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TOWARDS A CONCEPTUAL FRAMEWORK FOR COMMUNITY-BASED PSYCHOSOCIAL INTERVENTIONS PROMOTING ADOLESCENT MENTAL HEALTH: PERSPECTIVES FROM THE GLOBAL SOUTH

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ABSTRACT

Adolescent mental health constitutes a significant global challenge, disproportionately affecting low and middle-income countries. In Sri Lanka, factors such as post-conflict legacies, socioeconomic inequality, and the weakening of community protective mechanisms have increased adolescent vulnerabilities. However, a comprehensive conceptual framework to guide community-based psychosocial interventions remains absent. This paper introduces an integrated, multidimensional framework that synthesizes Bronfenbrenner's (1979) ecological systems theory, Putnam's (2000) social capital framework, and Ungar's (2012) social-ecological resilience theory. The framework organizes community-based psychosocial interventions into four interdependent domains: relational and family systems, peer and social network dynamics, community structures and institutional linkages, and cultural and contextual responsiveness. Three cross-cutting principles participatory engagement, cultural humility, and a social justice orientation support all domains, promoting multilevel, culturally grounded, and structurally transformative approaches in contrast to biomedical paradigms. This framework provides guidance for social workers and policymakers in developing interventions that enhance family support, peer relationships, service coordination, and cultural responsiveness. Additionally, it establishes a foundation for policy reform and future research on the implementation and evaluation of community-based interventions.

Keywords*: adolescent mental health, community-based psychosocial interventions, ecological systems theory, social capital, resilience.*

1. Introduction

Adolescence is a period of profound psychosocial change in which biological maturation, identity formation, and expanding social interactions create both vulnerability and developmental opportunity. The World Health Organization (WHO, 2021) estimates that one in seven adolescents aged 10 to 19 has a clinically diagnosable mental disorder, yet most receive no evidence-based psychosocial support. This gap is especially acute in LMICs, where mental health services are under-resourced, stigma is entrenched, structural poverty amplifies vulnerabilities, and governance frameworks are weak (Patel et al., 2018). Mental disorders emerging during adolescence have enduring consequences for educational attainment, occupational functioning, social participation, and lifelong wellbeing (Gore et al., 2011).

Sri Lanka offers a particularly instructive context for examining the sociocultural and structural determinants of adolescent psychosocial wellbeing. Adolescent mental health in the country is shaped by the long-term psychological sequelae of ethnic armed conflict, urban-rural socioeconomic inequalities, parental labour migration, and rapid digital transformation (Jayasinghe et al., 2020). Formal mental health services, where available, remain concentrated in urban centres and are structured around biomedical diagnostic models poorly suited to addressing the relational, social, and cultural dimensions of adolescent distress. Community-based approaches responsive to these dimensions remain critically underdeveloped.

Social work, grounded in principles of social justice, human rights, ecological perspectives on development, and participatory practice, is uniquely positioned to address this structural deficit (IFSW, 2014). However, a significant theoretical gap persists: the absence of systematic, contextually grounded, and epistemologically coherent models to guide the development, implementation, and evaluation of CBPIs for adolescents in Global South settings. Frameworks imported from the Global North tend to reproduce Western epistemological and clinical assumptions that lack contextual applicability in Sri Lanka and comparable settings.

This paper addresses this gap by developing a multi-dimensional conceptual framework for CBPIs targeting adolescent mental health in Sri Lanka and analogous Global South contexts. The framework integrates ecological systems theory (Bronfenbrenner, 1979), social capital theory (Putnam, 2000), and social-ecological resilience theory (Ungar, 2012), anchored in practice-informed

understandings of Sri Lankan and South Asian sociocultural contexts. The paper proceeds as follows: a critical review of relevant literature; articulation of the theoretical foundations; detailed elaboration of the four intervention domains and cross-cutting principles; implications for social work practice, policy, and research; and concluding reflections.

2. Literature Review

2.1 Global and Regional Adolescent Mental Health

Mental health disorders in adolescence constitute a significant yet systematically under-addressed burden on global health and welfare systems. Depression, anxiety disorders, and conduct-related presentations account for approximately 16% of the health burden among individuals aged 10 to 19, with the majority lacking access to appropriate care (WHO, 2021). These disorders undermine educational attainment, impair social functioning, and substantially increase the risk of lifetime mental illness and social exclusion (Gore et al., 2011).

