ACCESS AND EXPERIENCES OF CARE

Mental Health and Psychosocial Services and Support in the Maldives:
A Qualitative Study with Actionable Recommendations 2025

The Asia Foundation
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MALDIVIAN NURSES ASSOCIATION
"Caring with a Professional Touch"

ACCESS AND EXPERIENCES OF CARE

Key Findings and Next Steps
for Mental Health Services and Support in the Maldives:
A Qualitative Study with Actionable Recommendations

2025

The Asia Foundation and the Maldivian Nurses Association

Author: Kaushi Jayawardena
Reviewed by: Dr Fathimath Shifaza and Roshan Dhammapala

Foreword

Mental, neurological, and substance use disorders are projected to become the leading cause of disease burden by 2030.[1] In South Asia, where services are scarce, stigma is high, and cultural explanations do not always align with treatment models, the need is especially significant. About 80 percent of people living with mental health challenges reside in low- and middle-income countries, yet only an estimated 13.7% receive appropriate treatment.[2] In the Maldives, approximately 3 in 10 people are estimated to experience mental health challenges.[3]

The Asia Foundation has, for more than 20 years of Mental Health and Psychosocial Support (MHPSS) programming in Sri Lanka, used a research-first approach to understand context, needs, and stakeholder perspectives before designing interventions. Building on that approach, this report presents one of the first nationwide qualitative studies to explore how people try to access care and how providers work to deliver it across 13 atolls. All data collection activities were completed in the Maldives and the core data collection team was also from the Maldives. It brings together the voices of service seekers, users, and service providers to illuminate where the system works, where it strains, and how it can improve.

The analysis and recommendations are guided by a systems perspective: it considers the interconnected roles of providers, users, referral and financing pathways, regulatory bodies, infrastructure, and social safety nets. Rather than focusing on symptoms or single programs, it looks at root causes and practical leverage points.

Above all, the report is intended for policymakers, practitioners, and development partners who are shaping the next phase of mental health care in the Maldives. The strategic priorities and recommendations are designed to be actionable, assignable, and evidence-informed, so that different stakeholders can advance complementary parts of a shared agenda for accessible, equitable, and effective care.

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Message from the Country Representative of The Asia Foundation

For more than two decades, The Asia Foundation has invested in strengthening the systems, structures, services, organizations, and partnerships that make mental health care possible across the region. In the Maldives, the need for mental health and psychosocial support is clear: Emerging estimates point to a significant share of the population living with concerns that would benefit from timely support. Recent polycrises may have intensified these pressures, while a dispersed island geography and small population create additional challenges for delivering care equitably and close to home.

This publication presents a nationwide qualitative study undertaken by The Asia Foundation in partnership with the Maldivian Nurses Association. Reflecting the voices of 127 participants across 13 atolls in the Northern, Central, and Southern regions, it brings together findings from both service providers and service seekers and translates them into actionable recommendations. This work continues the foundation's long-standing practice of grounding mental health programming in rigorous research and practical evidence.

We share these insights with humility and purpose. Our hope is that this report serves as a useful starting point for collective action: supporting holistic well-being, fostering long-term recovery, and building the resilience and capacity of systems and communities to respond to present and future challenges. We look forward to partnering with government, professional bodies, civil society, and communities across the Maldives to advance these goals.

Johann Rebert
Country Representative in Sri Lanka and the Maldives
The Asia Foundation

Message from the President of the Maldivian Nurses Association

The Maldivian Nurses Association is honored to have collaborated with The Asia Foundation on this pioneering study, Improving Access to Mental Health Care in the Maldives. This research represents a vital step toward understanding the real experiences of service providers and service users across our islands and toward building a more equitable, compassionate, and community-based mental health system.

As nurses and healthcare professionals, we are often the first points of contact for individuals and families in distress. This study highlights the urgent need to strengthen our capacity to provide timely, person-centered mental health care, while also ensuring that those who care for others are supported themselves. The voices of service providers and communities shared here reflect not only the challenges, but also the resilience and commitment within our health system.

On behalf of the Maldivian Nurses Association, I extend my deepest appreciation to The Asia Foundation for its partnership and to all the participants who shared their experiences with honesty and courage. It is our hope that the findings and recommendations of this study will guide evidence-based reforms, enhance collaboration across sectors, and ensure that mental health care becomes accessible to every individual, in every island of our nation.

Together, we can create a future where seeking help is met with understanding, dignity, and hope.

Mariyam Shifaana Hussain
President
Maldivian Nurses Association

Acknowledgement

We gratefully acknowledge the leadership and support of former and current Country Representatives, Dinesha de Silva Wikramanayake and Johann Rebert, whose stewardship made this initiative possible. Sincere appreciation is extended to the Maldivian Nurses Association (MNA) for its full partnership and enthusiasm as co-pilot of this study.

Our thanks to colleagues in The Asia Foundation's Maldives office, the Sri Lanka MHPSS Unit, and MNA, the technical team that shaped and steered this work (names listed at the end of this report). We also thank the National Health Research Council for its thorough review and approval of the ethics application for this study.

We are grateful to Professor Fathimath Shifaza and Roshan Dhammapala for their thoughtful reviews and guidance in refining the analysis and recommendations, and to the dedicated enumerators who led data collection, translation, and transcription.

Finally, we extend deep appreciation to the many institutions and individuals, service providers and community members, who generously shared their time and experiences. Their perspectives underpin the findings and recommendations presented here.

This study was funded by The Asia Foundation.

How this report is structured

- **Background and Methodology:** What was studied, why, and how? What were the strengths and the limitations?

- **Findings:** Four key themes that set the stage for the recommendations sections.

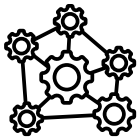
- **Strategic Priorities (SP1–SP4):** Actionable recommendations, supported by global research and intervention evidence, and organized under interconnected priorities, including evidence spotlights that bring together research findings to support the recommendations that focus on:

    - Strategic Priority 1 → Reducing barriers to accessing specialized care.
    - Strategic Priority 2 → Reducing barriers to providing specialized care.
    - Strategic Priority 3 → Building early response and alternative, stepped-care pathways.
    - Strategic Priority 4 → Adopting a public-health approach to mental health.

- **Next steps:**
    - The shifts the system now needs
    - Low cost and low intensity changes
    - 2-Year priorities and actions
    - What measuring success might look like

- **References**

As you read...



Think in terms of systems.

- Care experiences reflect complex interactions among people, services, rules, financing, information, culture, and geography. Not every factor could be fully explored, but the lens stays on root causes and linkages.[4]

Expect diverse (and sometimes unfamiliar) perspectives.

- As a qualitative study, this report intentionally includes experiences and viewpoints you may not have encountered or considered. Voices included in this study span providers, caregivers, users, seekers, migrants, women and men, youth and older adults, persons with disabilities, humanitarian workers, and community leaders, reminding us that intersectional identities shape how people encounter care.

Interpret findings with confidentiality in mind.

- Quotes are anonymized as much as possible, evidence is synthesized with global literature to protect participants in a close-knit professional community.

Use the strategic priorities as a map.

- The four Strategic Priorities translate insights into coordinated actions that different stakeholders can carry forward at policy, institutional, service, community, and household levels.

Consult the evidence spotlights.

- Refer to the curated sections that synthesize global research and study findings to underpin these recommendations.

Background

The Need

Mental, neurological, and substance use (MNS) disorders represent a growing global concern and were projected to become the leading cause of disease burden by 2030.[5] Despite 80 percent of affected individuals residing live in low- and middle-income countries (LMICs), only an estimated 13.7% receive appropriate treatment.[6]

This global pattern is evident in the Maldives, where estimates identify high mental health morbidity.[7] Around 3 in every 10 people were estimated to have a mental health condition, with women twice as likely as men to face problems such as depression and anxiety. For young people aged 13–15, about 1 in 6 had seriously considered suicide in the last year and around 1 in 7 had survived a suicide attempt.[8]

Improving and expanding access to mental healthcare and support is therefore a public-health imperative. Greater accessibility not only alleviates individual and family suffering but also supports broader objectives such as the protection of human rights and the advancement national development.

The Gap

In the Maldives, mental health services have remained largely centralized in urban areas, leaving outer atolls with significant gaps in service provision.[9] Both global and local research identified multiple barriers that constrain help-seeking behavior and limit the effective delivery of care. These include stigma, low levels of health literacy, financial constraints, geographic distance, poor interprofessional coordination, and provider burnout.[10] As a result, expanding the number of services may be insufficient without addressing the contextual barriers and enablers that shape access to and provision of mental healthcare service uptake is likely to remain limited.

Background

The Gap

Only a limited number of studies in the Maldives have systematically investigated the factors that facilitate or impede access to mental health services nationwide. Notably, no known previous research has employed a qualitative approach to examine the experiences of both service users and providers across different regions. This study therefore addresses this critical gap and explores the individual, social, cultural, structural, and institutional factors that shape access to mental health services in the Maldives.

The Approach

The study was guided by the World Health Organization's pyramid for an optimal mix of mental health services,[11] and a framework for understanding patient-centered access to health systems.[12] The conceptualization of the study was further informed by a broad review global and local literature, while methodological elements were adapted from a similar study conducted in Sri Lanka by The Asia Foundation and the Institute for Health Policy.[13]

This research was underpinned by The Asia Foundation's broader commitment to designing mental health interventions and strengthening systems based on lived experiences and local realities. The study centered on the lived experiences and perspectives of both service users and providers, capturing how individuals interpret and navigate real-life challenges in accessing or delivering mental healthcare.

Background

The Aims

The overarching aim of this study was to generate actionable recommendations for improving mental healthcare services across multiple levels of service delivery in the Maldives. This was achieved through a qualitative inquiry with service users and providers, focusing on the enablers and barriers to accessing mental healthcare. Specifically, the study explored and documented:

- Commonly presented mental health needs as perceived by service providers and service users.
- Factors that facilitated or hindered effective, inclusive, and holistic mental healthcare provision, across personal, infrastructural, patient, and policy levels.
- Elements that supported or obstructed individuals in perceiving, seeking, reaching, and engaging with mental health services.
- Recommendations from both service providers and users aimed at improving access and reducing barriers.

The Significance

Designed as an action-oriented study, this research moved beyond spotting gaps to generate practical, locally grounded strategies for strengthening the mental health system. It is among the first island-wide qualitative inquiries in the Maldives to compare service seeker and provider perspectives, with sampling across the North, South, and Central regions to enhance national applicability.

Using qualitative methods, it produced rich insights at individual, community, organizational, and policy levels, enabling actionable recommendations to address the treatment gap more effectively and equitably. These findings offer critical guidance for national strategy, support decentralization, and inform reforms responsive to the lived realities and needs of communities across the Maldives.

Methodology

1 The Design

The study utilized a qualitative descriptive design to map barriers/enablers, services, and support pathways across contexts, capturing lived experiences and under-explored processes.

2 The Participants

N = 127. Recruited through purposive sampling.
Service providers: **18**
(M = 8, F = 10)
Service Seekers/Users: **109**
(M = 35, F = 74, FGDs = 14)
From the Northern, Central and Southern regions of the country.

3 The Data

This study gathered data through focused group discussions with service seekers/users and through semi-structured interviews with service providers.

4 The Analysis

Data analysis involved coding, categorization and clustering, and theme-based analysis loosely based on Braun and Clarke's (2006) six-step framework for Thematic Analysis.

5 The Safeguards

Ethical approval was obtained from the National Health Research Council prior to data collection All tools were reviewed by the Maldivian team for cultural fit (norms, stigma, power dynamics), piloted, refined, and supported by trained data collectors. Safeguards included anonymity, informed consent, the right to withdraw, privacy protections, distress referral, and debriefing.

Strengths & limitations

What worked well?

- We spoke with 18 service providers (semi-structured interviews) and 109 community members (FGDs) across 13 atolls, offering broad geographic and stakeholder coverage.
- Sample size exceeded common guidance for qualitative saturation (which is around 9–24 interviews, 4–8 FGDs, as indicated by Wutich and colleagues in 2024 recommending sample sizes for qualitative data analysis), increasing confidence that major themes were captured.
- Case-story vignettes used during FGDs enabled discussion of sensitive topics (e.g., self-harm, substance use) without forcing personal disclosure.
- We used a full-team enumerator debrief and reflection after data collection ended, kept an audit trail of analysis decisions, and produced thick descriptions of context.
- The draft was peer-reviewed by academic and practitioner reviewers in the Maldives and Sri Lanka.

What were the limitations?

- As a qualitative descriptive study, participation was necessarily limited. Findings should be read as analytic insights, not population estimates.
- Participation was uneven across atolls and cadres, some high-need groups (youth, persons with disabilities, migrants, people with substance-use concerns) were harder to recruit due to stigma, sensitivities, logistics, and, in some locations, disease outbreaks.
- Time and funding constraints prevented a more exhaustive set of voices from both provider and seeker perspectives, those with stronger views or better networks may be over-represented.
- Multilingual data carries a risk of meaning loss despite careful translation and checking.
- Findings reflect a snapshot in time. They may not fully capture seasonality, policy shifts, or service fluctuations, except where older participants reflected on longer trajectories.
- Team backgrounds and prior relationships may have influenced recruitment and interpretation despite reflexive practices and checks.
- Confidentiality concerns in small communities may still have curtailed disclosure on highly sensitive issues.

Findings

The following themes briefly highlight key insights from this mapping study and informed the strategic priorities and their actionable recommendations. Both service providers and service seekers noted signs of improvement in mental health services, even as access remained limited. This section is intentionally concise as the aim of this report remains dedicated to solutions and next steps rather than dwelling on problems alone.

Theme 1: A Reactive, Centralized System Under Strain

Participants described a system under pressure, with demand outpacing capacity, lack of local services and little space for early response.

Escalating Demand and Limited Throughput

Service users described significant individual and societal impacts, including economic consequences and the intergenerational transmission of distress. While mood and anxiety concerns were most frequently presented (see figure 1), providers also saw a wide spectrum, from public health issues to trauma, personality, and substance use. Notably, some presentations were suitable for non-specialist, lower-intensity support rather than specialized care.

The service providers reported that the healthcare system is increasingly overwhelmed, facing disproportionately high and rising caseloads relative to the population size. Some service providers had waiting lists as long as 60 to 100 people. The National Mental Health hotline received more than 12,000 calls over the past two years, with the numbers continuing to grow. Delays in service access, stigma, and low engagement with busy providers prompted discontinuation and acute re-entries that further swelled caseloads. This places significant strain on the system and makes it difficult to meet the growing, complex needs of diverse populations.

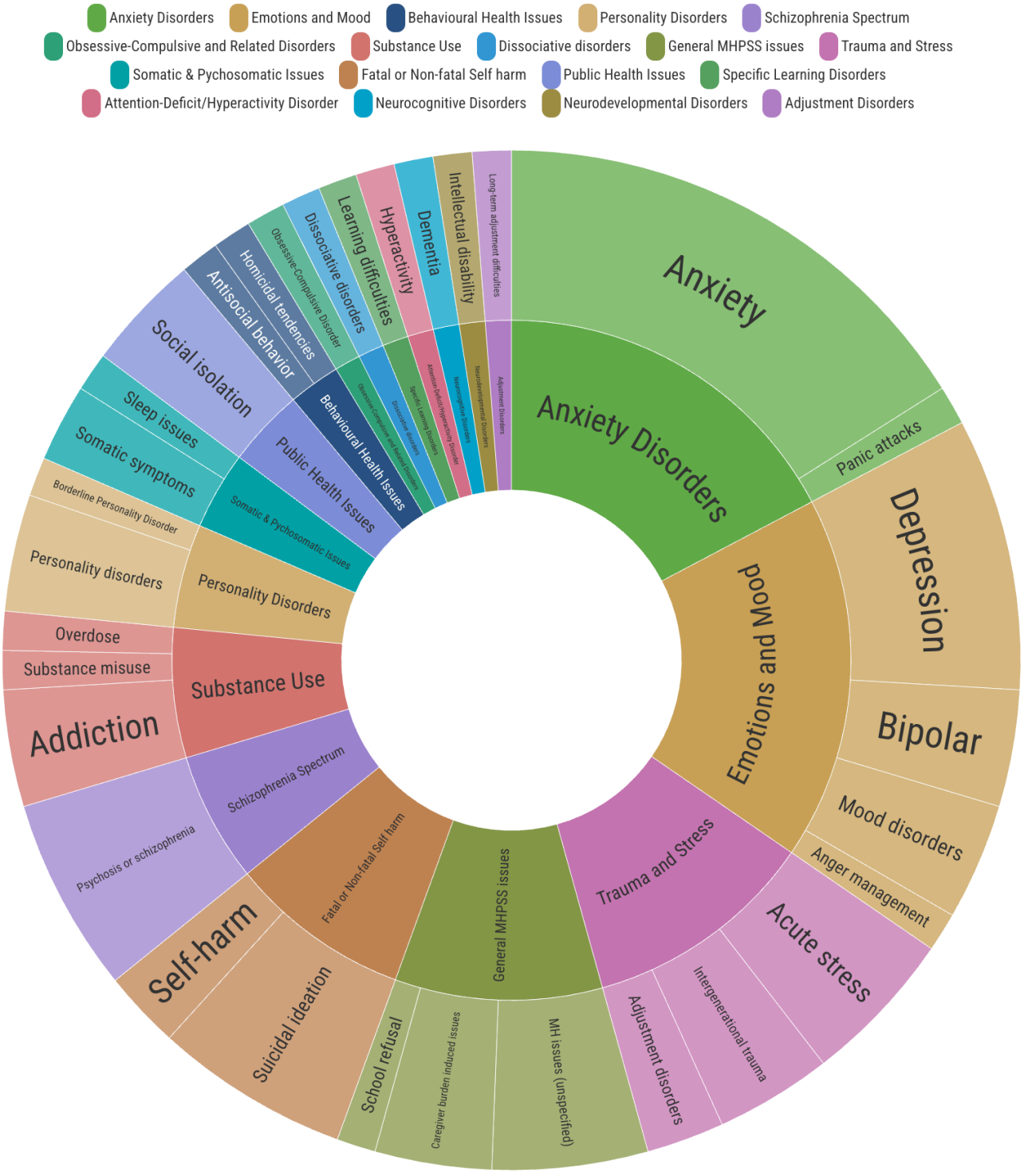


Figure 1. MHPSS issues being presented to service providers in the Maldives

Providers noted:
"The number of patients is huge compared to the population here."

