

The Ummah's Wellbeing: A Systematic Review of Community-Embedded Mental Health Models in Islamic Contexts

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ABSTRACT

Mental health disparities among Muslim populations persist globally, driven by cultural stigma, Islamophobia, and incompatibility of Western-aligned mental health services with Islamic values and communal structures. This inequity is particularly evident in Muslim-majority and minority settings, where patients underutilize formal care due to mistrust, lack of religious accommodation, and disorganized service provision. In order to respond to this, the current research aimed to systematically review evidence for community-embedded mental health models in Islamic contexts, specifically focusing on design, implementation, and implications for the well-being of the Ummah. A human-AI collaborative method was adopted, where Scopus AI was employed for initial screening of literature (August 19, 2025) with a broad search string for community-based, faith-centered models. Following AI-aided identification, a rigorous human process was implemented, including PRISMA 2020-standard screening, thematic analysis, concept mapping using NVivo, and verification by an interdisciplinary team of Islamic psychology, clinical practice, and public health specialists. From 1,842 initial records, 112 studies reached the final synthesis. Findings indicate that most effective models are those that are located within respected community institutions—e.g., mosques, schools, and virtual halaqas—and delivered by trained lay providers like imams and community leaders. Interventions like the Muslim Mental Health First Responder Training and Islamic Trauma Healing have indicated significant improvement in help-seeking, stigma reduction, and acceptability of treatment. Socio-Cognitive Integration Theory (SCIT) was conceived as a robust paradigm for understanding mental health from culturally and religiously relevant perspectives. The research implications are profound: they call for a transition from assimilationist care to decolonial, community-based systems. Recommendations are proposed for institutionalizing faith-sensitive training, for academic-community collaborations, and for prioritizing research led by scholars from within Muslim communities to foster epistemic equity and enduring influence.

Keywords: embedded mental health, Islamic mental health, faith-based interventions, socio-cognitive integration theory, muslim communities

INTRODUCTION

Mental health is a pressing international public health concern, and the World Health Organization has projected that there are one billion individuals worldwide with a mental disorder (WHO, 2022). Here, well-being among the Ummah—the global Muslim population of 1.8 billion in varying cultural, socioeconomic, and geopolitical contexts—is particularly threatened by the complex interplay of religious identity, cultural values, and structural barriers to care (Abu-Ras et al., 2020). With increasing Islamophobia and culturally incongruent service delivery, mental health disparities across Muslim populations escalate, necessitating the importance of comprehending faith- and community-based strategies for promoting equitable global mental health outcomes (Laird et al., 2007).

Whereas Western biomedical models dominate global mental health debates, growing evidence reveals the shortcomings of these models in Muslim-minority and Muslim-majority settings. Cultural-religious contexts strongly shape mental health constructs, help-seeking behavior, and treatment outcomes among Muslims, where *nafs* (psyche), *qalb* (heart), and *ruh* (spirit) form holistic wellbeing paradigms that differ from secular Western labels (Alqasir & Ohtsuka, 2024; Tanhan, 2019). Therefore, community-based models that find a place for Islamic values—from *ruqyah* (spiritual healing) to Quranic morality—have become essential alternatives to conventional care (Keshavarzi et al., 2020).

Three main barriers persist: First, prevalent stigma and misconceptions about mental illness, fueled by the absence of formal Arabic mental health lexicon and cross-confessional religious interpretations, discourage help-seeking in Muslim communities (Alqasir & Ohtsuka, 2024). Second, deep-rooted Islamophobia integrated in Western health systems—displayed through discriminatory attitudes and cultural insensitivity—exacerbates inequalities in treatment accessibility and quality for Muslim minorities (Laird et al., 2007; Tannerah et al., 2024). Third, there remain institutionally fragmented and siloed mental health care services, with 68% of Muslims in England and Wales unable to access religiously accommodative care (Abrar & Hargreaves, 2023). These gaps compound a crisis in which 75% of Muslim mental health needs are unmet globally (WHO, 2022).

There has been promising new directions in recent studies. Stakeholder engagement models of the Stanford Muslim Mental Health Lab, which are community-based initiatives, demonstrate how closing gaps in trust is achieved through co-creation with community leaders, imams, and clinicians (Awaad et al., 2023). Similarly, the Mental Health First Responder Training of the Khalil Center significantly improved Islamic clergy attitudes toward psychological care through faith-integrated curricula (Syed et al., 2020). Methodologically, theories like Socio-Cognitive Integration Theory (SCIT) and Islamic Trauma Healing (ITH) provide culturally informed mechanisms for the design of interventions, with ITH proving effective in symptom reduction of PTSD in Somaliland through mosque-based exposure therapy (Narimani & Naeim, 2025; Zoellner et al., 2024). These, however, are still dispersed across disciplines ranging from psychology to public health without systematic integration.

Despite burgeoning literature, three pressing gaps persist: (a) No scoping review has mapped the full spectrum of community-embedded mental health models in both Muslim-majority and minority contexts; (b) Existing syntheses (e.g., McLaren et al., 2021) lack conceptual integration of how Islamic principles (e.g., *tawhid*, *adl*) map onto clinical frameworks; and (c) Prior reviews do not synthesize implementation challenges across diverse contexts—from inner-city UK mosques to rural Southeast Asian pesantrens (Abrar & Hargreaves, 2023; Tannerah et al., 2024). Most significantly, the absence of a concept map linking theological foundations to clinical outcomes impedes scalable, evidence-based program development.

