Grant Proposal

Breaking Barriers: Strengthening Provider Understanding of API Cultural History to Reduce Shame and Fear

Elaina Falefitu Evans

University of Washington Tacoma

TSOCW 5323: Integrative Practice II

Dr. Anindita Bhattacharya, MSW, PhD

02/27/2026

Breaking Barriers: Strengthening Provider Understanding of API Cultural History to Reduce Shame and Fear

Short Overview

API ROOTS: Recognizing Origins, Overcoming Trauma, and Strengthening Support, formally known as *API ROOTS,* is a culturally competent and responsive training program that is designed to strengthen and increase the confidence and effectiveness of providers' ability to provide adequate and culturally appropriate services to the Asian Pacific Islander (API) populations. Many API individuals face stigma, cultural barriers, and have limited access to providers that have the appropriate skills and knowledge that is needed to address the mental health factors that API individuals bring to the table. *API ROOTS* will deliver a 12-week training curriculum that will include teaching cultural values, intergenerational trauma, familial dynamics, and community-informed practices that will improve provider cultural competency as shown by self-assessment before and after the training has been completed. This 12-week training curriculum will utilize two measurement tool that have been validated, Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) and Healthcare Provider Cultural Competence Instrument (HPCCI). These measurement tools will be supplemented with API specific statements that are not already discussed to address relevancy to API clients. The goal of *API ROOTS* is to improve the confidence, comfortability, cultural knowledge, improve attitudes, and provide culturally competent care that can ultimately increase help-seeking behaviors and help the Asian Pacific Islander population feel better supported.

Problem Description & Analysis

What is the Problem?

The need for culturally relevant services is called upon to increase the accessibility and utilization rates of mental health services by Asian American Pacific Islanders by reducing stigma, shame, mistrust, and negative perceptions of mental health (Cutrer-Parraga et al., 2024; Fa'alogo-Lilo & Cartwright, 2021; Garrett et al., 2025; Kwan et al., 2020). These are commonly experienced by Asian American Pacific Islanders that are either hesitant or seeking out mental health resources and to guide providers to more culturally accurate and relevant therapeutic approaches (Fa'alogo-Lilo & Cartwright, 2021). Past literature suggests that the knowledge and awareness surrounding mental health stigma and cultural barriers experienced by Asian American Pacific Islanders have been fructifying (Kwan et al., 2020) as the AAPI population continues to grow in the United States. Additionally, racial trauma that is experienced and identified creates conflict within the AAPI youth, which further limits access to care (Shalingram et al., 2022). Although this paper is generally focusing on information coming from the United States, this is a social issue that is happening nationally around the world. A significant amount of research that has been done stems from studies conducted in the U.S. Although there is growing research on Asians and Asian American mental health in countries outside of the U.S., unfortunately this is not always the case for Pacific Islanders. When studies are done on the PI population, statistics generally come from the Pacific Islanders that are residing in the U.S. For the sake of this paper, the scope will largely be focusing on AAPI in the United States.

Knowledge Gaps in Research & Barriers

When considering disparities based on AAPI mental health, there is limited research on AAPI and mental health. Much of literature focuses on Asian Americans while Pacific Islanders are not heavily researched and discussed. Secondly, the aggregation of data and lumping Asian Americans with Pacific Islanders despite the various and differing cultures, values, and religion is another disparity. Many lump Asians with Pacific Islanders even though there are significant arguments as to why it is crucial to disaggregate AAPI folks (Cutrer-Parraga et al., 2024). To illustrate, Kwan et al. (2020) had touched on the mental health services and why it is important but the study itself, was not specific to the subgroups of Pacific Islanders. The gap within the preponderous amount of research is so large that even participants are recognizing these gaps. With mental health services, numerous participants had requested future studies that will disaggregate the groups and focus on gender groups specifically, and adolescents separately (Cutrer-Parraga et al., 2024). Additionally, another disparity that may be experienced by AAPI is citizenship and immigration status. To illustrate, Abe-Kim et al. (2007) had found that second-generation immigrants are similar to their parents in relation to their behaviors and patterns of using mental health services. Interestingly, third-generation immigrants were more likely to use mental health services when compared to second-generation immigrants (Abe-Kim et al., 2007). There are various drivers to these disparities, some of which include stigma and shame, which promotes a sense of secrecy and avoidance of professional help. Secondly, collectivist values are another driver, which serves as saving face and focusing on family harmony, further discouraging AAPI folks from seeking help because it may "expose" familial issues. Language barriers are the last driver that will be mentioned. With some of the AAPI population not having English proficiency, it makes it mor challenging for immigrants to utilize the mental health services.

AAPI mental health was not considered and thought of as frequently until COVID-19 happened. This pandemic had exacerbated the mental health challenges that were experienced by Asians and Pacific Islanders and added challenges such as increased racism, violence, implicit and explicit bias, and discrimination. Once COVID-19 became prevalent all around the world, many began blaming this group because this just so happened to be the place of origin. Because COVID-19 originated in China, many became discriminated specifically towards Asian members. Both implicit and explicit prejudice were factors that negatively impacted AAPI (Kite & Whitely Jr., 23), resulting in this significant shift of our understanding as to why AAPI may not have high utilization rates of mental health services. Because of these different types of discrimination and prejudice that is experienced by Asian Americans, this unfortunately puts this group at risk for higher levels of mental disorders (Wu et al., 2020), which ultimately leads to the urge of needing more support systems offered to AAPI communities.

Major Shifts in Understanding

Based on the literature and lived experiences from stakeholders that were interviewed, evidence shows that we as a whole are beginning to understand that stigma is something that is deeply rooted and connected to the API population through being racially socially reinforced, connected to cultural identity, and family centered (Cutrer-Parraga et al., 2024; Fa'alogo-Lilo & Cartwright, 2021; Garret et al., 2025; Wu et al., 2020). Additionally, many stakeholders stated that they felt once COVID-19 happened in 2020, this was when API mental health was becoming considered. Prior to this significant pandemic, they felt that the model minority myth was core identifying factor for the API community. This invalidated many of their feelings relating to help-seeking behaviors. After COVID-19, there was an increase in resources and support being

offered for this Asian Pacific Islander group specifically, as they were the scapegoat for prejudice, discrimination, and violence. Further, with the elder stakeholders that were interviewed, when they were younger, they stated that the world that they live in now has become more understanding. When asked to explain more, they stated that people are less judgmental when it comes to struggling, and struggling has become more normalized. Instead of embracing the model minority myth, from the stakeholder's experience, API folks have become more comfortable at sharing how they feel and have increased help-seeking behaviors.