"The continuous flow of calls can sometimes be overwhelming, especially during peak hours, making it difficult to give extended attention to each caller."

A service seeker also noted:
"Waiting times can be frustrating. If an appointment changes, delays are longer, and sometimes patients are told it's canceled because the doctor is absent. In some cases, they wait three to four hours."

Crisis-First Practice

Providers reported limited early screening and triage, so mild and moderate cases occupied specialist slots while complex cases faced delays or were lost to follow-up.

This is a particular challenge in a resource-limited, geographically dispersed context like the Maldives. When capacity is thin, practice skews toward reactive, treatment-oriented care: people are engaged late, and responses focus on emergencies. Over time, this normalizes the idea that care is short, urgent, and about problem-containment (e.g., brief crisis consults, medication starts, safety checks), rather than also including ongoing, relational support such as screening, psychoeducation, skills building, and follow-up. This was evident in the experiences shared by both service providers and seekers.

Additionally, this also meant that prevention and promotion efforts were minimal.

One provider said:
"... But along the way we do understand just providing services is also not enough. We have to ensure the prevention at different levels."

Another added:
"Patients only come here in a crisis state."

A hotline service provider shared similar experiences:
"Many callers are seeking someone to listen to them and provide immediate emotional support"

Low visibility and navigability of care pathways

A provider said:
"People don't know whether they need to go to a counselor, psychologist, or psychiatrist."

Service seekers echoed:
"Not enough information is available. What is available is either unusable or not helpful."

The current information environment seemed to produce many navigation failures. Seekers mentioned this was especially the case for young children and those with disabilities. Participants described uncertainty about roles and routes, including how to choose appropriate, affordable providers and where to start, unless they had prior experience. Even crisis hotlines were sometimes used simply to ask for information and available resources.

Participants said that it is difficult to navigate social welfare systems, such as Aasandha and NSPA. Even individuals who had sought help for themselves or someone close to them were not certain of where other services existed, the cost, the travel, or the waiting time. This included information on when to seek help, when something can be managed by themselves or with low-intensity support, and when they might need specialist care.

Misinformation and self-diagnosis online were filling the vacuum, leading to late, mismatched, or fragmented entry into care.

A provider said:
"People only learn about the disorders that are popular online."

Theme 2: System Design Features That Produce Inequity and Demoralization

Participant accounts pointed to structural arrangements that shaped who reached care, how people were treated, and whether progress was visible.

Model–Need Misalignment

Participants consistently framed distress as arising from community-level social and relational factors, adverse childhood experiences, family conflict, weak support networks, school and peer pressure, gendered risks, and stigma ("the things they hold inside, they are expressing or releasing this in the form of harm," said one service seeker about self-harm). They often used local somatic idioms (headache, insomnia) rather than Western disorder terms. Figures 2 and 3 show the determinants of MHPS issues as perceived by service providers and seekers.

A provider mentioned:
"The complaint would be headache, 'I can't sleep', 'I have body pain'. I will ask 'fikurukuranee'?" (are you worried/overthinking?)

Both parties also reported that most of support needs were non-clinical, recovery-oriented and community-based, centering on trustworthy relationships, family care, compassionate community, practical help with navigation, and support from trusted adults such as teachers (see figure 4).

A service user mentioned:
"What I needed was not just medicine, it was someone to talk to, someone to understand what I was going through."

This commentary indicated a mismatch between need and service fit: high demand for psychosocial, recovery-oriented, and therapeutic support was being met by a system organized around 'treatment' and medication.

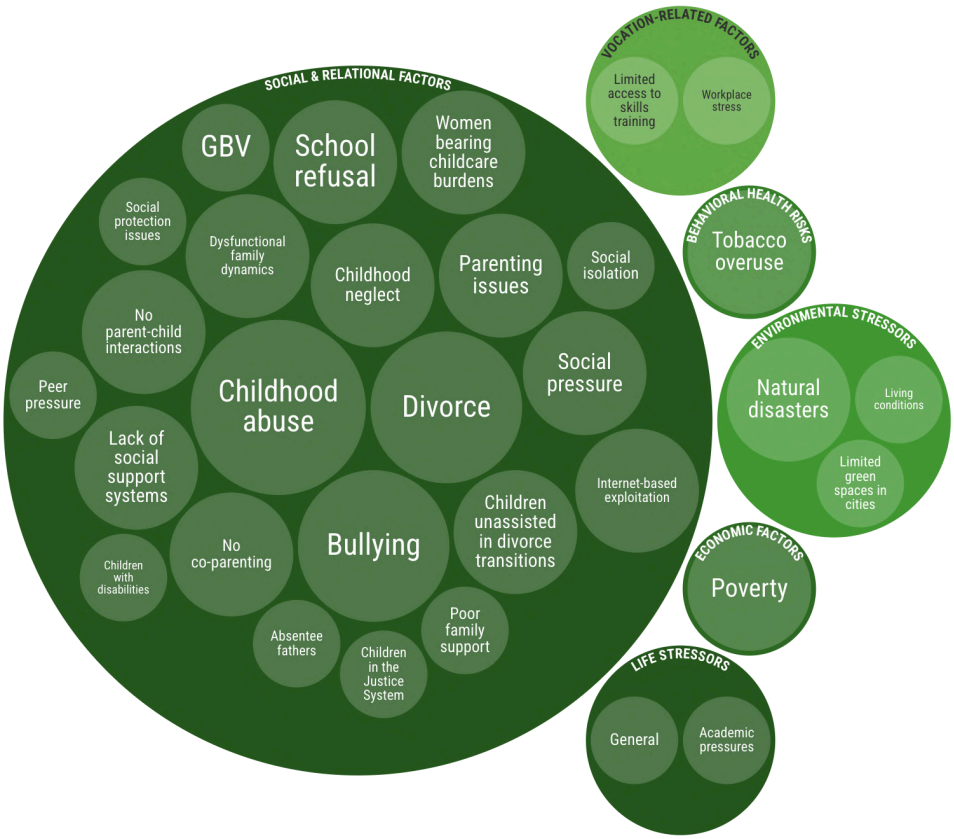


Figure 2. ***Service provider perceptions of determinants of MHPS Issues.***

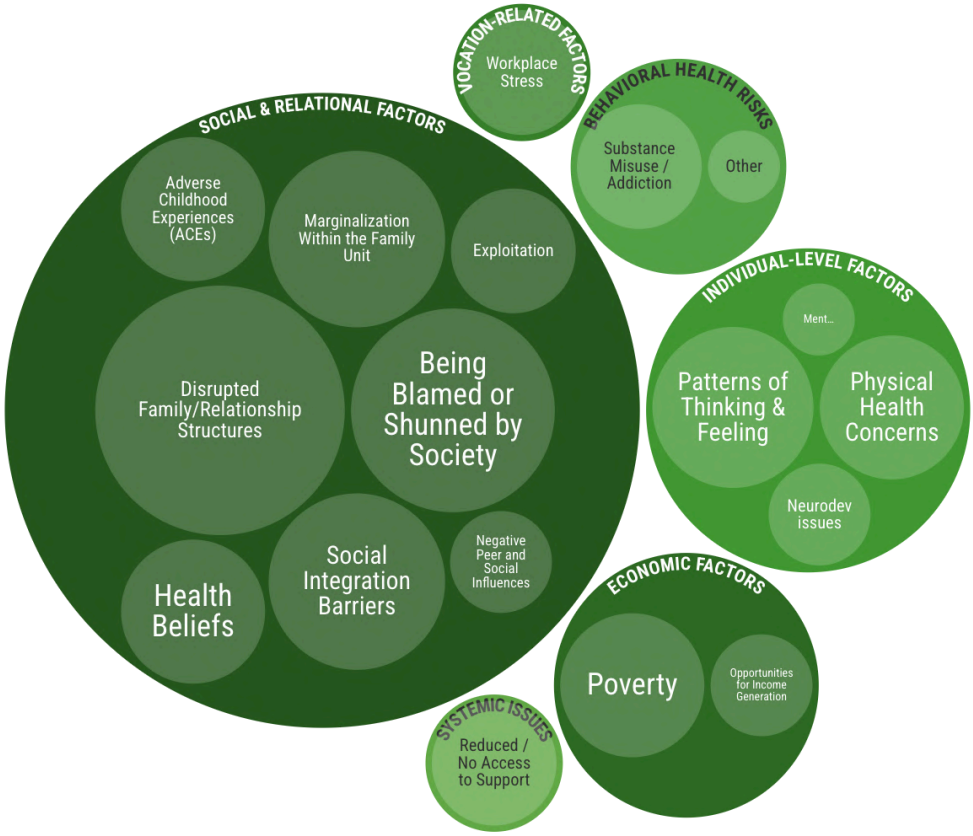


Figure 3. ***Service seeker and user perceptions of determinants of MHPS Issues***

Figure 4. ***Service seekers' preferred support needs for mental health challenges.***

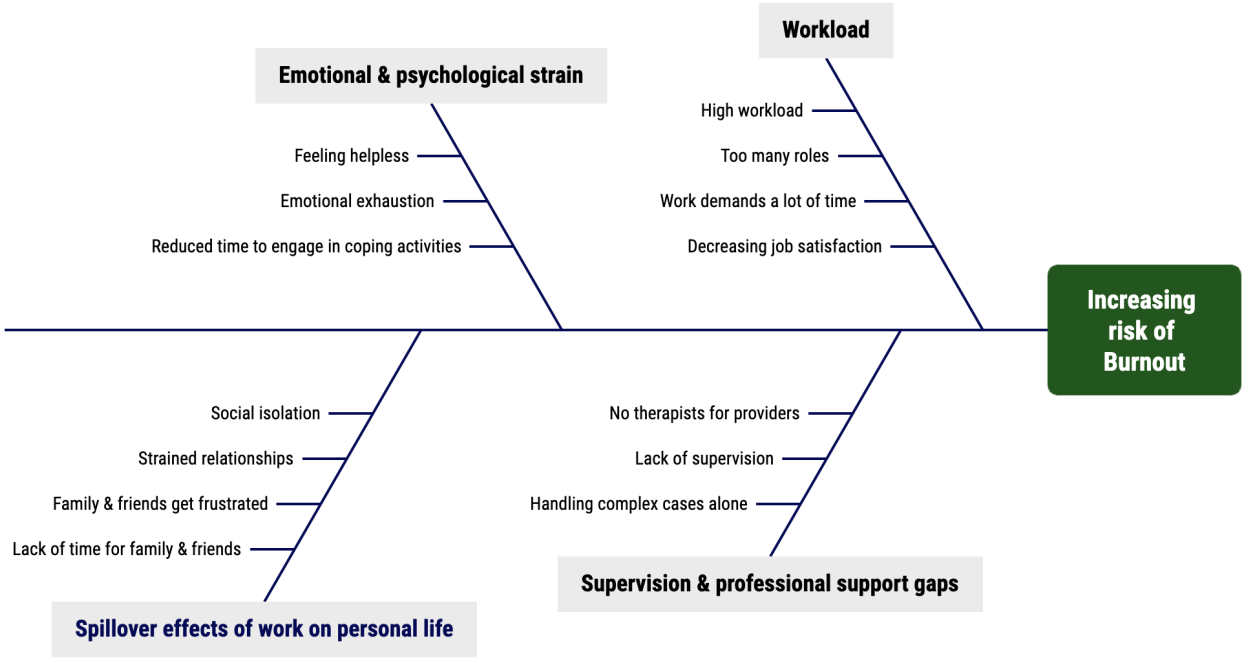


Figure 5. ***Factors increasing risk of burnout for service providers.***

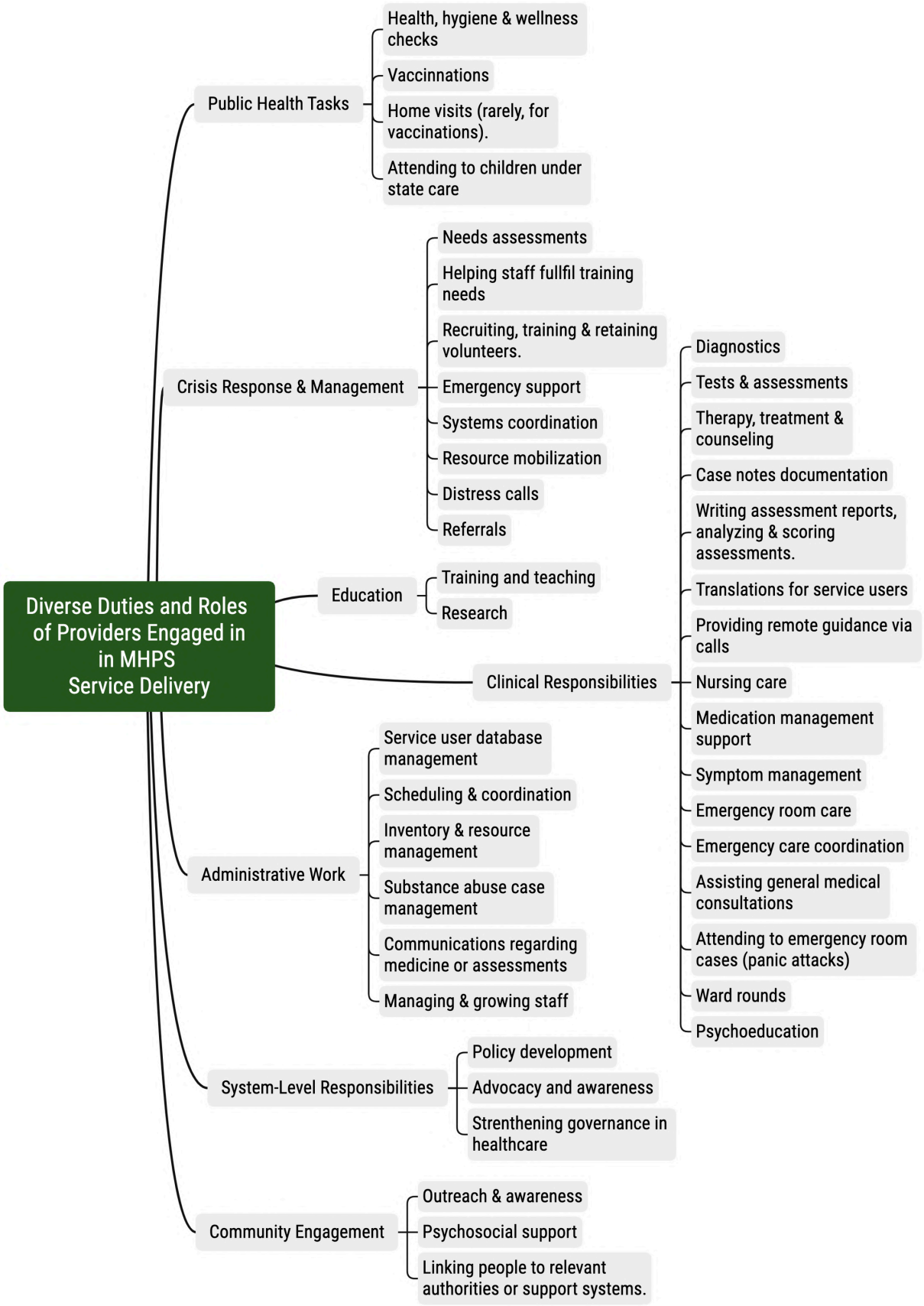


Figure 6. ***Complex and layered roles played by service providers fulfilling MHPS roles.***

For instance, some participants some said religious, moral, and cultural interpretations often guided help-seeking and made biomedical explanations feel incongruent. They struggled with experiencing things they explained in terms of faith, religion, and cultural beliefs ("low faith", "mobile phone use", "lack of discipline", "possessed") that the medical system did not accommodate, which diverted them from accessing care, reduced engagement and adherence. Many believed medication could worsen problems or create dependence. Other seekers and many providers, conversely, found religion and cultural explanations to be frustrating, and not helpful.

