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Indigenous and diaspora healing knowledge in U.S. mental health systems: A systematic review of cultural adaptation, access, and outcomes

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Abstract

Objective: This systematic review examined how Indigenous and diaspora healing knowledge has been adapted, integrated, or engaged within U.S. mental health systems, with particular attention to cultural adaptation, access to care, and reported outcomes. It focused on how mental health services respond to culturally grounded healing practices, community-based support systems, and alternative help-seeking pathways among Native and diaspora populations. The review also considered whether these forms of healing knowledge are meaningfully incorporated into care or remain peripheral to dominant clinical models.

Methods: The review was organized according to PRISMA 2020 principles and drew on literature addressing Indigenous healing, immigrant and refugee mental health service use, culturally adapted psychotherapy, community-based mental health support, and community-linked models of care. Searches were structured around mental health, Indigenous and diaspora populations, traditional healing, cultural adaptation, access, and outcomes. Extracted studies were synthesized thematically because the evidence base was conceptually related but methodologically diverse.

Findings: Four major themes emerged. First, Native mental health scholarship consistently frames healing within sovereignty, land, spirituality, kinship, and community authority. Second, immigrant and diaspora studies show that access is shaped by cost, insurance, language, stigma, trust, migration stress, and reliance on family, faith leaders, and informal networks. Third, culturally adapted interventions can improve engagement and some clinical outcomes, but adaptation is unevenly described and often under-evaluated. Fourth, the strongest models of care are those that move beyond surface cultural competence toward community-led and culturally grounded service design.

Conclusion: U.S. mental health systems need more than standard cultural competence frameworks. They require structurally responsive, community-centered, and culturally grounded approaches that recognize the legitimacy of multiple healing systems and the importance of trust, informal support, and community control in mental health care.

Keywords: Healing Knowledge; Cultural Adaptation; Access To Care, Mental Health Systems; Native Populations.

1. Introduction

Mental health care is not understood, experienced, or practiced in the same way across all populations. In the United States, many dominant models of care are built on biomedical and psychotherapeutic assumptions that often treat culture as a secondary modifier rather than a central condition of distress, recovery, and treatment engagement (Bryant-Davis, T., 2019). This creates an important challenge for Native and diaspora populations whose experiences of mental health are frequently shaped by histories of colonization, migration, spirituality, kinship, community relations, and collective memory. For many Indigenous communities, healing is inseparable from land, ceremony, tradition,

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identity, and community survival. For many immigrant and diaspora communities, mental health is closely tied to migration stress, family separation, language barriers, social exclusion, and reliance on trusted informal support systems outside formal clinical care (Bhugra, 2021).

Recent Native mental health scholarship has made clear that the issue is not simply whether mainstream mental health care can become more culturally sensitive. Gone (2023) argues that American Indian and Alaska Native mental health concerns must be understood within a postcolonial framework in which common forms of distress are linked to the enduring effects of colonial disruption, cultural loss, and imposed systems of care. In this view, mental health care for Native communities cannot be reduced to the adaptation of standard Western treatments. It must also address the question of whose knowledge is treated as legitimate and who has the authority to define healing. O'Keefe et al. (2021) reinforce this position by emphasizing tribal sovereignty, self-determination, and the need for systems of care that reflect Native spiritual, cultural, and relational worlds. Their paper also shows that Indigenous community mental health workers can help reduce stigma, increase the availability of culturally effective care, and strengthen systems rooted in community values and local knowledge.

The importance of traditional healing becomes even clearer in work that examines integration at the service level. Hartmann & Gone (2012), in a community-based study of an urban American Indian health organization, found that community members viewed ceremonial participation, traditional education, culture keepers, and community cohesion as central to a successful healing program. At the same time, they documented tensions involving trust, poverty, transport, multitribal representation, and the integrity of traditional practice in urban settings. Their findings are important because they show that integration is not a simple matter of adding culturally themed activities to existing clinical services. Instead, it involves negotiation over authority, authenticity, place, and the relation between formal mental health services and Indigenous healing systems. Redvers & Blondin's (2020) scoping review similarly shows that the literature on traditional Indigenous medicine in North America already includes themes such as ceremonial healing, use of traditional medicine, traditional healer perspectives, and integration with Western systems. Together, these studies suggest that Indigenous healing is not absent from the literature; rather, it is often insufficiently centered within mental health systems themselves.