Theoretical Framework

A useful framework exploring the root causes and consequences of this social issue is acculturation theory. To illustrate, with acculturation theory, this framework focuses on how individuals may adapt to a new culture after migrating or immigrating to a new country. Acculturation and assimilation can lead to stress, anxiety, depression and conflicts with self-identity with different generational immigrants (Abe-Kim et al., 2007). Continuing to look at this theory, some risk factors adding to this issue be language barriers, discrimination, shame, stigma, and cultural dissonance, to name a few. Some protective factors may be strong family and community ties, strong cultural and spiritual identity, and resilience through adversity. As AAPI communities share collectivist values, this specific population relies on family and community relationships to persevere, which leads to resilience despite negative impacts happening to them (Fa'alogo-Lilo & Cartwright, 2021& Garret et al., 2025). Additionally, AAPI spiritual and cultural connections can bring a sense of peace and hope, further adding to this reliance aspect (Abe-Kim, 2007; Cutrer-Parraga et al., 2024; Fa'alogo-Lilo & Cartwright, 2021; Garret et al., 2025; Kwan et al., 2020).

Population of Interest

To better understand the AAPI's community challenges, I hope to achieve the goals of being able to identify what specific facts prevent AAPI folks from accessing mental health services, how barriers can vary for different subgroups, and my last goal is to be able to understand and discover the AAPI community's awareness and attitudes towards mental health. Anyone that identifies as AAPI and has previously had or knows someone in their life that struggles with mental health issues will be of interest. The needs assessment will be conducted in the Tacoma, Washington geographical area, but there will not be a limit on information that may come from different geographical areas. As long as the population of interest identifies as AAPI and has experience with mental health challenges, the data will be considered. Providers, advocates, and other practitioners serving the AAPI community are some people I'd like to include within my population as well. Utilizing both primary and secondary data, I hope to collect demographic data, barriers for access, utilization rates, how many providers are available and culturally trained. I would like to know if there are different barriers for different subgroups, how does cultural beliefs and stigma impact and influence help-seeking behaviors and service utilization, and what are the most talked about reasons for now seeking support. When considering this targeted population, the best go-to information would be from surveys, interviews, and peer-reviewed literature focusing on AAPI mental health disparities and barriers. It may also be helpful to discover information from community and faith organizations along with schools and healthcare providers. While trying to remain as inclusive as possible, depending on the AAPI subgroups, information and sources will be different for varying sub-populations. To illustrate, when working with elders, I may consult with faith leaders and caregivers. When

working with younger folks, I may reach out to school counselors, family members, and other youth organizations. If working with LGBTQ+ AAPI, I would utilize identity specific support groups and organizations that this population may subscribe to. Carrying this information is extremely important and some key stakeholders will be AAPI community members, mental health providers, and community leaders and elders.

Micro-Level Evidence-Based Interventions/Best Practice

Considering micro-level interventions, the Iwamasa (2025) recommends that tailoring specific therapeutic modalities and understanding the values that AAPI folks share such as cultural values like collectivism, family dynamics, and how there is an emotional restraint can be helpful when creating interventions and more culturally appropriate programs (Iwamasa, 2025). Additionally, Shaligram et al. (2022) identified and addressed how racial trauma and identity can create conflict amongst AAPI youth further reducing the access and increasing the barriers in which AAPI youth will utilize services. The last thing that is mentioned regarding micro-level interventions was becoming more culturally competent in family engagement, intergenerational dialogue, and creating more language access and more culturally competent mental health providers (Mental Health America, 2025 & Renehan, 2022). The interventions that are mentioned above do have clear outcomes, with reducing stigma, improving access to care, increasing engagement, and enhancing emotional well-being for all AAPI, but especially amongst youth and immigrant families that identify as AAPI (Mental Health America, 2025; Mok, 2023; PHI, 2023 & Renehan, 2022). As of this moment, these AAPI mental health programs have been effective because they address critical barriers that are experienced by this group of individuals which is considered a strength. However, there are still issues that need to be addressed such as the limited disaggregation of AAPI folks, insufficient data and research, persistent stigma and lack of public awareness, and underrepresentation in the mental health work field (Mental Health America, 2025; Mok, 2023; PHI, 2023; Ross, 2023 & Schlossberg, 2023).

Mezzo-Level Evidence-Based Interventions/Best Practice

PHI (2023) attempts to reduce stigma and increase mental health literacy for all AAPI groups but has an emphasis on youth and families. Mok (2023) emphasizes the power of being able to tell stories and have connections with peers that may have similar situations by creating safe spaces to share experiences and promote healing and reducing the stigma surrounded by what was experienced. Additionally, Jongen et al. (2018) has tried to review workforce interventions that can improve the providers knowledge, awareness, and responsiveness to cultural needs. These interventions have positive outcomes that consist of increasing mental health literacy with AAPI youth, reducing stigma, finding strength and safety in telling your own story, creating more school-based mental health programs designed to identify the early stages of mental health concerns, improving provider cultural competency, and enhancing patient satisfaction (Mok, 2023; PHI, 2023; Ross, 2023; Schlossberg, 2023 & Jongen et al., 2018). Not only did these interventions succeed with increasing mental health literacy and reducing stigma by engaging families and individuals, but it also helped foster trust within the AAPI mental health communities which is something that should not be easily disregarded, which is a strength. Although there are a lot of strengths, some limitations are (yet again) lack of disaggregating data with AAPI, lack of long-term funding, lack of integration with mainstream services and institutions, underrepresentation with AAPI voices with community leaders, elders,

and youth, and lastly, there still is persistent stigma despite all of the outreach that has been done which stems from the older generations (Kim & Gonzales, 2024; Lee, 2021; Mok, 2023; NeuroLaunch, 2025; PHI, 2023; Ross, 2023 & Schlossberg, 2023).

Macro-Level Evidence-Based Interventions/Best Practice

Finally, looking at macro-level interventions that have been effective, there are multiple organizations that are advocating for culturally specific mental health services, such as NAMI (Mok, 2023). This resulted in creating more funding to increase the culturally tailored programs that can be applied to minoritized communities, especially for AAPI (Mok, 2023). Additionally, Jongen et al. (2018) and Shaligram et al. (2022) both describe interventions that improve cultural competency and anti-discrimination in the workforce and bringing awareness. These interventions have been effective as these programs improve the provider awareness and responsiveness to cultural needs along with helping normalize having discussions on the impact and awareness of the racial trauma and mental health that takes place within the health systems (Jongen et al., 2018 & Shaligram et al., 2022). Some clear outcomes that have occurred is increasing both funding, awareness, improving the relationships with patients and providers, and creating public recognition on racism mental health impacts with minoritized communities, further increasing support for AAPI individuals and communities (Jongen et al, 2018; Mok, 2023 & Shaligram et al., 2022). A few strengths with these current interventions are successfully allowing the AAPI mental health barriers to be discussed in conversations that create and adopt policies further advocating for equitable funding and culturally specific mental health services (Mok, 2023). Another strength is that these interventions are incorporating cultural competency in the mental health care which creates a safer environment for clients and brings to light the legislative efforts that have been discussed to help address the negative mental health effects on racism, especially with AAPI youth (Jongen et al., 2018 & Shaligram et al., 2022). Again, as mentioned before, disaggregating data, limited representation, and having sustainable funding for culturally specific programs continue to remain missing across all micro, mezzo, and macro-level interventions (Mok, 2023; PHI, 2023 & Shaligram et al., 2022).