A young service seeker said:
"Our parents, our grandparents, instead of asking what happened,
they will say go pray."

Other accounts pointed to a skills gap: people "learned" disorder names online or in treatment, but not what to do. "People only learn about the disorders that are popular online," a provider observed. Instead of a diagnosis, participants asked for concrete everyday skills. "We need parenting support, how to talk to children, how to manage devices, how to raise them well," a provider said.

These highlight the need to rethink the presentation and even the objective of clinical services.

Progress Was Hard to See

Frequent interruptions (costs, distance, queues) reduced the quality of engagement, leaving providers unsure about outcomes. Service providers were navigating complex and diverse roles (see figure 6), which also reduced the time they had to evaluate progress, reflect on what works and what does not. Service users did not feel like equal partners in the recovery journey, and many accounts indicated rushed appointments, careless treatment, and the doctor's dismissal of their challenges.

Service users said:
"Developing trust takes time, but because there are long gaps in waiting time & appointment cancellations, we can't really develop this trust."

"Some doctors make discouraging or disheartening remarks."

Follow-up was another structural blind spot: the system appeared mostly designed for first contact rather than continuity and completion of care. These issues left both service providers and seekers feeling that support was not very helpful or meaningful.

A service provider said:
"People don't come regularly. ... You don't really see improvement or get to feel that what you're doing is working."

Greatest Need Meant Least Access

Intersecting vulnerabilities (poverty, disability, age, gender, migration) were reported to compound barriers. Participants noted that obstacles clustered for those with less social power, producing sharper access gaps in small communities. Criminalized or moralized concerns narrowed support options and deterred helpers, disability and migration status limited communication and service navigation, and poverty heightened exposure and confidentiality risks (see figure 7).

Furthermore, as triage was not embedded, services absorbed all levels of need instead of routing people to the right level (see Theme 4). Without first-line screening, mild and moderate cases used specialist time while complex or urgent cases waited.

Service users felt that:
"A child from a low-income family may struggle to receive treatment support, while a powerful figure's presence can lead to better assistance."

"People with hearing disability have zero access because there is no interpreter. ... How can they access hotlines?"

"If you are from a poor family, confidentiality leaks quickly."

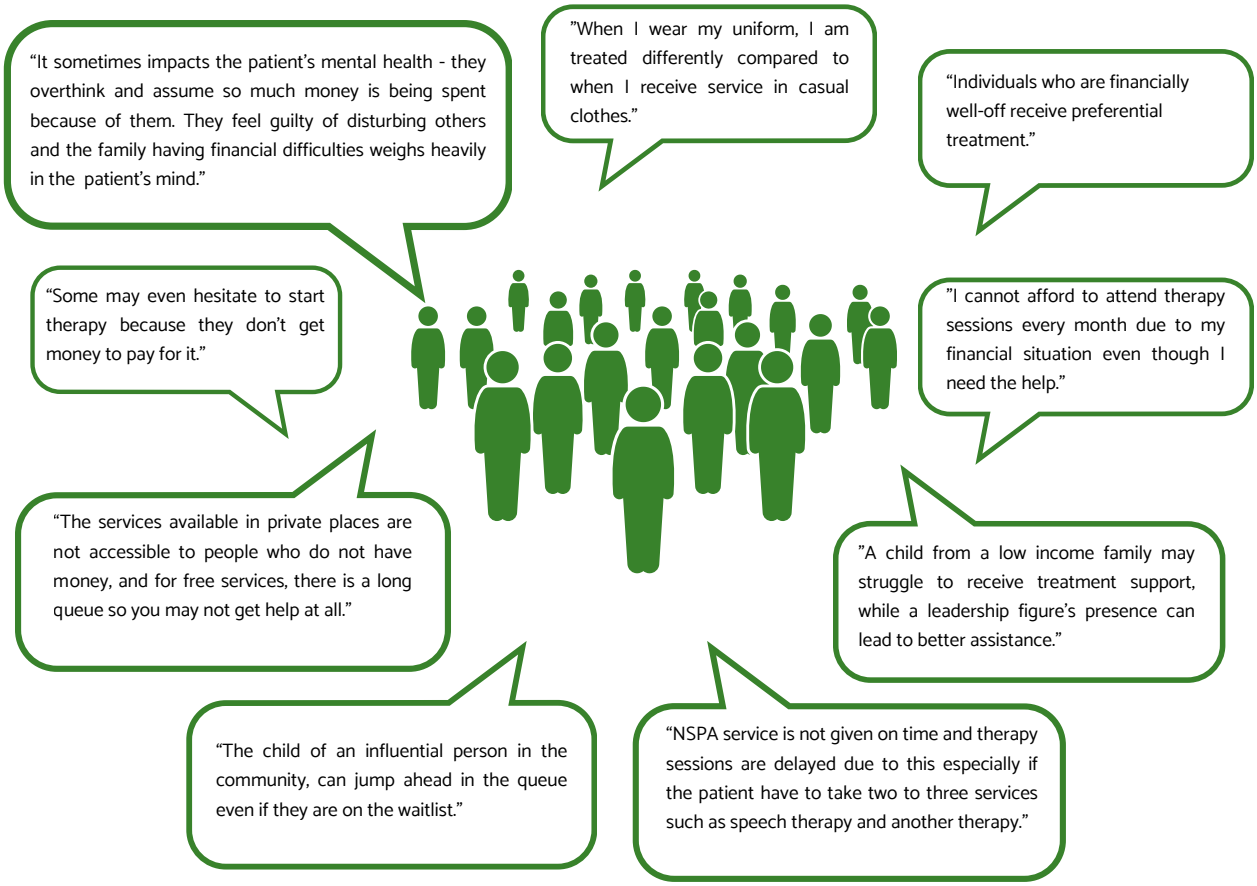


Figure 7. ***Challenges experienced by service seekers when accessing services.***

Trust Deficit in Specialized, Clinical Care

Trust is often a precondition for engagement and continuity in any support service. However, a majority of the service seekers expressed low or no trust in clinical services. For some, perceived poor-quality care drove this, for others, breaches of confidentiality eroded trust. Perceived private issues and negative encounters seemed to make the benefits feel outweighed by risks.

One service seeker said:
"Don't want rumors to spread. So do not want to sit even near [location name omitted]."

"It's hard to open up when you don't know how they [service providers] will talk about you later," said one service seeker. In some cases, clinicians were perceived as outsiders who should not hear private family issues. Some felt "passed around" between institutions without continuity, which eroded trust. Participants also noted confidentiality breaches that indicated the system penalized disclosure while depending on it.

Another driver of low trust in clinical services was the stigma attached to "seeing a doctor" for mental health. In some communities, challenges became stigmatized only once people sought care, and treatment (especially medication) was widely equated with "having a mental illness."

Service providers observed:
"When you go to school counselors to seek help, others consider it shameful, labeled as possessed by ghosts, the problem happens as soon as they seek help only."

"People might fear ostracisation if others find out they take medication. But they will come here if there are counselling services."

Theme 3: Hidden Costs of Specialized Care

Direct costs and hidden social–emotional costs made care feel unsafe or unaffordable. Caregiver and provider wellbeing both were at risk, reducing engagement in treatment and positive outcomes for service users.

Added Social and Emotional Costs

Therapeutic services alone were extremely costly to access over the long term. Medication could cost up to MVR 7,000 and therapy fees sometimes were between MVR 550 to 15,000 per session, with centralization, waits, and cancellations, travel and accommodation could add up to MVR 25,000 to 50,000 per care episode. Many service users felt personally responsible for the financial burden on loved ones and chose to discontinue treatment due to cost.

Service users disclosed:
"I spent 50,000 MVR in just 20 days. I just couldn't continue."

"Sometimes . the appointment gets canceled because there's no transport. . Just the trip to Malé can make you feel more depressed."

"Spending 1,500 in a day is a lot. Sometimes we travel and come back without even being seen. It does not feel worth it: We wait in the queue and return without getting a number."

Engaging in social safety-net schemes and financial assistance also caused frustration and anger. Participants mentioned "very minimal" enforcement of ethical codes in small communities where confidentiality breaches are consequential, leading people to avoid seeking help to avoid exposure.

Pressures were compounded for criminalized mental health concerns with few safe service routes, and in small-population settings where confidentiality leaks, reputational risks, discrimination, and marginalization were high. Some caregivers—often fathers—blocked access, viewing difficulties as shame or exaggeration. The costs of care work fell largely to women and intensified in nuclear families without childcare, for single mothers and grandmothers, and for women who were both breadwinners and primary caregivers.

Service seekers commented:
"Especially if it is a girl. People will know. Information leaks easily. Confidentiality is a big issue."

"When there is a mental health problem, people tend to distance themselves . saying you are 'crazy' or have 'lost your mind.'"

"They will ask 'Your kid is an autistic kid or a mad kid, right?'"

Caregiver Load and Care Friction

Caregivers often play a pivotal role in a person's access to mental health journey, influencing willingness to seek help and remain in care. Families, particularly in collectivistic cultures, provide daily care, emotional support, and advocacy for recovery as well. Participants in this study said that misaligned or poorly timed caregiver involvement often impeded care. Service users sought consistent care, empathy, and patience from carers, while providers struggled to balance therapeutic priorities with caregiver expectations and to involve families in supportive, not obstructive, ways.

A service provider shared:
"Parents ask therapists to tell children what they want the child to do. And sometimes they ask us to suppress the emotions of children."

Caregivers faced substantial emotional, financial, and logistical strain—disproportionately borne by women —e.g., single mothers, grandmothers, primary earners. Many were excluded from, or unclear about, their role in treatment planning and received limited guidance, language barriers with foreign therapists compounded difficulties, alongside high costs and restricted access to medication and assessments. Fragmented coordination and prolonged stays in Malé further disrupted family life and income.

A service user said:
"Needing an attendant 24/7 when a child is at [the hospital] and separated from the child is really tough."

Meanwhile, a service provider remarked:
"Parents tell friends or neighbors about therapy sessions, and then children feel their confidentiality was breached by us."

These pressures led to treatment delays, discontinuation, or resistance driven by mistrust, stigma, or belief-based objections, caregiver burnout and emotional disengagement that weakened follow-through, and increased conflict with providers—such as pressure to use therapy as discipline or breaches of confidentiality—undermining therapeutic alliances and child outcomes.

"I once spent three months in Male' with my 18-year-old child for treatment, enduring many struggles. After returning, I sought an online consultation, and when the child expressed feeling better, the doctor insisted that without his consent, the medication could not be continued. Then, abruptly stopped the treatment without further discussion with us as parents," shared a service seeker.

Provider well-being at Risk

Access costs are often examined from the service user's perspective, this study shows that providers also shoulder substantial personal and professional costs to deliver care within the current system.

Service providers admitted:
"I have over 60 open cases and no one to refer the complex ones to."

"Each day brings different experiences and emotions,
as we never know what kind of cases we might receive.:

"I believe that if the working hours could be 6 hours, it would be easier for us, as it's a mentally exhausting profession."

"We carry the trauma of others but don't have time or space to deal with our own feelings about it," said a service provider.

The service provider's extensive workload, emotional labor, and lack of learning and supervision opportunities eroded throughput and confidence. Many service providers reported a strong sense of isolation and a feeling of having to carry burdens alone, often with waitlists exceeding 100 people, because multidisciplinary and interdisciplinary collaboration was the exception, rather than the rule. Their workloads also prevented them from engaging in important well-being practices that help providers avoid burnout and provide better services. Their links for social support and care were especially challenged (see figure 5). In such contexts, diminished provider well-being can often translate into weaker therapeutic alliances and reduced positive outcomes for both the provider and user.

Service providers revealed:
"When the working hours end late, it's almost the end of the day, and we don't even get time to spend with family."

"Actually, sometimes our families & friends get frustrated–sometimes–you know, when the work demands too much time all the time."

Service providers who did report high satisfaction, motivation to deliver quality care, and a sense of fulfilment highlighted several key factors that enabled them to provide quality service, including supportive working conditions, learning and advancement opportunities, positive perceptions about their work, robust support systems, and access to resources (see figure 8). Providers who prioritized self-care and maintained empathy for both service users and themselves also reported higher satisfaction, motivation, and fulfilment. However, their coping mechanisms were dependent on time away from work, which was extremely limited for many service providers (see figure 9). Interestingly, non-Maldivian therapists reported greater satisfaction with support, remuneration, and working conditions. These are strengths to build on.

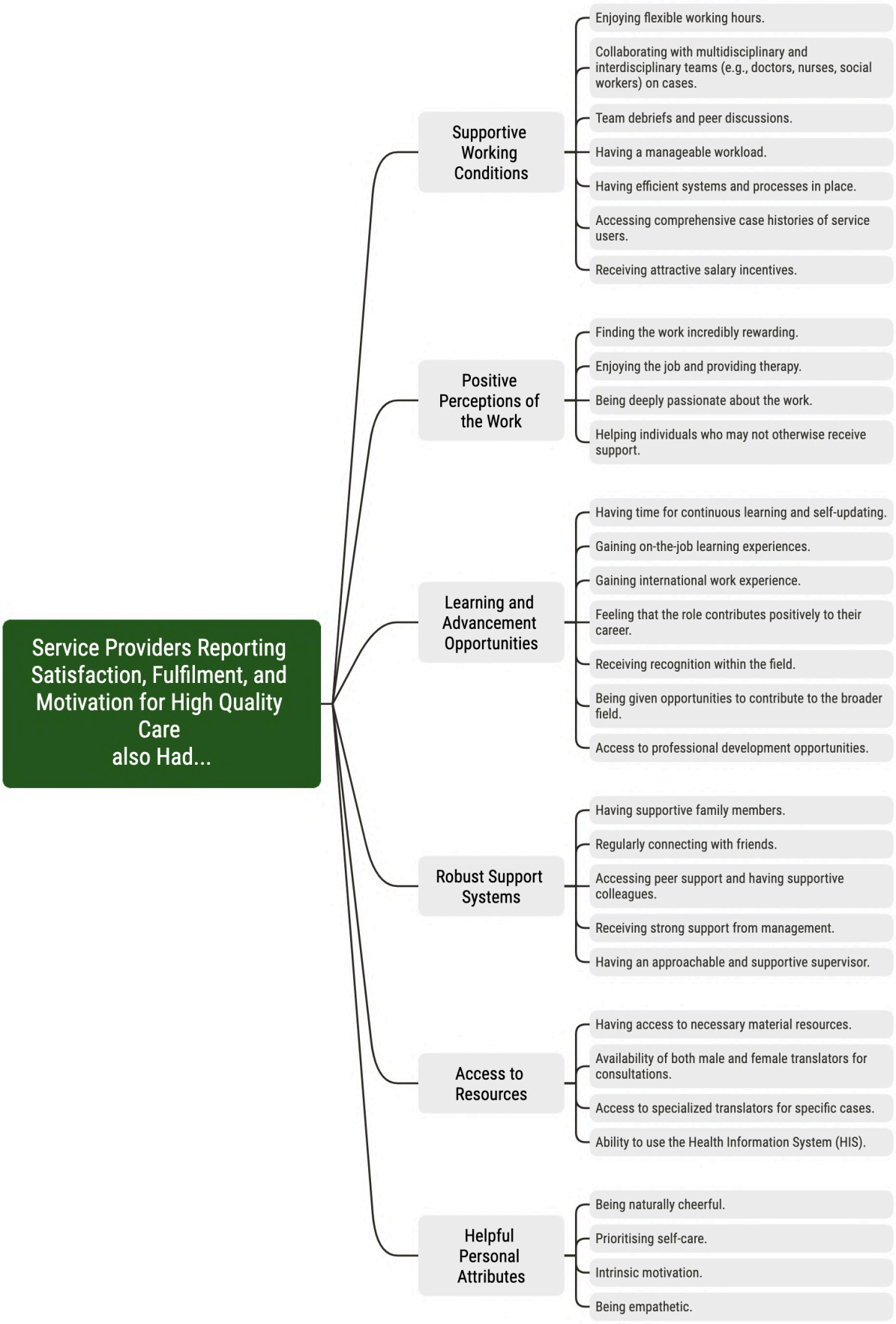


Figure 8. ***Enablers of meaningful and higher quality service provision.***

One service provider said:
"I truly enjoy the work I do, especially the opportunity to help people, who may otherwise not be able to afford it, improve their mental health. It's incredibly rewarding to make a positive impact."

While burnout is common across health care, and mental health worker burnout is sometimes minimized as "more of the same," other clinicians typically rely on mental health professionals to recover and return to effective practice. This gives MHPSS service providers a dual role: caring for the public and restoring the wider health workforce. That contribution should be explicitly recognized, resourced, and protected.