In South Asia, adolescent mental disorders are prevalent and inequitably distributed, compounded by poverty, gender disparity, community violence, and limited access to educational and social protective resources (Kieling et al., 2011). Sri Lankan studies report elevated rates of depressive disorders, anxiety, and suicidal ideation, particularly in the Northern and Eastern provinces most affected by conflict-related structural legacies (Husain et al., 2011). The COVID-19 pandemic further exacerbated pre-existing vulnerabilities through school closures, disrupted peer networks, household economic losses, and withdrawal of institutional support (Jayasinghe et al., 2020). Mental health literacy remains low, and help-seeking is constrained by stigma, geographic barriers, and inadequate service provision.

2.2 Community-Based Psychosocial Interventions: Conceptual and Empirical Foundations

CBPIs are theoretically informed, community-embedded programmes aimed at promoting mental and psychosocial health, preventing psychological disorders, and sustaining adaptive social functioning across the life course (van Ommeren et al., 2005). They adopt a social-ecological perspective, locating mental health outcomes not within the individual as a site of pathology but within multi-level interactions across familial, peer, community, institutional, and broader sociocultural systems (Patel et al., 2018). A growing evidence base supports the effectiveness of structured peer support programmes, school-based psychosocial

curricula, community resilience-building interventions, and family-strengthening programmes in producing measurable mental health benefits for adolescents in LMIC contexts (Barry et al., 2013; Jordans et al., 2016).

However, the evidence base remains methodologically heterogeneous, and insufficient attention has been paid to implementation fidelity and contextual adaptation. Existing CBPI models often neglect cultural specificity, theoretical coherence, and adaptation guidance for resource-constrained and culturally diverse settings (Lund et al., 2011). In Sri Lanka specifically, community mental health programming has historically been reactive and crisis-driven, mobilised in response to acute humanitarian emergencies such as the 2004 Indian Ocean tsunami and the end of armed conflict in 2009, rather than constituting proactive, rights-based, and developmentally informed programming (Somasundaram & van de Put, 2006).

2.3 Epistemological and Theoretical Gaps

Critical analysis of the literature reveals several interconnected theoretical and epistemological constraints that limit the development of effective, culturally responsive CBPIs in the Global South. First, dominant intervention paradigms continue to be shaped by Western psychological epistemologies that privilege individualistic, cognitivist, and biomedical conceptualisations of mental health. These frameworks have limited validity in Sri Lankan and South Asian contexts organised around collectivist values, spiritual and religious worldviews, and intergenerational relational obligations (Kohrt & Hruschka, 2010). Their uncritical importation risks epistemic exclusion of indigenous knowledge systems and the production of interventions perceived as foreign or stigmatising by intended beneficiaries.

Second, prevailing CBPI models are largely single-level in focus — attending to the individual, family, or community in isolation — without offering an integrative systemic model that accounts for the dynamic interdependence of these levels. This fragmentation reproduces a reductionist conception of adolescent mental health determinants. Third, the generative roles of social capital, community cohesion, cultural assets, and indigenous helping traditions in promoting adolescent resilience have been systematically undertheorised and under-operationalised. These gaps collectively strengthen the case for a multilevel, holistic, culturally responsive, and theoretically integrated conceptual framework.

3. Theoretical Foundations

The conceptual framework presented in this paper was systematically developed by using a theoretical idea integrating method, which is based on critical literature review and contextual analysis. The author analysed the available CBPIs and found that there were continued areas of lack of cultural responsiveness, theoretical consistency and multi-level integration. Three theory frameworks were then chosen that were conceptually compatible, in their capacity to explain mental health among adolescents from multiple social levels, and had already been shown to be relevant to adolescent mental health in community-based interventions in non-Western contexts. Theories were analyzed and synthesized in order to bring them together to create an integrated, multi-dimensional structure from which each theory provided complementary conceptual resources. This framework was then contextualised by examining the sociocultural, historical and structural realities in Sri Lanka, to ensure that the domains and principles of the framework are relevant to the practice context in the Global South.

3.1 Ecological Systems Theory

Bronfenbrenner's (1979) ecological systems theory conceptualises individual development not as an internally driven maturational process but as the emergent product of progressively nested, hierarchically structured environmental interactions. The microsystem encompasses the immediate contexts of direct and recurrent engagement, including family and school peer groups; the mesosystem characterises connections and interactions between microsystem settings; the exosystem refers to broader social structures and institutional processes that indirectly shape development; and the macrosystem encompasses the cultural values, normative frameworks, and ideological orientations pervading the broader social ecology. This model provides a theoretically robust basis for identifying and critically examining the multilevel, interactive, and contextually variable risk and protective factors shaping adolescent mental health trajectories.