Promising Interventions for Barriers AAPI Experience

I believe that potential and promising interventions for this social problem could have more culturally relevant training opportunities for providers to provide better adapted services and have a more in-depth understanding of AAPI communities, and partnering with AAPI community members can help promote this understanding. Providing CBT in a way that is modified to demonstrate the values of AAPI folks can increase engagement and potentially reduce dropout rates. Another intervention that will be practical on the mezzo-level is to have larger mental health clinics to partner with local AAPI organizations and cultural centers. Further, I believe that it would be helpful and equally promising for best practice if we as a society can train school counselors and providers with cultural competency to improve awareness and communication. Looking into macro-level interventions, mandating disaggregated data collection can prove significantly promising as this can help distinguish the disparities experienced by AAPI subgroups and help advocate for state agencies to report mental health data by subgroup identities, making it more applicable and specific.

How will I Adapt the Interventions to Fit This Social Need for AAPIs?

I'd like to adapt the Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) modalities to modify and reflect collectivist values, emotional restraint, and restoring family harmony and communications amongst the AAPI culture. One of the barriers that is identified for lack of utilization of mental health services is feeling like a therapist wouldn't understand what the client has been through, hopefully resulting in reducing stigma, shame, mistrust, and negative perceptions of mental health that AAPIs experience (Cutrer-Parraga et al., 2024; Fa'alogo-Lilo & Cartwright, 2021; Garrett et al., 2025; Kwan et al., 2020). I believe that starting at the micro-level will prove beneficial in preventing generational trauma and negative views on mental health to change if the newer generations have a good mental health experience.

Stakeholder Information

With the interviews that were conducted, I had interviewed 4 stakeholders/participants. All of my participants have pseudonyms to protect their privacy and vary in age. The youngest I had interviewed was a 23-year-old, and the oldest I had interviewed was 44 years old. All of these stakeholders identified as being Asian and or Pacific Islander. These participants also had direct experience with utilizing mental health services, struggled with mental health, or knew someone that used services or had mental health challenges. Some of my participants were more connected directly to the social issue. Some of my stakeholders were college students that were studying how life varies for minoritized communities, some were professors at a university teaching about mental health disorders, and some of the participants were working individuals that had direct experience receiving mental health support and observing family members struggle with mental health. All of the participants that were interviewed for this social issue had experience with mental health and were within the community. Although there were some various opinions and perspectives, there were a lot of overlapping themes when it came to providing mental health services to the Asian American Pacific Islander community.

How The Issue is Defined

The issue of barriers AAPI's experience with mental health access is defined as a compounded set of barriers which include cultural stigma, financial inaccessibility, and lack of cultural competency amongst providers. When looking at these three barriers together, it discourages help-seeking behaviors, reduces the effectiveness of mental health care when it is accessed and limits the affordability of these services, which all result in AAPI individuals to have negative experiences, and unfortunately, sometimes these mental health concerns remain untreated.

Etiology

The etiology of the barriers that AAPI experience with mental health services connect with the intersectionality of cultural stigma, the systemic inequalities, and provider inexperience with cultural contexts other than their own. Stigma has deep roots in the traditional values that discourage vulnerability, which is a core value that AAPI hold near and dear. Participants have stated that they do not want to be seen as vulnerable, which is why they do not talk about mental health. Structural issues such like high costs and limited insurance coverage, for example, make it extremely difficult and challenging for AAPI folks and minoritized groups in general to have access to mental health services, making it highly inaccessible. Additionally, the lack of culturally competent providers compounds these challenges, further creating a cycle where

mental health continues to remain unaddressed, even when AAPI folks are wanting extra help and support.

Lived Experiences

My participants lived experiences revealed a loud cry for help by talking about the silence, stigma, and the systemic barriers. It was shared amongst all the participants that mental health was never discussed in their families growing up, further reinforcing the generational stigma that is experienced. Many of the participants described avoiding services due to high costs and the skepticism about provider effectiveness, when considering the lack of cultural competency. One participant noted that therapy was personally helpful for her, yet her family remained unsupportive of the mental health conversations, highlighting the tension between individual needs and the cultural expectations within the families. My participants lived experiences touch on this rough and harsh cycle of unmet mental health needs, leaving AAPI individuals feeling unseen and unsupported.

Effectiveness of Existing Programs

Based on the participants I had interviewed, the effectiveness of existing mental health services for the AAPI communities are mixed. While one participant had described that therapy was personally helpful, others had described that services were ineffective when providers lacked cultural understanding. One participant shared that a family member of his had discontinued care/services because it was not meeting their needs. Collectively, the participants had agreed that mental health services can be effective if the provider is culturally competent, but without cultural competency, services fail to be effective for the AAPI communities

Disparities and Main Drivers

Disparities in AAPI mental health access are experienced by intersecting identities such as race, ethnicity, immigration status, socioeconomic status, gender and age. These are all topics that the participants had touched on when doing the interview. Low-income families struggle with the cost of care. LGBTQ+ AAPI folks experience additional stigma, and generational differences that further add to the disparities that are experienced. The main drivers of these disparities include cultural stigma, financial inaccessibility, lack of culturally competent providers, language barriers, and lack of understanding of values. Together, these disparities and main drivers create further barriers across various AAPI identities and individuals.

Needs the Participants Wanted Addressed

Participants identified several priorities for addressing AAPI mental health needs and wants. Many of the participants put an emphasis on the importance of providers receiving training in diverse racial and ethnic groups rather than relying on Eurocentric approaches and modalities. They have also noted that cultural competency is imperative for the effectiveness of mental health services and is a significant want they would like to have addressed. They had also expressed an interest in having safe spaces that can allow vulnerability, allowing AAPI individuals to feel supported when considering mental health services. Additionally, some participants had highlighted that they would like to have families and communities be more aware and educated on mental health so that it is not dismissed and silenced. They believe that if families can feel more comfortable talking about mental health from the beginning, they would feel less isolated and more supported. Overall, much of the participants wants that they would

like addressed boils down to culturally responsive services, community education, and a systemic change within the familial system to reduce stigma and inclusivity.

Strategies to Address the Priorities

Ultimately, participants had identified cultural competency training that moves away from the Eurocentric approaches as a strategy that can be utilized to address the priorities of creating more culturally competent mental health services. Another strategy that participants had discussed was bringing awareness of the mental health struggles that AAPI individuals experience to normalize and reduce stigma that is experienced. Ultimately, these participants want to feel heard, they want to feel comfortable, and most importantly, they want to feel safe when utilizing mental health services, and these are some of the strategies that the participants have come up with to encourage change.

