

Testimony by Dr. Marielle A. Reataza, MD, MS
Ways and Means Committee
Hearing on “Substance Use, Suicide Risk, and the American Health System”
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Introduction

Chair Neal, Ranking Member Brady, and Members of the Ways and Means Committee,

It is an honor to testify in front of you today to speak on topics which are important to me and the communities I am part of and serve. My name is Dr. Marielle Reataza, and I am the Executive Director of the National Asian Pacific American Families Against Substance Abuse (NAPAFASA), a nonprofit organization which has served Asian American, Native Hawaiian, and Pacific Islander communities (AAPIs) on matters involving behavioral health, substance use disorder, problem gambling, advocacy for increased language access, and access to healthcare services for over 30 years. Throughout our decades’ worth of service, we have worked closely with AAPI communities on the ground, at schools, at faith-based organizations, community events, in partnership with clinical providers, and on public health and policy measures that range from local to nationwide initiatives. My academic background has been dedicated to public education, healthcare delivery and administration, interdisciplinary research, and health policy and law. Additionally, I have fourteen years of experience working closely with communities, having been a public high school teacher, medical doctor, researcher, community advocate, and working in public and behavioral health. Currently, I serve on the SAMHSA Steering Committee for Harm Reduction. As an Asian American, and more specifically, a Filipina American immigrant, I consider my body of work to be in service of the communities that raised me. I thank the committee for recognizing the importance of addressing behavioral health, including substance use and risk of suicide, and the systems in place that support the health and wellness of all Americans.

I commend the Committee for recognizing and seeking to mitigate the ongoing mental health crisis, one that has surely been exacerbated by the devastating impacts of COVID-19. COVID-19 has led to the death of over 944,510 Americans¹, in addition to a growing concern around the long-term and sometimes disabling effects of COVID². Americans have also undergone financial hardship, loss of employment or underemployment, housing instability, inadequate access to healthcare³, and the reason we are here today—the mental and emotional tolls as a consequence of the aforementioned, in addition to the long-term isolation from our families, friends, and community support networks.

¹ Centers for Disease Control and Prevention. COVID Data Tracker. Atlanta, GA: US Department of Health and Human Services, CDC; 2022, February 26. <https://covid.cdc.gov/covid-data-tracker>.

² Mayo Clinic. COVID-19 (coronavirus): Long-term effects. 2022, February 26. <https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-long-term-effects/art-20490351>.

³ Bundorf MK, Gupta S, Kim C. Trends in US Health Insurance Coverage During the COVID-19 Pandemic. JAMA Health Forum. 2021;2(9):e212487. doi:10.1001/jamahealthforum.2021.2487.

As the Committee discussed and heard at the February 2nd hearing, there are several factors contributing to our nation's ongoing mental health crisis. Across communities, reports show increased rates of substance use disorder, overdose-related deaths, domestic violence, and suicide. Concurrently, there is also demand for mental and behavioral health services rising faster than we can deliver it⁴. As reported by HRSA in 2015, this rising demand was already anticipated well before COVID-19. I am deeply troubled by our inability to meet these needs as they are guaranteed to require more resources, even as we recover in the years to come.

Mental health in AAPI communities: the stigma and barriers to care

In my work with NAPAFA, our community partners, and as an Asian American myself, I have particular concern over the health and wellness of AAPI communities. First, it is worth noting that broadly, the term "AAPI" represents people from approximately 50 ethnic groups and over 100 different spoken languages⁵. While we share many common, beautiful values, each of these groups represents different traditions and histories. This poses significant challenges when trying to understand AAPIs. East Asian history and culture vary greatly from those of Southeast Asians, which also vary from South Asians as well as Middle East Asians. Native Hawaiians and Pacific Islanders also represent several and diverse ethnic groups and languages and are commonly underrepresented in AAPI data. Some of us are fair-skinned, while some of us are brown or darker-skinned, and the diversity in our cultures is also reflected by the diversity of our outward presentations. Unfortunately, much of what has been portrayed about AAPIs strongly underrepresents the diversity of our communities, which can lead to gross misunderstandings about our experiences and needs. These misunderstandings have resulted in long-term neglect of our most marginalized and often vulnerable community members, including a lack of culturally and linguistically appropriate mental and behavioral health services. In this regard, AAPIs are less likely to seek mental and behavioral health services altogether. This has created the illusion that AAPIs do not need these critical services.