A related but distinct pattern appears in the literature on immigrants, refugees, and broader diaspora populations (FitzGerald & David Scott, 2022). Here, the central concern is often not sovereignty in the same sense as the Native literature, but access, trust, cultural fit, and the relationship between formal services and informal support systems. A systematic review by Derr (2016) showed that immigrants from Asia, Latin America, and Africa tend to use mental health services at lower rates than non-immigrants despite equal or greater need. Derr (2016) also found that structural barriers such as cost, lack of insurance, and language barriers intersect with cultural barriers such as stigma, distrust, and preference for help from family, friends, or religious leaders. These findings are important because they suggest that access is not just about service availability. It is also about whether services are seen as meaningful, trustworthy, and socially acceptable.

The literature on culturally adapted interventions adds another layer to this discussion. Hwang et al., (2015) showed in a randomized controlled trial that culturally adapted cognitive-behavioural therapy for Chinese Americans with depression produced better overall symptom improvement and lower dropout than standard CBT, even though many participants remained clinically depressed by the end of treatment. McDermott et al., (2024) further demonstrate that adaptation can involve language, persons, metaphors, concepts, goals, methods, context, and content, rather than translation alone. Rathod et al., (2018) add that culturally adapted mental health interventions often show moderate to large effects, but the evidence base remains limited by heterogeneity, incomplete reporting of adaptation processes, and variable methodological quality. These studies collectively suggest that cultural adaptation matters, but that the field still lacks a strong consensus on which forms of adaptation work best, for whom, and under what conditions.

The Native trauma literature also points to the limits of adaptation when deeper historical and cultural issues are not addressed. Gameon & Skewes, (2020) argue that culturally adapted evidence-based treatments can be useful but may not be sufficientwhen interventions do not address community-specific systems such as historical trauma. Their review distinguishes between culturally adapted interventions and culturally grounded interventions developed from the ground up based on Indigenous needs, values, and social realities. This distinction is especially important in Native contexts, where interventions imposed from outside may fail even when superficially adapted.

Despite growing scholarship in each of these areas, the current evidence base remains fragmented. Recent studies tend to examine Native healing, immigrant service access, and cultural adaptation as partly separate literatures. Native mental health research often focuses on sovereignty, traditional healing, and community-controlled interventions. Diaspora mental health research often focuses on barriers to service use, informal help-seeking, and adaptation of

mainstream therapies. Adaptation reviews bring these conversations closer together but often do so across global contexts rather than within one U.S.-focused synthesis. This review addresses that gap by examining how Indigenous and diaspora healing knowledge has been adapted, integrated, or engaged within U.S. mental health systems, and what is known about access and outcomes among Native and diaspora populations.

Recent work outside the main Native and diaspora literature also suggests that this question has become increasingly important in practice. Community-based mental health support, culturally competent crisis intervention, support systems in recovery from mental health emergencies, telehealth-based access, and equity in virtual reality mental health applications have all emerged as issues of growing interest in U.S. mental health work (Ajayi & Thompson, 2025; Gordon et al., 2025; Egbunu et al., 2018; Botwe & Esho, 2025).

The objective of this systematic review was therefore to synthesize evidence on four linked issues; the cultural adaptation or integration of healing knowledge, the role of community and informal support in access to care, the reported outcomes of culturally adapted or culturally grounded interventions, and the major gaps that still limit the development of culturally responsive U.S. mental health systems.

2. Methodology

This study adopted a systematic review design guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework. The review was designed to identify, screen, select, and synthesize literature on how Indigenous and diaspora healing knowledge is represented, adapted, integrated, or engaged within mental health systems in the United States. The review question was: "*How has Indigenous and diaspora healing knowledge been adapted, integrated, or engaged within U.S. mental health systems, and what is known about access and outcomes among Native and diaspora populations?".*

2.1. Search strategy

A structured search strategy was developed to identify relevant studies across major health and social science databases. The databases searched were PubMed/MEDLINE, PsycINFO, Research Gate, Scopus, Web of Science, CINAHL, and Google Scholar. These databases were selected because they provide broad coverage of psychiatry, psychology, public health, community health, and interdisciplinary social science research. Additional hand-searching of reference lists from eligible articles was used to identify further relevant studies.

