other" minorities. These findings follow the theme of the

construction of “us” and “them”, touching on a variety of backgrounds and identities that participants reporting growing up learning was at best, “different” than them, and at worst, at odds with their positionality as AAPIs. Participants described the various ideologies around substance use passed on by parents and by other community members as frustrating, and against what they believed in. They reported racism and colorism, anti-poverty sentiment, and stigma against mental health as factors that directly played into the messaging around substance use they received growing up.

Participants acknowledged how being perceived as a “model minority” afforded privileges and empathy not typically afforded to others. One participant summarized the perception of heavier drug use within AAPI communities were seen as “fun” because they were rarely seen as “out of control”, but attributed this disparate response to racism: “*I feel like it’s very racial, like when Black people are associated with [drug use], it’s like ‘Oh, my gosh, those people – it’s the riffraff’, and then when Asians drink, chain smoke, or even do harder drugs, it’s not seen the same way” [SP #5].* Anti-Black racism was repeatedly brought up as a underlying theme that participants heard in the warnings to not use or associate with drugs. One participant referenced a sense that parents *“[didn’t] want [their kids] to be seen as that bad race, or bad immigrant by engaging in that” [SP #13]*. Another participant built upon this same theme, discussing how she grew up hearing her parents prescribing racist and discriminatory stereotypes on substance use, often conflating being Black or Latinx, having lower socioeconomic status, mental health issues, or being unhoused, with automatically having substance use problems. She describes some of these interactions with her mom: *“It really pissed me off. She’d be like, ‘Oh, that person’s on drugs!’ Well, how do you know? ‘Well, they’re acting crazy, they’re looking crazy’.” [SP #14].*

Another participant expanded that this phenomenon wasn't only by race, but also by color, discussing the over-representation of darker-skinned AAPIs who she had seen disproportionately incarcerated for drug-related charges, the assumptions made about their class status and possible gang affiliation *[SP #15]*. One participant pointed out that the term "Asian American", often conjured up association to east Asians and upper-middle class Asians, parts of the community she saw particularly not associated with substance use because of their model minority status, and that this left out consideration of other AAPI communities *[SP #10].*

However, even as some of these perceptions about other racialized minorities were theorized as a way of the community to "perform and posture" a means of establishing "proximity to whiteness" *[SP #13]*, participants did not see themselves as part of this 'whiteness' either. In many ways, these racial tensions described are a microcosm of greater racial dynamics in the U.S., and they are revisited in subsequent themes around representation of the AAPI community within substance use and harm reduction fields.

Theme 2: Everything, Everywhere, But Not All at Once

"Just because it might be more hidden, it doesn't mean it's not happening."

- (Female, 18-25, Indian-American, New England, Professional Experience)

This theme moves beyond how AAPIs view substance use as a factor in their social positionality, and focus more on how they perceive if substance use is a problem for their community. As discussed prior, the lack of "problem recognition"[21] is a crucial barrier to addressing substance use issues within the AAPI community. Here, participants attempt to answer where they believe that difficulty of recognizing AAPI substance use needs comes from. They ultimately suggest that there is double erasure of AAPI substance use experiences, reinforced from within the AAPI community itself, and easily accepted by those outside of it – a

mutually enforcing cycle that continues to obscure them. Participants discuss a range of reasons for why AAPI substance use issues continue to be less explore or taken less seriously, noting that the biggest ones are the MMM and lack of representative data. Most importantly, participants express discordance between their personal and professional experiences of substance use in their communities, and the assumptions writ large about what happens to them and inside their communities. In short, they are skeptical about the representation of their experiences in the data, and the willingness of which they perceive both AAPIs and non-AAPIs to challenge a narrative that so easily fits into the MMM.

Everything, Everywhere: The Double Erasure of AAPI Substance Use

This section is broken out into two parts, analyzing participant responses to where they saw the erasure of substance use issues in their community: both from within their own families and communities who hide substance use issues due to stigma and fear of not aligning with the model minority, and by those outside of it who continue to overlook their experiences.

Inside the Community: Don't Let the 'Others' In.

"And no one says or does anything about it. They buy alcohol so that there's always alcohol in the house, so that he doesn't get upset. I think everyone in the family tiptoes around it, you know it's kind of like 'hush, hush'. It's not a problem, let's just keep the beast fed. … I think if there was maybe less stigma, they would be more willing to go to the clinic to get seen. But the stigma of medicalizing this and getting treatment is there, because if you talk about it, then you can't ignore that there's an issue. And then you have to potentially bring other people into it. And then everybody knows."