While there is no question that the term AAPI itself broadly represents an extremely diverse group, a value that we tend to share involves a strong sense of collectivism and preference for community over individualism. Many of us grow up with or living near our extended families, often choosing to live in multigenerational households. Growing up around so much family, whether by blood or by association, enriches our support networks and our sense of interdependence. This is normal for us. In our communities, there is a general desire to share—our burdens but also our resources, and it is this sharing of ups and downs that makes us so tightly-knit.

However, no family or community is perfect, and it is important that I not romanticize the nature of our closeness. Because of the tight-knit nature of our communities, there can be reluctance to openly share matters deemed shameful or problematic by the family and/or community, including concerns regarding mental illness, problem gambling^{6,7}, and substance use disorder.

⁴ Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation. 2015. National Projections of Supply and Demand for Behavioral Health Practitioners: 2013-2025. Rockville, Maryland.

⁵ National Alliance on Mental Illness. Asian American and Pacific Islander. 2022, February 26. <https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Asian-American-and-Pacific-Islander>.

⁶ Constante A. Gambling addiction can be silent struggle for Asian Americans, with few culturally sensitive solutions. NBC News. Published February 22, 2021. <https://www.nbcnews.com/news/asian-america/gambling-addiction-can-be-silent-struggle-asian-americans-few-culturally-n1257070>.

⁷ Chan AK, Zane N, Wong GM, Song AV. Personal gambling expectancies among Asian American and White American college students. *J Gambl Stud*. 2015;31(1):33-57. doi:10.1007/s10899-013-9397-2.

Additionally, in some communities, there is much pressure applied to youth to succeed, and this success is considered one for the family and often the community altogether. Consequently, there is also much perceived pressure not to “fail,” generating added fear in sharing matters that might ostracize them from the larger body of community. This fear of openly discussing failures can cause a great deal of distress for individuals and families dealing with issues regarding mental and behavioral health, only exacerbating isolation for issues that require a strong social support network. At times, individuals seeking care must also seek services in private, which can be challenging since we often reside in multigenerational households, even when telehealth is available. Additionally, telehealth is not always feasible for members of our communities, especially if language access and technology are barriers. As a result, individuals and families needing mental and behavioral health services often do not seek services.

Another reason why individuals and families do not seek help for these matters is due to the lack of culturally responsive services. Navigating overly complex and confusing systems of insurance and providers is already difficult for most, but finding a system and provider who can grasp the nuances of AAPI traditions and practices is essential for behavioral health models to succeed in AAPI communities. For instance, finding a therapist who is fluent in one of the many AAPI languages is essential for therapy to be accessible. An estimated 34% have limited English proficiency⁸. Additionally, AAPI ethnic groups sometimes have their own cultural practices for managing issues; thus, how we simply talk about issues can be further complicated by language and culture. Furthermore, while we in the US often call modalities like these “alternative medicine,” these are practices rooted in generations of community and points of cultural pride. This perception that our practices and medicines are “othered” or worse, obsolete, can be damaging to some communities, further adding reluctance to seeking care and generating a sense of mistrust outside of the community.

An important barrier to seeking care for many also involves navigating the healthcare system. Mental and behavioral health services are often expensive, rendering them inaccessible, especially when it is not feasible to trial different providers before benefits run out, when insurance is available. A significant proportion of AAPIs are born outside of the US¹¹. With that in mind, something that is not openly discussed by our communities is that there is a significant proportion of us who are undocumented immigrants. Understandably, there is much fear in disclosing this status, but as someone who was formerly an undocumented immigrant myself, I understand what it feels like to carry the day-to-day weight of knowing that you are not welcome and do not belong, sometimes in a country that you did not choose to live, especially when opportunities are limited and returning to your country of origin is not an option.

Lastly, there are many in our communities who have undergone unspeakable traumas, whether in this generation or in the generations of our past. Some of us come from countries who have withstood centuries of colonialism and cultural erasure. Some of us come from countries who have lived through several iterations of authoritarian rule, war, exploitation, and poverty. This further complicates the nature of our willingness to discuss mental and behavioral health issues, especially outside of our communities. Having lived in Garden Grove near Little Saigon¹² for over a decade, many of my friends’ families came from Vietnam after the war. Some of them

⁸ AAPI Data. Infographic—percentage of Asian Americans with limited English proficiency (2017). <https://aapidata.com/infographic-limited-english-2-2/>.