The implication for CBPI design is that interventions operating at a single systemic level are structurally limited in achieving sustainable and equitable effects on adolescent mental health. Effective CBPIs must simultaneously address attachment and caregiving patterns within microsystems; foster communicative and collaborative linkages between microsystem and mesosystem actors; build purposive alliances with civil society and formal service systems at the

exosystemic level; and cultivate destigmatising, help-seeking-favourable norms at the macrosystemic level. In Sri Lanka, structural features such as family cohesiveness, intergenerational solidarity, religious community membership, and communal affiliations represent an unparalleled foundation for adolescent psychosocial wellbeing.

3.2 Social Capital Theory

Putnam's (2000) social capital framework identifies the characteristics of effective social organisation — civic and community networks, generalised norms of reciprocity, and interpersonal and institutional trust — that collectively enable coordinated collective action, equitable resource allocation, and the delivery of common social goods. Social capital theory reorients analytical attention toward the social relational basis through which individuals and communities access resources, support, and opportunity. Three analytically significant dimensions are identified: bonding capital (dense, affectively rich bonds within families and close peer networks); bridging capital (informationally diverse ties across social boundaries); and linking capital (vertical ties connecting community members with formal institutional actors, services, and policy systems).

Applied to CBPI design, social capital theory positions the relational infrastructure of communities as a principal mediating variable between structural disadvantage and individual mental health outcomes. Interventions that strategically strengthen bonding capital within family and peer systems, develop bridging capital across community organisations and civil society networks, and cultivate linking capital between communities and formal service systems are theorised to generate more durable and structurally embedded mental health outcomes than those relying on individualised change processes. This focus has particular relevance in Sri Lanka, where conflict, post-conflict poverty, displacement, and social fragmentation have substantially eroded community social fabric, making the intentional reconstruction of relational trust, reciprocity norms, and civic cohesion an indispensable precondition for legitimate and effective psychosocial intervention.

3.3 Social-Ecological Resilience Theory

Ungar's (2012) social-ecological resilience framework reconceptualises resilience as a negotiated, emergent process in which the developing person interacts with the social, institutional, and cultural ecology in which they are embedded. In this reconceptualisation, resilience is not an internal individual trait but an assemblage

of contextually produced outcomes, contingent on individuals' ability to negotiate access to seven interdependent resource categories: material resources, relationships, identity, power and control, cultural adherence, social justice, and social cohesion. The transformative practice implication is that enhancing adolescent resilience requires not only developing personal capacities but also altering the contextual, institutional, and cultural conditions that enable or constrain access to these foundational developmental resources.

Applied to CBPI design, Ungar's framework enables a theorised shift in intervention logic from pathology-based and deficit-oriented approaches toward asset-based, community-grounded, and systems-focused orientations. Rather than positioning the adolescent as the primary object of therapeutic redress, this modality directs intervention activity toward locating, mobilising, and sustaining the community, cultural, and relational resources that constitute the enabling conditions of resilient functioning. In Sri Lanka, this involves sustained and epistemologically humble engagement with culturally specific and historically constituted systems of resilience — including the protective functions of religious and spiritual practice, intergenerational family systems, communal traditions of reciprocity, and indigenous systems of knowledge and healing — as integral components of contextually adequate CBPI design.

4. The Conceptual Framework: Architecture and Domains

4.1 Framework Architecture and Cross-Cutting Principles

The framework presented in this paper is a theoretically synthesised, contextually sensitive, and operationally applicable guide for developing, implementing, monitoring, and evaluating CBPIs targeting adolescent mental health in Sri Lanka and analogous Global South settings. It integrates ecological systems theory, social capital theory, and social-ecological resilience theory across four mutually dependent domains: (1) Relational and Family Systems; (2) Peer and Social Network Dynamics; (3) Community Structures and Institutional Linkages; and (4) Cultural and Contextual Responsiveness. These domains are not sequential stages but dynamic, mutually reinforcing levels of social influence whose interactive configurations shape the conditions for adolescent psychosocial wellbeing.