Key Assessment Findings

As I look for key assessment findings based on research and the interviews I've conducted, findings continue to suggest that AAPI individuals experience barriers with mental health utilization that is deeply rooted in cultural stigma, lack of culturally competent care and systemic inequalities. All the participants have discussed mental health as taboo, which then leads to silence to the struggles that may surface with the fear of having feelings dismissed. This directly connects with the cultural stigma and shame being significant deterrents with mental health utilization. An important barrier that is identified is that providers lack cultural understanding which result in distrust, and low utilization rates. Across all findings, there seems to be a call to increase AAPI representation within the community and workforce for professions to receive additional training.

Emerging Priorities

Based on these findings, I believe that there are many priorities that emerge. Stigma reduction is one priority that emerges that needs to be addressed. This might be approached by discussing the taboo surrounding mental health and created culturally appropriate awareness that normalizes mental health experiences. Culturally competent care is another priority. This could be addressed by expanding provider training by requiring training with minoritized groups to better understand the traditions, values, and lived experiences to increase effectiveness. Language accessibility is a third priority that surfaces. Ideally, being able to provide various language services and materials to allow a wider AAPI population to utilize services would be helpful. The last priority that emerges is creating a safe and inclusive space for AAPI to be open. This could be addressed by additional training to prevent discrimination, racism, and trauma-informed care for AAPI communities.

Individual and Community-Level Outcomes

Some individuals and community-level outcomes I would like to see is reducing the stigma that AAPI experience and increasing utilization rates and increased and improved trust and better mental health experiences. Many AAPI struggles with mental health issues, I'd love to see lower rates of AAPI that have untreated depression, anxiety, suicidal ideation, and trauma by having early interventions and culturally responsive care to provide support. Lastly, I'd also like to see greater AAPI representation with professionals in the mental health field along with having a better culturally responsive system. This could be increasing the number of providers

that identify as AAPI or setting up clinics in a way where they integrate cultural values, language accessibility, and trauma-informed practices.

Targets of Change

As the main issue, I'd like to address relates to the barriers that AAPI individuals experience that result in low utilization rates, I believe that a target of change are the providers that provide services AAPI population. Mental health providers and faith leaders are targets of change because the services that they provide directly impact the AAPI community. The idea here is that if we can change the approach and knowledge with providers and faith leaders, by extension, it then can help and benefit the utilization rates of AAPI communities that receive mental health services. Promoting change of awareness, knowledge, and competency within the providers, it can help normalize mental health discussions, shift attitudes of mental health, and have competency trainings with AAPI-specific values.

Potential Capstone Ideas

My initial Capstone idea was to create more opportunities for providers to receive culturally competent training in the AAPI culture, values, traditions, and barriers to care. Maybe this could include having AAPI culture specific as a required training for Continuing Education Unit (C.E.U) credits. Another idea I had was to create more workshops and/or campaigns to normalize the mental health conversations in AAPI communities. This could include workshops within universities for students or a local organization that gathers communities to allow stories to be shared and told to reduce shame and stigma while increasing the safe spaces. When looking at what support exists for these potential ideas, there are various organizations such as the National Asian American Pacific Islander Mental Health Association (NAAPIMHA), the Asia Pacific Cultural Center (APCC), AAPI Thrive, NAMI, and P.E.A.C.E which can host events to reduce stigma, provide training, community education, and workshops to culturally honor these communities.

A challenge that I think would need to be considered is the finances of training professionals. Training professionals requires an investment in finances, sometimes requiring scholarships, mentorships, and continuing education which is not cheap. Another challenge is the generational differences as elders may be more likely to resist change compared to the younger generations. Some questions that'd need to be answered are: which AAPI subgroups will the training address? How will diversity with AAPI be represented? Which cultural values, traditions, and lived experiences should be prioritized in training? Which primary providers should be trained? What would be the best format for training? How might cultural stigma, generational differences and experiences of racism and discrimination be incorporated in the curriculum?

Needs Statement

Based on the current interventions, resources, and lived experiences from the stakeholders that were interviewed, there are some major gaps that were discussed that were considered when making the most effective and relevant Asian Pacific Islander training curriculum intervention. The most significant gaps and barriers that were presented within literature and stakeholder interviews consist of feeling like there is not enough understanding of the API culture that providers have to provide holistic support and the lack of comfortability with

sharing feelings with family members due to the shame and fear that comes along with being vulnerable. I specifically would like to address the reported feelings that providers do not have enough understanding and cultural knowledge relating to how to support the API community to the best of their ability. The theoretical framework that will guide this API training curriculum intervention is acculturation theory. As mentioned previously, acculturation theory will be utilized to explain how API individuals and communities are affected and marginalized, which can further help support this training intervention which will focus on reducing stigma and fear for the Asian Pacific Islander population. In order to maintain effectiveness with this intervention, voices from API individuals that have experienced cultural shame, fear of being gossiped (Cutrer-Parraga et al., 2024; Fa'alogo-Lilo & Cartwright, 2021; Garret et al., 2025), discrimination, model minority myth, and hesitation and fear of being misunderstood by providers (Abe-Kim et al., 2007; Kim & Gonzales, 2024; Renehan, 2022) will all be considered to ensure that these perspectives are informative in the way this intervention is shaped. These perspectives and experiences will be key drivers in the way that this intervention is shaped, ensuring cultural competency, sensitivity, and trust-building for providers to give the utmost support for the API population.

Description of Intervention

My proposed intervention, *API ROOTS: Recognizing Origins, Overcoming Trauma, and Strengthening Support,* formally known as *API ROOTS*, is a 12-week hybrid training program that is designed for providers serving Asian Pacific Islander populations in the mental health setting. This training curriculum will include the option to have in-person or online trainings and 12 modules, one for each week discussing various topics related to the historical contexts of the API population to foster cultural competence and understanding of the upbringing and historical backgrounds that Asian Pacific Islander communities experience. To address the knowledge gaps with providers serving API communities, *API ROOTS* is designed to address these historical, linguistic, cultural, and sociopolitical contexts that shape API experiences.

To incentivize participation in this training program, *API ROOTS* offers continuing education credits (CEUs), which allows licensed clinicians and providers to meet the professional requirements to renew their annual license, and develop culturally grounded skills. This training will also be utilized for unlicensed mental health providers, case managers, and clinical interns and trainees that are working in community mental health agencies, school-based programs, and primary care behavioral health settings with significant API caseloads to expand the wealth of knowledge to practice cultural competency.

Over the course of 12 weeks, participants will engage in structured learning modules, reflective practice, case-based application, and community informed activities. The curriculum will include guest speakers from API communities, small-group discussions, and guided skill development. Training sessions will be hosted at partnering community mental health agency, or a university affiliated training center, with recruitment supported through professional networks, agency partnerships, and community organizations.