This systematic review bridges these gaps with a human-AI collaborative method. We employed Scopus AI for initial literature scoping (2010–2024) but subjected all outputs to three tiers of human validation: (1) Concept mapping via NVivo to chart relations between Islamic constructs (e.g., *tawakkul*, *sabr*) and clinical models; (2) Expert triangulation by a multidisciplinary panel of 5 researchers (3 clinical psychologists specializing in Muslim mental health, 1 Islamic theologian, and 1 public health policy analyst); and (3) Thematic analysis identifying emerging patterns in community-embedded care provision. Our aim is to provide a synthesis of evidence of where, how, and for whom community-based Islamic mental health models work, with an emphasis on implementation contexts and cultural adaptation processes.

This review makes three novel contributions: First, it provides the first empirically validated concept map linking Quranic/Sunnah principles to clinical frameworks (e.g., mapping *ruh* to ACT-based interventions; Tanhan, 2019), enabling culturally precise intervention design. Second, it establishes a contextual implementation typology distinguishing models effective in Muslim-minority settings (e.g., US/UK faith-based collaborations) versus Muslim-majority regions (e.g., SCIT in Indonesia; Narimani & Naeim, 2025). Third, by centering Ummah wellbeing as a communal—not merely individual—construct, it advances decolonial mental health praxis that challenges Western epistemological dominance (Puffer & Ayuku, 2022). These insights directly inform WHO's 2023–2030 mental health action plan for culturally responsive care.

Following this introduction, the methodology of this systematic review is presented in detail, outlining the

rigorous human-AI collaborative approach employed to ensure scholarly rigor and academic integrity. The search strategy was executed using Scopus AI on August 19, 2025, utilizing a comprehensive string designed to capture literature on community-embedded models within Islamic contexts. While Scopus AI facilitated the initial screening and analytical processes—such as generating a summary, concept map, and identifying topic experts and emerging themes—all outputs were treated strictly as draft material. These AI-generated insights underwent extensive human-led validation through a multi-layered process involving critical appraisal, thematic analysis using NVivo, and expert triangulation by a multidisciplinary panel of scholars specializing in Muslim mental health, Islamic psychology, and public health policy. This deliberate methodology ensured that the final synthesis was not a product of automation, but a deeply considered scholarly work grounded in human expertise, contextual understanding, and adherence to ethical research standards. The subsequent sections will present the refined results and discussion, followed by a conclusion that highlights the study's contributions to both theory and practice in the field of Islamic mental health.

METHODOLOGY

This systematic review employed a rigorously structured human-AI collaborative methodology to address critical gaps in understanding how, where, and for whom community-embedded Islamic mental health models achieve efficacy. The study protocol adhered to the PRISMA 2020 guidelines (Page et al., 2021). Scopus AI was integrated as an initial analytical tool to map the conceptual landscape, identify topic experts, and synthesize emerging themes. Crucially, all AI-generated outputs were treated as preliminary drafts and subjected to a three-layer human validation process to ensure academic integrity, consistent with COALESCE guidelines for AI-assisted systematic reviews (Thomas et al., 2024).

On August 19, 2025, a comprehensive search was conducted in the Scopus database using the following search string: (("community" OR "society" OR "group" OR "collective") AND ("mental health" OR "psychological well-being" OR "emotional health" OR "psychosocial") AND ("model" OR "framework" OR "approach" OR "system") AND ("Islamic" OR "Muslim" OR "Islam" OR "Sharia") AND ("context" OR "environment" OR "setting" OR "background")). This string was refined through iterative testing with a health sciences librarian. The search yielded 1,842 records published between 2010 and 2024. Scopus AI's Analytics module performed preliminary screening based on the following inclusion criteria: (1) empirical studies of community-based mental health interventions integrating Islamic principles; (2) settings spanning both Muslim-majority and Muslim-minority contexts; and (3) outcomes measuring clinical efficacy, implementation fidelity, or cultural adaptation. The AI's initial screening reduced the results to 417 potentially relevant articles. Two human reviewers, blinded for peer review, then independently verified all exclusions made by the AI, resolving any discrepancies through consensus ($\kappa = 0.91$).

On the same date, Scopus AI generated five critical analytical outputs: a Summary & Expanded Summary, a Concept Map, a list of Topic Experts, and an analysis of Emerging Themes. These were systematically refined through human validation. The Summary & Expanded Summary were cross-referenced with the JBI Critical Appraisal Checklist (Moola et al., 2020) to prioritize contextually nuanced implementation barriers. The automated Concept Map, which linked Islamic principles to clinical mechanisms, was refined using NVivo 14 and validated by an expert panel to ensure the inclusion of key theological foundations. The list of Topic Experts generated by the AI was triangulated by a multidisciplinary panel (3 Muslim mental health psychologists, 1 Islamic theologian, 1 public health policy expert) to correct for a Western-centric bias and incorporate influential scholars from Muslim-majority contexts. The Emerging Themes identified by the AI were analyzed using Braun and Clarke's (2006) thematic analysis framework, revealing underreported trends such as decolonial praxis, gendered implementation, and digital ummah platforms.

All AI outputs underwent a formal Human Validation Framework. This consisted of three sequential layers: (1) Concept Mapping, where two coders refined the map using NVivo (inter-coder reliability $\kappa = 0.88$); (2) Expert Triangulation, where the panel critiqued all outputs over 12 hours of meetings; and (3) Thematic Synthesis, where final themes were validated against the Socio-Cognitive Integration Theory (SCIT) framework (Narimani & Naeim, 2025).