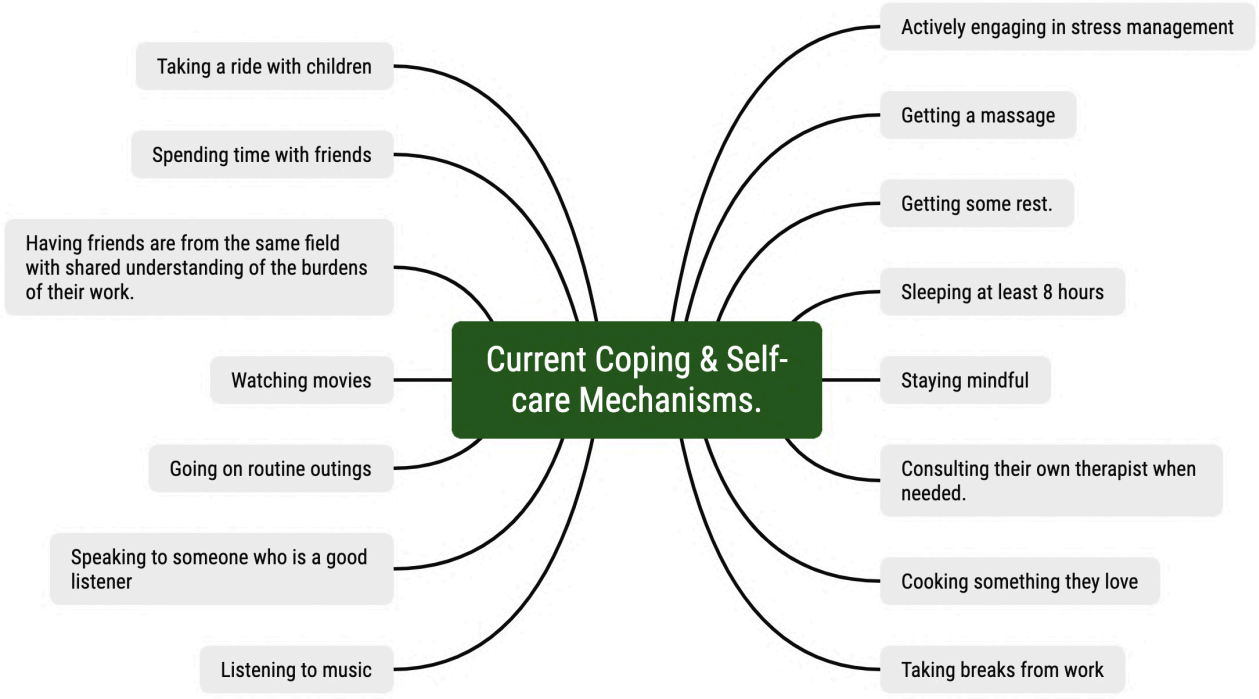


Figure 9. ***Current coping mechanisms of service providers.***

Theme 4: Missing Tiered Care and Early Steps

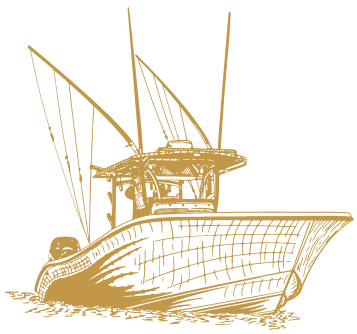
Participants pointed to scarce low-intensity options, uneven use of existing resources, and a tendency to privilege disorder labels over practical skills to cope or manage challenges.

No First Line Leading to Crowded Last Line

One service provider suggested:
"School-aged groups need someone to screen and give primary support in the initial stage."

The lack of screening and triage created high workloads at specialist levels for issues that did not always require intensive therapy or medication. Providers stressed the value of a first line that sorts urgency, offers brief support, and guides referral in everyday settings.

However, shortages of psychiatric nurses, psychologists, and counsellors resulting in issues such as unmanageable student: counsellor ratios in schools, which meant that the places where early detection could occur lacked staff to do it. Because many service seekers arrived late and in a severe condition, specialized services became longer and more complex, locking services into a loop of overcrowded services, low engagement, and constrained capacity.



"If a fishing boat is lost at sea or there's a sudden death, 400 others in the community are affected. If someone could do some basic screening, understand who actually might need help, and refer them, that alone would be very helpful, explained a service provider.

In addition, there were instances recounted by service providers, where the service user was in a crisis situation unable to access specialist care but could not get support from available providers due to tight regulations.

Capacity Gaps in Individual and Community Care

Self-management of issues was often the default, followed by interpersonal, relational, faith-related resources for support (see figure 10). This can help in the short term, but may not be effective over time unless they build new skills and knowledge to navigate their challenges. As self-care practices and skills were not commonly known or taught, this had led many individuals to turn to AI or online sources for private, immediate support, which may be useful for information or reflection, but has been highlighted as an unsafe option in the long term. This was especially the case for persons with disabilities and youth. A young service seeker added that sometimes self-managing backfired: "Most people will do something by themselves, we have seen [the] condition going from bad to worse because people don't know how to deal with these kinds of things...". The lack of community-based care also added further barriers not just to accessing care but also for sustained support.

Service providers stated:
"There is a lack of well-established community-based support services. This complicates the continuity of care and recovery process."

"As policies and ethics are so strictly regimented, other PSS practitioners are not at liberty to suggest alternatives. Even if the person has an urgent issue and can't find the prescribed medication."

Everyday Gateways

Participants preferred low-visibility contact and everyday platforms that normalised support without signalling a psychiatric label, quiet intake with call-backs and youth-centre supports were recalled as acceptable ways to ask for help. They indicated that alternative supports were acceptable but not well known. For instance, peer-based support systems were valued as some mentioned that people trust their friends over counsellors. Parenting groups and primary-care touchpoints felt safer and more comfortable, especially for women, allowing discussion of broader concerns while accessing basic guidance.

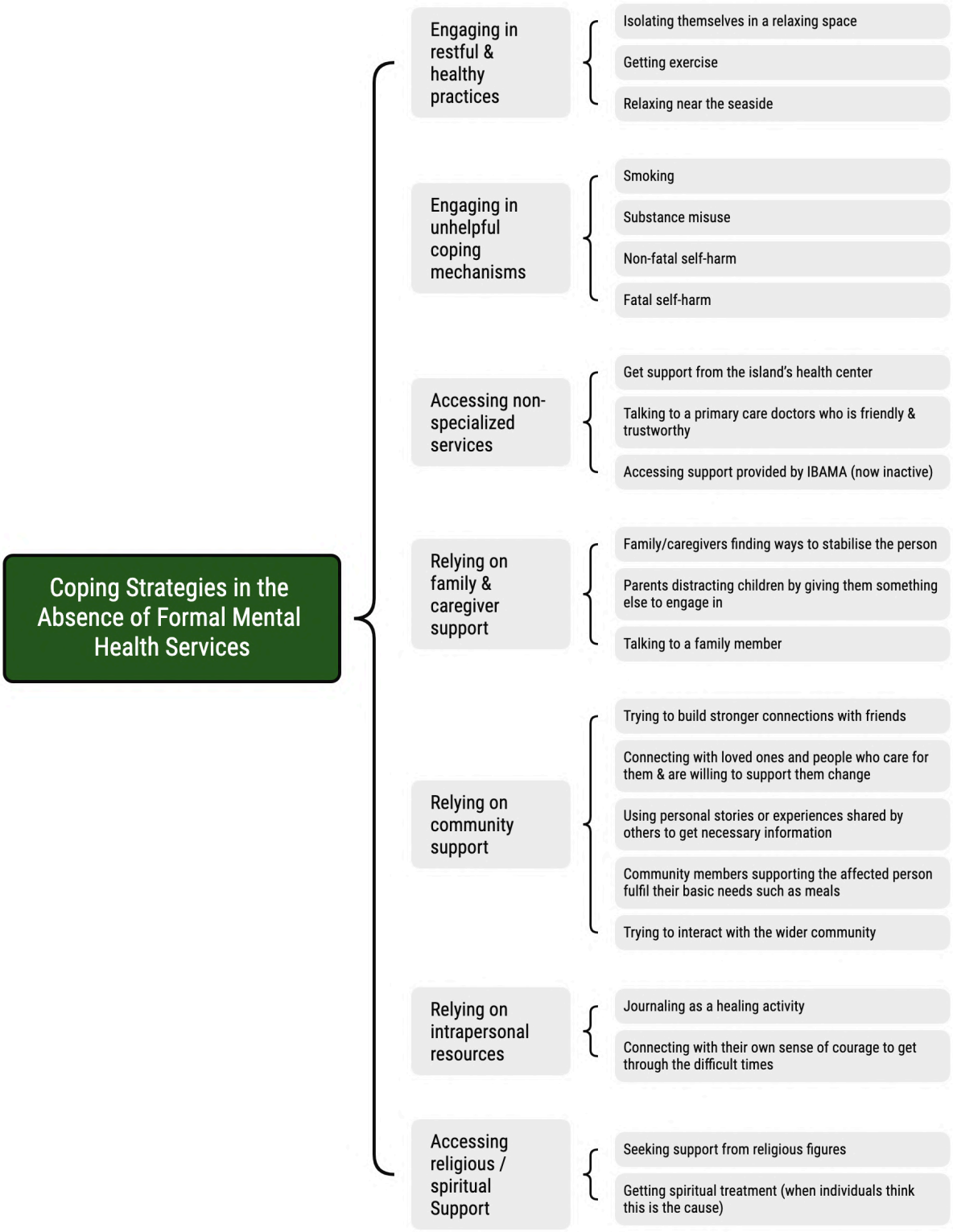


Figure 10. ***Coping and management strategies used by service seekers/users in the absence of access to other support services***

A service seeker recalled:
"Someone would sit at a help desk, take personal information . quietly [at the youth center], and a counselor would call back." – Service Seeker

Service providers noted:
"Women find services more accessible through parenting support. . Then it becomes easier to talk about their other anxieties. Even divorce."

"Normal doctors & nurses give counseling/advice when a specialized person is not available. The on-duty person will provide support to walk-in cases"

Everyday touchpoints (schools, parenting groups, peers, online communities, even peer therapists) were valued when they normalized help-seeking, provided non-clinical support, and built practical coping and navigation skills, often resonating more than technical diagnoses but were underutilized. Participants highlighted peer support, especially online, for connection and hope.

Service seekers also felt the same:
"When someone sees others who have improved, they feel hope that they can improve too."

"What I needed was not just medicine, it was someone to talk to, someone to understand what I was going through."

In a dispersed geography such as the Maldives, local, community-based health services, especially for mild to moderate distress and psychosocial issues, were seen as essential for timely care. As one service seeker mentioned, "It would be easier if the services were available on the island, even if people need to pay for them." While participants noted sparse community options, several mentioned that sustained community contact felt safer and more acceptable.

A service seeker shared:
"There is an NGO here that follows up with people in treatment and engages them in activities. That ongoing contact builds trust."

Non-clinical support was valued even by service providers, with one saying: "Having someone who listens can significantly impact a person's well-being. Even small adjustments to daily routines can bring about meaningful improvements."

Many service providers and service seekers were already relying on non-specialist support. Service seekers approached primary healthcare providers or religious leaders, while psychiatrists sought the help of social workers and similar providers to conduct follow-up.

"One of my best experiences was collaborating closely with nursing staff and social case workers through complex discharge issues for a patient. The teamwork and shared commitment made a real difference. Then it felt like overcoming the challenge was both rewarding and motivating."

- Service Provider

Conclusion

Across groups, service provider and seeker participants converged on linked insights.

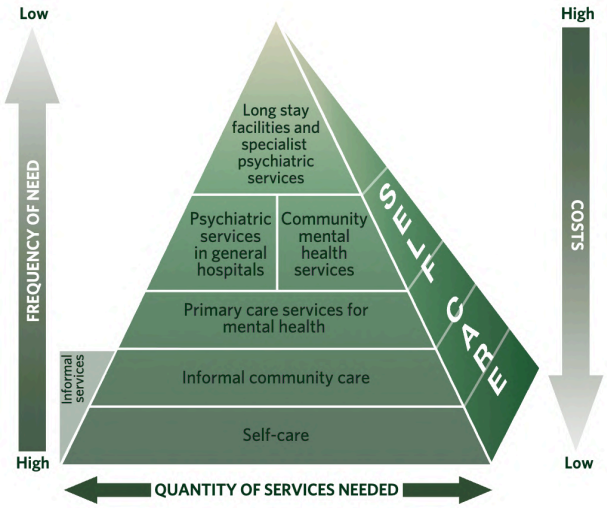
- Service providers were doing their best. However, demand exceeded local capacity in a centralized system, normalizing reactive, crisis-oriented care.
- System design shaped who reached care and how, with weak continuity and constrained access where need was greatest.
- Specialized services were hard to use and deliver when trust was fragile, costs and time burdens were high, for both the providers and seekers.
- Service models did not align with lived explanations and preferences; low-visibility, everyday entry points offered more acceptable routes.
- Opaque pathways and limited navigation information hindered timely entry and appropriate referrals.
- Hidden social and emotional costs drove discontinuation and late re-entry to care.
- Provider workloads, isolation, and limited supervision reduced quality and throughput, linking staff well-being to user outcomes.
- These dynamics suppressed help-seeking and crowded service waiting lists, while stepped and early community options remained scarce or underused.
- Self-care was often the default, but skills gaps led to complications and risky reliance on unvetted sources (e.g., AI chatbots).

Together, these findings point to the need for clear pathways, earlier and closer supports, and better-enabled providers, setting up the four strategic priorities that follow.

Recommendations

This section presents evidence-based recommendations organized under four strategic priorities (SP1–SP4). Each priority includes specific, actionable measures that can be taken up by a range of actors to advance that priority.

The recommendations are aligned with the World Health Organization's service-organization pyramid for an optimal mix of mental health services, spanning self-care, informal community care, primary care, community-based services, and general hospitals.[14]



While any stakeholder – government, professional bodies, providers, community organizations, development partners, and civil society – can lead, co-lead, or support these actions, primary leadership and enabling support are expected from those advancing and regulating healthcare, delivering services, shaping policy, and educating the workforce. The goal is a coordinated, multilevel response that improves access, quality, and continuity of mental health and psychosocial support across the Maldives.

Strategic Priority 1

Reduce Barriers to Accessing Specialized Care

Specialized services remain the dominant pathway for mental health support in the Maldives, yet access is limited and uneven. Long waits, high financial, social, emotional, and time costs, centralized facilities, workforce shortages, and unclear referral pathways delay or prevent timely care, particularly for children, persons with disabilities, low-income households, and others with existing vulnerabilities. Even where services exist, weak coordination, confidentiality concerns, prior negative experiences, and stigma often deter engagement.

Reducing these barriers is essential for progress toward Universal Health Coverage and Sustainable Development Goal 3, and for easing long-term pressure on the health system. The actions that follow set out practical steps to make specialized care more available, affordable, and acceptable, grounded in the perspectives of service providers, users, and seekers.

1.1 Update Mental Health Services to Reflect Recovery-Oriented Practices and Principles

Shift Maldivian mental health services toward recovery-oriented and skill-building approaches to bridge the gap between provider and user expectations, reduce stigma, and promote hope, dignity, and long-term well-being alongside essential clinical care.

Current services prioritize acute symptom management and crisis stabilization. While essential, this emphasis leaves little space for continuity of support, skill building, and everyday supports that prevent relapse and reduce future service load.

Different understandings and expectations of "recovery" were present: Providers tended to emphasize symptom reduction, medication adherence, and clinical stability, users described recovery as feeling heard, rebuilding trust and relationships, and having time and space to heal. Exclusive focus on crisis care and symptom reduction has downsides. They can unintentionally reduce agency and increase relapse risk.[15] This misalignment contributed to disillusionment and disengagement on both sides. Users reported rushed sessions, cancellations, feeling "passed around," shame, and loss of dignity, providers reported fatigue and limited observable progress.

A scoping review in Asia revealed that people often framed recovery as a transformative journey, and recovery is better understood as adaptation while maintaining roles, relationships, and meaning.[15] Across contexts, coexisting with biomedical and culturally, religiously influenced explanations, the most common enablers were strong social networks, faith, meaningful daily activity, empathetic professionals, and individualized coping.[16]

To bridge this gap, services should incorporate recovery-oriented practices (RoPs) and skill building alongside clinical care. RoPs center the person (not the diagnosis), emphasizing hope, dignity, autonomy, valued roles, and participation, even with ongoing symptoms.[17] In high-income contexts, RoP programs reduced psychiatric hospitalization from 24 to 14 percent, shortened the average stay by more than 1 month, and yielded approximately USD 17,000 in savings per person, they also improved quality of life, social inclusion, and employment outcomes.[18]

For providers, practicing recovery-oriented practices:

- Strengthen therapeutic alliances and engagement.
- Improve provider job satisfaction and user functioning.
- Reduce repeated crisis use and free up specialist capacity.[19]

Evidence Spotlight: Skill Building

- **Meta-analysis of 100+ RCTs found strong support for social skills training, cognitive remediation, and social cognition training, especially within integrated models (e.g., Integrated Psychological Therapy).[20]**
- **A seven-session online CBT skills (COPE) reduced anxiety and improved academic performance in adolescents.[21]**
- **Life-skills training (communication, problem-solving, health maintenance) improved well-being and interpersonal functioning.[22]**

Integrating recovery-oriented and skills-based approaches, with proper training, supervision, and small workflow changes, can align user and provider expectations, rebuild trust, improve outcomes, and reduce avoidable crisis care, particularly in a resource-constrained, geographically dispersed system.