¹¹ New American Economy. Combating the AAPI perpetual foreigner stereotype. Published 2021, May 20. <https://research.newamericaneconomy.org/report/aapi-perpetual-foreigner-stereotype/>.

¹² Kim CK. Little Saigon—A cultural heritage site. Preserve Orange County. Published February 13, 2020. <https://www.preserveorangecounty.org/tracts/2020/2/13/little-saigon-conservation-of-a-cultural-community>.

came with their families to flee the Khmer Rouge¹³. Some had fled the Secret War in Laos¹⁴, and such is part of the story of Suni Lee, a Hmong American and US Olympic champion. These histories, while occurring overseas, do not even involve the consequences of anti-Asian legislation and Japanese internment camps occurring here on soil which I am proud to call home. The Philippines, my country of origin, was only granted its independence from the US in 1946, despite having been colonized by Spain for over 300 years. I share these stories as just a few of many, in recognition of our diverse, complex pasts in hopes that they will shed some light on better paths to healing ahead. According to SAMHSA, AAPIs demonstrate the lowest help-seeking rate of any ethnic or racial group¹⁵.

The tolls of the COVID syndemic on AAPI communities

Many have called for the COVID-19 pandemic to be redefined as a syndemic^{16,17}, a model which better recognizes the interactions between the biological, socioeconomic, and environmental factors that worsen health outcomes. The data clearly reveal that COVID-19 has disproportionately impacted communities. For instance, a community-led team of researchers in partnership with the NHPI COVID-19 Data Policy Lab at the UCLA Center for Health Policy Research found that Native Hawaiians and Pacific Islanders experienced the highest per capita death rate in the US, which have been attributed to health and socioeconomic inequities that existed prior to COVID-19.¹⁸ Notably, many Asian Americans, despite living in cities such as San Francisco which boast a robust Asian American community, have received imprecise or no information in their native languages with respect to testing, safety, housing, and critical care services¹⁹. Additionally, while Filipinos and Filipino Americans make up only 4% of registered nurses in the US, they make up nearly one-third of all COVID-related deaths among registered nurses.²⁰ The syndemic has also resulted in a significant rise of anti-Asian sentiment and hate crimes. Between March 19, 2020 and September 30, 2021, 10,370 hate incidents against AAPIs were reported to Stop AAPI hate,²¹ with AAPI women and girls persisting as prime targets of hate and discrimination.²² These hate crimes range from verbal harassment to physical violence and death. In August 2020, local news circulated a video of a man harassing Hong Lee, an Asian American woman, in broad daylight at a restaurant just walking distance from my apartment and

¹³ Quackenbush C. 40 Years After the Fall of the Khmer Rouge, Cambodia Still Grapples With Pol Pot's Brutal Legacy. Time. Published January 7, 2019. <https://time.com/5486460/pol-pot-cambodia-1979/>.

¹⁴ Public Broadcasting Service. The Hmong and the Secret War: The Hmong American Story. Published November 19, 2017. <https://www.pbs.org/video/the-hmong-and-the-secret-war-zwwpgu/>.

¹⁵ SAMHSA. 2019 NSDUH Data Tables. Published 2020, September 11. <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

¹⁶ Horton R. Offline: COVID-19 is not a pandemic. Lancet; 396(10255): P874, September 26, 2020. [https://doi.org/10.1016/S0140-6736\(20\)32000-6](https://doi.org/10.1016/S0140-6736(20)32000-6).

¹⁷ Asian Pacific Partners for Empowerment, Advocacy and Leadership. The syndemic of COVID, racism and mental health: Implications for smoking among Asian Americans. Published May 5, 2021. <https://youtu.be/LAy8td8KFBg>.

¹⁸ Corina S. Penaia et al. "Disparities in Native Hawaiian and Pacific Islander COVID-19 Mortality: A Community-Driven Data Response", American Journal of Public Health 111, no. S2 (July 1, 2021): pp. S49-S52.