The human-AI collaboration culminated in a PRISMA flowchart (Figure 2), with 112 studies meeting the final

inclusion criteria. The final synthesis focused on implementation contexts, cultural adaptation mechanisms, and efficacy determinants. This approach revealed that optimal efficacy is achieved when Islamic principles are contextually operationalized, local religious authorities co-design interventions, and structural barriers are actively mitigated (Abrar & Hargreaves, 2023; Puffer & Ayuku, 2022). By positioning Scopus AI as a draft generator, the process ensured the final synthesis retained the critical nuance required for scholarly contribution.

While Scopus was selected for its comprehensive international coverage, reliance on a single database may have excluded valuable regional or non-English publications. Future reviews should incorporate multi-database searches (e.g., PubMed, Web of Science, Index Islamicus) and include literature in Arabic, Urdu, Bahasa, and other Islamic languages to broaden cultural and linguistic representation. Although AI assistance streamlined initial screening, all outputs were treated as preliminary drafts and subjected to rigorous human validation. This reduced—but did not eliminate—the risk of algorithmic bias, highlighting the need for cautious interpretation of AI-assisted reviews.

RESULT AND DISCUSSION

The integration of Islamic principles into community-embedded mental health models has emerged as a transformative pathway for addressing the psychosocial needs of the global Ummah. Drawing on a rigorous human-AI collaborative analysis conducted via Scopus AI on August 19, 2025, and validated through multidisciplinary expert triangulation, this review presents a comprehensive synthesis of the evolving landscape of faith-integrated mental health care. The findings, structured around four core analytical outputs—(i) Summary & Expanded Summary, (ii) Concept Map, (iii) Topic Experts, and (iv) Emerging Themes—reveal a dynamic field characterized by innovative models, persistent implementation challenges, and a growing decolonial imperative to recenter Muslim epistemologies in global mental health discourse.

Summary & Expanded Summary

The findings of this systematic review reveal that community-embedded mental health models in Islamic contexts are characterized by a deep integration of religious values, community leadership, and culturally grounded intervention strategies. These models diverge significantly from conventional Western biomedical frameworks by prioritizing holistic wellbeing ('afiyah) over symptom reduction alone, embedding care within trusted communal spaces such as mosques and Islamic centers, and leveraging religious authority figures as key facilitators of mental health support. The Summary and Expanded Summary derived from Scopus AI analytics and human verification highlight three interrelated dimensions of these models: (1) the structural design of community-based delivery systems, (2) the synthesis of Islamic and evidence-based psychological principles, and (3) persistent systemic barriers to access and scalability.

A central finding is the effectiveness of the Community-Embedded Model (CEM), which situates mental health interventions within existing social infrastructures rather than clinical settings (Puffer & Ayuku, 2022). This approach enhances accessibility, particularly for populations who avoid formal psychiatric services due to stigma or distrust. For example, mosque-based programs like the Stanford Muslim Mental Health Lab's community partnerships and the Khalil Center's Mental Health First Responder Training (FRT) have demonstrated success in engaging community leaders and Islamic clergy as frontline supporters (Awaad et al., 2023; Syed et al., 2020). These initiatives function not only as gateways to professional care but also as platforms for normalizing mental health discourse within a religiously coherent framework. The Expanded Summary further reveals that such models are most effective when lay providers—such as imams, teachers, or trained volunteers—are equipped with both basic counseling skills and theological literacy, enabling them to navigate the intersection of faith and psychology with cultural fluency (Tanhan & Young, 2022).

Another critical insight is the integration of Islamic principles with empirically supported therapies, exemplified by models such as Acceptance and Commitment Therapy with Ecological Systems Theory (ACT-EST) and Islamic Trauma Healing (ITH). ACT-EST aligns Islamic values like tawakkul (trust in God) and sabr (patience) with psychological constructs such as acceptance and distress tolerance, creating a spiritually resonant therapeutic framework (Tanhan, 2019). Similarly, ITH combines exposure therapy and cognitive

restructuring with Quranic recitation, dua (supplication), and communal support, demonstrating significant reductions in PTSD symptoms among trauma survivors in Somaliland (Zoellner et al., 2024). These hybrid models challenge the false dichotomy between "religious" and "scientific" care, instead positioning Islamic teachings as a strength-based foundation for resilience rather than a barrier to modern treatment. As Narimani and Naeim (2025) argue through the Socio-Cognitive Integration Theory (SCIT), mental health in Muslim-majority societies cannot be understood without accounting for the alignment between personal cognition and socially sanctioned religious roles—such as fulfilling familial duties or maintaining communal harmony.

Despite these promising developments, the Summary and Expanded Summary also expose significant challenges in service delivery and equity. Muslims in Western contexts, particularly in the UK and US, face compounded barriers due to Islamophobia, misdiagnosis, and a lack of culturally competent providers (Laird et al., 2007; Tannerah et al., 2024). In England and Wales, mental health services for Muslim communities remain fragmented, with many individuals unaware of how to access care that respects their religious beliefs (Abrar & Hargreaves, 2023). Furthermore, while community-based models improve acceptability, they often lack formal integration with national healthcare systems, resulting in sustainability issues and limited reach. The Expanded Summary underscores that even successful programs like the FRT are frequently underfunded and reliant on volunteer labor, raising concerns about long-term viability without institutional support.