1.2 Clarify Pathways to Care and Resources for Service Users and Providers

Improve access to information, service navigation, and visibility of available care options.

Participants frequently reported uncertainty about where or how to start mental health care. As evidenced by other studies, unclear information and weak navigation tools are the most significant barriers to accessing timely, appropriate care.[23] By contrast, simple enablers, such as easy-to-find information and leaflets at clinics, were cited as helpful by study participants.

1.2.1 Update the National Registry of MHPSS Providers

A public, user-facing registry of licensed MHPSS providers would support informed choice and appropriate use of services.

Minimum fields should include:

- areas of expertise,
- languages, translator, interpreter, sign-language interpreter availability,
- cost ranges (travel, accommodation, service fees, tests),
- referral pathways (visual where possible),
- modality (in-person/telehealth) and booking, and
- accessibility considerations.

Hosting this directory on Ministry or Health Protection Agency sites and promoting via social media and local clinics would increase reach. Clear, multi-channel information (digital, print, and human call-backs) improves safety, trust, and uptake, enabling earlier intervention and continuity.

1.2.2 Establish Clear and Contextualized Referral Protocols

In a centralized system, structured referral is essential for timely, equitable access and to relieve overburdened tertiary services. Without clear referral guidance, participants often struggled to determine eligibility, appropriate contacts, or support service seekers through the next step in care. This uncertainty results in missed opportunities for early intervention and leads to overreliance on centralized tertiary facilities, where some therapists reported caseloads exceeding 60 clients per month.

Referrals often require providers to persuade users to continue care, yet explaining the need can be difficult when seekers fear or mistrust unfamiliar facilities (especially for mental health) and when religious or cultural beliefs heighten reluctance. Referral protocols should therefore embed clear communication strategies that build trust and support follow-through. Resources such as the Pathways Community HUB Manual (2016) offer adaptable guidance. Evidence indicates that the success of referral systems hinges on technological, organizational, and patient-centered factors.[24] Other studies note that mobile- or web-based tools are especially effective in contexts with high network coverage, as is the case in the Maldives.[25] Therefore, high internet penetration (over 86%) and social media use (over 71%) in the Maldives provide a strong base for digital way-finding.[26] Leveraging community hubs that can act as low-threshold entry points in this process is important. International examples, such as contextualized school guides from the Wisconsin Department of Public Instruction (2019), demonstrate the model's potential. Similar adaptations could be piloted and scaled in the Maldivian context (see SP3 for more).

International models (e.g., service navigation programs in Australia's Primary Health Networks) report improved access, user experience, and continuity, particularly for vulnerable groups, and can reduce pressure on centralized services.[27]

1.3 Support Existing Cross-Island Peer Support Networks

Recognize and integrate peer-led support structures

to improve system navigation and encourage help-seeking.

Informal and semi-formal peer networks (such as Mental Health Support Group Maldives) already fill critical gaps in the Maldivian mental-health system by offering practical guidance (finding the right service, locating medication, understanding therapy options) and the solidarity that formal pathways often lack. Migrants and persons with disabilities also highlighted online peer groups as preferred entry points as seeing others find help and recover builds hope. Peer support is a low-cost, high-impact complement in a context of limited professionals and high demand.

Rather than duplicate efforts, authorities can recognize and amplify trusted groups, provide light technical and financial support (training, resources, digital access), and integrate trained peers into clinics and outreach, leveraging lived experience to improve trust and bridge access for youth, rural populations, and those wary of stigma.

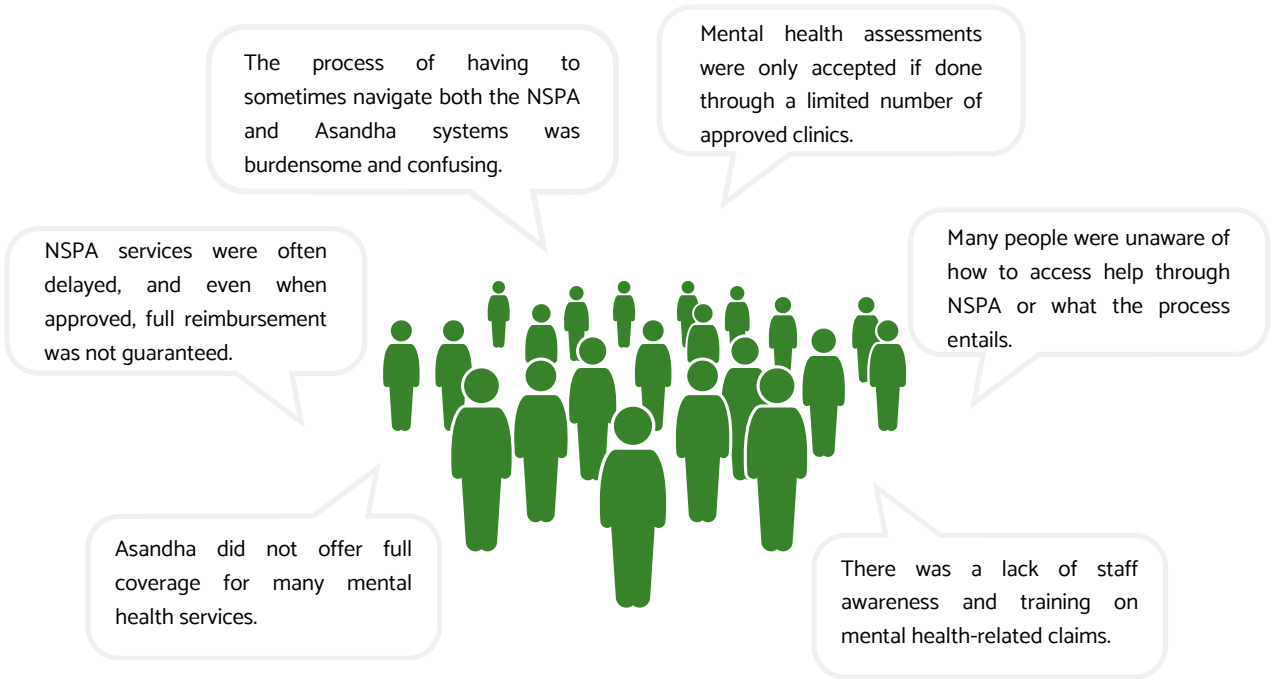


Figure 11. ***Service access challenges related to social security schemes.***

1.4 Make Aasandha and NSPA Systems More User-Facing

Streamline access to health financing schemes through improved communication, staff training, and service coverage.

Many service users reported confusion, delays and contradictory information when accessing mental health benefits through Aasandha or National Social Protection Agency (NSPA) which are the country's primary health financing schemes (see figure 11). A lack of trained staff to sensitively support individuals with psychosocial needs further undermines effective use. Improving transparency and user-facing support is essential for timely and equitable access to care.

Participants suggested several interventions to make the Aasandha and NSPA schemes more user-friendly through relatively simple interventions:

- Create **a single point of entry** (online or physical) where users can get information on both schemes.
- Educate **help desk staff** and support officers on mental health services and support at hospitals and clinics.
- Review and increase **the list of eligible clinics and providers** for mental health under Aasandha and NSPA.
- Equip **receptionists and intake officers** at NSPA and Aasandha with basic mental health awareness to reduce stigma and improve user experience.

By reorienting these schemes to center the user experience, rather than merely process transactions, these systems can become enabling mechanisms, rather than barriers, to continuity of care.

1.5 Reduce Burden on Caregivers

Acknowledge and address caregiver needs to reduce caregiver stress and improve continuity of care, especially for children.

As outlined in the findings, caregivers are essential to service seeking, access, continuity, and recovery. At the same time, evidence shows that caregiving, especially to children or spouses, leads to emotional strain, marital conflict, stigma, and future-related anxiety.[28]

Evidence Spotlight: Caregivers and Mental Health Recovery

Research shows that:

- Caregivers were seen as "standing alongside" the person in recovery. They offered practical support, such as watching for changes in symptoms and speaking up with or for the person in discussions with the mental health team. They are well placed to offer social support in the forms of emotional support, companionship, instrumental support, and validation. [29]
- Caregivers' stigmatising attitudes significantly reduced young people's use of services (in the UK), and even caregivers of individuals with mental health conditions often saw mental illness as a personal weakness and avoided others with similar experiences (in Sri Lanka).[30]
- Most families wish to be involved in treatment, and most service users support such involvement, yet actual collaboration between mental health professionals and families is limited. The role of families in mental health care is often undervalued across both high- and low-income contexts, and family-centered approaches remain rare.[31]
- Caring for someone places heavy emotional, mental, and practical demands on caregivers, which can seriously affect their own wellbeing. Since caregiver wellbeing is strongly linked to better symptom management, greater use of services, fewer hospital admissions, and lower relapse rates for the person they support, protecting and strengthening caregivers' mental health should be treated as a core priority, not an add-on.[32]

Yet providers, users, and carers in this study alike reported that caregiver burdens, coupled with unclear roles and involvement, often complicated engagement and disrupted care. In light of these findings, strengthening support to caregivers becomes a necessary system investment.

These could take the form of:

- **Collaborative care planning** between therapists and parents, with clear roles, mutual respect, and boundaries.
- **Psychoeducation for caregivers** on children's mental health, therapeutic goals, confidentiality, and recovery processes.
- **Practical support services**, such as respite options, financial subsidies, and caregiver accommodations in hospitals.
- **Support groups** that address general parenting or wellness topics, reducing stigma while creating spaces for connection and discussion.
- **Training for service providers** (e.g., school counsellors) in family engagement, boundary-setting, and conflict de-escalation.
- **Embedding caregiver involvement** into Recovery-Oriented Practices, which emphasize the value of natural supports throughout the recovery journey.

1.5.1 Create a Family Involvement Framework

Many service providers described family members, especially parents of child and adolescent clients, as either completely absent and resistant or overly involved in ways that undermined therapeutic progress.

Without a shared understanding of roles, boundaries, and goals, these interactions become sites of tension, compromising not only the child's trust in the therapist but also the provider's capacity to maintain professional integrity.

A **Family Involvement Framework** would set shared protocols for safe, appropriate, and respectful caregiver engagement by:

- clarifying when and how to include families;
- explaining boundaries (e.g., confidentiality in child or adolescent care);
- offering counseling for caregivers; and
- guiding providers to set limits and involve families constructively.

Core elements could include routine early family briefings, locally adapted caregiver guides or handouts, training for school counselors and clinical staff on family dynamics and communication, and screening tools to flag when involvement may be harmful or should be limited.

1.5.2 Introduce a Short-Term Residential and Transport Support Program into Existing Social Safety Nets

Participants highlighted that short-term hospital admissions, especially for children, disrupt caregiving, employment, and family life, with limited accommodation or support for attendants. Centralized stabilization options and long-distance travel compound costs and stress, further marginalizing families already stretched by caregiving.

Therefore, expanding existing social safety nets to include targeted supports for mental health-related travel and short stays could help ensure timely and equitable access, reduce dropouts, protect caregiver well-being, and lessen late-stage, high-cost crises without adding strain to the system.

This could include:

- **Transport subsidies** for individuals and families seeking care outside their island or at regional hubs.
- **Accommodation support**, including guesthouse partnerships for low-cost co-stays.
- **Emergency funds** or fast-track mechanisms for urgent mental health travel.
- **Short-term residential support options** outside key tertiary hospitals, especially for families with young people.

This initiative could build on existing frameworks like Aasandha, NSPA, or the Disability Allowance, ensuring that mental health care is not treated separately from other basic health and social entitlements. Resources should target parents or caregivers of children or persons with other disabilities, individuals from remote islands, and those needing emergency psychiatric care to prioritize vulnerable groups.

This recommendation links to earlier suggestions for improving navigation and caregiver inclusion, ensuring that even the most marginalized can access care without facing insurmountable costs.

1.6 Update confidentiality protocols for context-specific use and share them with users.

Revise confidentiality and ethics training and protocols to add practical small-community safeguards across all staff and clear breach-response steps.

Across the study, many service seekers and users described challenges when it comes to confidentiality and being able to feel safe and protected when accessing mental health services.

"If you are from a poor family, confidentiality leaks quickly," said a service seeker, indicating that intersecting vulnerabilities, such as low socioeconomic status, intensify barriers to help-seeking. People from lower-income families not only face discrimination in the form of being treated with less respect but also encounter greater risks of confidentiality breaches. Their comments and the unique challenges of small communities indicate the need for safeguards beyond traditional ethics training for service providers and all other personnel involved in service provision (receptionists, attendants, translators, administrative staff, and others).

Training should be practical and address situations such as

- encountering acquaintances in queues;
- offering private waiting options;
- using discreet scheduling;
- implementing silent token queues; and
- providing anonymous reporting channels (see recommendations 4.5.1 and 5.4.2).

Many service users reported experiencing breaches of confidentiality. Island-level safeguarding procedures should therefore specify required responses, including prompt acknowledgment and apology, notification, and concrete remedial steps.

Together, these recommendations remove practical and relational barriers that keep people from specialized care. Recovery-oriented practice aligns service experiences with what service users and seekers value, while clear pathways, an updated provider registry, and peer networks reduce confusion and drop-off and improve engagement. Making Aasandha and NSPA easier to navigate improves affordability and timeliness. Supporting caregivers and clarifying confidentiality strengthens trust and sustained engagement. This strategic priority expands equitable access across islands, improves continuity and outcomes, and reduces avoidable pressure on specialist services, moving the Maldives toward universal health coverage and SDG 3 and toward a nation where people can reliably access the support and services they need.

Strategic Priority 2

Reduce Barriers to Providing Specialized Care

A distinctive feature of this study is that access was examined from both provider and user perspectives. As much as there is a need to reduce the roadblocks that service seekers meet along the care pathway, it is equally important to ensure that providers work in conditions that enable them to improve the quality of support they offer while also taking care of themselves.

Improving provider conditions is not only about workforce expansion. It means optimizing the structures, systems, and policies around practice, and ensuring the support, training, supervision, and opportunities for personal growth that keep providers motivated and fulfilled. Burnout is easy to dismiss as it is commonly associated with healthcare professionals, but when other healthcare workers need support, recovery, and healing, it is mental health professionals who are called on.

This priority, therefore, sets out short- and long-term adaptations to support the existing mental health and psychosocial support workforce to strengthen their ability to provide better services.

2.1 Recognize the Need to Invest in Service Provider Well-being

Address the emotional burden, burnout, and isolation experienced by mental health providers through systemic support and well-being measures.

Mental healthcare professionals reported heavy workloads, long waitlists, and small teams. These conditions heighten the risk of stress, professional impairment, and burnout if unaddressed.[33] When provider well-being erodes, it also impacts the service users: access shrinks (fewer appointments, longer waits), costs rise (attrition, recruitment, rework), and disparities widen (services thin out first in hard-to-staff locations). Chronic overextension leaves little room for rest or reflection, which are essential for providing high-quality care, a concern echoed in global literature linking emotional exhaustion to compromised clinical performance and reduced empathy.[34] As one provider put it, **"We carry the trauma of others but don't have time or space to deal with our own feelings about it."**

Conversely, adequate time, supportive supervision, and trust in management are associated with lower burnout and better performance.[35] Investing in well-being protects continuity, safety, and the capacity to deliver recovery-oriented, person-centered care.

Building on the factors service providers indicated as being enablers and motivators (see figure 8), starter measures can include interventions that span supportive working conditions, learning and advancement opportunities, recognition, support systems, and access to resources, discussed in the following recommendations. Well-being standard could also be embedded in the licensing and contracting process (e.g. Continuing Professional Development [CPD] hours, supervision).

2.2 Move Beyond Conceptual Training to Focus on Client-Facing, Practical Skills in Training

Equip providers with applied therapeutic skills like psychoeducation, communication, and motivational interviewing to improve engagement and care quality.

Mental health professionals in the Maldives face a challenging dual reality: while service users seek more responsive and empathetic care, service providers report critical gaps in the day-to-day skills needed to deliver such care. Importantly, providers did not report gaps in theoretical and conceptual knowledge, they reported gaps in the everyday skills that make care work, especially when time with service users may be limited. When there are lapses in such skills, users disengage, adherence drops, relapse risk rises, and clinicians experience more conflict and burnout, further shrinking access and quality.