The search terms were built around four core concepts: mental health, target populations, healing knowledge and cultural adaptation, and access or outcomes. Search strings included terms such as "mental health" OR "behavioral health" OR psychotherapy OR counseling OR trauma, combined with Indigenous OR "American Indian" OR "Alaska Native" OR Native OR tribal OR immigrant OR refugee OR diaspora OR ethnocultural, and with "traditional healing" OR "traditional medicine" OR ceremonial healing OR spirituality OR "community mental health worker" OR "cultural adaptation" OR "culturally adapted" OR "culturally responsive" OR "culturally grounded." These were then linked to service-related terms such as *access OR utilization OR "service use" OR engagement OR outcome OR effectiveness OR acceptability OR integration.* Boolean operators "AND" and "OR" were used to improve both sensitivity and specificity. The search strategy broadly followed the logic used in prior systematic reviews of immigrant mental health service use, culturally adapted mental health interventions, and adaptation reviews in related populations.

2.2. Eligibility criteria

Studies were included if they focused on Native or diaspora populations in the United States, addressed mental or behavioral health, and examined Indigenous healing, traditional healing, culturally adapted care, mental health service use, or community-based mental health support in relation to access, adaptation, or outcomes. Both qualitative and quantitative studies were eligible, including randomized trials, observational studies, qualitative studies, scoping reviews, and systematic reviews. Studies were excluded if they were not U.S.-based, lacked a clear mental health focus, or discussed culture only in general terms without linking it to healing, service use, or outcomes.

2.3. Screening

Screening followed a staged process. Titles and abstracts were first reviewed for obvious relevance to the review question. Studies passing this stage were then examined in full text. Full-text screening assessed each article against the predefined inclusion and exclusion criteria. Priority was given to studies that dealt directly with Indigenous healing systems, culturally adapted interventions, community-linked mental health models, immigrant or diaspora help-

seeking, and culturally meaningful pathways into care. The selection process was organized in line with PRISMA 2020 principles, although this draft does not report final flow counts because those depend on the completed search record.