¹⁹ Marco della Cava. Asian Americans in San Francisco are dying at alarming rates from COVID-19: Racism is to blame. USA Today. Published 2020, October 18. <https://www.usatoday.com/in-depth/news/nation/2020/10/18/coronavirus-asian-americans-racism-death-rates-san-francisco/5799617002/>.

²⁰ NPR. Filipino American health workers reflect on trauma and healing on COVID's front lines. Published 2021, November 9. <https://www.npr.org/sections/health-shots/2021/11/09/1052062334/covid-filipino-american-health-workers-burnout>.

²¹ Stop AAPI Hate. Stop AAPI Hate National Report: 3/19/20 to 9/30/21. Published 2021, November 18. <https://stopaapihate.org/wp-content/uploads/2021/11/21-SAH-NationalReport2-v2.pdf>.

²² Pillai D et al. The Rising Tide of Violence and Discrimination Against Asian American and Pacific Islander Women and Girls. Published 2021, May 20. https://stopaapihate.org/wp-content/uploads/2021/05/Stop-AAPI-Hate_NAPAWF_Whitepaper.pdf.

one that I had frequented regularly²³. Already anxious from the proximity of this incident and fearful of walking outside alone, I moved several months later after I was harassed by a neighbor at my door. Unfortunately, moving is not an option for many.

Given the emotional and community tolls of losing large proportions of our interdependent families and communities, combined with the fear of death and AAPI-directed violence, I have great reason for concern around the mental health and wellness of our communities. One in five Asian Americans experiencing racism have been found to display psychological and emotional harm caused by racism, showing heightened symptoms of depression, anxiety, stress, including physical symptoms. The experience of racism during the syndemic has also been found to have a strong association with post-traumatic stress disorder²⁴.

Without appropriate and accessible care, prevalence rates of substance use disorder, accidental overdose-related deaths, and suicide rates have risen in AAPI communities. Certain groups among AAPIs are also more likely to struggle with tobacco use disorder, with ongoing use contributing to deaths related to lung cancer, pancreatic cancer²⁵ and cardiovascular disease, with cancer, heart disease, and stroke being the leading causes of mortality among AAPIs. While AAPIs have generally been seen as low-risk for alcohol use disorder, data suggest that due to false perceptions around the “model minority” myth, alcohol use disorder is also likely underreported²⁶. Some localities have also seen a 196.1% increase of accidental overdose-related deaths among Asians during the first five months of the syndemic²⁷. Lastly, in 2018, the CDC already reported that suicide is the leading cause of death among Asian American young adults age 15-24, despite suicide being the tenth leading cause of death in the US²⁸. While our understanding of these data is still developing over the course of the syndemic, knowing the reluctance that AAPI communities already demonstrate in seeking care pertaining mental and behavioral health, combined with the lack disaggregated data among AAPIs, I have much reason to believe that these cases have been chronically underreported and require much more investigation to be well understood.

Recommendation 1: Increase capacity for community-driven and culturally-responsive mental and behavioral health services, including improved language access

Having been invited to speak today, I am grateful for the chance to advocate for the wellbeing of AAPI communities. One way in which this can be improved is by increasing capacity for community-driven and culturally responsive services. Doing so would address a number of issues that contribute to our communities’ reluctance to seek mental and behavioral health

²³ Kareen Wynter. Video shows man hurling racial insults at Asian woman in Central L.A. restaurant. KTLA News. Published 2020, August 16. <https://ktla.com/news/local-news/video-shows-man-hurling-racist-insults-at-asian-woman-in-central-l-a-restaurant/>.

²⁴ Saw A et al. Stop AAPI Hate Mental Health Report. Published 2021, May 17. <https://stopaapihate.org/wp-content/uploads/2021/05/Stop-AAPI-Hate-Mental-Health-Report-210527.pdf>.

²⁵ Gad, Mohamed M et al. “Temporal trends of incidence and mortality in Asian-Americans with pancreatic adenocarcinoma: an epidemiological study.” *Annals of gastroenterology* vol. 33,2 (2020): 210-218. doi:10.20524/aog.2020.0450.

²⁶ Iwamoto, Derek Kenji et al. “Under-Researched Demographics: Heavy Episodic Drinking and Alcohol-Related Problems Among Asian Americans.” *Alcohol research : current reviews* vol. 38,1 (2016): 17-25.