Activities & Training Materials

First, to ensure that *API ROOTS* will thrive, there will be a training curriculum which speaks on cultural aspects, values, traditions, historical context, intergenerational trauma, stigma and family structure. This training module will be adaptable for in-person or virtual training

meetings to ensure that various formats are available to allow the widest range of easy access for providers. With each week of training, there will be differing API experts or individuals with lived experiences to speak on specific topics of the week and promote events that are happening around them. For these webinars to happen, we will need to hire a presentation technology specialist to provide written notes to supplement the training courses. The individuals that conduct the training will be providers that are already trained in API cultural competency and have direct experience working with API communities. Individuals that are not trained prior will be ineligible to train providers participating in the training. Staff will be recruited through professional postings or online job postings such as LinkedIn, Indeed, and professional networking. The head of the training program and the staff will work closely together, incorporating Asian Pacific Islander culture and history to guarantee that modules are interactive and accessible (see Appendix A). These training modules will last for an hour and 30 minutes once a week. By the end of the program, participants will have completed a total of 18 hours total dedicated to learning about API historical contexts. Further, this training program will be made in a way that is ethical and culturally sensitive to various experiences that can provide mutual support to promote confidence in the providers.

To ensure efficacy and effectiveness of the program, program evaluation staff that are independent from the training facilitators will administer and conduct follow-up surveys that discusses providers knowledge, attitudes, and comfortability, with a sampled group of participants at 3, 6, and 12 months post training completion. The first assessment method that will be used to collect data will be the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R). This tool will measure the knowledge, skills, awareness and desires of the providers taking *API ROOTS* training. This assessment will be supplemented with three API specific knowledge questions through a Likert-type scale from 1-5, strongly disagree-strongly agree scale (see Appendix B). The second assessment measurement tool will be the Healthcare Provider Cultural Competence Instrument (HPCCI) (see Appendix C). This measurement tool is dedicated to understanding the awareness and attitudes scale, which will be helpful in determine if there are improved attitudes from providers after training. This scale will also be paired with a supplemental three API specific attitude questions on a Likert-type scale (see Appendix B & C).

API ROOTS will utilize various materials that are designed to support culturally competent learning from the application of CBT and DBT skills with API clients. Key materials and curriculum will consist of having facilitator manual outlining weekly objectives, lecture content, discussion prompts, and instructions for experiential activities. PowerPoint slides will be provided in each session, presenting important concepts related to cultural values, immigration histories, trauma, stigma, and evidence-based therapeutic strategies in a written format to supplement the verbal learning. Additionally, a case vignette study guide will allow providers to practice culturally specific scenarios can give cognitive restructuring, behavioral activation, mindfulness, distress tolerance, and interpersonal effectiveness skills within the API contexts. Participants will also have the opportunity to receive journals (if they want) to reflect their experiences in the weekly training and provide self-assessment with their learning. There will also be a plethora of worksheets that are CBT and DBT inspired models, language access tools, and API specific cultural context to support and integrate learning further. Finally, there will also be attendance logs and certificates provided amongst completion of the training for CEU documentation purposes.

Resources and Personnel

Successful implementation of the *API ROOTS* training will require a combination of paid staff, volunteer contributors, and material resources that support both the cultural and clinical components of the program. Key important personnel that will be paid include a Program Coordinator, whom of which will be responsible for scheduling, communication with agencies, CEU documentation, and managing hybrid learning logistics; a Lead Trainer with expertise in CBT, DBT, and culturally responsive practice with API communities; and an Evaluation Specialist who will design, administer, and analyze pre- and post-training assessments. Other contributors to the *API ROOTS* consist of API community leaders, cultural historians, bilingual clinicians, and individuals with lived experience, who may serve as guest speakers or cultural consultants through volunteer or stipend roles. To encourage the best success with recruiting these community leaders and experts, *API ROOTS* will utilize professional networks such as NAMI Pierce County, NASW, Comprehensive Life Resources (CLR), Tacoma Area Coalition of Individuals with Disabilities (TACID), and community partnerships with Asia Pacific Cultural Center (APCC) and the Asian Pacific Islander Coalition. Outreach will be recruited through LinkedIn and direct networking with clinicians known for their work with API populations. Recruitment will also include a group that is comprised of elders, and experts in API culture and history that is willing can guide and develop the training curriculum to ensure cultural accuracy.

Advertising and Informing Target Population

In order to advertise *API ROOTS* training program to ensure that it is going to the appropriate population, digital flyers will be provided within various settings such as community mental health agencies, university training sites, and behavioral health clinics. Further, advertising and announcements will be shared through listservs such as the NASW, LinkedIn, and developmental calendars that are solely focused on CEU credentials for providers. Additionally, API organizations such as APCC and the Asian Pacific Islander Coalition will support advertising and informing providers that serve populations that go to their organizations. Social media platforms like community newsletters will also be utilized for promotion of this training program. Presentations amongst these organizations and agencies will further promote the training program through word of mouth. These messages of promotion will speak to *API ROOTS* CEU eligibility, along with the cultural significance and relevance enhancing the need to participate in this API culturally training program.

Barriers/Other Considerations

An important barrier to consider is that although *API ROOTS* training will be offered either online or in-person, those that choose the online option may not have access to stable Wi-Fi or an electronic device that can be used for the trainings. To accommodate this, physical paper materials can be sent to the address that the provider submits to receive copies to learn. Additionally, if needed, if they cannot make it to in-person or online synchronous training session, office hours will be help once a week with a window span of one hour and thirty minutes to provide extra support to ask clarifying questions to clear some confusion. These office hours can be through a phone call or support consultation groups, which would not take any Wi-Fi usage.

Another consideration to think about is that there may be some emotional reactions from providers taking this training, they may feel shame or guilt when learning about the

misunderstandings and historical contexts of Asian Pacific Islanders. They may feel a sense of overwhelm when considering the various complexities and nuances of API cultures. To anticipate these reactions, this training will be transparent in openly speaking about the possibility of discomfort that may be experienced and normalizing these feelings. At the end of the training session, there will be a voluntary 15-minute period where providers can talk amongst one another to verbalize how they are feeling and practice guided mindfulness, if providers choose to engage in this activity.

Project Goals and Outcomes

The long-term goal of *API ROOTS* is to have mental health providers apply culturally responsive practices in clinical settings, which will include culturally appropriate engagement and communication strategies when working with Asian Pacific Islander clients. Through its inclusive, culturally responsive training, this intervention hopes to increase the comfortability levels of providers serving API populations. Another long-term goal of this training intervention is to reduce mental health disparities amongst the API populations by expanding and increasing equitable access to culturally competent, trauma-informed, and stigma-free mental health services, resulting in greater trust and engagement in care. These two goals will work side-by-side during the training sessions to prepare providers to serve API populations. Both of these goals are designed to create and improve client relationships with providers, while also challenging the larger societal norms that perpetuate the model minority myth, stigma, shame, and fear regarding help-seeking behaviors.