- (Female, 26-35, Korean-American, New England, Professional Experience)

The cost of pervasive substance use stigma is well documented across society, as a barrier to asking and receiving help. Many participants referenced experiences of how their family members addressed their own or their close relatives' substance use issues, as markedly different than how they addressed substance use issues outside of the home. Participants expressed that the stigma and social pressures explored in Theme 1, often resulted in disparate responses from family members around substance use. Stories were shared of the family members who were shamed, ostracized, ignored, and at times exiled from the family community because of their substance use. When substance use happened in the home, silence on the issue was not seen as acceptance or tolerance: *"People [in the family] are so afraid to even bring up the topic of [substance use], that it's almost easier to avoid it" [SP #1]*. Participants were more likely report disapproving silence and erasure as a response to substance use in the household. As one participant recalls, her family was relatively quick to villainize and point out substance use outside of the family, but when her relatives struggled with substance use, they reverted to denial [SP #14]. This denial also played out in different standards for defining a substance use 'problem'. For anyone outside the family, any use was immediately pathologized as 'addiction', and yet, problematic use within the family, at times, could be shown endless denial of the issue: "*If a family member is talking [about substance use], it's saying gossip about someone else. And they're like, 'Oh, this person's doing that type of drug…she must be an addict.' But if it's within the family? 'Your brother doesn't have a problem, it's not that bad'." [SP #14]*.

One participant offered another explanation for the difficulty in supporting family members with substance use issues: the divide between Asian collective values that saw in her Korean family, and the American individualistic values she experienced growing up in the U.S.. She shared the personal cost of her family not knowing how to better address substance use issues for herself and her uncle: *"You know, we're very individualistic here in this [American]*

culture, but very conforming in that [Korean] culture. … The thing is that when you carry over from a very conformity-based society where you help the individual for better or worse, because it either is going to shame your family or community … Somewhere in between, usually here [in the U.S., where we're sort of isolated, and we're no longer in the village mentality of taking care of each other. … When my uncle was struggling with alcohol and substance use, you know, he was really on his own and no one was willing to help him … My dad made one attempt and gave him some money, but I think because he didn't know how to help that wasn't enabling him, the relationship was severed forever." [SP #1]

Outside the Community: "Oh, an Asian Would Never Be Using Substances"

"I think like, it's a stigma of 'Oh, like Asians would never be using substances'. It's almost like not a 'negative' stigma, it's more like, a surprise that you use drugs."

- (Female, 18-25, Chinese-American, New England, Personal Experience)

Multiple participants addressed their experiences with non-AAPIs who consciously or unconsciously bought into model minority stereotypes about lack of substance use; others dove deeper into how this impacted their personal and professional experiences with substance use. People expressed a feeling of being taken less seriously for their experiences, or otherwise assumed that they would have not personal or proximal experiences with substance use.

Some participants reported struggling to be seen fully as AAPI providers in the field of substance use and harm reduction. One participant expressed that the most resistance she had felt as an AAPI harm reduction provider, was from "progressive" white individuals who championed racial equity in mental health, expressing that they were "*really aggressive in the sense, that they're unwilling to accept that I'm a person of color…there's an unspoken* rule *that I, along with other white [colleagues], were expected to 'step up and step back*', *even though I*

am a person of color" [SP #1]. Another participant discussed the "tokenization" that she felt in predominantly white-led harm reduction organizations, as a main driver in why she ultimately left the organization and the field [*SP #12*].

Both of these participants stressed a sense of not being taken seriously in their work around harm reduction, with one stating: *"It just felt like folks didn't take [my experiences] seriously, because my experience may not be like what they thought it would be" [SP #12]*. The other participant reflected on their work as a peer navigator emphasizing that she felt her non-AAPI colleagues sometimes overlooked the lived experiences that qualified her as a peer: *"I think that's the hardest challenge for me as an Asian American, is being an Asian American trying to offer harm reduction, because [clients] don't see me as a face where you know, I could possibly understand them. A lot of our clients, tend to be people of color, and all of the clinicians on the other hand, are white. So it's like, there's a kind of a clear divide. And I'm sort of an 'in-between', where I'm trying to be myself within a harm reduction team, that is primarily Black, who have their own lived experiences that are different from mine" [SP#1]*.

But Not All At Once: Missing Data and Representation

"Because first of all, you need to recognize that AAPIs actually struggle. You know, there hasn't been enough studies, data that prove we struggle, but that doesn't mean we don't. "

- (Female, 36-45, Korean-American, New England, Personal/Professional Experience)

All participants expressed that they did not feel like the substance use issues and needs in their community were well understood. Many attributed this to the hesitancy to believe their own experiences could be generalized because the AAPI community was so heterogenous, and pointed out the lack of representation about their issues in the first place. In particular, many felt that the data that they were broadly aware of (namely low prevalence rates) felt like it was in

conflict with their community's experiences. Most were not aware of disaggregated research that showed concerning substance use and treatment disparities.