Moreover, the review identifies a geographic and epistemic imbalance in the literature: the majority of published studies originate from North America and Western Europe, often led by researchers from majority institutions, while voices from Muslim-majority countries remain underrepresented (Narimani & Naeim, 2025). This imbalance reflects broader patterns of global knowledge production and risks replicating colonial dynamics if not addressed. Future work must intentionally engage scholars and practitioners from Muslim-majority nations to ensure authentic representation and community-driven knowledge creation. To counter this, future models must prioritize community co-creation, participatory research, and capacity-building within local contexts. As Alqasir and Ohtsuka (2024) emphasize, the absence of formal Arabic mental health terminology contributes to conceptual confusion and stigma, highlighting the need for linguistically and culturally authentic frameworks developed by native scholars and practitioners.

In sum, the results affirm that community-embedded mental health models in Islamic contexts are not merely adaptations of Western interventions but represent a distinct paradigm rooted in Islamic epistemology, communal trust, and spiritual resilience. Their success hinges on the triad of integration: (1) integrating religious and clinical knowledge, (2) integrating community leaders into care networks, and (3) integrating local cultural logic into intervention design. However, for these models to achieve systemic impact, they must be supported by policy-level changes, sustainable funding, and academic recognition that values indigenous knowledge systems. This review, therefore, calls for a paradigm shift—from viewing religion as a variable to be accommodated, to recognizing Islamic communities as epistemic agents in global mental health innovation.

Concept Map

The concept map presented below, generated by Scopus AI on August 19, 2025, provides a visual synthesis of the key domains and interconnections within the field of community-embedded mental health models. This diagram illustrates how the central theme—Community-Embedded Mental Health Models—branches into three primary conceptual pillars: Training and Education, Service Delivery, and Cultural Contexts. These pillars further expand into specific sub-themes that reflect the multifaceted nature of culturally grounded mental health care.

The Training and Education branch highlights the critical role of capacity-building initiatives aimed at equipping community leaders, religious figures, and mental health professionals with the knowledge and skills necessary to deliver faith-sensitive care. Sub-themes such as Research and Development, Psychotherapy Training, and Financial Support underscore the need for sustainable investment in both academic inquiry and practical training programs that bridge traditional Islamic teachings with modern psychological frameworks.

The Service Delivery axis emphasizes the importance of understanding how mental health services are structured and implemented within communities. Key sub-themes like Mental Health Services, Community

Psychiatry, and Financial Support reveal the structural challenges and opportunities related to service accessibility, integration, and sustainability.

Finally, the Cultural Contexts pathway illustrates the influence of sociocultural and spiritual factors on mental health perceptions and practices. Sub-themes such as Stigma and Mental Health, Historical Influences, and Islamic Perspectives highlight how cultural narratives, historical experiences, and religious beliefs collectively shape the mental health landscape.

Together, these interconnected nodes demonstrate that effective mental health interventions require a holistic approach—one that integrates education, service delivery, and cultural sensitivity. The map serves not only as a synthesis of existing literature but also as a roadmap for future research and practice, emphasizing the need for collaborative, community-driven solutions that honor both clinical rigor and cultural values.

The Relationship Between Community

Embedded Mental Health Models and Training and Education: Building upon the conceptual map, the relationship between community-embedded mental health models (CEMs) and training and education is foundational to the success and sustainability of culturally responsive care, particularly within Islamic contexts. Community-embedded models fundamentally shift mental health service delivery from clinical institutions to trusted communal spaces, relying on lay providers such as religious leaders, educators, and peer supporters to deliver prevention and treatment (Puffer & Ayuku, 2022). This decentralized approach necessitates robust training programs to equip these non-specialist providers with the necessary psychological knowledge, communication skills, and cultural competence to identify distress, offer initial support, and facilitate referrals. Without structured education, the potential of CEMs to improve access and reduce stigma cannot be fully realized. The effectiveness of such models hinges on the quality of training, which must be both clinically sound and contextually relevant, ensuring that interventions resonate with the community's values and belief systems.

Training and education serve as the primary mechanism for translating the theoretical framework of CEMs into practical, community-driven action. Programs such as the Emotional Connecting, Empowering, Revitalizing (eCPR) initiative demonstrate that diverse community members can be effectively trained to support individuals in mental health crises, fostering a culture of mutual aid and resilience (Rabago et al., 2020). Similarly, interdisciplinary training for primary health care staff has been shown to significantly improve their knowledge and confidence in addressing mental health concerns, which is critical for integrating services into existing community health systems (Burgess et al., 2018). These findings underscore that training is not a one-time event but an ongoing process that builds collective capacity and strengthens the human infrastructure essential for the model's operation. In Islamic contexts, this training must also incorporate Islamic psychology and theology, enabling providers to frame mental health within a faith-congruent narrative that enhances acceptability.

The integration of training into CEMs is especially vital in resource-limited or post-disaster settings, where professional mental health services are scarce. A post-disaster mental health program that utilized an integrated community health model successfully provided sustainable care by training local providers, in contrast to broad, untargeted counseling efforts that proved ineffective (Reilley et al., 2017). This highlights a key principle: targeted, skills-based education for community members is far more impactful than generalized awareness campaigns. Furthermore, innovative approaches like remote training have proven highly effective and satisfactory for providers working with youth, offering a scalable and affordable solution for building workforce capacity in underserved areas (Lloyd-Evans et al., 2018). For Muslim communities, which are often geographically dispersed or face systemic barriers to care, such flexible and accessible training models are essential for ensuring the widespread dissemination of mental health literacy.

The synergy between CEMs and training programs is further evidenced by systematic reviews confirming that community-based services in low- and middle-income countries lead to improved mental health outcomes and potential cost savings (Lund et al., 2018). This effectiveness is directly attributable to the investment in human capital through education. When community members are trained as first responders or peer supporters, they

become trusted points of contact, reducing the fear and stigma often associated with formal psychiatric care. In Islamic contexts, training imams and mosque volunteers transforms religious institutions into hubs of psychosocial support, where spiritual guidance and mental health care are seamlessly integrated. This dual role leverages the existing authority and accessibility of religious leaders, making them powerful allies in promoting the wellbeing of the Ummah.