The first outcome of *API ROOTS* is for mental health providers to demonstrate an increased knowledge of API mental health needs. This outcome will be measured through changes in pre- and post-training assessment responses that utilize a cultural competence instrument (IAPCC-R). Success will be shown by at least a 45% increase on an average post-training scores compared to pre-training scores. A second indicator of achieving this outcome will be increasing the percentage of trained professionals that report using culturally responsive engagement strategies (appropriate communication, family-centered approaches) on a regular basis with API clients. Success will be measured through a post-training self-reported survey, with success defined as at least a 50% increase in the utilization of culturally responsive engagement strategies. To evaluate the application and effectiveness of these skills, a sample size of providers will complete follow-up surveys at 3, 6, and 12 months after training has been completed to track the success and applications of culturally responsive practices as time moves forward.

The second outcome *API ROOTS* is for mental health providers to improve attitudes towards culturally responsive care. This outcome will be indicated by the number of providers reporting more comfortability and favorable attitudes towards culturally responsive API mental health strategies by the awareness and sensitivity HPCCI measurement tool. Success will be shown by an increase of at least 35% on average post-training assessment scores when compared to pre-training scores. The second indicator of progress towards this outcome is relative to providers incorporating more cultural factors into conceptualizations as shown by pre- post-tests and case vignette responses. To measure long-term impact of this training program, voluntary follow-up surveys will follow at 3, 6, and 12 months after the training program has ended. The achievements of *API ROOTS* training will be recognized through achieving its intended outcomes and indicators that produce meaningful and observable improvements with API

culturally responsive care. The total time that will be needed to complete this training will be approximately 3 months of training (See Appendix D). Offering this training at a discounted price for $250 for 12 weeks of training enhances accessibility. This also requires financial support through grants and partnerships with various organizations (see Appendix E**).** *API ROOTS* will make changes for the API community, one provider at a time.

References

Abe-Kim, J., Takeuchi, D. T., Hong, S., Appel, H., Nicdao, E., Zane, N., Sue, S., Spencer, M. S., & Alegria, M. (2007). Use of mental health—related services among immigrant and US-born Asian Americans: Results from the National Latino and Asian American Study. *American Journal of Public Health*, 97(1), 91-98. https://doi.org/10.2105/AJPH.2006.098541

Cutrer-Parraga, E. A., Allen, G. E. K., Miller, E. E., Garrett, M. F., Conklin, H., Franklin, C. N., Norton, A., Hee, C., & Coffey, B. K. (2024). Perceptions and barriers about mental health services among Pacific Islanders: An interpretative phenomenological analysis. *Journal of Counseling Psychology*, 71(2), 89-103. https://doi.org/10.1037/cou0000719

Fa'alogo-Lilo, C., & Cartwright, C. (2021). Barriers and supports experienced by Pacific Peoples in Aotearoa New Zealand's mental health services. *Journal of Cross-Cultural Psychology*, 52(8-9), 752-770. https://doi.org/10.1177/00220221211039885

Garret, M. F., Cutrer-Parraga, E. A., Allen, G. E. K., Young, E. L., Urbina, K. J., & Hull, I. M. (2025). "It Would Ruin My Life": Pacific Islander male adolescents' perceptions of mental health help-seeking—an interpretative phenomenological analysis focus group study. *International Journal of Environmental Research and Public Health*, 22(1). 62. https://doi.org/10.3390/ijerph22010062

Iwamasa, G. Y. (2025). *Recommendations for the Treatment of Asian-American/Pacific Islander Populations*. American Psychological Association. https://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/psychological-treatment

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: a systematic scoping review. *BMC Health Services Research*, *18*(1), Article 232. https://doi.org/10.1186/s12913-018-3001-5

Kim, C., & Gonzales, C. (2024). A Review of Factors Contributing to Asian Americans' Underutilization of Mental Health Services. *Journal of Student Research (Houston, Tex.)*, *13*(1). https://doi.org/10.47611/jsrhs.v13i1.6398

Kite, M. E., & Whitley, B. E. (2016). *Psychology of prejudice and discrimination*. Routledge/Taylor & Francis Group.

Kwan, P. P., Soniega-Sherwood, J., Esmundo, S., Watts, J., Pike, J., Sabado-Liwag, M., & Palmer, P. H. (2020). Access and utilization of mental health services among Pacific Islanders. *Asian American Journal of Psychology*, 11(2), 69-78. https://doi.org/10.1037/aap0000172

Lee, E. S. (2021a, July 8). *As AAPIs, we need therapists who look like US*. Mental Health America. https://mhanational.org/blog/as-aapis-we-need-therapists-who-look-like-us/

Mental Health America. (2025). *Asian American / Pacific Islander communities and Mental Health*. https://mhanational.org/position-statements/asian-american-pacific-islander-communities-and-mental-health/

Mok, C. (2023, July 19). *Addressing Mental Health Barriers in the AAPI Community*. National Alliance on Mental Illness (NAMI). https://www.nami.org/asian-american-pacific-islander/addressing-mental-health-barriers-in-the-aapi-community/

NeuroLaunch.com. (2025, March 10). *Asian American Mental Health: Navigating Cultural Stigma and seeking support*. https://neurolaunch.com/asian-american-mental-health/

Public Health Institute. (2023). *Breaking down barriers to mental health care for AAAI Youth*. https://www.phi.org/about/impacts/breaking-down-barriers-to-mental-health-care-in-asian-american-and-asian-immigrant-communities/

Renehan, C. M. (2022). “Model Minority” Mental Health: An Examination of the Barriers to Effective Care Among Young AAPIs. *Undergraduate Journal of Public Health*, *6*. https://doi.org/10.3998/ujph.2317

Ross, A. (2023, October 14). *Mental health barriers in the AAPI community*. Minds Without Borders. https://www.mindswoborders.org/blogs/mental-health-barriers-in-the-aapi-community

Schlossberg, J. A. (2023, May 9). *Confronting mental health barriers in the Asian American and Pacific Islander Community*. UCLA Health. https://www.uclahealth.org/news/article/confronting-mental-health-barriers-asian-american-and-2

Shaligram, D., Chou, S., Chandra, R. M., Song, S., & Chan, V. (2022). Addressing Discrimination Against Asian American and Pacific Islander Youths: The Mental Health Provider’s Role. *Journal of the American Academy of Child and Adolescent Psychiatry*, *61*(6), 735–738. https://doi.org/10.1016/j.jaac.2021.11.021

Wong, Y. J., Deng, K., Lee, C. S., Grimes, J., & Li, P. F. J. (2018). Asian Pacific Islander Americans’ and White Americans’ Suicide Methods. *Asian American Journal of Psychology*, *9*(4), 318-326. https://doi.org/10.1037/aap0000127