²⁷ Substance Abuse Prevention and Control. Data report: Accidental drug overdose deaths in Los Angeles County during the COVID-19 pandemic. January 2021. <http://publichealth.lacounty.gov/sapc/MDU/SpecialReport/AccidentalDrugOverdoseReport.pdf>.

²⁸ CDC. Cause of death. Published 2018, December 31. https://www.cdc.gov/nchs/data/dvs/lcwk/lcwk1_hr_2017-a.pdf.

services. Some of the studies I already referenced earlier, e.g., those involved with Stop AAPI Hate and the NHPI COVID-19 Data Policy Lab, were only possible because they were done by and in partnership with communities and community leaders. Not only does increasing capacity for this type of outreach serve to address stigma and the fear of being ostracized, but these avenues also allow for better data collection methods, thereby allowing for improved understanding of the needs of our communities that we might otherwise be reluctant to share or discuss.

Additionally, I urge the Committee to look into ways to increase the education and training of AAPI mental and behavioral health providers, as well as developing capacity for cultural sensitivity and responsiveness for providers in general. Language access continues to be barriers to our care, and I am hopeful that the Committee will address this gap.

Recommendation 2: Broadly implement data disaggregation in data collection and reporting efforts

As with my first recommendation, I urge the Committee to build capacity for improved data collection methodology. Some of this can be accomplished through broadly enforced data disaggregation collection and reporting. As discussed previously, certain groups within the broader AAPI community are consistently neglected in data collection efforts; consequently, there is often underreporting and poor understanding of what issues are actually present and for which reasons. Because AAPIs also represent diverse socioeconomic statuses, I recommend that data also be stratified for income, education, immigration, language, gender and sexuality, and housing, including inquiry around multigenerational households.

Recommendation 3: Implement harm reduction principles and strategies to mitigate risk and deaths in all communities

Harm reduction is a combination of modalities that ultimately aim to do two things—reduce harm for individuals and their communities and reduce risk of death, whether accidental or intentional. Reducing harm can look like a number of things, including providing access to peer-driven support networks, providing capacity for robust community support through education, needle exchange programs, safe smoking kits, pill take-back programs, medication assisted treatment, and supervised safe consumption services. Reducing harm also involves practices that prioritize the restoration of communities, appropriate and affordable access to healthy foods such as fresh fruits and vegetables, and stable housing. These methods have been shown to reduce harm related to substance use disorder, as well as reduce transmission of disease. For some people, abstinence is part of harm reduction, and I would agree. However, abstaining from substance use altogether is not always possible, especially when there are very few options available, removing the inciting factors is not feasible, and when communities such as AAPIs are already reluctant to seek help. Unfortunately, whether a drug is considered “illegal” or “illicit,” substance use disorder and overdose-related deaths have worsened over the course of the syndemic.

I understand that implementing harm reduction principles and practices is challenging for many, due to funding constraints, lack of access to available programs, and fundamental differences in ideology. Ideally, nobody would have to resort to behaviors that are self-destructive and harrowing for severely impacted families and communities. However, substance use and behavioral health altogether are such complex processes that require both intimacy and focus on structures and systems that contribute to substance use disorder and overdose-related deaths.

Harm reduction aims to address these very intimate processes. Harm reduction involves evidence-based and community-vetted methods that prioritize overall wellness and reduction of disease transmission in ways that can sometimes only be addressed through individualized and more intimate methods of care.

Conclusion

With mental and behavioral health providers already in demand greater than we can fill the need, I worry about the long-term impact of the syndemic on our communities. I acknowledge the challenge in speaking about such a large and diverse group, and I insist to the Committee that issues regarding mental and behavioral health in Asian American, Native Hawaiian, and Pacific Islander communities require much more nuance and further investigation. Ultimately, I have come to the understanding that challenges surrounding mental health are much less exceptional and are more likely to be consequences of everyday, common circumstance. We have observed these truths during the COVID-19 syndemic, whether or not they make it to a published study or are even openly discussed.

I thank the Committee for inviting me to testify. I am grateful for this opportunity to share the experiences of Asian Americans, Native Hawaiians, and Pacific Islanders regarding mental and behavioral health, substance use, suicide risk, and our interactions with the American health system. I urge the Committee to consider my recommendations carefully.