Three cross-cutting principles function as non-negotiable operationalising imperatives across all four domains and at every stage of CBPI conceptualisation, design, delivery, and evaluation. The principle of participatory engagement mandates substantive, meaningful, and empowered involvement of adolescents,

families, caregivers, community members, and civil society actors throughout intervention processes, ensuring CBPIs are responsive to locally identified needs rather than externally imposed agendas. Cultural humility requires practitioners and researchers to approach communities as holders of complex, community-validated local knowledge and healing practices deserving critical respect and genuine dialogue, rather than as passive consumers of professionalised expertise. The social justice orientation demands that CBPIs function not merely as technical service-delivery instruments but as structural change vehicles that acknowledge and actively address the underlying social determinants of adolescent mental health — poverty, discrimination, social exclusion, and inequitable access to developmental resources.

4.2 Domain 1: Relational and Family Systems

The family constitutes the primary microsystem most directly and causally shaping adolescent psychological development and mental health. A substantial and methodologically diverse body of empirical evidence confirms that warm, consistent, and emotionally attuned caregiving relationships serve as protective buffers against the onset and escalation of adolescent mental illness. Conversely, chronic family conflict, parental psychopathology, disrupted attachment, and exposure to domestic violence represent established risk factors with known neurobiological, psychological, and relational effects persisting into adulthood (Bayer et al., 2006). CBPIs operating in this domain should incorporate culturally adapted family-based elements, including strengthening parenting skills and caregiving sensitivity; improving caregiver-adolescent communication quality; reducing family-related stress through integrated material and psychosocial support; and addressing specific vulnerabilities associated with parental mental illness, substance use, and domestic violence. These elements should maintain a strengths-based orientation that builds on existing relational capacities and cultural resources within family systems.

Contextually appropriate application of this domain in Sri Lanka requires recognition of the intergenerational, extended, and community-embedded family structures characteristic of the country's ethnically, religiously, and socioeconomically diverse populations. Grandparents, extended kin, community elders, and religious leaders play substantive roles in adolescent socialisation and identity development, and should be strategically engaged as relational resources by CBPIs rather than marginalised in favour of nuclear family models. Furthermore, the widespread phenomenon of parental labour migration —

particularly mothers engaged in overseas domestic employment — constitutes a structurally prevalent and empirically significant risk factor for attachment disruption, behavioural difficulties, emotional dysregulation, and mental health vulnerability, which CBPIs must specifically and purposefully address.

4.3 Domain 2: Peer and Social Network Dynamics

The centrality of peer relationships to adolescent mental health is among the most robustly established findings in developmental psychology, sociology, and social work. The normative relational reorientation of adolescence — from family-centred toward peer-centred contexts — means that the quality, density, and structural features of peer relationships exert pervasive influence on mental health trajectories and psychosocial wellbeing. Positively reinforcing, mutually affirming peer relationships are consistently associated with greater social competence, improved emotional regulation, enhanced stress resistance, access to informal social support, and the progressive stabilisation of a confident personal identity (Barry et al., 2013). Conversely, peer victimisation, chronic social exclusion, and exposure to peer networks characterised by substance misuse or antisocial norms represent well-documented risk factors for a broad range of adolescent mental health adversities. Effective CBPIs in this domain include peer support and befriending programmes, developmentally scaled social skills and emotional literacy training, restorative justice and conflict transformation approaches, and anti-bullying and social inclusion initiatives.

Peer-led intervention modalities are particularly promising in the Sri Lankan context, where evidence consistently indicates that adolescents are more willing to disclose mental health concerns and seek support through informal, peer-mediated frameworks than through formal, institutionally mediated mechanisms. Training and supervising young people as community mental health awareness ambassadors and informal referral connectors is theoretically coherent, programmatically feasible, and capable of enhancing community reach, cultural legitimacy, and long-term sustainability while simultaneously reducing stigma. The accelerating integration of digital technologies into the relational ecologies of Sri Lankan adolescents presents both risks — including cyberbullying, harmful social comparison, and exposure to self-harm content — and opportunities for scalable, peer-mediated digital mental health promotion, which CBPIs must account for strategically and critically.

4.4 Domain 3: Community Structures and Institutional Linkages

The third domain shifts analytical and programmatic attention to the exosystemic level — encompassing the formal and informal community systems, civil society organisations, and institutional structures within which adolescent mental health is embedded and through which CBPIs can be most effectively supported, sustained, and institutionalised. Operationalising this domain requires systematic community asset and capacity mapping; establishing inclusive, equitable, and sustainable partnerships between community organisations and statutory services; and developing functional, culturally responsive, and non-stigmatising referral pathways connecting psychosocially at-risk adolescents and families to appropriate professional services.