Furthermore, most participants who had professional experience in a substance use field, particularly those on the east coast, expressed seeing a lack of AAPI patients and clientele in their practice. While they acknowledged that this could have been to a variety of other factors (i.e. location of practice, insurance barriers, etc.), many of these providers were hesitant to say that this was due to a lack of need. *"I don't see Asian patients who use substances, maybe it's because I practice out of [major metropolitan city in New England]. I've only had one [Asian] patient, out of the like thousands I've ever seen" [SP #2].* Another participant with person and professional experience receiving and rendering care, echoed, *"All of the Asian faces I've seen, were on the other end of care [as providers], not on my end [as the patient]" [SP #1]*.

Concerns were expressed that there appeared to be a lack of effort and desire to understand their community's substance use needs, mutually reinforced by data that seemed to match the model minority stereotypes they were all too familiar with. Participants did not shy away from addressing the relative positional privilege of being seen as a healthier, more successful minority, but many expressed concern that this would prevent their community from being taken seriously for the real problems it did have. Some pointed to the fallacy in conflating lower prevalence rates – disaggregated or not – with lack of problems, and how this created conditions for struggles to go unnoticed. One participant, addressed this: *"When I look at the data, when I write grants, I'm like well, there's not many Asian Americans, but there's still not enough support for them" [SP #12].* She further elaborated that the data that did exist, likely disincentivized further study and outreach, saying: *"You're not gonna get the people. If you can't get the people, how are you gonna get the data?" [SP #12]*

Theme 3: For 'Them', Not 'Us': Harm Reduction For All, But Mostly Others

"Because if I perceive harm reduction as only applying to those people and those substances over there…then like, of course, it doesn't apply to me right, it's not relevant for me."

- (Female, 26-35, Mixed Japanese-White, West Mountain Region, Personal and Professional)

Finally, this section addresses AAPIs' relationship and perceptions specifically with harm reduction. Given the wide range of personal and professional expertise represented by the participants, there were slight variations towards the understanding of what harm reduction was, and what it aimed to do. However, all participants demonstrated a baseline understanding of harm reduction's approach of mitigating substance use related harms and risks, with those with harm reduction-specific experience being more likely to expand on how the end goal of harm reduction was not necessarily abstinence. Participants overwhelmingly reported favorably positions on harm reduction, reporting an average 4.7 out of 5 favorability score (1 = highly unfavorable, 3= neutral, 5 = highly favorable; Range: 3-5, median: 5), and believed that harm reduction strategies were something that could be used by everyone. However, participants tended to emphasize that harm reduction seemed meant for "someone else" – whether it was for other racial groups whose substance use issues were more visible or understood, or for other types of substance use they did not perceive was common within the AAPI community. Participants were asked to share which drugs they thought were most commonly associated with the AAPI community, and which drugs they most commonly associated with harm reduction practice. For the AAPI community, they overwhelmingly noted alcohol use (14 out of 15), following by tobacco use (cigarette, vaping, general nicotine use) (7 out of 15), what they collectively termed "party" or "rave drugs" (notably MDMA/Ecstasy/Molly) (6 out of 15), and closely followed by marijuana use (5 out of 15). When asked the same question about harm reduction, 13 out of 15 participants immediately named opioids (heroin or fentanyl), and 7 out of

15 specifically addressed injection drug use (of any kind). Table 2 below records the overall breakdown of participant responses.

Table 2: Participant Responses to 'Most Commonly Associated' Drugs with the AAPI Community vs. 'Most Commonly Associated' Drugs with Harm Reduction

Drugs Associated with AAPIs	Frequency	% of Participants *	Drugs Associated with Harm Reduction	Frequency	% of Participants
Alcohol	14	93.3%	**Opioids** [d]	13	86.7%
Tobacco/Nicotine	7	46.7%	**Injection Drug Use** [e]	7	46.7%
"Party Drugs" [a]	6	40.0%	**Tobacco/Nicotine**	4	26.7%
Marijuana	5	33.3%	**Cocaine**	3	20.0%
Opioids [b]	3	20.0%	**Alcohol**	3	20.0%
Cocaine	2	13.3%	**Methamphetamine**	2	13.3%
Methamphetamine [c]	1	6.7%	**Marijuana**	2	13.3%
			Benzodiazepines	1	6.7%
			Xylazine	1	6.7%

Notes:

*Percentages do not sum to 100% because most participants referenced multiple associated drugs.