2.4. Data extraction and analysis

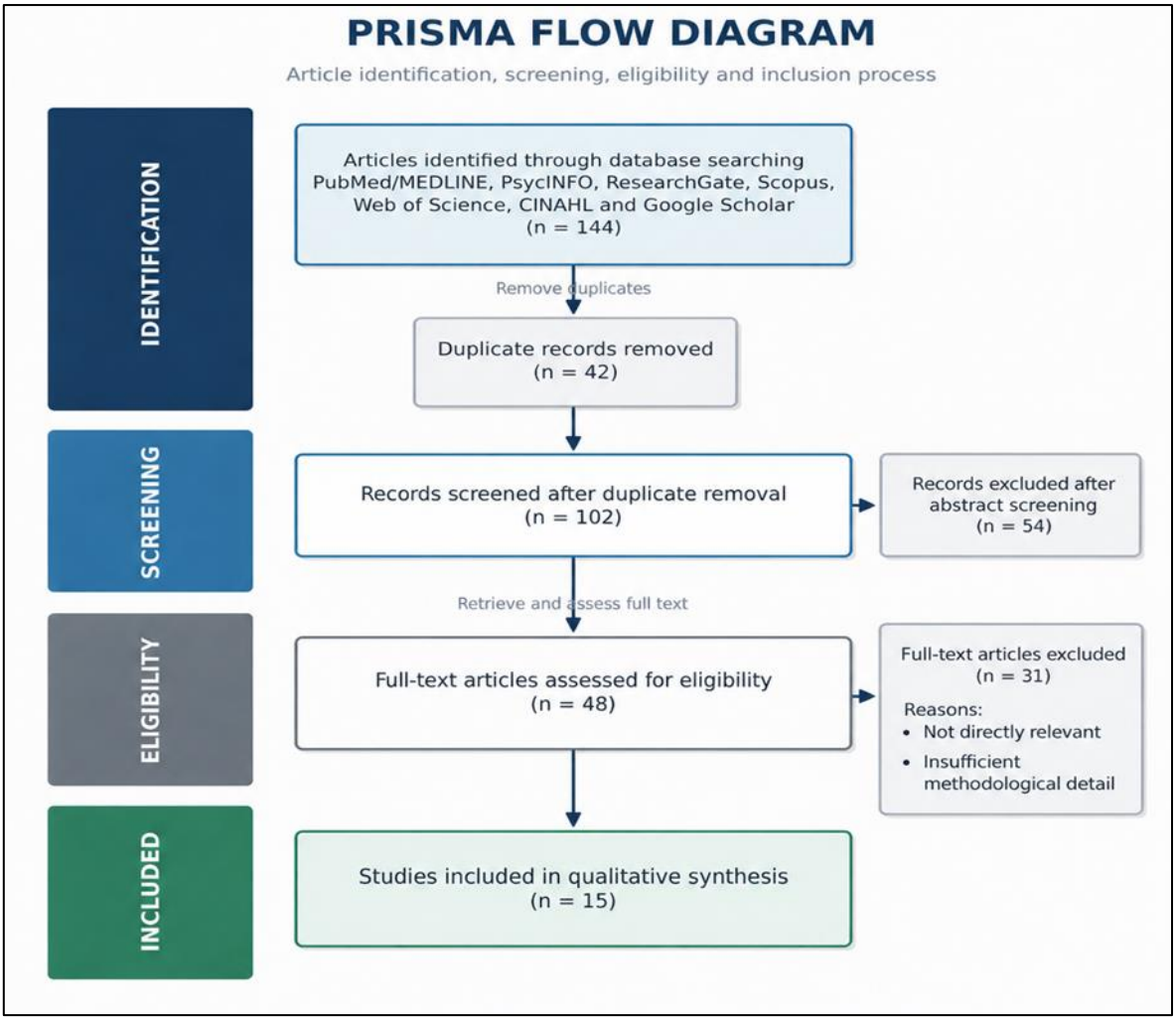
A structured data extraction template was developed to collect relevant information from each included study. The extracted items covered key methodological and substantive features of the literature, including author and year of publication, study design, setting, target population, participant characteristics, mental health focus, type of healing knowledge or intervention, form of cultural adaptation or integration, access-related barriers and facilitators, reported outcomes, and major methodological limitations. Additional attention was given to how each study conceptualized healing knowledge, cultural adaptation, and access to care, because these concepts were not defined in exactly the same way across the literature (Derr, (2016); Hwang et al., (2015); Rathod et al., (2018).

The extraction process also considered whether the studies located healing primarily within formal clinical services, community-based systems, informal support structures, or traditional healing practices. Particular attention was paid to whether healing was framed as an addition to mainstream mental health care, as a culturally adapted version of an existing intervention, or as a culturally grounded or community-led model developed from within the population itself. This was important because the included literature suggested that the meaning of adaptation differed substantially across Native and diaspora contexts (Hartmann & Gone, (2012); O'Keefe et al., (2021); Redvers & Blondin, (2020).

The analysis was conducted through thematic narrative synthesis. This approach was selected because the included studies were diverse in design, population, intervention type, and reported outcomes. The evidence base included a randomized controlled trial, a qualitative community-based study, systematic reviews, a scoping review, a review of meta-analyses, and broader conceptual or practice-oriented reviews (Hartmann & Gone, (2012); Hwang et al., (2015); Derr, (2016); Rathod et al., (2018); Redvers & Blondin, (2020). A pooled meta-analysis was therefore not appropriate because the studies did not provide sufficiently comparable intervention structures, outcome measures, or population groups for statistical aggregation (Rathod et al., 2018).

The extracted findings were organized into major thematic categories aligned with the review question. These themes included healing knowledge and cultural adaptation, access barriers and facilitators, community-led integration and workforce models, and reported outcomes and limitations of the evidence. Within each theme, the analysis compared how Native-focused studies and diaspora-focused studies approached healing, access, and mental health care, while preserving the important differences between these populations and contexts (Gone, (2023); Derr, (2016); McDermott et al., (2024). This allowed the review to identify both points of convergence across the literature and areas where the evidence remained fragmented or underdeveloped.