In the multi-ethnic, multi-religious, and pluralistic social fabric of Sri Lanka, religious institutions — Buddhist temples, Christian churches, Islamic mosques, and Hindu kovils — have historically played pivotal roles in psychosocial support, moral guidance, social cohesion, and crisis management within their respective communities. CBPIs that actively incorporate and structurally integrate the contributions of religious leaders, faith community networks, and spiritually grounded traditional helping practices as genuine partners in community-based mental health promotion are substantially better positioned to achieve community reach, cultural legitimacy, and sustained engagement than programmes operating in isolation from these established social frameworks. Simultaneously, the development of local mental health referral systems that connect informal and traditional support networks with primary health care, social work services, and specialist mental health care constitutes an indispensable structural complement to direct community programming.

4.5 Domain 4: Cultural and Contextual Responsiveness

Cultural and contextual responsiveness is conceptualised within this framework not merely as one parallel domain among four, but as the epistemological and ethical foundation upon which the validity, applicability, and efficacy of any CBPI ultimately depends. Genuine cultural responsiveness requires practitioners and researchers to develop and sustain a critically reflexive understanding of the historical, cultural, social, political, and economic contexts that adolescents and their communities inhabit, and to systematically operationalise that understanding across every stage of intervention design, implementation, adaptation, and evaluation. In Sri Lanka, this demands sensitivity to the differentiated psychological experiences, healing practices, and communal formations of Sinhala, Tamil, and Muslim communities and their internal diversities; the

enduring structural consequences of armed conflict, forced displacement, and institutionalised violence; and the diverse roles of Buddhism, Hinduism, Islam, and Christianity in shaping local ontologies of mental health, illness, and recovery.

Culturally responsive CBPI practice must move beyond the methodological inadequacy of translating Western mental health scales, diagnostic categories, and intervention protocols into local languages without addressing the conceptual incommensurabilities between biomedical frameworks and locally grounded understandings of distress and healing. It instead requires participatory and community-based methodological strategies — including community-based participatory research, collaborative ethnographic inquiry, and community-led co-development processes — that position local epistemic systems, culturally specific idioms of distress, and community-based healing practices as authoritative components of a comprehensive psychosocial response. The theoretically grounded, respectful, and practically informed synthesis of Ayurvedic medicine, spiritual counselling, and indigenous knowledge systems with evidence-based psychosocial intervention modalities represents a theoretically compelling, empirically promising, and ethically imperative direction for the development of community-owned and transformative CBPIs in Sri Lanka and the Global South.

5. Implications for Social Work Practice, Policy, and Research

5.1 Social Work Practice

The proposed framework carries substantial and wide-ranging implications for restructuring and strengthening social work practice in adolescent mental health in Sri Lanka. Social workers — equipped with ecologically and systems-informed training, anti-oppressive practice orientations, and professional commitments to advocacy and participatory engagement — are uniquely positioned to operate across all four framework domains as facilitators, community organisers, capacity builders, inter-agency coordinators, and systemic advocates. Within the relational and family systems domain, social workers can offer culturally adapted family support and evidence-based parenting programmes, conduct context-sensitive systemic family assessments, and lead strengths-based therapeutic conversations to strengthen protective family functioning. At the peer and community levels, they can provide professional leadership and reflective supervision of peer support programmes, facilitate community asset mapping, sustain multi-agency

and inter-sectoral partnerships, and advocate structurally for conditions that promote adolescent wellbeing.

The framework's emphasis on professional identity and practice orientation is on a transformative, community-focused, and institutionally grounded paradigm move from case-management to community development, structural advocacy, social action and collective capacity building. These approaches focus on the common factors that are determinants of adolescent mental health. Achieving this transformation necessitates comprehensive reform of social work education in Sri Lanka. Theoretical knowledge, methodology, cultural sensitivity and ethical commitment must be handed to practitioners in undergraduate and postgraduate training programmes so they can design, implement, adapt and effectively evaluate CBPIs in the context of the community service work environment in Sri Lanka, which is both culturally diverse and has limited resources.

