

MENTAL-HEALTH INTERVENTIONS FOR BLACK AND ASIAN
ADULTS IN U.S. PUBLIC AND COMMUNITY SETTINGS:
A QUANTITATIVE SYSTEMATIC REVIEW

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Abstract

Mental-health disparities continue to be an important public-health issue in the United States, and racial and ethnic disparities have been observed in access to mental-health services, treatment uptake, treatment engagement and recovery. Black and Asian adults have mental-health needs, but receive lower rates of treatment than White adults. The purpose of this systematic review was to determine the efficacy of public and community mental-health interventions for Black and Asian adults in the United States, focusing on clinical outcomes and equity measures like treatment initiation, retention, adherence, completion, and continuity of care. The quantitative systematic review was conducted using data extracted from scientific literature and was based on the PRISMA 2020 guidelines. MEDLINE, CINAHL and Web of Science databases were searched from 2015 to 2025 with the addition of grey literature searching. Eligibility criteria were set up using the PICO structure and methodological quality were evaluated by Critical Appraisal Skills Programme (CASP) checklist for randomised controlled trial. Seven randomised trials met the inclusion criteria. Interventions ranged from culturally adapted cognitive behavioural therapy (CBT), mindfulness-based cognitive therapy (MBCT), trauma-informed collaborative care, anxiety-management with resource navigation, to digitally delivered CBT. Among Chinese American adults, symptom improvement was quicker and attrition was lower for those receiving culturally and linguistically adapted CBT. Collaborative and navigation-based models had shown continuity, and digitally delivered interventions had shown significant reach, but also had issues with treatment initiation and completion. It was possible and acceptable, but the evidence of comparative clinical effectiveness was more inconsistent, regarding mindfulness-based interventions. In sum, the results suggest that intervention content is not enough to decrease the gap in mental health inequalities. Language, cultural relevance, practical barriers, navigation and sustained engagement are key issues to consider in equitable public health intervention through delivery mechanisms.

1. Introduction

Access to adequate mental-health services is not uniform across racial/ethnic groups, and mental health is a critical aspect of population health. Mental-health inequalities include

variations in mental-health need, in access to mental-health services, in treatment and recovery across population groups, and are considered a significant public-health problem in the United States. The evidence reviewed in

this brief suggests that racial/ethnic disparities exist not just in the prevalence and identification of mental health problems, but also in the likelihood of seeking treatment and staying in treatment.

According to the national estimates in the source document, about 59.3 million U.S. adults (or 23%) suffered from any mental illness in 2022. Among adults who had any mental illness, 56.1% received treatment, while 37% of Black adults and 36% of Asian adults did. All of these differences are significant from a public health point of view because if interventions are to have a population benefit, individuals who have symptoms must be able to access and stay in appropriate services.

A symptom burden is also significant. In 2022, depression symptoms were detected in 21.4% of adults and anxiety symptoms were detected in 18.2%, during a two-week period, through population monitoring. The source also mentions discrepancies in prevalence of having a major depressive episode across racial and ethnic groups, as well as how some groups may have a lower prevalence than others, perhaps due to under-identification. This means prevalence statistics might not be sufficient to capture the mental-health experiences of minority populations.

Convenience of care goes beyond services. Perceived understanding and trust, language concordance, cultural responsiveness can affect a person's interest in seeking help and in treatment. The survey data referenced in this report did not include data on the number of Black adults or Asian adults who found a culturally understanding clinician, but 46% of Black adults and 55% of Asian adults indicated that they had a problem. There were no survey data for number of Black adults nor Asian adults who had a problem, with 46% of Black adults and 55% of Asian adults finding a culturally understanding clinician.

These inequalities offer a significant justification for interventions targeting clinical symptoms and the organisation of care. Literature reviewed in this review was culturally adapted psychotherapy, mindfulness-based interventions, collaborative care, community health-worker approaches and digital interventions. There is some previous evidence

that culturally adapted psychotherapy may be more acceptable and clinically effective, and collaborative care may be able to integrate mental-health care into primary-care systems. The benefits of digital interventions are that they can have a wider reach but can also add another layer of access and retention.