In addition to thematic synthesis, the methodological quality of the included studies was examined critically. This appraisal focused on the appropriateness of study design, clarity of sampling procedures, transparency of intervention or review methods, adequacy of outcome reporting, and the extent to which each study clearly explained its concept of healing knowledge or cultural adaptation. Special attention was given to recurring limitations in the literature, including small sample sizes, weak comparison groups, limited long-term follow-up, heterogeneity in intervention design, and incomplete reporting of adaptation processes (Gameon & Skewes, (2020); Hwang et al., (2015); Rathod et al., (2018). This critical assessment supported the interpretation of the evidence and helped identify gaps requiring further research.



Source: Author's construct (2026)

Figure 1 PRISMA flow diagram showing the article selection process in the study

2.5. Quality appraisal and synthesis

The evidence base reviewed here is methodologically diverse. It includes systematic reviews, a scoping review, a randomized controlled trial, qualitative community-based work, and broader conceptual reviews. Because of this heterogeneity, a pooled meta-analysis was not appropriate. Instead, the extracted material was synthesized using thematic narrative synthesis. This approach is also consistent with recent adaptation reviews that used structured descriptive synthesis because of variation in population, intervention type, provider, and outcomes. Thematic synthesis in the present review was organized around four analytical domains: conceptions of healing knowledge and cultural adaptation, access barriers and help-seeking pathways, systems integration and community-led models of care, and reported outcomes and limitations of the evidence.

3. Results and discussion

This review identified nine eligible studies addressing Indigenous and diaspora healing knowledge, cultural adaptation, access to care, and mental health outcomes in relation to U.S. mental health systems. Studies were published between 2015 and 2025. Extracted data included study design, country or setting, target population, mental health focus, sampling approach, sample size or number of included studies, recruitment or data source, and mode of administration. Table 1 presents the summary characteristics of the included studies.

The included studies were predominantly situated in the United States, although some review studies synthesized evidence across North America or across broader Indigenous, refugee, and minority ethnic contexts. Five studies focus mainly on Nati or Indigenous populations, especially American Indian and Alaska Native communities. These included Gameon & Skewes, (2020), Redvers & Blondin, (2020), O'Keefe et al., (2021), and Gone, (2023).

Table 1 Summary of study characteristics

Citation	Nation	Study type/design	Period studied	Mental health focus	Participant age (yrs)	Target population / setting	Sampling frame	Sampling strategy	Sample size (n)	Recruitment	How administered
Hwang et al., (2015)	USA	Randomized controlled trial	Screening and treatment period reported in study	Major depression; culturally adapted CBT vs standard CBT	18–65	Chinese American adults in community mental health clinics	Clinic patients meeting DSM-IV criteria	Random assignment	61 randomized	Community mental health clinics	Baseline screening, randomization, psychotherapy sessions
Derr, (2016)	USA	Systematic review	Literature search covered studies published before review date	Immigrant mental health service use	Mixed	U.S.-based immigrant populations	Seven databases	Systematic database search	62 included studies	Database search	Structured review and abstraction
Rathod et al., (2018)	Mixed/ international	Review of meta-analyses	Review period reported in study	Culturally adapted mental health interventions	Mixed	Minority ethnic and culturally diverse populations	Multiple databases	Systematic review of reviews	12 reviews	Database search	Narrative synthesis of meta-analytic reviews
Gameon & Skewes, (2020)	USA, Canada, Australia, New Zealand	Systematic review	Review of published intervention studies	Trauma interventions in Native communities	Mixed	Native communities	Database search	Systematic review	15 studies	Database search	Narrative synthesis of intervention studies
Redvers & Blondin, (2020)	North America	Scoping review	Historical and contemporary literature	Traditional Indigenous medicine / healing	Mixed	Indigenous medicine literature in North America	Multiple databases	Scoping review framework	249 included articles	Database search	Title/abstract screening and thematic grouping