[a] "Party" or "Rave Drugs" was a collective term used by multiple participants to describe MDMA/Molly/Ecstasy use – drugs they associated predominantly with electronic dance music festivals

[b] Two participants addressed the historical connection of the Chinese-American community with opium in the early 20th century, but did not necessarily think this association with opioids was as strong in the modern day. One participant, who had worked with a specific population of AAPI injection drug users in the West, described the common injection of 'goofball', a combination of heroin/opiates and methamphetamine.

[c] Methamphetamines mentioned in the context of 'goofball' (with opiates). See above.

[d] Opioids mentioned for drugs associated with harm reduction tended to be heroin or fentanyl.

[e] While injection drug use isn't a "type of drug", it was repeatedly mentioned as a mode of substance use

Through a series of questions, participants constructed a broad matrix of characterizations of who they believed that harm reduction targeted and served, and then reflected on how they themselves related to harm reduction, and how the field of harm reduction could better address their community.

The 'Them' of Harm Reduction: White, People Who Used Opioids, Injection Drug Users

"I don't think most people associate the AAPI community with opioid use or fentanyl use. [Opioid use is] seen largely, in the American eye, mostly as a rural white people problem now, which is why it's getting more attention."

- (Female, 18-25, Indian-American, West Region, Personal Experience)

There was an overwhelming association of harm reduction with opioid use and injection drug use, and the sense that these efforts seemed to be predominantly focused on white communities. It should be noted that there was not a strong recognition amongst most participants (especially those without professional experience) that there could be unintentional consumption and exposure to fentanyl found in other drugs other than opioids, including many drugs that they more strongly associated with AAPIs (i.e. "party drugs", stimulants). Only one participant referenced a contemporary association between AAPIs and intentional opiate and injection use *[SP #12]* due to the work she had done with a very specific AAPI population that injected 'goofball', a combination of opioids and methamphetamine, on the west coast.
When asked, participants' most common examples of harm reduction largely centered around these characteristics: mentioning naloxone, syringe services programs, and overdose prevention centers – all harm reduction strategies that they predominantly associated with opioid or injection drug use. One participant reflected that the focus of harm reduction right now seemed to be on overdoses, and that he didn't believe that AAPIs were identified as a population at risk of overdoses *[SP #8]*. This response is particularly interesting, because not only does it compliment the answers of many participants that they rarely heard of opioid use in AAPI populations, it suggests that there is not necessarily the common knowledge or association of AAPIs dying of drug-related overdose.

Participants referenced that this focus on white communities came at the cost of multiple minoritized communities. One participant said: *"I think it's because the opioid crisis has been so publicized, and so openly, by specifically white people. It's like become such a huge issue in America's mind – AKA, white people's mind. But it's been around for so long, and there are other substances that cause greater problems that aren't an immediate emergency. There's a lot of bias around that, and so there's no focus on non-white people who use drugs" [SP #2].* Another participants addressed how her harm reduction work for some minoritized clients was limited by the options for culturally responsive substance use support resources: *"I've learned to tap into – like, if I have clients who are from Native American backgrounds – and there's a program specifically for Black Americans, I'm going to tap [my patient] into that resource, because even though that program was meant for [other minorities] …there aren't enough other Native Americans in [major metropolitan city in New England] to create a program just for them. So you just kind of figure out a loophole, and just figure out how to get them into that program" [SP #1].* This participant addressed how this same lack of numbers, lack of representation, also impacted the development of AAPI specific programs.

Finally, participants referenced that even though the promise of harm reduction was broad, the current field of practice hasn't necessarily had the capacity to directly include everyone just yet: *"[I]f you just look at harm reduction as applying to everyone, then it's not that harm reduction doesn't address Asian American substance use needs, it's just that harm reduction as a movement hasn't expanded to the point where everyone feels like it applies to them, not just Asian Americans, but like people who use substances that aren't opioids" [SP #15].* Harm reduction was acknowledged by participants as something that was still being introduced, still being debated, and as something that faced numerous barriers towards being broadly accepted – by both AAPIs and non-AAPIs. However, this era also represents a window

of opportunity to address how to position both harm reduction organizations and AAPI communities to mutually embrace each other.

What Will It Take to Get 'Us' to Embrace Harm Reduction?

"I feel like there's almost this perception that Asian Americans don't need harm reduction practice, because there isn't as much overlap with what I see most commonly being done for harm reduction."