The underlying theory for the review integrates the Dahlgren-Whitehead model of determinants of health and culturally relevant and intersectional approach. There are many factors at play that impact mental health, ranging from socioeconomic status, social environments, to health care systems and the broader structural conditions. Poor mental-health outcomes can be related to poverty, discrimination, lack of access and lack of cultural responsiveness for racialised and minoritised communities, which may interact. Cultural adaptation theory also suggests that relevance of the intervention can be enhanced if there is a match in terms of language, values, and communication styles with participants' experiences.

The review thus posed the following question: How effective are community and public mental-health services for Black and Asian people in the United States?

The study's goal was to measure intervention efficacy and to combine equity-related outcomes of treatment initiation, engagement, completion and continuity. The goals were to determine which interventions and delivery models are relevant, to understand the impact on symptoms and outcomes of treatment, to explore the importance of cultural and linguistic tailoring and care-management mechanisms, and to evaluate methodological quality.

2. Methods

2.1 Study design

The design of the review was quantitative systematic-review, as the review aimed to assess the effectiveness of the interventions and to compare the changes in the validated mental-health measures between the RCTs. The quantitative synthesis also enabled a consideration of clinical outcomes in addition to service outcomes, such as initiation,

attendance, attrition and completion, as well as symptom severity and response and remission. The review was conducted using the approach suggested by the PRISMA 2020. The review question and eligibility criteria were framed using PICO and the intervention content and

delivery characteristics were supported using the TIDieR principles. Given the potential for considerable variation in intervention type, setting and outcome, synthesis was done in a narrative way, with statistical pooling only as an additional method using SWiM guidance.

Table 1: PICO application to review

PICO component	Reframed description
P	United States adults (18+) who identify as Asian and/or Black
I	Interventions delivered with the intention of improving outcomes or service access for the target groups, including psychosocial/behavioural programmes, ethnically tailored approaches (CBT), mindfulness-based formats (MBCT), collaborative-care models, digital interventions, and community/lay-worker or multi-component programmes
C	Care as normally provided within services (usual/standard care)
Primary outcomes	Change in symptom severity measured using validated instruments (e.g., PHQ-9, PTSD, CES-D-related measures; Appendix VI), plus remission and/or response when reported
Secondary outcomes	Service-use and implementation indicators, including initiation, turnout, adherence, attrition, referral linkage or stability, and fulfilment or perceived cultural fit
D	Clustered and Individual RCTs

2.2 Search strategy

MEDLINE (PubMed), CINAHL and Web of Science databases were used for searching. The strategy included controlled vocabulary and free-text terms that were associated with black and asian populations, mental-health conditions, culturally adapted interventions, CBT, mindfulness, collaborative care, care management, community health workers and digital interventions.

The terms for search were also those related to treatment initiation, attendance, adherence, dropout and continuity. The search covered 2015–2025. Additional searches were performed on ClinicalTrials.gov, ProQuest and other relevant organisational databases to ensure that grey literature was looked for and publication bias was minimised. EndNote was used for the records to be imported, screened and deduplicated.

Table 2: PICO derived search terms

PICO	Search terms
Population	“African American*” OR “Afro-American*” OR “Black American*”, OR “South Asian*” OR “East Asian*” OR “West Asian*” OR “Asian Indian*” OR Korean OR Chinese OR Filipino* OR Vietnamese
Interventions	“cognitive behav*” OR CBT, “cultural tailoring” OR “ethnically adapt*” OR meditation OR MBCT, “integrated care” OR “collaborative care” OR “care management” OR “peer navigator*” OR “lay health worker*” OR “community health worker*”, telepsychiatry OR mHealth OR online OR digital OR “faith-based” OR “church-based”
Comparators	“standard care” OR “usual care”
Outcomes	severit* OR remission, PHQ-9 OR CES-D OR GAD-7 OR ISI OR “PCL-5”, retention OR dropout* OR attend* OR adher* OR engage*, OR continuity
Design	trial OR random* OR pragmatic OR cluster* OR “difference-in-differences”

2.3 Eligibility criteria

U.S. adults (aged 18 years and older) who identified as Black and/or Asian were reviewed. The interventions were considered eligible if they were psychosocial or behavioural, culturally adapted CBT or mindfulness, collaborative or integrated or digital or community or lay-worker. Individual and cluster RCTs were eligible. Studies needed to

provide validated mental-health outcomes and/or provide outcomes that could be extracted relating to implementation and/or equity. Any setting can be used such as healthcare, community, municipal, faith-based or telehealth. Studies which have been published in English between 2015 and 2025 were included.