O'Keefe et al., (2021)	USA	Practice-oriented review/article	Contemporary systems context	Indigenous community mental health workers; mental health equity	Mixed	American Indian and Alaska Native communities	Existing literature and service models	Narrative / practice review	Not applicable	Not applicable	Narrative synthesis and policy discussion
Gone, (2023)	USA	Annual review	Reviews key literature over recent decades	AI/AN community mental health services; addiction, trauma, suicide; Indigenized therapies	Mixed	American Indian and Alaska Native communities	Published literature	Narrative review	Not applicable	Not applicable	Literature review and conceptual synthesis
McDermott et al., (2024)	Mixed / international	Systematic review of randomized controlled trials	Contemporary trial literature up to review date	Cultural adjustments and psychological therapies' acceptability	Adults	Refugees and asylum seekers	Eligible randomized controlled trials	Systematic review	18 included studies	Database search	Systematic review and coded synthesis

Three studies focused primarily on immigrant, refugee, or diaspora populations, namely Derr, (2016), Hwang et al., (2015), and McDermott et al., (2024). One study, Rathod et al., (2018), provided a broader synthesis of culturally adapted mental health interventions across culturally diverse populations.

The evidence base was methodologically diverse. It included one qualitative community-based case study, one randomized controlled trial, three systematic reviews, one scoping review, one review of meta-analyses, one practice-oriented review, and one annual review. Hartmann & Gone, (2023) reported findings from four focus groups involving 26 participants from an urban American Indian community. Hwang et al., (2015) reported a randomized controlled trial of culturally adapted cognitive-behavioral therapy among Chinese American adults in community mental health clinics. Derr, (2016) synthesized 62 U.S.-based studies on immigrant mental health service use, while Redvers & Blondin, (2020) reviewed 249 articles on traditional Indigenous medicine in North America. Gameon & Skewes, (2020) included 15 studies, and McDermott et al., (2024) included 18 randomized controlled trials. This diversity in study design, population, intervention type, and outcome focus indicates heterogeneous evidence base and supports the use of thematic narrative synthesis rather than pooled quantitative meta-analysis.

Four broad areas of emphasis were evident across the included studies. These were traditional healing and Indigenous systems of care, access barriers and service use, cultural adaptation of psychotherapy and psychosocial interventions, and community-led or culturally grounded models of care. These patterns informed the thematic organization of the next stage of the review.

In addition to the summary of study characteristics shown in Table 1, two further tables were used to organize the findings more systematically. Table 2 presents the thematic summary of findings across the included studies, while Table 3 summarizes the main methodological strengths and limitations of each study

Table 2 shows that the included studies converged around several recurring themes. First, the Native-focused literature emphasized the central place of Indigenous healing knowledge, sovereignty, and community-led care. Second, the diaspora-focused literature highlighted the role of structural and cultural barriers in shaping access to formal mental health services. Third, studies on culturally adapted interventions consistently suggested that adaptation can improve acceptability, retention, and some clinical outcomes, although adaptation remained unevenly described across the literature.

Table 2 Thematic summary of findings

Citation	Theme	Main findings	Implication for review topic
Gone, (2023)	Indigenous systems and sovereignty	American Indian and Alaska Native mental health inequities are tied to postcolonial disruption, and tribal communities should retain authority over how mental health care is defined and delivered.	Supports the view that Native mental health care must move beyond mainstream cultural competence toward Indigenous authority and community-led systems.
O'Keefe et al., (2021)	Community-led workforce models	Indigenous community mental health workers can improve trust, reduce stigma, increase cultural responsiveness, and address gaps in the Native mental health workforce.	Highlights a practical model for embedding culturally grounded support within mental health systems.
Redvers & Blondin, (2020)	Traditional Indigenous medicine	The literature on Indigenous medicine in North America clustered around general traditional medicine, integration with Western systems, ceremonial healing, usage, and healer perspectives.	Confirms that traditional healing remains an active and relevant body of knowledge for mental health and wellness.
Gameon & Skewes, (2020)	Culturally grounded trauma care	Native trauma interventions often reported positive outcomes, including reduced distress, better coping, improved family relationships, and stronger cultural connection. However, the evidence base was methodologically limited.	Suggests that culturally grounded trauma approaches are promising, but stronger evaluation is still needed.