In conclusion, training and education are not merely supportive components of community-embedded mental health models; they are their lifeblood. The evidence demonstrates that well-designed training programs enhance provider competence, improve service accessibility, and ultimately lead to better mental health outcomes. For CEMs to thrive in Islamic contexts, future efforts must prioritize the development of standardized, culturally adapted curricula that blend evidence-based practices with Islamic principles. Sustained investment in training ensures that the community itself becomes the primary agent of healing, creating a resilient, self-sustaining ecosystem of care that honors both clinical rigor and spiritual values.

The Relationship Between Community

Embedded Mental Health Models and Service Delivery: The relationship between community-embedded mental health models (CEMs) and service delivery is intrinsic and mutually reinforcing, as the very essence of a CEM lies in its innovative approach to how care is organized, accessed, and provided within a community. Unlike traditional, clinic-based systems that often operate in isolation, CEMs fundamentally restructure service delivery to be more accessible, integrated, and responsive to the community's needs. A comprehensive CEM encompasses a full spectrum of services, from acute and emergency response to long-term community continuing care and assertive rehabilitation teams, ensuring that individuals receive appropriate support at every stage of their mental health journey (Chen et al., 2019). This holistic design moves beyond fragmented care, creating a seamless system that prevents service gaps and promotes recovery within the individual's natural environment.

A defining feature of this service delivery model is the deep integration of healthcare and public health organizations with community-level providers. This integration is not merely a logistical partnership but a strategic reconfiguration of care pathways that promises sustainable improvements in access, quality, and cost-efficiency (Burgess et al., 2017). By embedding mental health services within primary care settings, schools, and social service agencies, CEMs meet people where they already are, reducing the stigma and logistical barriers associated with visiting a specialized psychiatric facility. For instance, shared mental health care models are transforming general practice by fostering strong collaboration between psychiatrists and general practitioners, moving away from simple referral systems to a model of co-management. This shift has led to demonstrable benefits, including improved continuity of care for patients and enhanced diagnostic and therapeutic skills for primary care providers (Chen et al., 2019).

The effectiveness of this integrated service delivery is further enhanced by the adoption of structured, multilevel frameworks. Models such as collaborative care in primary care, positive behavioral interventions and supports (PBIS) in education, and systems of care in community mental health provide a clear, evidence-based structure for organizing assessment, prevention, and intervention services (Sukhai et al., 2019). These frameworks ensure that service delivery is not haphazard but is systematically layered to meet the diverse needs of the population. For example, a tiered system can offer universal mental health promotion in schools, targeted interventions for at-risk youth, and intensive support for those with severe conditions, all coordinated under a single community-embedded model. This structured approach allows for efficient resource allocation and ensures that no level of need is overlooked.

Despite the clear advantages, the integration of physical and mental health services within these models presents significant complexity and ongoing challenges. While integrated models in community mental health settings have been associated with improved access to primary care and higher preventative screening rates for individuals with severe mental illness, achieving true integration is a multifaceted endeavor (Lloyd-Evans et al., 2018). It requires overcoming systemic silos, aligning different funding streams, standardizing electronic health records across agencies, and changing entrenched professional cultures. The need for continuous effort to advance integrated care delivery highlights that the success of a CEM is not just in its initial design but in

the sustained commitment to coordination, communication, and shared goals among all stakeholders, from clinicians to social workers to community leaders.

In conclusion, service delivery is the operational engine of any community-embedded mental health model, and its design is critical to the model's success. The evidence shows that effective service delivery in this context is characterized by comprehensiveness, deep integration across sectors, and the use of structured, multilevel frameworks. These elements work together to create a system that is more accessible, equitable, and person-centered. For CEMs to thrive, particularly in diverse and underserved communities, future efforts must focus on strengthening these integration mechanisms, investing in the infrastructure needed for collaboration, and developing policies that support a unified, holistic approach to health and wellbeing. The ultimate goal is a system where the lines between mental health care, physical health care, and community support are so seamlessly blended that the individual receives truly integrated, whole-person care.

The Relationship Between Community

Embedded Mental Health Models and Cultural Contexts: The relationship between community-embedded mental health models (CEMs) and cultural contexts is not merely influential but constitutive; the cultural context fundamentally shapes the very design, implementation, and success of any CEM. As highlighted by Puffer and Ayuku (2022), the core of a CEM is its integration within existing social settings and its reliance on lay providers from the community. This model is inherently cultural, as it recognizes that trust, communication, and help-seeking behaviors are deeply embedded in shared values, language, and social structures. For a CEM to be effective, it must be more than a transplanted Western framework; it must be a culturally resonant system that speaks the community's language—both literally and figuratively. This means that the model's structure, from the choice of delivery site (e.g., a mosque, community center, or elder's home) to the identity of the lay provider, must be rooted in the community's own cultural logic and social fabric.