Table 3: Eligibility Criteria based on PICO

Domain	Inclusion	Exclusion
Population	U.S. Asian and/or Black adults (18 and above)	Non-U.S. samples or studies with other ethnicity
Interventions	Psychosocial/behavioural, CHW/lay-delivered, ethnically tailored mindfulness, CBT, digital, collaborative/integrated care, community/religion linked programmes	Pharmacotherapy, policy-related restructurings without participant data, stigma-only promotions without access endpoints
Comparators	Usual care or equivalent comparison condition	Single-group pre-post designs, case reports
Outcomes	Validated symptom scales before and after intervention (e.g., ISI, CES-D, PHQ-9) and extractable statistics, response/remission using traditional cut-offs (e.g., $\geq 50\%$ reduction, GAD-7 ≤ 5 , PHQ-9 < 5), implementation and equity results (initiation, adherence/attendance, attrition, linkage/continuity, satisfaction such as CSQ-8)	Qualitative-only outcomes, unvalidated measures without usable descriptive statistics
Study design	Individual and cluster RCTs	Cross-sectional designs, qualitative-only studies
Setting	U.S. healthcare, school, municipal, church/mosque, or telehealth delivery contexts	Non-U.S. delivery locations, laboratory-only analogue studies
Timeframe	2015–2025	Before 2015
Language	English	Non-English publications

2.4 Quality appraisal and synthesis

The CASP checklist for RCTs was used to evaluate methodological quality. Randomisation, participant accounting, blinding, baseline comparability, equality of care, effect size, precision, applicability, outcome coverage, benefits compared to harms or costs were evaluated when assessing the study. Judgements were not seen as stand-alone indicators of the quality of overall study, but rather served to frame the validity and limitations of each specific result.

Data were extracted on study design, population, setting, intervention dosage, intervention characteristics, comparator, outcome measures and main findings. Evidence was synthesized by the narrative synthesis approach, which was organized by intervention, delivery model (culturally adapted psychotherapy, anxiety-management and navigation, mindfulness-based care, collaborative care and digital interventions).

3. Results

3.1 Study selection

A total of 227 records were found in the database search. 203 records were screened for title and abstract, after removal of 24 duplicate records. The 173 were excluded and 30 full text papers were assessed. Twenty-three full-text papers were then excluded. These were due to the lack of randomisation, population that did not match the review focus, non-U.S. setting, interventions not within the scope of the review, inadequate validated outcome information, and protocols without results. So, 7 randomized trials were finally included.

The seven trials were held in community mental-health clinics, primary-care, Federally Qualified Health Centers, public hospital services and national digital programmes. Most of the studies were conducted with the Chinese American and African American populations. Some of the studies had mostly female participants, and the Asian evidence was mostly in the form of adults who are Chinese American.

3.2 Culturally adapted psychotherapy

Hwang and colleagues (2015) compared culturally adapted CBT to a standard version of CBT in 2 community mental-health clinics with Chinese American adults who were diagnosed with major depressive disorder. The participants were assigned to either culturally adapted CBT or standard CBT and got 12 sessions over a span of a week. The intervention was adapted to include bilingual/bicultural therapists, language-concordant materials and culturally relevant values and framing.

The culturally adapted intervention resulted in faster improvement for depressive symptoms, and the symptom trajectory was towards adaptation. Importantly, in this study, the attrition rate at the end of the treatment was 7.4% in the adapted CBT group and 26.1% in the standard CBT group. This is important for health equity, as it not only led to clinical improvement, but also to more treatment continuation.

There were, however, some limitations to the study. The sample size was small and there was some uncertainty regarding blinding of the

outcome assessors and baseline depression was more severe in the culturally adapted arm. All these factors limited the precision and certainty of the findings. However, its CASP assessment was rated as moderate quality.

3.3 Anxiety management and navigation

The Calmer Life intervention was evaluated with 40 older adults who were at risk for neglect of routine care and most of whom (82.5%) were Black. The intervention included anxiety-management skills and resource linkage plus structured communication with primary care providers. These contacts were distributed over a 3-month period, about 8–10 contacts per month.