Derr, (2016)	Access barriers and help-seeking	Immigrants in the U.S. often use mental health services less than non-immigrants. Common barriers included cost, lack of insurance, language barriers, stigma, distrust, and reliance on family, friends, or religious leaders.	Shows that access depends not only on service availability but also on trust, social support, and culturally meaningful pathways into care.
Hwang et al., (2015)	Culturally adapted psychotherapy	Both standard CBT and culturally adapted CBT reduced depressive symptoms, but the adapted intervention produced greater overall improvement and lower dropout.	Indicates that culturally adapted psychotherapy can improve engagement and outcomes in diaspora populations.
Rathod et al., (2018)	Adaptation effectiveness	Culturally adapted interventions generally showed moderate to large effects, but the literature was limited by heterogeneity, small samples, and poor reporting of adaptation processes.	Supports adaptation as a useful strategy, while also showing the need for more rigorous and transparent evaluation.
McDermott et al., (2024)	Adaptation processes and outcomes	Adaptations extended beyond language to include persons, metaphors, concepts, goals, methods, context, and content. Adapted interventions often showed moderate to large effects, though acceptability evidence was limited.	Shows that effective adaptation is multidimensional and should not be reduced to translation alone.

The thematic summary also showed an important distinction between Native and diaspora studies. Native-focused work tended to emphasize traditional healing, community authority, cultural continuity, and culturally grounded systems of care. In contrast, diaspora-focused work tended to emphasize barriers to service use, informal support systems, and the adaptation of mainstream psychotherapy. Even so, both bodies of evidence pointed to the same broader conclusion: mental health services are more effective when they are trusted, culturally meaningful, and responsive to community realities.

Table 3 indicates that the evidence base is valuable but methodologically uneven. Some studies provide rich conceptual and community-based insight, while others offer stronger evidence on intervention effects or service access. However, common limitations recur across the literature, including small samples, heterogeneous study designs, incomplete reporting of adaptation processes, and limited long-term follow-up. These limitations make it difficult to compare studies directly or to determine which intervention elements are most responsible for positive outcomes.

Taken together, Tables 2 and 3 show that the literature converges around a few consistent themes: the centrality of Indigenous healing knowledge in Native mental health care, the importance of trust and informal support systems in diaspora help-seeking, the promise of culturally adapted interventions, and the need for stronger community-led models of care. At the same time, the tables reveal clear methodological gaps that should shape interpretation of the evidence. These patterns provide the basis for the thematic discussion that follows in the Results and Discussion section.

Table 3 Methodological strengths and limitations of included studies

Citation	**Strengths**	**Limitations / quality concerns**
Gone, (2023)	Strong conceptual and systems-level synthesis of AI/AN mental health issues; centers sovereignty and Indigenous knowledge.	Narrative review rather than primary empirical study; does not provide pooled effect estimates.
O'Keefe et al., (2021)	Strong practice relevance; highlights workforce and equity issues in Native communities.	Practice-oriented review rather than empirical evaluation; limited direct outcome data.
Redvers & Blondin, (2020)	Broad scoping review with a large number of included articles; useful thematic mapping of Indigenous medicine literature.	Scoping design does not assess intervention effectiveness in the same way as a systematic review or trial.
Gameon & Skewes, (2020)	Clear focus on Native trauma interventions; useful distinction between culturally adapted and culturally grounded interventions.	Small and heterogeneous evidence base; weak comparison groups; limited internal and external validity across included studies.

Derr, (2016)	Large U.S.-focused systematic review; strong synthesis of access barriers and service-use patterns.	Focused on service use rather than direct intervention outcomes; included studies varied in population and measures.
Hwang et al., (2015)	Randomized controlled trial design; direct comparison between adapted and standard psychotherapy.	Small sample; limited remission despite improvement; focused on one diaspora subgroup only.
Rathod et al., (2018)	Higher-level synthesis across meta-analyses; useful overview of effectiveness patterns.	Heterogeneity across reviews; limited clarity on which adaptation elements drive outcomes.
McDermott et al., (2024)	Strong focus on adaptation components and acceptability; systematic review of trials.	Mainly refugee/asylum-seeker evidence; not U.S.-only; acceptability reporting remained limited.