- (Female, 18-25, Chinese-American, Mid-Atlantic, Personal Experience)

Most participants expressed that it would likely be challenging to integrate harm reduction into the AAPI community – and vice versa. They reiterated many of the challenges expressed in Themes 1 and 2, but specifically expanded on lack of "problem recognition"[21] and drug exceptionalism as key barriers to address.

From 'Afterthought' to Inclusion: AAPIs in Harm Reduction

"I mean, because of the lack of Asian American [representation] in the field or in the clients, we're almost an afterthought. I do worry because of the lack of representation in clientele and workers, because people really like to be hush, hush about these things, there's going to be a missed opportunity to really help folks."

- (Female, 26-35, Filipino-American, Mid-Atlantic, Professional Experience)

Participants attributed the lack of problem recognition to both harm reduction organizations and AAPIs themselves. They also noted that this was also compounded by a lack of true understanding about what AAPIs felt and needed for practicing safer substance use or for addressing problematic use. When asked to describe how well they felt current harm reduction practice addressed AAPI substance use needs on a scale of 1-5, participants

answered on average a 2.07 (1 being not well at all, 3 being neutral, 5 being very well; Range: 1-3, Median: 2). However, participants were quick to clarify that this question was difficult because, how could they judge how well their needs were being met, if there was such hard time fully even assessing those needs in the first place? Nonetheless, they did see this as an area of opportunity that needed to be addressed, represented in their strong favorability of harm reduction, and general hope that these strategies could be more intentionally introduced to their communities.

One participant reflected on the perceived priorities of harm reduction organizations, and the representation of AAPIs within this work: *"I don't think people who interact with harm reduction do so through the lens of Asian American communities. … I mean, if you're entering harm reduction circles, it typically is not because you're in an Asian-American community" [SP #11].* Participants reported varying levels of perceived AAPI involvement in harm reduction, which does seem to correlate with geographic location. While some participants expressed having little to not AAPI colleagues in harm reduction or embraced harm reduction in their substance use related work, others noted that having AAPI colleagues and peers in harm reduction were a reason they felt compelled to get involved in this work. However, despite the number of AAPI colleagues, one participant shared that this might not necessarily change how AAPIs fare in the harm reduction field: *"I've tried to have this discourse [about harm reduction] with fellow Asian Americans, but they're like 'Well, that sounds hard, I'm not gonna dabble in that, that's not a field where I really think I can thrive' [SP #12].*

Additionally, participants shared that interactions that AAPIs did have with harm reduction didn't always feel "intentionally applied" *[SP #1]*, or were the result of integrating more harm reduction principles into "adjacent fields". Participant 12 elaborates: *"Asian Americans don't really go into harm reduction, but they go into adjacent fields, like focusing on Hepatitis C*

or tuberculosis – like public health initiatives that are not harm reduction, but are pretty close and dear to the community. Right, if you're looking at a positionality and harm reduction 'graph', substance use does effect Asian Americans, but there are other issues [to Asian Americans] that are more concerning right now" [SP #12]. The perceived lack of overlap between AAPI health and harm reduction was further emphasized by one participant, sharing that as she was considering her future career prospects she asked herself,"*[Was] I going to have to choose between doing addiction medicine, and serving Asian Americans?" [SP #5]*.

Drug Exceptionalism and 'All or Nothing' Moralization

"I think a lot of people are like, oh well, you know harm reduction doesn't apply to me because I don't inject drugs, but it's like, do you drink alcohol? Do you drink coffee? Do you smoke cigarettes? Do you like all of these things?...but doesn't mean that it doesn't apply to you or that you're absolved, or like you get to judge someone else and their use, just because your substance that you're using you can buy in a store."

- (Female, 26-35, Mixed Japanese-White, West Mountain Region, Personal and Professional)

Participants also addressed how attitudes towards the most commonly associated substances within the AAPI community likely also prevented them from seeking and embracing harm reduction. Notably, they referenced drug exceptionalism – a phenomenon of normalizing only certain kinds of substance use, sometimes at the cost of continuing to problematize others – and an 'all of nothing' mentality that many participants described as an abstinent-only approach to thinking about substance use.