The intervention improved anxiety and depressive symptoms compared with enhanced community care. The anxiety effect was around $d=0.7$ with statistically significant results found for anxiety and depressive outcomes. The programme also tackled practical challenges through telephone assessment and through including resource navigation and primary-care communication. The presentation shows how service organisation can be part of the therapeutic pathway and not part of the administrative pathway.

The study gained a strong CASP judgement, with a score of 9/11, but due to the small sample size, the findings were not necessarily precise.

3.4 Mindfulness-based interventions

There were two trials that investigated adapted MBCT for Black adults. Powers et al. (2023) conducted a feasibility pilot with 34 Black adults from primary-care clinics in a public-hospital system. Eight group sessions were provided, each session would be set up for a week, and if needed, HIPAA compliant zoom would be utilized. At post treatment, retention was 76% and 67% at one month. 4.94 sessions were attended on average, and 95% judged the groups as helpful.

The results were mainly feasibility and acceptability findings with little definitive clinical effectiveness. It was a small study for robust between-group conclusions of efficacy and was given a limited CASP judgement.

The adapted MBCT intervention was also studied in an urban hospital with 70 Black adults who suffered from PTSD symptoms and depression in the context of publicly funded healthcare (Au et al., 2024). Eight sessions of weekly lessons were given, including online sessions in COVID-19. PTSD and depression scores were not significantly different between the groups, but there was a significant decrease in PTSD avoidance symptoms. The study did not thus give convincing proof of general superiority, but only of feasibility and of a definite clinical signal.

The mindfulness studies collectively imply that the psychological intervention in groups may be acceptable and accessible when it is delivered via safety-net approaches, but further trials and extended follow up are needed.

3.5 Trauma-informed collaborative care

Meredith et al. (2022) assessed trauma-informed collaborative care among 42 African American adults with probable PTSD in four FQHCs. The intervention lasted nine months and combined measurement-based follow-up, care management, brief psychotherapy and psychoeducation, medication support, warm hand-offs and social-needs linkage.

The reduction in PCL-5 scores was greater under trauma-informed collaborative care than enhanced usual care, although the reported p-value was 0.08. Provisional PTSD status decreased by 57% compared with 33%, while participants completed an average of 5.2 of seven planned follow-up contacts. These findings suggest a potentially important role for embedded care management in maintaining continuity within primary-care settings.

The small sample created substantial uncertainty around effect magnitude, and the study was therefore classified as moderate quality.

3.6 Digital interventions

Jonassaint et al. (2018) conducted a study on guided computerised CBT for anxiety and

depression in primary-care collaborative care. Treatment initiation was 75% among African American participants, and 87% for White participants. The completion rates for all eight sessions were 29% compared to 43%. But of those who started treatment, the changes in symptoms were generally similar. PHQ-9 change was -6.6 compared with -5.5 , while GAD-7 change was -5.3 compared with -5.6 . More telephone support was provided to African American participants by care managers. This study illustrates one important difference between intervention efficacy and intervention reach. After treatment began, the level of symptom improvement was generally comparable, except at the beginning and end of treatment.

In a study of 333 Black women in the Black Women's Health Study, Zhou et al. (2022) assessed the effectiveness of internet-based CBT. Participants received either standard iCBT-I, culturally tailored iCBT-I or sleep education. The intervention consisted of six online modules covering sleep restriction, stimulus control, cognitive restructuring and sleep hygiene.

Both CBT groups had significant improvement in insomnia symptoms at 6 months relative to education. The culturally tailored intervention was also more likely to be completed than standard iCBT-I (78.2% vs. 64.8%). The results illustrate potential for national reach opportunities through digital interventions and potential for culturally adapted content to increase engagement and adherence.

4. Quality of the Evidence

The CASP appraisal demonstrated variation in methodological strength across the seven trials. Zhou et al. (2022) received the highest score at 10/11 and was judged strong. Stanley et al. (2016) received 9/11 and was also judged strong. Hwang et al. (2015), Jonassaint et al. (2018) and Meredith et al. (2022) received moderate judgements, while Powers et al. (2023) was classified as limited.