4. Future Directions and Research Gaps

A major gap in the literature is the lack of U.S.-focused reviews that bring Indigenous healing knowledge and diaspora help-seeking pathways into one analytic frame without collapsing their differences. Native mental health literature is often grounded in sovereignty, land, ceremony, and community control. Diaspora mental health literature is more often grounded in access barriers, migration-related stress, and adaptation of mainstream interventions. Future research should not erase this difference. Instead, it should examine how mental health services can become more legitimate, trusted, and culturally grounded for populations whose healing traditions and social realities are not fully reflected in dominant care models.

A second gap concerns intervention reporting. Studies show that adaptation is often discussed in broad terms without enough detail on who led the adaptation, what was changed, why it was changed, and how adaptation decisions were linked to local evidence or theory (McDermott et al., (2024); Rathod et al., (2018). This makes replication difficult and weakens comparisons across studies. Future research should report adaptation processes more explicitly and distinguish clearly between surface adaptation, deep adaptation, and culturally grounded intervention development.

A third gap is the limited attention to implementation and system design. O'Keefe et al., (2021) and Gordon et al., (2025) highlight Indigenous community mental health workers as one promising strategy, but more research is needed on how traditional healers, peer supporters, community workers, and formal clinicians can collaborate within real U.S. service settings. Related work on community-based support, crisis response, support systems in recovery, telehealth, and virtual reality indicates growing interest in alternative and decentralized models of care. However, stronger empirical work is needed to show how such models can be aligned with Native and diaspora healing priorities rather than merely expanding access to the same culturally thin services.

A fourth gap concerns outcomes. Hwang et al., (2015) showed symptom gains and reduced dropout, but remission remained limited. Gameon & Skewes, (2020) found positive outcomes, but long-term durability was uncertain. Future studies should therefore assess a wider range of outcomes, including trust, cultural safety, service retention, community fit, and connection to tradition, in addition to clinical symptom change. These broader outcomes may be especially important in populations for whom healing is relational, spiritual, and community based.

Finally, stronger ethical and policy engagement is needed. In Native contexts, issues of sovereignty and epistemic justice are central, while in diaspora settings, key concerns include affordability, language access, stigma, legal precarity, and navigating both formal and informal care systems. Policymakers and clinicians must therefore move beyond generic cultural competence toward approaches that support community authority, fund culturally grounded interventions, and enable meaningful collaboration across diverse healing traditions.

5. Conclusion

This systematic review shows that Indigenous and diaspora healing knowledge remains highly relevant to the future of U.S. mental health systems, but the literature does not treat these populations in the same way. In Native contexts, the evidence centers sovereignty, traditional healing, community authority, and the need to recognize Indigenous knowledge as more than an accessory to standard care. In diaspora contexts, the evidence centers barriers to service use, help-seeking through family and religious networks, and the adaptation of mainstream interventions to fit

culturally specific meanings and relationships. Across both contexts, the strongest lesson is that mental health care works better when it is community-linked, culturally grounded, and trusted.

The review also shows that cultural adaptation is not a minor technical matter. It involves questions of power, meaning, and institutional legitimacy. In some cases, adaptation may improve engagement and outcomes, as seen in culturally adapted CBT and in broader reviews of adapted interventions. In other cases, especially in Native contexts shaped by historical trauma and colonial disruption, adaptation alone may be insufficient, and culturally grounded interventions or community-led healing models may be more appropriate.

The evidence base remains limited, as many studies rely on small samples, short follow-up periods, or insufficiently detailed adaptation processes. There is a need for stronger mixed-methods research, improved reporting, and more community-led evaluation. Nevertheless, existing literature points to a clear conclusion: U.S. mental health systems must move beyond narrow notions of cultural competence toward more structurally responsive, community-informed, and pluralistic models of care. For Native communities, this requires recognizing Indigenous healing on its own terms, while for diaspora communities, it involves improving access alongside respect for informal support systems and culturally grounded meanings of help-seeking. Ultimately, mental health care must be designed in ways that communities can recognize as their own.

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