Wong, Y. J., Wang, L., Li, S., & Liu, H. (2017). Circumstances preceding the suicide of Asian Pacific Islander Americans and White Americans. *Death Studies, 41*(5), 311-317. https://doi.org/10.1080/07481187.2016.1275888

Wu, C., Quian, Y., & Wilkes R. (2020). Anti-Asian discrimination and the Asian-white mental health during COVID-19. *Ethnic and Racial Studies*, *44(5)*, 819-835. https://doi.org/10.1080/01419870.2020.1851739

Wyatt, L. C., Ung, T., Park, R., Kwon, S. C., & Trinh-Shevrin, C. (2015). Risk Factors of Suicide and Depression among Asian American, Native Hawaiian, and Pacific Islander Youth: A Systemic Literature Review. *Journal of Health Care for the Poor and Underserved, 26*(2), 191-237. https://doi.org/10.1353/hpu.2015.0059

Appendix A- *API ROOTS* 12 Week Module Format

Please note that the contents of this 12-week module format represent an idea that will be further developed and enhanced by API ROOTS as time goes on before the launch of this program. We reserve the rights to make changes and updates as deemed necessary.

Module 1: Understanding API Diversity, Histories, and Cultural Contexts

This first module will introduce participants to the various diversities that are experienced within the Asian Pacific Islander communities, providing emphasis on the significance of historical, cultural, and sociopolitical contexts and how it may shape the mental health experiences. Providers will begin to build a foundational understanding and awareness of cultural humility.

Key Objectives:

- Understand the heterogeneity of API communities, including ethnic, linguistic, and migration differences
- Explore and discover how experiences such as colonization, immigration, displacement, and war can impact and effect mental health needs
- Introduce cultural humility as an ongoing practice rather than a fixed skill
- Guided reflection: Participants will recognize their own cultural biases and potential blind spots that can be explored.

Module 2: Stigma, Shame, and Help-Seeking Behaviors in API Communities

Module 2 will examine and discuss how shame, stigma, "saving face" and community visibility negatively impact help-seeking behaviors. Providers will learn how cultural experiences and norms form emotional expression and disclosure.

Key Objectives:

- Participants will identify cultural and structural factors that contribute to the stigma API communities face
- Participants will understand how shame, family representation and collectivism values influence help-seeking behaviors
- Participants will learn strategies to help reduce the stigma felt by API clients and build rapport with them
- Case reflection: analyze a case vignette that involves an API client experiencing stigma-related barriers.

Module 3: Intergenerational Trauma, Family Dynamics, and Cultural Values

Module 3 will allow participants to explore how intergenerational trauma, filial piety, collectivism, and family hierarchy influence client experiences.

Key Objectives:

- Participants will understand intergenerational trauma that is related to migration, immigration, displacement, and war

- Participants will examine how cultural values such as respect for elder's shape family roles and values
- Participants will identify common intergenerational conflicts that appear in API families
- Skill practice: providers will use genograms to explore intergenerational patterns.

Module 4: Language Access, Communication Styles, and Cultural Formulation

Module 4 will allow the chance for providers to focus and learn about language diversity, interpreter use, and culturally congruent communication.

Key Objectives:

- Participants will understand the impact of language access on diagnosis, rapport, and treatment
- Providers will learn what best practices are out there when working with interpreters
- Providers will explore and discover high contexts versus low context communication styles
- Participants will practice culturally informed interviews that utilizes the DSM-5 Cultural Formulation Interview

Module 5: Racism, Discrimination, and the Model Minority Myth

While progressing to this module, participants will learn more about how racism, xenophobia, model minority myth, and discrimination can form and shape mental health outcomes that are experienced by API clients and how they access services.

Key Objectives:

- Providers will critically think about and understand the psychological impact of racism and anti-Asian hate impact Asian Pacific Islander mental health and how the model minority myth might reinforce stigma further reducing help-seeking behaviors.
- Participants will also identify various barriers that API clients experience when trying to utilize services
- Providers will consider and reflect on their own personal assumptions and biases

Module 6: Trauma-Informed Care for API Clients

As we are now halfway through the training, providers will now learn how to integrate trauma-informed practices and connect it with cultural responsiveness.

Key Objectives:

- Participants will be able to identify the traumatic experiences that happen in API communities and provide specific information relating to how these experiences may be traumatic
- Participants will be able to apply the core principles and concepts of trauma-informed care in ways that remain culturally responsive for the API population
- Providers will be able to identify ways that trauma may surface in symptomology for Asian Pacific Islander clients.

Module 7: Culturally Responsive CBT for API Clients

With module 7, providers will take a dive into Cognitive Behavioral Therapy concepts to align and connect the cultural values, communication norms and the worldviews that the clients may have to better support cognitive restructuring and adaptations.

Key Objectives:

- Providers will begin to understand how cognitive restructuring may need cultural adaptation
- Providers will think about and explore various ways to discuss thoughts, emotions, and behaviors in a culturally competent way
- Providers will utilize a CBT thought log which will use culturally relevant client example to practice these CBT skills

Module 8: Culturally Responsive DBT for API Clients

Module 8 will focus on Dialectical Behavioral Therapy skills and connect these skills with cultural values and emotional regulation, familial harmony and communication.

Key Objectives:

- Providers will begin to understand how DBT skills connect and align with the collectivist values and relational harmony, which are values and identities that are closely aligned with the API community
- Participants will also explore culturally responsive ways to teach mindfulness skills and distress tolerance
- Providers will begin to learn and communicate effectively when working with hierarchical family structures

Module 9: Working with Refugee, Immigrant, and First-Generation Clients

When working through this module, providers will learn the differences in the experiences of immigrants, refugees, and first-generation clients and learn how to adapt and tailor the care that is provided appropriately and accordingly.

Key Objectives:

- Participants will learn and understand the acculturation stress, various identities, and role reversal
- Providers will be able to understand the needs of refugee clients that include but are not limited to trauma and resettlement stressors
- Providers will also navigate how to explore the challenges that first-generation clients experience such as identity, belonging, individual, and familial expectations

Module 10: Community Engagement, Cultural Brokers, and Collaborative Care

As we are gearing up for the last final sessions of the training program, participants will learn the importance of community partnerships and significance of support systems that are culturally aligned with the Asian Pacific Islander community.

Key Objectives:

- Providers will learn the important roles that elders, cultural brokers, and community leaders play in the Asian Pacific Islander experiences.
- Participants will learn different strategies to build rapport with API organizations and agencies to further support the API community
- Providers will discover and explore different collaborative care models that highlight and include cultural strengths

Module 11: Ethical Practice, Boundaries, and Provider Self-Reflection

Participants will begin shift focus from learning integral cultural practices, and will now think about boundaries, self-reflection and ethics that should be considered when providing services to the API community. This will include but is not limited to boundaries, dual relationships and provider positionality.