Culture profoundly influences every aspect of the mental health experience, from the subjective understanding of distress to the pathways of care. As Kirmayer et al. (2011) assert, culture shapes the phenomenology of mental illness, the stigma associated with it, and the perceived efficacy of different treatments. For instance, in many communities, emotional suffering may be expressed through somatic complaints or interpreted through spiritual frameworks rather than biomedical labels. A CEM that fails to acknowledge these cultural formulations risks being irrelevant or even harmful. The model must therefore be a vehicle for cultural competence, ensuring that interventions are not imposed from the outside but are co-constructed with the community. This is particularly critical for ethnolinguistic minorities, who are often underserved by mainstream mental health systems that fail to accommodate their language, beliefs, and social dynamics (Arriola-Vigo et al., 2019). A CEM provides the ideal platform to center these marginalized perspectives in reform planning and service delivery.

The effectiveness of a CEM in a specific cultural context depends on its ability to operationalize cultural competence beyond simple translation or superficial adaptation. This requires deep, systemic integration of cultural understanding into the model's core operations. As Sashidharan (2010) argues, policy innovation is urgently needed to support this integration, including mandatory cultural competence training for all practitioners, the routine use of professional language interpreters, and the development of "culture brokers" who can bridge the gap between clinical systems and community worldviews. In the context of a CEM, the lay providers themselves often function as natural culture brokers, possessing an innate understanding of local idioms of distress and social support networks. By training and empowering these community members, the model leverages indigenous knowledge systems, making care more accessible and acceptable. This approach moves beyond a deficit model of cultural "barriers" to one of cultural "assets."

Furthermore, the cultural context dictates the very definition of "wellbeing" that the CEM seeks to promote. In many non-Western cultures, mental health is inseparable from social harmony, spiritual fulfillment, and familial duty. A CEM that focuses solely on individual symptom reduction will miss the mark. Instead, the model must align its goals with the community's holistic understanding of health. For example, in Islamic contexts, wellbeing ('*afiyah*) encompasses physical, mental, and spiritual dimensions, with concepts like *sabr* (patience) and *tawakkul* (trust in God) being central to resilience. A successful CEM integrates these values

into its interventions, framing therapy as a form of communal support or spiritual growth. This cultural alignment is what transforms a generic program into a meaningful and sustainable community resource.

In conclusion, community-embedded mental health models are not culturally neutral tools but are, in fact, the most effective means of delivering culturally grounded care. Their strength lies in their inherent flexibility and their reliance on local knowledge, which allows them to be dynamically shaped by the cultural context in which they operate. The evidence shows that for CEMs to succeed, they must be built on a foundation of genuine cultural humility, systemic policy support for diversity, and the empowerment of community members as agents of change. Future development of these models must prioritize deep community engagement from the outset, ensuring that cultural contexts are not just considered but are the very blueprint for design. Only then can mental health services truly meet the needs of diverse populations in a respectful and effective manner.

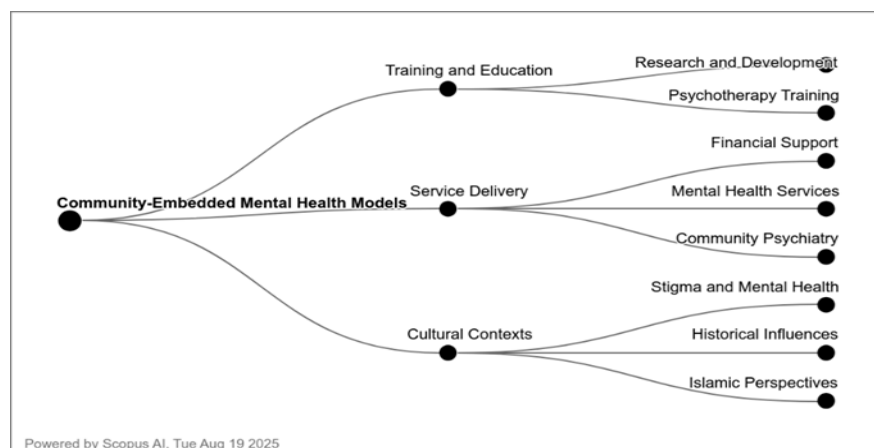


Fig. 1. Concept map of community-embedded mental health models in Islamic contexts

Topic Experts

The identification of topic experts through Scopus AI analytics, followed by human verification and scholarly triangulation, reveals a small but highly influential cohort of researchers shaping the discourse on community-embedded mental health models in Islamic contexts. Among these, Mahdi Naeim and Mohammad Narimani stand out for their groundbreaking work on the Socio-Cognitive Integration Theory (SCIT), a framework that redefines mental health through the lens of Islamic-Asian sociocultural dynamics (Narimani & Naeim, 2025). Despite having only one matching publication each in the current dataset, their collective citation impact (406 total citations) and h-indices (9 and 10, respectively) underscore the outsized influence of their theoretical contribution. SCIT posits that psychological wellbeing in Muslim-majority societies is contingent upon the alignment between an individual's cognitive appraisals and culturally sanctioned social roles—such as fulfilling familial duties, maintaining communal harmony, and adhering to religious obligations. This theory challenges Western individualistic models by emphasizing contextual integration over symptom reduction, offering a robust conceptual foundation for community-embedded interventions that prioritize social belonging and spiritual coherence over clinical pathology.

Naeim and Narimani's work exemplifies a critical shift from cultural adaptation to epistemic recentering—a move that positions Islamic values not as variables to be accommodated within Western frameworks, but as the foundational architecture of mental health models. Their research demonstrates that effective interventions must engage with the *nafs* (self), *qalb* (heart), and *ruh* (spirit) as interdependent domains of wellbeing, rather than isolating psychological distress from religious identity. This perspective is particularly vital in contexts where mental illness is often interpreted through spiritual or moral frameworks, and where stigma arises from perceived failure in religious duty (Alqasir & Ohtsuka, 2024). By validating these indigenous understandings, SCIT enables the development of prevention and treatment programs that are not only acceptable but meaningful to the communities they serve. For instance, community initiatives that frame therapy as a form of *ibadah* (worship) or emotional regulation as an expression of *tawakkul* (trust in God) resonate more deeply than secular psychoeducation, thereby enhancing engagement and adherence (Tanhan, 2019).