Their interviews indicate gaps in:

- Plain-language psychoeducation (diagnosis, recovery, what to expect).
- Medication conversations (benefits, risks, side effects, shared decisions).
- Engagement skills (active listening, empathy, de-escalation, repair after rupture of confidentiality).
- Working with ambivalence, denial, and low readiness for change (e.g., Motivational Interviewing).
- Culturally and spiritually congruent conversations (addressing alternate explanatory models such as religion without confrontation).
- Brief, structured interventions for mild or moderate needs (problem-solving, behavioral activation, sleep, parenting skills).
- Step-up or step-down decisions (a range of processes for adjusting the level of support and care based on need or changing circumstances such as assessing risk, when to refer and how to follow up).

A service provider shared:
"You can tell when a client is holding something back, but we don't always know how to help them open up or deal with denial."

A practical training package for service providers should include elements such as,

- Skills labs with demonstrations, role-plays, and standardized scenarios (e.g., medication side-effects, faith-only frames, parent conflicts),
- Observed practice with feedback (following the mini-Clinical Evaluation EXercise [CEX] style) through short observed sessions, with immediate, structured coaching on specific behaviors,
- Routine supervision (individual and group) using real cases, selective video review, and targeted coaching,
- Motivational Interviewing foundations (assessing readiness, eliciting change talk, rolling with resistance) reinforced with refresher sessions and fidelity checks, and
- Accessible job aids, including plain-language explanation sheets, side-effect discussion guides, teach-back checklists, and brief-intervention scripts.

Evidence Spotlight: Benefits of Motivational Interviewing in Therapy

- Motivational interviewing (MI) is a collaborative, goal-oriented communication style that resolves ambivalence and strengthens a person's own motivation for change. It helps clinicians "roll with resistance" rather than confront it.[36]
- Even brief MI (e.g., two 15-minute sessions) can increase service uptake among people not actively seeking help.[37]
- MI improves youth engagement and supports ongoing participation in therapy/counseling, especially for those with low readiness to change.[38]
- Works with beliefs & stigma: Effective where stigma and alternative explanatory models are barriers to starting treatment; helps align care with client values. Structured MI training boosts clinician confidence and reduces provider stigma or social distance toward service users.[39]
- System fit: Integrates well in stepped-care models and can be complemented by digital motivation or readiness tools in high-literacy contexts like the Maldives.[40]

2.3 Reduce Barriers to Accessing Learning Opportunities

Expand access to ongoing training through flexible, remote, and structured learning platforms to build skills and confidence.

Research participants expressed a strong interest in continuing education and skills development. However, many reported that current systems did not effectively support or incentivize ongoing learning. Providers emphasized that access to practical, client-facing skills training is limited, which compounds challenges in delivering high-quality care.

They identified several critical needs to enhance professional development:

- Online educational opportunities to enable learning while working.
- Hands-on training through increased time in teaching hospitals.
- Continuing Medical Education (CME) and refresher courses.
- Community of Practice networks and peer learning forums.
- Knowledge exchange platforms for evidence-based practices.
- Support for self-development and career progression.

Without these opportunities, providers reported feeling isolated and underprepared, particularly when facing ethically complex or emotionally demanding cases. Strengthening access to learning not only enhances provider competence but also supports their motivation, confidence, and capacity to engage effectively with service users.

Remote Learning Platforms for Service Providers

Given the challenges of dispersed island geography and the high cost of travel, service providers in the Maldives highlighted online education as a critical gap. Expanding, endorsing, and actively promoting credible online learning opportunities can help bridge this divide.

When such resources are visibly supported and shared, providers are more likely to see them as legitimate and accessible, rather than feeling isolated from the tools and guidance they need. Globally recognized platforms now offer free or low-cost access to expert-led courses, peer learning, and practical skills development that can be effectively leveraged in the Maldivian context.

Evidence Spotlight: In-person vs Online Training

Access realities matter: Participants mentioned that in-person supervision was often inaccessible for remote atolls; travel constraints limited the frequency and equity of training.

- **A systematic review showed initial training plus ongoing consultation or supervision significantly improves uptake of evidence-based practices and boosts real-world competence and confidence.[41]**
- **Multiple studies have found that online or virtual clinical skills training is as effective as face-to-face training, with high satisfaction, meaningful skill gains, and successful application in practice.[42]**
- **Strong for youth work: Remote mentorship, peer networks, and interactive e-learning are particularly effective for providers working with adolescents and young adults with serious mental health conditions.[43]**

With high digital literacy in the Maldives, remote/hybrid models offer flexibility, scalability, and sustainable skill development comparable to (and sometimes surpassing) traditional formats.

Reputed Remote Learning Platforms for Service Providers

NextGenU

NextGenU.org is the world's first free, globally accessible, competency-based platform for health education. Founded by Dr. Erica Frank and supported by the Ulrich and Ruth Frank Foundation for International Health, NextGenU aims to expand access to high-quality training and address global shortages in the healthcare workforce.

Courses are developed by subject matter experts, curriculum designers, and academic leaders, and are delivered in collaboration with internationally respected partners, including the Centers for Disease Control and Prevention (United States), the World Health Organization, Harvard University, Stanford University, and the North Atlantic Treaty Organization (NATO). The platform is cost-free, ad-free, and designed to eliminate barriers to education while promoting global health equity.

It offers practical, evidence-based courses relevant to the Maldivian context, especially for primary care providers and non-specialist clinicians managing common mental health concerns.

Key topics include:

- Management of Mental Health Disorders in Primary Care
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Alcohol Counselling
- Depression Counselling
- Psychological Counselling
- Tobacco cessation
- Mental Health Nursing
- Practice Support for Mental Health

These modules may be particularly valuable for building foundational skills in mental health assessment and intervention, especially in settings where access to specialists is limited.

Remote Learning Platforms for Service Providers

FutureLearn

FutureLearn is a global learning platform offering flexible, high-quality online courses and qualifications developed by leading universities and specialist organizations. Since its launch in 2013, it has supported over seven million learners worldwide to upskill and reskill in diverse and in-demand fields.

From micro-credentials and certificates to full degrees and short courses, FutureLearn helps close global skills gaps through accessible, remote learning opportunities. Many of their courses come with free limited access, allowing more learners from LMICs to access education opportunities. Courses are designed to meet real-world needs and are guided by a team of global educators, researchers, and professionals committed to inclusive and impactful education.

FutureLearn collaborates with more than 100 prestigious institutions which includes:

- King's College London (United Kingdom)
- University of St Andrews (United Kingdom)
- University of Edinburgh (United Kingdom)
- University of Glasgow (United Kingdom)
- Royal Holloway, University of London (United Kingdom)
- London School of Hygiene & Tropical Medicine (United Kingdom)
- University of Nottingham (United Kingdom)
- University of Auckland (New Zealand)
- Monash University (Australia)

These platforms can offer flexible, trusted, and low-barrier pathways for Maldivian service providers to strengthen their mental health competencies, regardless of location or resource constraints.

2.4 Recognize the Need to Increase Access to Supervision and Support

Strengthen formal and informal supervision systems to reduce isolation and improve care quality.

Strengthening supervision is particularly critical for newly trained or solo practitioners working in isolated settings, where professional support is scarce. Service providers highlighted that the absence of peer debriefing, formal mental health support, or consistent clinical supervision leaves them particularly vulnerable to emotional strain when handling high-risk or ethically complex cases such as child abuse or self-harm. In some cases, providers struggled to complete the required supervision hours needed for licensing or registration. Often hindered by travel, distance, or lack to qualified supervisors. As one provider explained: "I've had to travel to Malé just to get supervision, it's just not sustainable."

In this context, prioritizing traditional supervision, which often centers on oversight and error identification, may be less effective than supportive, mentorship-based models. Supportive supervision strengthens health system relationships by fostering teamwork, open communication, and ongoing problem-solving, while mentorship extends beyond technical skill-building to include broader professional development, helping individuals grow in confidence, capacity, and career trajectory.[44]

2.4.1 Explore Novel Ways to Ensure Accessible Supervision

Adopting group, tele-, transnational, and incentivized supervision models can help expand access in resource-limited contexts.

Several strategies can be adopted to expand access to supervision:

- Incentivize supervision roles: Encourage experienced clinicians to take on supervisory responsibilities by offering recognition, modest financial incentives, or professional development credits. This helps address the reluctance of potential supervisors due to increased workload or lack of institutional support.
- Group supervision: Many practitioners can be supervised together in a group, reducing time and cost while also helping them learn from each other's cases and challenges, and successes.
- Build global partnerships: Establishing formal partnerships with international therapeutic networks or training institutions to provide subsidized or volunteer-based remote supervision. These collaborations can offer regular support to Maldivian therapists while introducing them to diverse modalities and global standards of practice.
- Standardize tele-supervision protocols: Promoting the use of structured tele-supervision by developing a national protocol that includes guidelines on format (e.g., frequency, duration), confidentiality, boundary-setting, case discussion templates, and strategies to maximize reflective learning in virtual settings.

The following principles could inform the design of supervision programs across the mental health sector, including within NGOs, schools, hospitals, and private clinics. Flexible, scalable models that blend virtual and in-person components can help make professional supervision an attainable standard, even in remote settings.

Research shows that effective supervision is enhanced when it is:

- Conducted on a regular basis.
- Embedded within protected time during the workday.
- Based on supervisee's choice or alignment with the supervisor's theoretical approach.
- Underpinned by a shared understanding of the purpose, cultural context, and expectations of supervision and
- Conducted by supervisors who receive training, support, and feedback, ensuring the quality of guidance provided is both consistent and reflective.[45]

Clinical Supervision & Support for Service Providers

Several globally recognized platforms offer free or low-barrier access to expert guidance, peer learning, and practical tools, that can be promoted and utilized in the Maldives.

NextGenU.org

In addition to courses, this platform also offers opportunities to mentor others and be mentored by other practitioners across the world.

Project ECHO (Extension for Community Healthcare Outcomes)

This is a global tele-mentoring model that connects primary care providers with specialist teams through regular virtual sessions. It fosters peer-to-peer learning, real-time case discussions, and practical support to deliver evidence-based care, especially valuable when direct specialist access is limited.

Supporting Clinical Supervisors Through Education

Being a skilled clinician doesn't automatically translate into being an effective supervisor. Many supervisors find themselves navigating this role without adequate preparation, which can lead to uncertainty and missed opportunities for growth, both for themselves and those they mentor.

Promoting targeted learning opportunities can help supervisors build confidence, develop effective teaching strategies, and view supervision as a meaningful part of their own professional development.

Some example free courses from FutureLearn:

Clinical Supervision: Teaching and Facilitating Learning

- Helps supervisors learn how to create a positive learning environment, assess learner needs, and support their personal development while balancing placement and academic priorities.

Clinical Supervision: Assessing and Providing Feedback

- Build confidence in assessing learner progress and delivering meaningful feedback. This course covers key workplace-based assessment tools and their application in clinical settings. Supervisors can explore models for observing performance, strategies for supporting learners in difficulty, and the role of feedback in promoting competence and growth.

Clinical Supervision: Planning Your Professional Development

- Supervisors can strengthen their supervision practice through structured self-reflection and goal setting. This course guides clinical supervisors in identifying their own learning needs, developing personal development plans, and improving based on learner and peer feedback. It also introduces principles of quality assurance and continuous improvement in education.

2.4.2 Establish a National Community of Practice for Mental Health

Many providers asked for a supportive network to reduce isolation and share expertise: "I wish... a counselling community network were in place." The creation of a digital nationwide community of practice (CoP) (as a group chat) can offer a powerful mechanism to strengthen collaboration, knowledge exchange, and coordinated action across the mental health sector. Such CoPs should extend beyond specialized mental health professionals to include primary care providers, focal points from other ministries, community focal points, cross-sector stakeholders (e.g., education, housing, youth affairs, gender), educators, university faculty, and school representatives.

If housed within a central health governance body such as the Ministry of Health, the initiative could directly address gaps identified during preliminary consultations, specifically, that key actors such as educators and training institutions are often excluded from decision-making processes that influence their curricula, policies, and practice. A well-structured CoP not only promotes inclusion and mutual respect across disciplines but also ensures consistent, transparent information-sharing throughout the system.

There could also be thematic communities of practice:

- Referral support CoP: brief, standardized case posts (presenting problem, age, language, urgency) with rapid advice and options for next steps.
- Continuous learning CoP: calendar of webinars, short courses, toolkits, and shared resources.
- Practice exchange CoP: new learning discussions, protocols, and peer coaching to bolster confidence and reduce isolation.

This lightweight structure strengthens collaboration, speeds problem-solving, and improves coherence across the system.

2.4.3 Consider Including Peer-Based Support Protocols

As qualified supervisors and their time is very restricted and limited in the Maldives, Peer Supervision Based support models can offer a very cost and resource effective solution.[46] In other countries with similar resource constraints structured protocols have been introduced to facilitate peer supervision meetings. For example, in Sri Lanka, counsellors attached to the children's and women's ministry dedicate half a day in monthly administrative meetings to a standardized process for presenting, evaluating, and discussing challenging cases. These have been adapted to structured processes that are then included monthly as a part of the administrative review meeting days.[47]

Several service providers reported that they were already accessing informal peer support networks when they needed guidance or emotional support. Over time, many had developed friendships within the same field, which made it easier to seek advice or share challenges.

> A service provider mentioned a supportive factor:
> "As most of my friends are from this field, when I'm stressed, it's very easy for me to get support. If I want to clarify something, I just call and get the information I need, everyone is supportive in that aspect."

When opportunities for expert supervision are limited, evidence suggests that peer-based support can foster a sense of connection among colleagues and help build a feeling of community.

2.4.4 Allocate Mandatory Protected Time for Mental Health Service Providers

Protected Time refers to scheduled periods during the workweek that mental health staff can dedicate to non-clinical work. This includes activities like supervision, professional development, case planning, and self-care, free from clinical duties. Such measures are especially important in high-stress, high-patient-volume settings.

Evidence indicates that it reduces burnout and improves their well-being, enhances the actual quality of care they provide, and increases staff retention.[47] To ensure meaningful uptake, protected time must be built into job roles, contracts, and shift rosters, rather than treated as optional or "bonus" time. Institutional leadership plays a critical role in legitimizing these practices, and systems should track, monitor, and support the regular use of protected time across roles and facilities.

Evidence Spotlight: Peer-led Supervision

- Peer supervision boosts quality and well-being. Studies show it improves provider performance, emotional support, quality assurance, and communication.[48]
- Non-technical groups also help. Evidence shows that service providers being in non-practice-oriented groups (e.g., virtual book clubs) alongside wellness initiatives and social events provide meaningful benefits.[49]
- Peer mentoring reduces burnout. Structured peer mentoring is an effective strategy for lowering exhaustion and sustaining engagement.[50]
- Peers can supervise reliably. Research indicates that while practitioners often prefer expert supervisors, trained non-specialists can conduct peer supervision and rate therapy quality as reliably as experts when using a psychometrically sound measure.[51]

With limited specialists, well-supported, protocol-driven peer models offer a scalable path to supervision, quality assurance, and workforce support.

2.4.5 Incentivize Team-Based and Interdisciplinary Care

Several providers highlighted the absence of collaborative care teams, noting that team-based care mostly occurred in medico-legal cases or when referrals came from the social and family development ministry. They identified supportive colleagues and teamwork as critical enablers of high-quality care. This also encourages cross-disciplinary learning, leveraging resources much more efficiently, reducing the time it takes to coordinate extra care and other services.

Structured processes, such as co-managing complex cases with regular check-ins, can further formalize collaboration, ensuring that staff are engaged and supported in delivering care. Even when full teams are not feasible, rotating groups (e.g., monthly case reviews or planning meetings) help. Facilities can also allocate brief protected time for informal inter-team check-ins to support coordinated care. Leadership plays a key role in enabling cross-role collaboration and can offer low-cost incentives like certificates, flexible scheduling, or recognition. Establishing clear case conferencing protocols can further encourage cross-sector engagement and help providers tap into a broader range of support and expertise.

Challenges and solutions: implementing team-based care

Common barriers

- Adds appointments, time, and costs for users and providers, infrastructure and staffing funds are often insufficient.
- User-side hurdles: limited health literacy, low motivation, organizational challenges, and functional impairment.[52]
- Practical frictions: cross-discipline scheduling, secure information-sharing, unclear roles/authority, and little protected time for case conferences.[53]

What works (from successful behavioral-health programs)

- Active leadership & adequate staffing with clear role descriptions.
- Simple referral pathways and standardised records to reduce handoffs and duplication.
- Routine team meetings with set agendas and follow-ups.
- Right sizing the model to patient need and local resources, align with payer requirements.
- Other enablers: brief cross-training, structured care plans, handoff checklists, patient navigation, transport/telehealth options, language access, basic metrics (continuity, wait times, outcomes).