Table 4: CASP Quality Appraisal of Included Studies

Study	CASP Score (/11)	Overall Quality
Au et al. (2024)	8.0	Moderate
Hwang et al. (2015)	8.5	Moderate

Jonassaint et al. (2018)	8.5	Moderate
Meredith et al. (2022)	8.0	Moderate
Powers et al. (2023)	7.5	Limited
Stanley et al. (2016)	9.0	Strong
Zhou et al. (2022)	10.0	Strong

The principal methodological limitations were small samples, limited follow-up, lack of feasible blinding in psychological interventions and, in some cases, secondary subgroup analyses. These limitations are important when interpreting apparently favourable findings because statistically significant results from small studies may have limited precision.

5. Discussion

The results show that both intervention content and delivery are important to reduce mental health inequalities. The interventions were more likely to include elements that would mitigate barriers to initiation, participation, and adherence to treatment across the seven trials.

The most obvious example is culturally adapted CBT. Hwang et al. showed that matching language and cultural framing to participants' background was correlated with both quicker symptom change and significantly reduced attrition. The theory is that cultural adaptation can affect the amount of treatment, as well as the initial acceptance of treatment. This is in line with other evidence that culturally adapted psychological interventions can increase acceptability and outcomes among ethnically minoritised populations.

The second mechanism is illustrated with the intervention "Calmer Life" which includes psychological skills and some guidance on how to make it work for them. Anxiety-management techniques were provided, in addition to resource linkage and systematic communication with primary-care providers. This is important because mental-health inequalities are not exclusively psychological. Other factors that can limit the effectiveness of interventions and prevent them from benefiting the entire population include transport, financial cost, administrative complexity, and difficulty in coordinating services.

Integration is also exemplified in collaborative care in FQHCs. Primary care was cohesive due

to the care managers, MBM, warm handoffs and social needs linkage. The small size of the Meredith et al. trial, and the fact that some of the findings did not meet the conventional criteria for statistical significance, does not detract from the value it suggests of routine integration of mental-health support into primary-care systems: the direction of findings and the successful completion of planned contacts suggest this.

Digital interventions evoked another pattern. Zhou et al. showed that internet-based CBT-Insomnia could be offered to a large population without the need for going to a clinic, thus decreasing travel and work and caregiving barriers. The results indicated that cultural tailoring was related to greater completion, meaning that digital interventions should not be considered as culturally neutral technologies. Engagement can be impacted by content, narratives, imagery and tone.

However, Jonassaint et al. showed that digital access is no guarantee of equitable access. Although improvements in symptoms were quite similar across all participants, African American participants were less likely to start or finish computerised CBT. This means that the critical equity issue might be present at engagement time and/or prior to engagement time and not during the therapeutic process itself. Human intervention by care managers is still relevant, however, as long as the main intervention is automated.

The mindfulness trials yielded more conservative results. Both studies showed that adapted MBCT could be offered in public or safety-net services and was well received by participants. There was less consistent evidence for the overall comparative clinical effectiveness, however. This indicates that feasibility and acceptability should not be taken as evidence of effectiveness. Further data on larger samples, with more sensitive comparators and longer follow-up will be needed before conclusions can be drawn regarding the population-level impact.

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6. Public-Health Implications

The results have multiple implications for public-health practice. First, services that are culturally and linguistically appropriate should be part of the routine provision of mental-health services, not an add-on. Treatment engagement may be enhanced by the use of bilingual and bicultural clinical capacity, culturally relevant materials and community-informed programme design.

Second, mental-health services should assess process outcomes in addition to clinical outcomes. If large proportions of individuals do not start or finish treatment then symptom reduction cannot be used to demonstrate that reducing an inequality. Routine monitoring and disaggregation of initiation, attendance, completion, attrition and continuity by ethnicity should, therefore, be done.

Third, care management and navigation can be incorporated into primary-care and safety-net systems. Both Calmer Life and trauma-informed collaborative care have found practical support and coordination can help alleviate some of the barriers to treatment. Fourth, mental-health programmes require engagement support.

Fourth, digital mental-health programmes need engagement support. While automated interventions can expand reach, reduced initiation and completion rates suggest that digital "delivery" can perpetuate inequalities if people do not receive support in getting started and staying engaged.