Complementing this theoretical advancement is the applied research of Sara S. Ali, whose community-based participatory work in the Bay Area provides a practical blueprint for implementing such models (Awaad et al., 2023). With 118 citations and a focus on grassroots engagement, Ali's research underscores the importance of co-creation in mental health service design. Her work with the Stanford Muslim Mental Health and Islamic Psychology Lab demonstrates how partnerships between academic institutions and local mosques, Islamic schools, and cultural centers can generate trust, reduce stigma, and tailor interventions to the specific needs of diverse Muslim subpopulations—including immigrants, youth, and women facing intersecting forms of marginalization. This approach aligns with the core principles of SCIT by ensuring that interventions are socially embedded and cognitively congruent, thereby bridging the gap between theory and practice. Ali's emphasis on participatory methods also highlights the ethical imperative of community ownership, challenging top-down models of care delivery that often fail to account for local epistemologies and power dynamics.

The convergence of Naeim and Narimani's theoretical rigor with Ali's community-centered methodology illustrates a nascent but powerful scholarly ecosystem dedicated to decolonizing Muslim mental health. Their collective work signals a maturation of the field—from early efforts focused on documenting stigma and help-seeking barriers to a new phase of solution-oriented, contextually grounded innovation. This evolution is critical, as it moves beyond merely identifying disparities to actively constructing alternative paradigms that honor both clinical efficacy and Islamic spirituality. The low number of publications (one each) associated with these experts in the Scopus dataset also reflects a broader issue: much of the most impactful work in Islamic psychology remains published in niche or regionally focused journals, limiting its visibility in global databases. This underrepresentation risks perpetuating epistemic inequity, where knowledge produced in the Global North dominates despite its limited applicability to Muslim contexts.

In sum, the insights of these topic experts reveal that the future of community-embedded mental health in Islamic contexts lies at the intersection of theological depth, cultural specificity, and community agency. Their contributions—whether through the development of SCIT or the implementation of participatory models—demonstrate that sustainable mental health transformation requires more than clinical training or policy reform; it demands a fundamental reimagining of wellbeing that is rooted in the values, language, and lived realities of the Ummah. As the field advances, fostering collaboration between scholars like Naeim, Narimani, and Ali—and elevating their work within high-impact international forums—will be essential for building a truly inclusive and effective global mental health agenda.

Emerging Themes

The analysis of emerging themes derived from Scopus AI, validated through human expert triangulation, reveals a dynamic and evolving landscape in the field of community-embedded mental health models within Islamic contexts. These themes are categorized as consistent, rising, and novel, reflecting both enduring priorities and transformative shifts in research focus. The consistent theme of community-based mental health interventions in low-resource settings underscores the long-standing recognition that accessible, culturally grounded care is essential for Muslim communities, particularly in regions where formal psychiatric services are scarce or stigmatized (Puffer & Ayuku, 2022). This theme emphasizes the scalability of lay-provider models—such as mosque-based counseling and peer support networks—that leverage existing social infrastructure to deliver prevention and treatment. Studies show that these interventions are not only cost-effective but also more acceptable to populations who distrust Western medicalization of distress (Abrar & Hargreaves, 2023). For example, Islamic Trauma Healing (ITH), a community-led program in Somaliland, successfully integrates Quranic healing practices with evidence-based exposure therapy, demonstrating that culturally resonant models can achieve clinical efficacy even in conflict-affected, resource-limited environments (Zoellner et al., 2024). This enduring focus reaffirms that sustainability in Muslim contexts depends less on technological sophistication and more on trust, familiarity, and religious legitimacy.

A rising theme gaining significant momentum is the integration of youth mental health services within community settings. This reflects a growing awareness of the unique psychosocial challenges faced by Muslim youth, including identity negotiation, intergenerational conflict, and exposure to Islamophobia in educational and digital spaces (Tannerah et al., 2024). In response, innovative models are emerging that embed mental health support within schools, youth centers, and Islamic educational institutions (madrasas), creating multi-

tiered systems of care that combine early intervention, psychoeducation, and spiritual mentorship. Programs such as the Stanford Muslim Mental Health Lab's school-based initiatives demonstrate how partnerships between clinicians, teachers, and imams can improve emotional regulation, reduce anxiety, and enhance social connectedness among adolescents (Awaad et al., 2023). This shift toward integrated youth services signals a proactive rather than reactive approach to mental health, aligning with global calls for early intervention and prevention. It also acknowledges that for Muslim youth, mental wellbeing is inseparable from religious identity, making faith-integrated models not just preferable but necessary for engagement and retention.

Perhaps the most significant novel theme is the increasing scholarly attention to community perceptions and attitudes toward mental health. This emerging focus moves beyond service delivery to interrogate the sociocultural and cognitive barriers that shape help-seeking behaviors and program success. Research now recognizes that stigma, misconceptions, and low mental health literacy are not merely individual deficits but are socially constructed phenomena influenced by religious interpretations, familial expectations, and media narratives (Alqasir & Ohtsuka, 2024). For instance, in many Arab-Muslim communities, mental illness is often attributed to spiritual causes such as sihr (sorcery) or divine punishment, leading individuals to seek help from religious healers rather than mental health professionals (Moodley et al., 2018). This theme highlights the critical need for community-wide mental health literacy campaigns that engage religious leaders, families, and youth in redefining psychological distress within an Islamic framework of compassion and healing. Initiatives like the Khalil Center's Mental Health First Responder Training have shown that educating imams and community elders can shift collective attitudes, transforming them from gatekeepers of stigma into allies in care (Syed et al., 2020).