Observed benefits once established

Program evaluations consistently report stronger communication across disciplines, clearer accountability, and smoother care transitions. Teams describe fewer missed handoffs, faster problem-solving, and more consistent follow-up for complex cases. Staff morale improves as workloads feel more shared and purposeful, users experience less repetition, better understanding of their care plan, and timelier access to the "right person" at each step. Overall, coordination gains tend to outweigh the initial setup costs, with steadier continuity and more reliable outcomes.[54]

2.5 Invest in Adapting and Validating Essential Tools & Resources

Prioritize the validation and localization of key assessment tools and user-friendly resources to improve care accuracy, accessibility, and self-help.

Throughout the study, both service seekers and service providers noted challenges stemming from the lack of assessment tools and learning resources. Assessment tools were especially scarce for children, for whom early identification is critical to appropriate support. Although the Maldives' National Protocol for Early Learning and Development Services recommends standardized assessments, it does not specify which tools are applicable.[55] While there is valid criticism of Western diagnostic labels, in the Maldivian context, such assessments are sometimes necessary to access financial and other support (e.g., Aasandha).[56] Furthermore, research highlights that culturally appropriate tools are essential for effective mental health care.[57]

A service provider commented:
"Access to a knowledge database is lacking in the Maldives, for example, knowing which therapy is suitable for different people."

Tailored instruments and resources can:

- Support accurate diagnosis, early identification, and timely support.
- Help individuals access entitlements and services (e.g., Aasandha or NSPA).
- Facilitate difficult conversations with parents who may be reluctant to acknowledge a child's challenges.
- Strengthen mental health literacy and engagement by providing clear, practical information and teaching coping or helping skills (e.g., resources like the Supporting People in Difficult Times [Basic Psychosocial Skills] course).
- Equip providers with the confidence and competence to address culturally specific concerns when tools reflect the lived realities of local communities.
- Support treatment continuity by helping clients stay engaged in daily practices, bridging long waiting periods between sessions, and maintaining consistent support between appointments.

Importantly, evidence indicates that such tools, when self-administered, can help reduce stigma, normalize symptoms, and encourage shared decision-making for patients. (This links to recommendations to digitize initial screening processes in the Maldives under Strategic Priorities 3 and 4.)

Recommended Screening Tools for Low-and Middle-Income Contexts

A systematic review of mental health screening tools in low-and middle-income countries (LMICs) revealed 4 scales that are highly recommended.[58] They are:

- Patient Health Questionnaire-9 (PHQ-9) – Screens for depression severity in adults.
- Hospital Anxiety and Depression Scale (HADS) – Assesses anxiety and depression in general hospital settings, minimizing influence of physical symptoms.
- Self-Reporting Questionnaire-20 (SRQ-20) – Developed by WHO for detecting common mental disorders in low-resource primary care settings.

The fourth, the Edinburgh Postnatal Depression Scale (EPDS), has already been validated for use in the Maldives (to the best of the researcher's knowledge), demonstrating feasibility for similar tools.[59] Other studies also recommend the Generalized Anxiety Disorder 7-item scale (GAD-7) for anxiety, the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) for trauma, the Alcohol Use Disorders Identification Test - Consumption (AUDIT-C), the Drug Abuse Screening Test (DAST-10), and the Columbia Suicide Severity Rating Scale (C-SSRS) for suicide risk assessment.[60]

Importantly, evidence indicates that such tools, when self-administered, can help reduce stigma, normalize symptoms, and encourage shared decision-making for patients.[61] This links to recommendations to digitize initial screening processes in the Maldives under Strategic Priorities 3 and 4.

In addition, research shows that visual methods can support emotional expression and understanding, particularly when verbal communication is limited and can even be used for eliciting feedback on the therapeutic process.[62] For example, Raven's Progressive Matrices, a non-verbal reasoning test, which is highly suited to low-literacy or multilingual settings, was already being used by some service providers who participated in this study.

2.6 Review and Make Modifications to the High Load of Administrative and Paperwork

Streamline documentation processes and explore collaborative approaches to reduce provider stress and improve care quality.

Routine documentation is a critical component of mental healthcare. It supports accurate diagnosis, treatment planning, continuity of care, and medicolegal protection. However, several service providers in this study shared that the volume and complexity of administrative work often interfered with their ability to focus on therapeutic work, engage with families, or dedicate time for professional development and rest.

A service provider stressed:
"Being asked to complete all the case notes
on the same day is a big challenge."

"Intake documents take so much time.
it is especially challenging for kids."

Reducing the administrative burden, through simplification, standardization, or shared approaches like collaborative documentation, can improve provider well-being and strengthen the quality of care delivered. See the evidence spotlight on documentation burden and collaborative documentation.

Evidence Spotlight: Documentation Burden and Collaborative Processes

Accurate records are essential for quality assurance and legal protection, yet the act of producing them can siphon time and attention away from patients.

- Documentation Burden (DocBurden): Studies show that there is stress and excess workload when documentation systems or requirements are misaligned with clinical work, covering not only writing notes but also reviewing, analyzing, and synthesizing data in ways that feel disconnected from care.[63]
- Time constraints and inefficient processes lead to incomplete/insufficient records, which compromise care quality and continuity.[64]
- While accurate documentation is essential for quality assurance and legal purposes, the act of creating and managing medical records can detract from the time and attention given directly to patients. This contributes to professional burnout and decreases the overall quality of service.[65]

In contrast, research has found more efficient and useful ways of documentation:

- Collaborative Documentation (CD): Providers and clients co-create session notes during or immediately after sessions, supporting person-centered and recovery-oriented care through transparency and shared understanding (See SP1). CD is associated with better communication, stronger therapeutic alliance, improved engagement, and gains in independent living and psychosocial functioning (observed in both mental health & rehabilitation settings).
- Implementation challenges & enablers: Real-time note-making can increase cognitive load without proper tools or training; successful adoption is often driven by organizational champions and supportive systems that model CD and build provider buy-in.[66]

2.7 Introduce Data and Analytics Mechanisms for Improving Care

Use service and user data to inform planning, track outcomes, and guide responsive, person-centered mental health services.

Data-driven approaches in mental health involve the systematic collection and use of information to guide decisions at individual, service, and policy levels. When implemented well, they support personalized interventions, improve resource allocation, and identify trends that inform preventive strategies.[67] These mechanisms also align with human-centered design (HCD) principles, ensuring services reflect the real needs, behaviors, and experiences of users.

Many service providers in this study described intense workloads, rapid case turnover, and frequent cancellations due to competing demands. These pressures often leave little time for reflective practice or data-informed decision-making. Introducing structured data and feedback mechanisms can help shift the system toward more responsive, efficient, and person-centered care. For example, in 2024, the Ministry of Social and Family Development published infographics summarizing the cases they handled, including the number, types, and even well-being-related issues.[68]

Such data can be used to:

- Target care: Regularly analyzing service data can help spot the most common presentations and plan predictably (e.g., dedicated follow-up clinic days) and design targeted interventions.
- Translate trends into early supports: If anxiety is prevalent, prioritize community options such as self-help groups, brief skills workshops, or public webinars to promote early intervention and de-escalation.

Patient-reported outcome measures (PROMs) offer a practical tool. These are structured questionnaires where service users report on aspects of their mental health, functioning, or well-being, or specific mental health conditions such as anxiety. Integrated into routine care, PROMs can guide clinical discussions, surface hidden concerns, and monitor progress over time, even between sessions.[69]

In addition to quantitative data, qualitative feedback should also be prioritised. Simple tools such as QR codes linking to anonymous service reviews or digital suggestion boxes can give users a voice. These mechanisms will go beyond satisfaction ratings, helping providers understand what needs to change, how, and for whom.

2.8 Use e-Mental Health to Ease Provider Load

Leverage digital tools to reduce workload for service providers and to scale care.

Several service providers highlighted the usefulness of the Health Information System (HIS), noting that having all relevant patient information consolidated in one place made their work significantly easier. This reflects the broader potential of technology to address challenges in the mental health system, particularly around remote assessment, symptom monitoring, and treatment compliance.[70] This recommendation also has relevance in Strategic Priorities 3 and 4.

As screening can also consume time, consider offloading these tasks to a private app that service seekers can use by themselves to decide on what kind of support they may need. This is further discussed in detail in the 3rd and 4th SPs.

2.9 Make Minor, Low-Cost Modifications to Existing Infrastructure & Resource Allocation

Address small but critical infrastructure gaps, such as medication, play spaces, and translation support, to strengthen service delivery.

Service providers highlighted several fundamental gaps in infrastructure and essential resources that directly impact the quality and continuity of care. These issues are not always visible in policy discussions but critically affect both provider capacity and patient outcomes.

Key issues raised included:

- Shortages of essential psychiatric medications, including for acute cases.
- Inadequate facilities for managing high-risk or acute episodes, such as:
  - No dedicated psychiatric wards for isolation or safe observation.
  - Too few beds for individuals experiencing severe episodes.
  - No proper rehabilitation facilities for longer-term recovery.
- Lack of age-appropriate therapeutic materials or spaces for children.
- Limited infrastructure for addiction treatment and recovery support.

> A service provider shared:
> "There's no room or resources for play therapy, puzzles, or other tools we need for younger clients."

These gaps increase pressure on already overburdened providers and leave vulnerable groups without safe, appropriate care. It also adds to the service provider's feelings of helplessness and stress. Addressing these infrastructure needs will require both immediate, targeted fixes (such as securing drug supply chains) and longer-term investments in psychiatric wards, beds, and rehabilitation centers.

However, small, targeted investments in infrastructure and resourcing can significantly improve the quality of care that service providers are able to deliver. Participants suggested practical upgrades such as creating child-friendly spaces within clinics and soundproofing consultation rooms in smaller facilities to ensure privacy, both of which contribute to a more supportive, inclusive care environment.

In addition to public infrastructure, adjustments in the private sector could also improve affordability. One example is subsidizing rent for private clinics. This could reduce the overhead costs that often make private mental health services expensive and out of reach for many.

Service providers recounted:

"Even if a patient knows broken English, after 2 to 3 times when I keep telling them, 'Sister, tell me,' then she will talk. It is very controlled. I can see the situation from the patient's face. The complaint would be headache, 'I can't sleep', 'I have body pain'. I will ask 'fikurukuranee?' Meaning, are you worried or overthiking? 'No no no'. She will start smiling. Then I talk 2-3 times and ask 'Really?' That's when the tears will start rolling, and then they will start talking."

"People at private clinics have to charge high fees because salaries, living expenses, and rent are so high."

Another key area is improving access to language support. It is clear that even with language barriers, service providers were doing very meaningful and impactful work. Therefore, increasing the availability of trained translators, especially in settings with foreign therapists or in regions with a high client load, can enhance communication and therapeutic outcomes. Policymakers can explore incentives for translators to work in mental health settings, simplify the translator accreditation process, and promote language learning as a viable employment path, particularly among youth in remote islands.

2.10 Review Licensing, Accreditation, and Registration Processes for Service Providers

Simplify and strengthen regulatory pathways to support workforce growth while ensuring accountability and service quality.

Almost all service providers, and even some service users, raised concerns about the over-regulation of licensing and registration pathways.

- Accreditation demands outstripped available capacity: Registration often requires supervised practice, yet placements are scarce even where demand is high.
- Over-regulation had widened the gap: Several felt that processes had been changed unfairly, leading to an increase in the treatment gap and a lack of essential service provider groups such as mental health nurses, psychologists, and speech and behavioral therapists. The process is lengthy and costly, slowing career advancement and making it hard for smaller clinics and organizations to offer competitive salaries, especially since mental health professionals often need to charge higher rates to recover the substantial costs of their qualifications
- Rules constrained timely care: Rigid interpretations of policy/ethics plus accreditation limits restrict what non-specialist PSS practitioners can do, even in urgent situations.

A service provider shared:
"As policies and ethics are so strictly regimented, other PSS practitioners are not at liberty to suggest alternatives. Even if the person has an urgent issue and can't find the prescribed medication."

- Accreditation was prioritized over practice oversight: Despite strict rules in some areas, oversight and continuous education are weak post-registration (few refreshers, supervision). Ethical safeguards often fail in small communities:

A service seeker stated:
"Confidentiality is a huge issue in Maldives. Even medical records get leaked. Some personal records have gone on news headlines. This is dangerous for us."

Together, these issues point to the urgent need to review and revise licensing, accreditation, and registration processes. The goal should be to remove unnecessary barriers that prevent capable individuals from entering the field, while also strengthening oversight and accountability once providers are in practice.

Some suggestions to rethink this process are:

- Simplifying registration pathways to reduce delays and unnecessary bureaucracy.
- Partnering with organisations in similar countries to offer students supervised placements and meet their hour requirements.
- Exploring group supervision models (combined with occasional individual sessions) to expand placement opportunities for mental health students.
- Developing a clear, practical code of ethics that can be consistently applied and monitored (See SP1).
- Reducing the financial and procedural burden on small clinics, to promote more equitable access to services.

Participants also called for licensing that proves applied skills (e.g., disability-specific training), not just credentials. They suggested a practical model: a mandatory disability module (online if needed) plus mentored, fixed-hour placements with persons with disabilities, co-designing programs with persons with disabilities: clear assessment criteria, recognition of prior learning, and ongoing supervision/CPD. This would standardize minimum competencies (communication adaptations, consent/safeguarding, accessible documentation, interpreter or caregiver coordination), reduce avoidable harm, and rebuild trust, especially for high-need groups.

A more balanced, supportive, and transparent regulatory system could improve both the availability and quality of mental health care across the country.

A health system can only extend meaningful access as far as it supports its providers. These recommendations focus on the basics that make good care possible: providers who are well-skilled, supported, and equipped. Investing in well-being, practical client-facing skills, accessible learning and supervision, and peer community-of-practice supports strengthens day-to-day practice and retention. Targeted, low-burden system adjustments such as clear paperwork, protected time, validated tools, simple data loops, e-mental health where it helps, and small infrastructure tweaks can reduce friction without large new costs. Reviewing licensing and accreditation aligns standards with real service needs. Implemented together, Strategic Priority 2 enables safer, more consistent, recovery-oriented care across islands, eases burnout, and improves service user and provider experience and outcomes.

Strategic Priority 3

Invest in Building Early Response and Alternative Care Pathways

The evidence is clear: most people do not begin their care journey in hospitals or psychiatric clinics; they start with everyday experiences, interactions and relationships. Participants described mental health struggles as deeply linked to family, peer, and social stressors, and expressed a clear preference for support that is nearby, informal, and non-stigmatizing. However, current systems route even mild distress through overburdened specialist channels, resulting in long wait times, mistrust, and missed opportunities for early intervention.

This priority organizes support where life happens, bringing practical skills, brief interventions, and early care into homes, classrooms, clinics, and neighborhood spaces, linking to specialist services only when needed. It makes early help easier to find, strengthens community literacy, and builds peer and family capacity, while equipping gatekeepers to respond safely. Primary health centers are aligned with straightforward protocols to provide brief, evidence-informed support before referral, through clear two-way pathways. The result is fewer avoidable bottlenecks and better follow-through.

3.1 Recognize the Need for Community-Based, Non-Specialized Mental Health Care

Acknowledge that most support needs are social and relational, requiring accessible, local, and stigma-free community-based care.

A scoping review in Asia indicated that a wide range of community-based recovery interventions, such as psychoeducation programs, empowerment and self-management training, forgiveness therapy, horticultural therapy, web-based cognitive training, and psychosocial interventions including relaxation techniques and mindfulness-based self-awareness, improved patients' knowledge, coping skills, social functioning, and overall quality of life.[71] Systematic reviews also show that peer support, support groups, and opportunities to become involved in community activities were key enablers of recovery in Asian contexts.[72] The latest Mental Health Action Plan in the Maldives also highlights the need for community-based care.

Furthermore, shifting services and resources from long-stay mental hospitals into non-specialized healthcare settings is a major cost-saving strategy for mental health systems in many countries.[73] WHO guidance also calls for deinstitutionalizing mental health care and embedding services within communities.[74] Tested implementation models, such as the WHO's Mental Health Gap Action Program (mhGAP) and the C4 model (Comprehensive, Collaborative, and Community-Based Care), are already available to offer scalable blueprints for coordinated care systems in low-resource settings.

3.2 Invest in Building Community-Based MHPSS as a First Line of Support

Establish island-level preparedness and integrate MHPSS into local systems as the foundational layer of care.

As highlighted previously, the geographic dispersion of the Maldives, coupled with the urgency of mental health needs at the local level, underscores the importance of building strong, community-based mental health and psychosocial support (MHPSS) systems.

In similarly dispersed geographies, such as the Pacific Islands, extensive reviews have stressed the need to decentralize mental health care as a practical and sustainable solution.[75]

Study participants who have been a part of emergency response and island-level coordination reported a lack of awareness and preparedness regarding mental health. Even frontline crisis managers expressed uncertainty in recognizing or responding to psychological distress:

> A service provider shared:
> "Even those managing crisis response lacked the knowledge to identify or respond to psychological distress."