Last but not least, equity auditing should be part of service evaluation. The apparent success of services can result in inequitable gains

among populations, even if there are no differences in access and outcomes at one time. Regular monitoring can help to identify areas of inequality and whether change in delivery promotes engagement.

7. Strengths and Limitations

This review had a number of strengths, such as highlighting the randomized evidence and interventions that were provided in the real world through public and safety-net services. The relevance to routine public-health practice was enhanced by the integration of community clinics, FQHCs, public hospitals, and primary care and national digital platforms. Outcome measures were used for interpretation and were validated, including the PCL-5 and ISI.

All processes of the project were consolidated and methodological transparency was enhanced through the use of explicit PICO criteria and CASP appraisal. Different types of interventions and outcome measures were evaluated in the context of the narrative synthesis, without being forced to enter into a non-appropriate pooled estimate of the intervention's effect.

Some drawbacks have to be taken into consideration, however, for interpretation. A few studies were small and/or short-term. It was not possible to blind in psychological interventions in general, so performance and detection bias may have occurred. There were some secondary subgroup analyses that were used in some findings, and Asian evidence was found mostly in the Chinese American population. There was also limited evidence for black men and a lack of representation of other Asian subgroups. Language restriction may be a language bias as well. Moreover, the reporting of sociodemographic variables and equity measures was inconsistent, making it difficult to be certain about the mechanism underpinning inequities in treatment engagement.

8. Recommendations for Future Research

Larger multisite randomized trials in FQHCs, VA, community mental-health, and community or faith-based settings should be targeted for future research. These would enhance generalisability and would generate more

evidence of implementation in routine services. In addition to Chinese American and female samples, recruitment should deliberately reflect the diversity of the Asian population as well as the inclusion of Black men. Studies should also include socioeconomic attributes, immigration and language status if applicable to allow for an examination of the intersectional mechanisms. Where possible, use active comparators rather than a wait-list or education condition as the primary comparator in future trials. Long term follow-up, of at least 12 months duration, would give greater evidence for durability and the continuity. The process outcomes of the equity dimension should be included in advance. A range of measures of the initiation, delivery, attendance, completion, and attrition and referral continuity should be provided in addition to symptom outcomes. Digital interventions must assess onboarding and human support and not just the ability of participants to access the programme. There is a need for larger efficacy trials for mindfulness-based interventions to go beyond feasibility evidence. Fidelity, training needs, costs, and feasibility of implementing culturally adapted interventions into routine service delivery could also be explored with hybrid implementation-effectiveness designs.

9. Conclusion

This is a systematic review that evaluated public and community mental-health interventions for Black and Asian adults in the United States. Seven randomized trials were identified and included which found that intervention delivery is a crucial aspect of mental-health equity. Culturally adapted CBT was correlated with faster improvement and lower dropouts among Chinese American adults. Anxiety management was facilitated with navigation and structured primary-care communication among underserved older adults. Collaborative care in FQHCs provided a means to keep in touch with AA adults in the care system in a trauma-informed way. Digital CBT showed both the potential for large-scale reach, as well as that initiation and completion of treatment could be unequal. Adapted mindfulness interventions were feasible and acceptable in safety-net

environments and evidence for broad comparative effectiveness was less consistent. Overall, the evidence indicates that public health interventions should focus on the entire continuum of recognition of need to sustained treatment, and not just symptom reduction. Reducing barriers to participation can be achieved through cultural and linguistic relevance, care management, navigation, flexible delivery and human support. The review also shows that intervention effects can never be completely divorced from the system in which the intervention takes place. A similar clinical effect could occur in those who complete the intervention, but with disproportionate population advantages and disadvantages if some groups are less likely to enter or exit treatment. Therefore, public health outcomes of initiation, engagement, and continuation should be viewed as key outcomes. The evidence base is limited due to small samples, limited follow-up, and inconsistent representation of racial/ethnic subgroups, as well as inconsistent reporting of equity-outcomes. More extensive multisite research with longer follow-up and with more robust representation is thus required in the future. Yet the studies included in this report demonstrate that a culturally responsive, engagement oriented delivery mechanism can be used in conjunction with proven psychological strategies to help ensure equitable access to mental health care in public and community contexts in the United States.

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