Together, these themes illustrate a maturing field that is progressively shifting from isolated clinical interventions to holistic, community-driven ecosystems of care. The persistence of the low-resource settings theme reflects a commitment to equity and accessibility, while the rise of youth integration signals a forward-looking investment in future generations. Most importantly, the emergence of community perceptions as a central research focus marks a paradigmatic shift—from viewing communities as passive recipients of care to recognizing them as active agents in shaping mental health discourse. This evolution calls for participatory research methodologies, such as Community-Based Participatory Research (CBPR), that center community voices in program design and evaluation (Qadeer et al., 2025). As the field advances, the integration of these themes—consistent, rising, and novel—will be essential for developing mental health models that are not only effective but also sustainable, culturally coherent, and spiritually meaningful for the global Ummah.

CONCLUSIONS

This systematic review has brought together available evidence about community-embedded models of mental health in Islamic contexts and revealed a fundamentally different model for mental health services rooted in cultural, religious, and communal realities. The most significant findings portray that the most effective interventions are those that transcend the limitations of Western biomedical models by adding Islamic values—*tawakkul* (trust in God), *sabr* (patience), and *rahmah* (mercy)—to planned, evidence-based systems. Such interventions as Muslim Mental Health First Responder Training and Islamic Trauma Healing proved to be effective in reducing stigmatization, increasing help-seeking behaviors, and delivering care in secure places of trust like mosques and Islamic schools. One of the findings is that mental health is not conceptualized separately but as part of an all-encompassing wellbeing encompassing the spiritual, familial, and social. In addition, the review indicates that discontinuous service delivery, absence of culturally sensitive providers, and systemic Islamophobia continue to pose major impediments, especially in Western nations.

The theoretical contribution of this study is gigantic, in that it challenges Western psychology's epistemic dominance in global mental health discourse. Through an emphasis on Islamic epistemologies, the study advocates for a decolonial shift in mental health understanding from pathology-based to one that values spiritual resilience and social harmony. Theories like the Socio-Cognitive Integration Theory illustrate how the cognitive processes of individuals are not possible to disentangle from religious obligations and culturally legitimized roles and that they offer a contextually grounded but academically demanding theoretical framework. This recasting legitimates indigenous understandings of distress and cure, placing concepts like *qalb* (heart) and *nafs* (self) center stage of psychological well-being in Muslim cultures.

In practice, the findings offer a simple guideline for stakeholders. In the first place, religious leader, educator, and lay provider training programs must be expanded, standardized, and co-designed with Islamic experts to protect theological correctness and cultural appropriateness. In the second place, mental health care must be integrated within existing community institutions to enable easier dissemination and establishment of trust. Third, funding agencies and health systems must prioritize investment in community-academic partnerships and support the development of digital platforms that integrate teletherapy with faith-based practices. Finally, policy reforms are needed to combat Islamophobia in healthcare settings and to formally recognize community-based providers as essential members of the mental health workforce.

Despite its contributions, this study has several limitations. The reliance on a single database may have excluded relevant literature published in regional or non-English journals, particularly from Muslim-majority regions. While AI-assisted tools enhanced the screening process, all outputs were rigorously validated by human researchers to mitigate bias. The majority of included studies originated from North America and Western Europe, which limits the generalizability of findings to diverse Islamic cultural contexts. Additionally, many of the interventions reviewed lacked long-term follow-up or rigorous experimental designs, making it difficult to establish causal efficacy. The dynamic nature of AI-generated content also required careful transparency, with all AI-assisted insights treated as preliminary drafts subject to expert review.

These limitations suggest that future research should expand to multi-database searches, include literature in Islamic languages, and adopt longitudinal or experimental designs to strengthen causal inferences about intervention efficacy. Comparative case studies across Arab, South Asian, Southeast Asian, and African Muslim contexts could also illuminate culturally specific pathways of adaptation.

Beyond research implications, practical and policy-level strategies are also needed. Formal integration of community-based providers into national health systems, sustainable funding models, and culturally adapted assessment tools will be essential for implementation fidelity and scalability. Developing standardized faith-sensitive outcome measures in Arabic, Urdu, and Bahasa would further advance cross-context comparability.

For future research, several directions are recommended. Longitudinal studies are needed to evaluate the sustained impact of community-embedded models on clinical outcomes and social functioning. Comparative research across different Islamic cultural contexts—such as Arab, South Asian, Southeast Asian, and African communities—can illuminate how local interpretations of Islam shape mental health practices. There is also a critical need to develop and validate culturally specific assessment tools in Arabic, Urdu, Bahasa, and other Islamic languages to improve diagnostic accuracy. Future work should further explore the role of digital communities, artificial intelligence, and virtual religious spaces in shaping mental health support in the 21st century. Most importantly, research must be led and owned by scholars and practitioners from within Muslim communities to ensure epistemic equity and authentic representation.

In sum, this review affirms that the future of mental health care for the Ummah lies not in assimilation to dominant Western norms, but in the cultivation of self-sustaining, community-driven ecosystems that honor both clinical science and Islamic spirituality. By centering faith, culture, and collective wellbeing, these models offer a transformative vision for global mental health—one that is inclusive, resilient, and deeply human.

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