Key Objectives:

- Providers will be able to effectively and efficiently identify dilemmas and issues that are present in culturally diverse settings
- Participants will discover and reflect on how the self-identity of the provider may influence the type and quality of care that is provided to API clients
- Providers will also learn strategies to maintain boundaries while also respecting the cultural norms that may be shared by Asian Pacific Islander clients

Module 12: Integration, Case Application, and Provider Competency Assessment

This final module and training session will reflect on all the learning that has been done these past 12 weeks through application, reflection, and competency evaluations.

Key Objectives:

- Providers will be able to effectively and accurately integrate and understand the cultural, historical, and clinical concepts from all previous modules that were completed
- Providers will be able to effectively and accurately integrate and apply CBT and DBT models to complex and challenging Asian Pacific Islander client scenarios
- Providers will be able to demonstrate culturally responsive assessment, interventions, and engagement skills
- Lastly, providers will be able to verbalize and articulate the growth that they've experienced while taking this training and identify the next steps to continue their learning and maintain cultural competency moving forward

Appendix B- Measurement Tool Survey Questions

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R)

Answer these questions using a 4-point Likert scale (strongly disagree, disagree, agree, strongly agree).

Cultural Awareness

- I am aware of how my own cultural background may influence my interpretations of API clients' behaviors or communication styles
- I recognize that API clients might experience mental health stigma and symptoms differently based on races and subgroups (ex, Southeast Asian, Samoan, Tongan, Pacific Islander, Cambodia, Thailand)

Cultural Knowledge

- I can successfully identify and explain API models of distress like spiritual imbalance, for example
- I am comfortable and familiar with how history and cultural contexts such as immigration, acculturation and intergenerational conflict impacts API mental health

Cultural Skills

- I am confident in asking API clients about family and cultural expectations that might impact and influence their personal treatment goals
- I can discover whether an API client prefers direct communication or indirect communication approaches while receiving services

Cultural Encounters

- I can reflect on previous encounters with providing services to API clients and can adjust the approach I use in future sessions and services
- I actively and proficiently look for opportunities to learn from my interactions with Asian Pacific Islanders to improve my API cultural responsiveness

Appendix C- Measurement Tool Survey Questions

Healthcare Provider Cultural Competence Instrument (HPCCI)

Answer these questions using a 5-point Likert scale (strongly disagree, disagree, neutral, agree, strongly agree)

Awareness and Sensitivity

- I think it is significant to understand how cultural stigma and fear might influence API individuals' willingness to speak up about mental health concerns
- I place value of the role of cultural contextual history such as familial expectations, immigration history and cultural identity in the API clients' treatment preferences

Culturally Responsive Behaviors

- I change treatment recommendations to support and align with API clients' cultural values where clinically relevant and appropriate
- I always ask clients how cultural beliefs and expectations may play a role and influence the individual goals for treatment

Patient-Centered Communication

- I change my communication style to match the way the client speaks. For example, I will mad indirect or direct communication and apply the norms common in various API cultures
- I always ensure that interpreters or staff that are bilingual are utilized effectively and appropriately to reduce language barriers that may show up

Self-Assessment

- I consistently and periodically evaluate my strengths and weaknesses when providing culturally competent and responsive care to Asian Pacific Islander clients
- I feel comfortable and confident when identifying misunderstandings and communication errors that may affect the work being done with API clients

Appendix D- *API ROOTS* Timeline

PHASE	**MONTHS**	**MAJOR ACTIVITIES**
1. Planning and Infrastructure	1-2 months	Staffing, partnerships, *API ROOTS* program setup
2. Curriculum Development	3-4 months	Build 12 modules that are co-created with the community ensuring API feedback
3. Recruitment and Outreach	5-6 months	Participant enrollment, CEU approval, market and advertising
4. Training Implementation	7-9 months	Deliver the 12-week *API ROOTS* training program
5. Evaluation and Follow-Up	10-11 months	Post-surveys, interviews, analysis
6. Longitudinal Follow-Ups	10-12+ months	3-, 6-, and 12-month follow-up surveys will be utilized to measure success after the training has concluded
7. Reporting and Sustainability	12 months	Final report of effectiveness and success, updates, and future planning to improve the training

Appendix E- API ROOTS Budget

Revenue			Notes
Individual Contributions		$15,000	Community donors, fundraising efforts
Private Grants	Grant 1: Seattle Foundation (Racial & Ethnic Equity)	$40,000	Culturally responsive mental health initiatives
	Grant 2: Premera Social Impact Program	$30,000	Behavioral health access and workforce development
	Grant 3: Other private foundations (ex. Kaiser, Ballmer group)	$25,000	Workforce development, community mental health
Government Grants	Grant 1: WA HCA: Mental Health Block Grant (MHBG)	$120,000	Workforce development, culturally responsive care
	Grant 2: WA HCA: SUPTRS Block Grant	$60,000	Behavioral health training and trauma-informed care
	Grant 3: WA Community-Driven Behavioral Health Grant	$35,000	Community-led culturally grounded initiatives
Program/Training Fees	Cost of program per participant	$30,000	$250 x 120 participants
In-Kind		$15,000	Donated space, volunteer speakers, materials
Other (university partnership, sponsorships)		$15,000	Institutional and community support
TOTAL REVENUE		$385,000	

PERSONAL EXPENSES	FTE	Annual Wages	Taxes & Benefits	Cost to Program	Notes
CEO/Program Director	0.75	$75,000	$22,500	$97,500	Strategic oversight, partnerships, grant compliance
Lead Trainer	1.0	$80,000	$24,000	$104,000	Curriculum delivery, facilitation, supervision
Program Coordinator	1.0	$55,000	$16,500	$71,500	Recruitment, logistics, CEU admin
Evaluation Specialist	0.5	$40,000	$12,000	$52,000	Pre- post-surveys, data analysis, reporting
Guest Speakers/ Cultural Brokers	--	--	--	$20,000	Honoraria for API community leaders
Total Personnel Expenses	--	--	--	$345,000	
NON-PERSONAL EXPENSES					
Space (Virtual platform/office)				$600	Donated space offsets cost
Technology and LMS				$600	Zoom license, LMS access
Materials and Supplies				$600	Printing, handouts, notebooks/journals
Communications and Outreach				$600	Advertising, flyers
Travel				$500	Speaker travel
Equipment				$500	Microphones, recording equipment
Food and Hospitality				$500	In-person sessions
CEU Accreditation fees				$500	Application and renewal fees
Other Expenses/ Contingency				$600	Miscellaneous/unexpected costs
Subtotal Personnel				$345,000	
Subtotal Non-Personnel Expenses				$5,000	
Admin/Indirect Costs				$35,000	10% Admin/Indirect. Organizational overhead fiscal management, HR, insurance
TOTAL EXPENSES				$385,000	