5.2 Social Policy

The proposed framework provides a theoretically grounded and empirically informed argument for systemic reform of adolescent mental health policy in Sri Lanka, repositioning community-based, preventive, rights-based, and participatory modalities at the centre rather than the periphery of the mental health system. Sri Lanka's current mental health policy remains predominantly hospital-based and specialist psychiatric-oriented, with limited investment in community mental health infrastructure, skilled workforce development, inter-sectoral coordination, and community participation models capable of providing a population-based preventive and promotive response to adolescent mental health needs (Ministry of Health, 2021). A rights-based policy realignment is needed to position community-based psychosocial support as a centrally resourced and institutionally sustained element of an integrated national mental health system, coordinated through the governance structures of health, education, social services, child protection, and community development.

But crucially, adolescent mental health policy is more than about reforming services. The framework emphasizes the policy need to tackle the structural and upstream drivers of adolescent mental health as part of a cohesive and sectoral set of policy tools that are politically sustainable, and includes social protection, educational equity, child rights, gender equality, post-conflict reparations, and inclusive community development. The mental health sector cannot sufficiently deal with the psychological effects of child poverty, food insecurity, educational exclusion, gendered violence, labour migration of parents and their effects, and of

course the effects of accumulated experiences of ethnic discrimination and post-conflict marginalisation, no matter how technically advanced the mental health sector interventions are. A truly transformative, rights-based and equitable adolescent mental health policy framework will therefore need to take a holistic approach that breaks down the barriers between sectors and embeds mental health in the wider social development, child welfare, human rights safeguarding and participatory governance systems in Sri Lanka.

5.3 Research Implications

The proposed framework constitutes both a substantive theoretical contribution to social work and community mental health scholarship and a programme of urgently needed empirical research. A primary research priority is the systematic development, cultural adaptation, community validation, and psychometric testing of context-specific, language-appropriate measures of adolescent mental health and psychosocial wellbeing in Sri Lanka — measures designed to capture the culturally specific idioms and symptoms of distress not adequately reflected in Western-derived standardised instruments. Participatory action research methodologies, positioning adolescents, families, community members, practitioners, and policy actors as co-investigators and co-producers of knowledge, represent a theoretically consistent and ethically appropriate approach to the co-design, progressive refinement, and community-based implementation of CBPIs grounded in the proposed framework.

Theoretically informed, multi-method research designs are required to elucidate the causal pathways through which social capital formation, family relationship quality, community cohesion, and culturally embedded protective factors interact to generate and sustain adolescent resilience and psychosocial wellbeing across developmental transitions and diverse social ecologies. Comparative, multi-site studies across the ethnically, linguistically, religiously, and socioeconomically heterogeneous populations of Sri Lanka are essential for producing differentiated and context-specific knowledge about the variable distribution of adolescent mental health determinants. Building the rigorous, ethically grounded, and action-oriented knowledge base that this framework envisions requires sustained and equitable research partnerships among universities, government agencies, non-governmental organisations, and communities themselves.

6. Conclusion

This paper has presented a theoretically integrated, socially grounded, and operationally applicable multi-dimensional conceptual framework for community-based psychosocial interventions to promote adolescent mental health in Sri Lanka and the Global South. The framework organises CBPIs across four interdependent domains — relational and family systems, peer and social network dynamics, community structures and institutional linkages, and cultural and contextual responsiveness — guided by the cross-cutting principles of participatory engagement, cultural humility, and social justice orientation. Each domain has been elaborated with sustained critical reference to the structural conditions, cultural resources, governance structures, and historical legacies specific to Sri Lanka's diverse and complex society.

The framework addresses an epistemologically significant and practically pressing gap in social work, community mental health, and Global South development scholarship: the persistent absence of theoretically coherent, culturally contextualised, and ethically grounded conceptual frameworks for CBPI development and evaluation in Sri Lankan contexts. In doing so, it constitutes a systematic challenge to the continuing hegemony of individualistic, biomedically constituted, and epistemologically Western-informed approaches to adolescent mental health promotion, and advances the transformative social work paradigm as a genuinely community-based, equity-oriented, and culturally responsive knowledge and practice platform.

This framework is offered simultaneously as a theoretical tool, an applied intervention guide, and an intellectual and ethical provocation intended to stimulate sustained critical discourse, methodological innovation, and transformative policy action among social work scholars, educators, practitioners, and policymakers committed to promoting equitable, inclusive, and genuinely community-based adolescent mental health in Sri Lanka and the Global South.

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