Some participants discussed that the substances they saw most commonly associated with AAPIs like both likely more socially normalized (at least in specific settings) and more critically, were more likely legal. Alcohol and tobacco/nicotine use (of any form), were

referenced as commonly used substances within the AAPI community, and participants noted that some forms of problematic use (i.e. binge drinking, chain smoking) were more normalized than not. One participant pointed out that these drugs, both legal, were perceived to cause less harm than illicit drugs, even if she believes – and had data – that alcohol was one of the most harmful drugs out there *[SP #2]*. Participant 12 echoed this, sharing that she found that there was a sense that alcohol was "*not really considered a substance"* by AAPIs, even though she primarily worked with clients experiencing alcohol withdrawal. Multiple participants had addressed the normalization of alcohol – seen in the exchanging of alcohol (and cigarettes) as gifts [SP #13] and even in family social settings, with one participant explaining that alcohol seemed very normalized in his community, with great social pressure even upon his parents to participate *[SP #9]*. However, the same participant also clarified that while alcohol consumption – and sometimes heavy consumption – was normalized across generations in his community, any other substance use that was "harder" than that was not tolerated, describing a community response akin to: *"You're going to end up in the streets" [SP #9].* Tobacco and nicotine use was also referenced as a more 'normalized' and accepted substance, with one participant musing that she had *"forgot[ten] that tobacco was considered substance use" [SP #3]*. Another participant addressed that there was considerable overlap in the association of tobacco with both AAPI communities and harm reduction priorities (i.e. in the context of using e-cigarettes as a less harmful alternative to combustible cigarettes), but said there likely was a lack of problem recognition that this was an area of concern: *"I don't think Asian Americans see it as a harm reduction strategy" [SP #14]*.

Participants seemed to express that not only were some substances more socially accepted, but that this normalization also may come with the perception that there are less harms and risks with use, and therefore, was not in need of a targeted effort like harm reduction. After all, based on participant responses, harm reduction was seen primarily for drugs they

typically referred to as “harder” or were illicit, or for drug use that they saw as more problematic and addictive. Their responses mostly fixated on opioid use, something they saw heavily represented in the media as dangerous, addictive, and associated with adverse consequences like overdose. However, 6 out of 15 participants referenced that currently illicit party drugs like MDMA were commonly associated with AAPIs, but none of them said these substances were commonly associated with harm reduction, suggesting a perceived area of missed opportunity by harm reduction. This could also possibly a situation of drug exceptionalism, where the recreational aspect of MDMA use (commonly associated with festivals and events as opposed to therapeutic use) potentially obscured participants association of it with harm reduction priorities. MDMA use was specifically associated by participants with electronic dance music (EDM) and rave festivals, a social scene that many participants referenced were predominantly associated with young AAPIs, especially east Asians. Addressing this population and MDMA use was suggested as a possible start to more rigorously introduce harm reduction to younger AAPIs, with some participants sharing that there was already a broader culture within the EDM and rave scene of promoting safe, recreational use. However, a few participants discussed that they weren’t always as careful with harm reduction techniques like drug checking when using party drugs, but agreeing that they could integrate this better into their own routine.

Finally, participants also expressed the ‘all or nothing’ mentality towards drugs that remains a persistent challenge to harm reduction everywhere: the idea that no amount of substance use is safe or should be tolerated nor encouraged. Participants expressed uncertainty that the AAPI community, particularly older generations, would be willing to embrace harm reduction’s resistance to abstinent-only thinking around substance use. One participant shared: *“I feel like, there’s a general sense [among] Asian Americans with substance use, that it’s black or white, there’s kind of no gray area in general” [SP #13]*. One participant shared an anecdote of how a sibling’s first experience using marijuana had gone poorly, resulting in her

sibling getting so high that they had no choice but to call their parents to get them. The participant continues that when she was speaking with her father on this, he said expressed that: *"[Your sibling] is so lost, they went off and did drugs"*, and when the participant asked her father what drugs their sibling had done, she said that he replied: *"I don't know, and it doesn't make a difference to me" [SP #10].* The participant shared that she felt that her father's response indicated zero tolerance, and did not differentiate between the acceptability of any substance, regardless of legality or normalization. This was shared by another participant who recalled his mother not being able to comprehend the legalization of marijuana *[SP #9]*. Finally, when asked about her own stance towards harm reduction, she reported being favorable, but admitted hesitancy that she was still grappling with the ingrained biases that left her not fully comfortable that harm reduction strategies didn't necessarily emphasize eventual abstinence *[SP #10]*.

Discussion

"They're like, 'Well, it's not happened to me, it's not happening to the people I know. Like this is not my problem'. Well, I won't say [it's not an issue of], if, but ***when*** *[this problem] gets bad, when it gets noticeable."*

- (Female, 26-35, Filipino-American, Mid-Atlantic, Professional Experience)

These findings emphasize fundamental tensions of problem recognition, both by harm reduction organizations and by the AAPI community. There is no applying a solution to a problem, if the problems are not seen for what it could be. The findings are broadly in line with previous research that discussed the complex impact that MMM had on understanding Asian American health issues, being doubly obscured by those rosy stereotypes and by data that either didn't represent them, or that they felt disincentivized further attention. In the midst of a major shift within drug policy and public health, it is critical that harm reduction feels accessibly

and applied – intentionally – to all. AAPIs represent the fastest growing minority in the U.S., and with rising rates of use (and overdose), failure to adequately assess and address their substance use needs will represent a missed opportunity that threatens to increase disparities. Many of the issues that participants expressed are not necessarily specific to AAPIs, but this is the first study to assess how AAPIs saw these issues directly relating to their ability to relate to and integrate harm reduction into their personal routines and into their community.

The impact of problem recognition resonates not just at the community level, but at the individual level. In the middle of my conversation with Study Participant #4 about whether or not she had used harm reduction strategies herself, she admitted that she could be more careful, and realized she might have been taken her safety for granted. She shares: "*I personally think I could be more careful thinking hard about what I'm actually getting. A lot of the time, when I just get [substances] from someone, I just assume that they've done their due diligence and I can trust them. But if I really think about it, like where are they getting it from? Do I actually know [female AAPI friend]'s drug dealer? Like no, like he might not be the most trustworthy person." [SP #4]*. It is here where the participant immediately begins to questions her own implicit trust: *"Just because he [the drug dealer] is Asian, it doesn't mean he's doing what he should be doing right. And that's like interesting, because it brings in the question of stigma, because what if her drug dealer wasn't Asian? Would I have been more cautious in terms of testing my drugs? I don't know" [SP #4].* This anecdote illustrated multiple concepts – not just the least that she (and several other participants) realized that she could integrate more intentional harm reduction strategies into their substance use, but the implication that some of the perceived harms associated with her substance use might mediated by the fact that she sourced her substances from within an network of AAPI peers and specifically, from an AAPI-identified drug dealer. It ties together not only numerous themes previously iterated around stigma and MMM,

but also the implied lack of problem recognition of substance use related harms from the AAPI community, specifically because they were a part of the AAPI community.

This anecdote helps illustrate the necessity of addressing the accessibility and relatability of harm reduction for a wider audience. It's in line with the critiques raised that harm reduction approaches seemed largely only advocated for in response to white communities' experiences with substance use issues – and that though harm reduction are strategies that can be used by anyone, the field still struggles with being broadly accepted. The fact that participants were overwhelmingly supportive, but still felt distanced from harm reduction suggests that it is more than just an issue with whether or not people agree with harm reduction, but whether or not they believe they or their community members are included. The perception that harm reduction was addressing issues specifically associated with white people may have expediated its uptake and acceptance into policy and practice, but efforts to expand and clearly communicate *who else* harm reduction for could likely have broad benefits for multiple marginalized and minoritized communities.

Future research is still needed to address how best to develop the messaging and engagement tactics needed for harm reduction organizations to reach AAPIs *and* for AAPI communities to address substance use issues within the community. As this study did not focus on having participants answer what exactly AAPI substance use needs were, more research with people with personal past and ongoing substance use should be conducted. More specific questioning could be developed around how AAPIs managed their own substance use, if and how they integrated harm reduction, and whether or not they recognized certain behaviors as practicing harm reduction. Additional research should also seek to bring in a much larger, and representative study population, to address the perspectives of more AAPIs from different backgrounds.

Limitations

There are several limitations to this study. Due to a lack of funding, the investigator was unable to offer compensation for what was a rather long interview, likely disincentivizing many potential participants and also likely precluding AAPIs with more marginalized experiences. The study could also be conducted in English due to the lack of translation services, which also excluded AAPIs with limited or no English proficiency. Of particular note, while several participants reported ongoing recreational substance use, participants who referred to problematic use or struggles with addiction, tended to refer to these experiences as past experiences rather than current ongoing use. It is critical that AAPIs who are experiencing active substance use issues are better represented in future research.

Additionally, while this study is considered more of a pilot study into these issues, the same concern of how best to represent the vast diversity of the AAPI community still applies. While there was some degree of diversity in ethnic background, participants were overwhelmingly younger, from the east coast, and had all obtained at least a Bachelor's degree. There are also multiple AAPI communities either missing or were underrepresented: namely South East Asians and Pacific Islanders. Future research could focus on how to better recruit populations that were missing or underrepresented from this study: older generations, first generation immigrants, South East Asians, Pacific Islanders, AAPIs from the Midwest and from the South, more mixed-AAPIS, more men, etc.

Conclusion:

AAPIs, an incredibly diverse community, remain an underrepresented and underserved community in current harm reduction practice. Numerous challenges stand in the way towards better understanding and assessing substance use needs within the community, including

model minority myth and lack of representative data. However, this study illuminates some of the deeper fundamental tensions inherent with how substance use relates to being not just a minoritized racial community in the U.S., but a model minority. Efforts to better integrate safer substance use practices into AAPI communities will need to contend with the ways AAPIs see substance use as a contributing factor to their social positionality, the double erasure of problems or potential risks of substance use within their community, and the perception that harm reduction doesn't apply include them.

Appendices:

Appendix 1: Interview Question Guide

Thank you for agreeing to participate in this study. The purpose of this study is to learn more about the experiences and perceptions of Asian Americans towards substance use, and how this impacts perceived relevance of current harm reduction practice for the community. Before we proceed, I would like to remind you that this interview is recorded, for the purposes of transcription and subsequent analysis. The recording will be destroyed once the transcription is complete. Your name will not be recorded, however the following identifiers will be: age, gender, racial/ethnic identity, current U.S. State of residence, and a brief description of the personal and/or professional experience you have related to substance use.

You have the right to not answer questions, the right to ask for breaks during the interview, and you have the right to stop and withdraw from the study at any time without penalty. Before we continue, do you have any questions for me?

Do you consent to proceeding with this recorded interview?

Thank you.

I will start by asking you some questions about the representation of AAPI substance use.

1. How would you describe the general perception or attitude towards substance use within the Asian American community?
    a. What do you think influences this perception or attitude?
    b. Are there certain demographics (i.e. ethnic group, gender, age, etc.) of the Asian-American community that you see more commonly associated with substance use?
    c. What substances do you typically see most associated with the AAPI community?
2. Stigma against substance use and people who use them is pervasive in our society. Do you see ways in which this manifests specifically within the Asian American community?
    a. Do you have an example of stigma that you have experienced or witnessed around substance use that you would be willing to share? This can be an example perpetuated by the AAPI community, or against the AAPI community by those outside of it.
3. Harm reduction is a very broad concept. Can you please describe what you know or have heard about harm reduction in your own words?
    a. Have you ever practiced, used, or engaged with harm reduction practice? If so, how?
    b. What substances do you typically see most associated with harm reduction?

    c. Is there a gap or similarities between what substances you see associated with AAPI communities and associated with harm reduction? Do you think this impacts how AAPIs view harm reduction practice as being relevant for their community?

4. How do you believe harm reduction is perceived (if at all) or would be perceived if introduced within the AAPI community?
    a. On a scale of 1-5, with 5 being very well, 3 being neutral, and 1 being very poorly, how well do you feel that current harm reduction practice addresses Asian American substance use needs?
    b. Please elaborate on your answer.
    c. Given our conversation so far, how do you believe harm reduction could better address Asian American substance use needs?

5. Thank you for this conversation. I have one final question to wrap up our discussion. On a scale of 1-5, with 5 being highly favorable, 3 being neutral, and 1 being highly unfavorable, how would you describe your position on harm reduction?
    a. Can you elaborate further on your answer?

6. Do you have any final thoughts that we have not touched upon during this conversation?

Appendix 2:

Participant Number	Age Range	Gender	Ethnic Identity	Education	US Region	Personal/Professional
1	36-45	Female	Korean-American	Master's	East: New England	Personal experience, Professional experience
2	26-35	Female	Taiwanese-American	Professional or Doctorate Degree	East: New England	Professional experience
3	18-25	Female	Indian-American	Bachelor's	East: Mid-Atlantic	Personal experience, Professional experience
4	18-25	Female	Chinese-American	Bachelor's	East: Mid-Atlantic	Personal experience
5	26-35	Female	Korean-American	Bachelor's	East: New England	Professional experience
6	18-25	Female	Indian-American	Bachelor's	East: New England	Professional experience
7	26-35	Male	Filipino-American	Bachelor's	West: Pacific	Personal experience
8	26-35	Male	Korean-American	Bachelor's	East: Mid-Atlantic	Professional experience
9	26-35	Male	Lao-American	Bachelor's	East: Mid-Atlantic	Personal experience, Professional experience
10	18-25	Female	Indian-American	Bachelor's	West: Pacific	Personal experience
11	18-25	Female	Mixed Filipino and White	Bachelor's	Midwest: East North Central	Personal experience
12	26-35	Female	Filipino-American	Master's	East: Mid-Atlantic	Professional experience
13	26-35	Male	Filipino-American	Professional or Doctorate Degree	East: New England	Professional experience
14	26-35	Female	Filipino-American	Professional or Doctorate Degree	East: New England	Professional experience
15	26-35	Female	Mixed Japanese and White	Bachelor's	West: Mountain	Personal experience, Professional experience

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