This foundational investment in local preparedness and community-based MHPSS serves as a critical first line of support, particularly in settings where specialist services are limited and centralized.

3.2.1 Take a 'Whole School' Approach to Strengthen Youth Mental Health Care

Issues related to children's and adolescents' mental health were consistently raised by both providers and service seekers throughout the study. Schools must therefore become a central hub for community-based mental health care.

Although the need is clear, many service providers noted the challenges of school-based counselling. The student-to-counsellor ratio was often unmanageable, and engaging with parents and school systems was described as difficult. Participants also pointed out that school staff often recognized children in distress but failed to take appropriate action.

> A service seeker shared:
> "Teachers are aware, but in schools, these kids [children with mental health challenges] are isolated, and other high social status kids are favored. They know the situation and are careless and do not take the necessary actions."

A recent study highlights that academic success is closely tied to students' social and emotional well-being.[76] Approaches that combine classroom instruction with social-skills development, counseling support, and community engagement–especially when embedded in the curriculum–improve understanding of mental health and foster more sustained attention to well-being, creating supportive school environments. A "whole-school" approach embeds mental health across the entire school environment (not just counselors) by engaging teachers, administrators, and staff. It includes training in mental-health awareness, early identification, and trauma-informed care, alongside a culture that values psychological well-being. Complementary programs (see SP4) build students' resilience, stress-management, and self-care skills. A multidimensional model that involves students, teachers, and parents creates inclusive, supportive schools where mental health is prioritized in daily practice and policy.

3.2.2 Invest in Community Level Screening and Early Detection Mechanisms

In the United States, available data indicate that two-thirds of primary care providers lack access to mental health specialists for referrals. As a result, approximately 90 percent of substance use disorders and 60 percent of general mental health conditions go untreated.[77] These figures tend to be worse in low- and middle-income countries (LMICs). Therefore, building the capacity of communities and individuals to identify early warning signs and seek help before conditions worsen is vital. This recommendation complements the task sharing and early intervention approaches discussed in Strategic Priorities 1, 2, and 4.

Lay health workers (trained community members) can be trained to use adapted screening tools such as the PHQ-9, while routine screening can be integrated into spaces like youth programs, school health events, and parenting groups. Participants raised strong concerns about confidentiality in small communities, with service users describing gossip and judgment when identified as needing support. As one noted, "People find it easier to trust the service provider if he/she is a stranger than a person they know." To mitigate this, private, self-initiated screening via digital tools (e.g., the Digital Mental Health Assessment app in Strategic Priority 4) can help users assess their needs discreetly, reducing stigma and enabling informed decisions about seeking care.

3.2.3 Build Clear Pathways and Processes from Screening to Referral

As outlined earlier, clear and accessible referral pathways are essential to reduce delays, confusion, and frustration in accessing support. They also promote a sense of agency in help-seeking. As pointed out by a service provider, "You have to give people options." While the Ministry of Health should ideally maintain referral protocols and pathways, other institutions can also lead or contribute. Island health centers, schools, CBOs, NSPA, local councils, the Red Crescent, and individual practitioners can compile concise, locality-specific referral lists for long-term use. These pathways should be co-owned and hosted across multiple organizations.

Human navigators

- Island-level navigators: Training Rapid Response Teams or designated mental health focal points to guide individuals through pathways and coordinate warm handovers.
- Standardized protocols: Using simple referral checklists, eligibility criteria, and handover scripts to streamline movement to the right level of care.
- Local directories: Mapping and regularly sharing service directories with providers and the public, including community-based and faith-based supports, and providing printed and multilingual versions.

System and digital supports

- Digital directories and matching: Tools such as the DMHA app can match users to the appropriate level of care (PSS worker, counsellor, psychotherapist, psychiatrist) and provide contact details. In remote islands, internet access, device availability, digital literacy, and language accessibility may limit uptake, offline or low-data modes and clear privacy safeguards should be considered.
- Booking and tracking: Where feasible, integrate search, booking, and referral status tracking. One example of a functional digital system is the NHS e-Referral Service (e-RS) in the UK, which enables general practitioners, other providers, and even service seekers to search for, book, and manage referrals for specialist care while giving patients visibility and choice in the process.

3.2.4 Create Non-Stigmatizing Everyday Entry Points to Care

When someone is identified as needing support, whether through self-referral, school screening, or a community worker, there must be accessible, low-stigma entry points for care. This recommendation focuses on visible, ordinary community spaces that normalize help-seeking without singling people out. When support is embedded in everyday settings, first contact feels routine rather than exceptional, which reduces stigma, builds familiarity, and improves follow-through after screening or self-referral. Participants described practical features that worked in the past: "Someone would sit at a help desk, take personal information quietly, and a counselor would call back," and "When you meet these people in the youth center, they will give information from all sides."

In practice, this means re-establishing youth centers and drop-ins that integrate game rooms, IT access, and informal activities with on-site information desks, using quiet data capture and call-backs to schedule support, assigning social workers to housing blocks for regular contact, basic guidance, and warm referrals, placing peer volunteers and information desks in community centers, mosques, and sports clubs with non-clinical walk-in times.

Primary care providers can also serve as accessible, non-stigmatizing entry points for mental health support, as they are typically associated with general medical care rather than mental health alone.[78] This potential is further explored in the task-sharing recommendations outlined in Section 3.3.

3.2.5 Invest in Community-Led Innovations Related to Mental Health

Recognizing that national mental health systems cannot address every local need, small-scale, community-driven interventions can offer a powerful complement. Microgrants can support locally designed initiatives, such as support groups, arts-based healing activities, Tea & Talk events, or public awareness campaigns, that are contextually relevant and highly responsive.

Evidence Spotlight: Community-led Mental Health Promotion

- Community delivery works when it is appropriately supported. Programs led by youth, women's, and faith-based groups prioritizing stigma reduction, well-being promotion, and support for vulnerable groups are effective when paired with basic reporting tools, mentorship, and light-touch platforms from government or oversight bodies.[79]
- Studies show that collaborating with local leaders and CSOs, through training and resource mobilization, improves engagement, fidelity, and reach of mental health activities.[80]
- Longitudinal research links increased neighborhood belonging and participation in locally invented initiatives to measurable gains in mental well-being.[81]
- Co-design reduces gaps. Interventions co-designed with vulnerable populations (e.g., women, migrants, persons with disabilities) demonstrate better uptake, cultural fit, and sustained effects.[82]

Community-led models, backed by simple supervision and data routines, maintain quality at low cost and reduce pressure on specialized services.[83]

3.3 Begin Structured Task Shifting and Task Sharing (TS/S)

Formalize and support the redistribution of basic mental health tasks to trained non-specialists to expand access and reduce strain on specialized services.

Global mental health experts argue that resource-limited countries should develop their own models of community psychiatry, building indigenous community mental health teams and that this approach should involve engaging and partnering with locally available resources, such as lay health workers and traditional healers, rather than replicating models from high-income countries.[84]

Task shifting and task sharing (TS/S) have become globally recognized strategies to expand access to mental health services in low- and middle-income countries (LMICs). These approaches redistribute tasks traditionally performed by specialized mental health professionals to trained non-specialists, particularly within primary healthcare (PHC) systems.

1. Task shifting and sharing can involve fully transferring responsibilities from one professional group to another. For instance, it can mean moving mental health screening duties from psychologists and psychiatrists to nurses and community health workers.
2. Alternatively, it may entail reallocating specific components of a service to a different cadre, such as clinical assistants or officers carrying out routine procedures in place of specialists in hospital settings.

In the Maldives, informal TS/S is already occurring. As one provider shared, "We do not have a psychiatrist. Doctors and nurses give counselling."

In other settings, providers were already practicing a form of "coordinated care", where communication occurred between primary care and mental health professionals on a case-by-case basis, typically following a generalist-to-specialist model. In some areas, services were physically "co-located," allowing easier access but still operating separately. For example, social workers, despite lacking formal MHPSS training, were sometimes asked by specialists to provide follow-up support after their consultations. These practices were motivated by a shared desire to meet community needs.

Evidence Spotlight: Task Shifting and Task Sharing (TS/S)

- TS/S shows proven gains in access and impact. Studies show TS/S expands reach, responsiveness, and effectiveness of care in low-resource and remote settings.[85]
- TS/S can include shifting selected functions to technology (e.g., digital data collection, triage/decision support, communication, and follow-up) freeing clinicians for higher acuity work (see SP1, SP2, SP4).[86]
- The WHO has recommended regulatory and implementation frameworks to guide TS/S rollouts where public health needs are acute.[87]
- Many countries are implementing TS/S interventions. Somalia is rebuilding primary health care by deploying new cadres (e.g., female health workers) for community-based support; Indonesia's experience shows TS/S is most effective when treated as a collaborative process with clear policy backing.[88]
- Success requires clear governance and role definitions, protected mental health budgets, supportive health information systems, and collaborative, community-oriented service delivery.[89]

3.3.1 Conduct a Mapping Exercise to Identify Acceptability, Appropriateness, Feasibility and Entry Points

Before implementing or piloting large-scale TS/S initiatives, a structured mapping exercise is essential to assess readiness, identify gaps, and clarify opportunities. Key areas to explore include:

- Existing cadres who can deliver mental health-related tasks (e.g., nurses, youth volunteers, teachers).
- Informal task-sharing already happens in crisis response, counselling, or referrals.
- Community-preferred help-seeking pathways (e.g., friends, peer support, religious leaders).
- Readiness and willingness among non-specialists to adopt new responsibilities.
- Community "champions" who can drive and sustain interventions.

Bowen et al. propose an eight-factor framework to assess feasibility before implementation.[90] Key elements include:

- Acceptability: Do service users and providers find the model appropriate?
- Demand: What is the likelihood of uptake?
- Implementation: Can it be executed as intended under real-world constraints?
- Practicality: Are time, staffing, and funding sufficient?
- Adaptation: What changes are needed to suit local contexts?
- Integration: Can it embed into existing systems?
- Expansion: Could it scale to other regions/populations?
- Limited-Efficacy Testing: Can early outcomes justify further roll-out?

This exercise also helps anticipate obstacles and plan for sustainable rollout.

3.3.2 Develop a National Framework and Plan for Implementing TS/S

A national TS/S framework is essential to guide ethical, context-sensitive implementation. Existing models, such as WHO's mhGAP and the C4 framework (discussed earlier), can provide strong foundations.

Key components should include:

- Defined goals, values, and guiding principles.
- Clear tiers of care (e.g., community PSS → counselling → psychiatric care).
- Defined scopes of practice and role boundaries for non-specialists.
- Training and referral mechanisms.
- Supervision and quality assurance (see recommendations on mentorship and supportive supervision as opposed to traditional supervision in Strategic Priority 2)
- Mechanisms to secure buy-in from relevant ministries and health councils.

It is important to acknowledge concerns that may arise around a non-expert-driven healthcare system, especially when it comes to supervision. However, research shows that while practitioners often express a preference for expert supervisors, non-specialist or lay providers can, with training, reliably conduct peer supervision and assess therapy quality using validated tools.[91] This has significant implications for resource-limited contexts like the Maldives, demonstrating the potential to expand supervision and maintain quality through structured, peer-led approaches.

Therefore, a TS/S framework can ensure consistency, accountability, and legitimacy across all levels of implementation and secure buy-in from ministries (Health, Education, Gender) and health councils as well.

3.3.3 Apply Implementation Science to Guide Roll-Out

Implementation science bridges the gap between research and practice by offering structured tools to support the adoption and sustainability of new interventions.[92]

The SHIFT-SHARE Framework for TS/S

Das et al introduced a promising model, Strategic Healthcare Implementation Framework for Task Shifting, Sharing and Resource Enhancement (SHIFT-SHARE), designed to guide health systems in reallocating tasks among different cadres of healthcare providers, especially useful in contexts facing workforce shortages.[93] They conceptualized this framework to offer a structured, stepwise approach to planning and implementing task shifting/sharing interventions, aligning with global best practices and emphasizing safety, quality, and long-term sustainability. SHIFT-SHARE is also grounded in change management theory and offers a practical blueprint for guiding complex system reform, making it well-suited for structuring TS/S efforts in the Maldives.

The model suggests implementing TS/S in six arcs: assess readiness and context, map workflows to select tasks, anticipate risks and put safeguards in place, build competencies with training, supervision, and enabling governance/tech, monitor coverage, quality, satisfaction, costs, and unintended effects, then plan for sustainability and embed in policy for scale-up. In short, start with diagnosis and design, de-risk and skill-up the workforce, and continuously evaluate, refine, and institutionalize what works.

Evidence Spotlight: Impact of Brief PFA and Skills Training

- Core gains across studies: A scoping review found Psychological First Aid (PFA) training significantly increases knowledge, practical skills, and self-efficacy for responding to people in acute distress.[94]
- Emergency readiness: PFA training has been linked to better disaster response preparedness and greater confidence in providing immediate emotional support.[95]
- Short courses work: A four-week program in the Pacific Islands (lectures, tutorials, simulations, clinical visits) improved participants' knowledge, skills, and attitudes for supporting people with mental health conditions.[96]
- Provider well-being benefits: In a randomized controlled trial, nurses who completed PFA training showed higher optimism, self-esteem, and psychological preparedness than controls, with benefits sustained over time.[97]
- Lasting learning: Nursing students receiving PFA training reported long-term improvements in self-efficacy and perceived competence.[98]
- Cultural adaptability: A culturally adapted PFA program for healthcare workers in China led to increased resilience and post-traumatic growth and reduced depressive symptoms and burnout.[99]

Brief, structured PFA and skills trainings strengthen both care quality and workforce resilience, making them high-value investments in low-resource and high-stress settings.

3.3.4 Train all Public-Facing Health Sector Staff in Psychological First Aid and Basic Psychosocial Skills

Participants strongly recommended that psychosocial support training be extended to all public sector staff, not just frontline or clinical personnel. Both service users and providers noted that many staff in health, education, coordination, and emergency roles lacked awareness or sensitivity around mental health, yet often served as first points of contact for distressed individuals. Training non-clinical personnel (e.g., administrative staff, ambulance drivers, receptionists, community officers) was seen as a key step toward early support and de-escalation.

Foundational training in Psychological First Aid (PFA) and Basic Psychosocial Skills (BPS) can help create more compassionate service environments, especially in small island communities where mental health resources are scarce. Seeing as how nurses and other primary care providers were already providing "counselling" (mental health support) where needed, strengthening these informal practices through structured training and supervision can improve consistency and quality. To support quality assurance, tools like WHO's Ensuring Quality in Psychological Support (EQUIP) can be adapted to ensure minimum standards across settings.

3.3.5 Train Primary Care Providers in Essential Non-Pharmacological Interventions

Common concerns like anxiety, depression, and substance use point to the need for accessible, non-pharmacological support at the primary-care level. Equipping primary-care providers with practical, evidence-based brief interventions offers a strong first line of response and enables timely support. Client-facing skills from SP2 such as motivational Interviewing, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and the Brief Negotiated Interview (BNI), can be implemented in primary care. While SBIRT and BNI are rooted in substance-use care, their core elements (empathic communication, goal-setting, behavior-change support) adapt well to broader mental-health concerns.[100]

3.3.6 Train Primary Care Providers in Pharmacological Interventions for Mild to Moderate Mental Health Issues

Evidence indicates that primary-care providers, including non-specialists, can safely prescribe and manage psychiatric medications for common conditions (depression, anxiety, PTSD, substance use) with appropriate training and validated screening tools, in low-resource settings.[100]

Medication-assisted treatment (MAT) can be delivered in primary care (e.g., buprenorphine for opioid use disorder, pharmacotherapies for alcohol use), and many curricula now include MAT training (e.g., buprenorphine waiver) and other guidance (see examples from Sri Lanka, the USA, and the WHO). Collaboration with psychiatric specialists for dose titration, medication changes, or complex monitoring, within integrated/shared-decision models, further strengthens safety and effectiveness.

3.3.7 Train Community Members in Informal Peer Support Mechanisms and Skills

Across interviews and FGDs, participants stressed that people typically turn first to friends, family, and community, not formal services, when distressed. See Figure 9 for coping mechanisms cited when specialist care was unavailable. Global evidence in Asian and LMIC settings echoes this, finding close social ties pivotal for recovery and help-seeking.[101]

> A service seeker suggested:
> "Someone should listen to [person's name] concerns, be it a friend or a close person. and try to convince him that this person cares and wants to help him to change."

This points to alternative care pathways that sit between home and clinic such as peer or befriending schemes, walk-and-talk check-ins, coffee-and-conversation drop-ins, social prescribing through primary care, and confidential helplines or online chat staffed by trained supporters. Equipping community/ frontline actors with supportive-communication skills, gatekeeper training, and simple referral/emotional-support pathways to improve access for high-need groups such as persons with disabilities.

- Disability needs vary widely, specialists cannot cover every permutation (e.g., basic sign language may be insufficient for someone deaf since birth).
- People with disabilities asked for relational, low-stigma support that is simple and human, being listened to, accompanied, and included in ordinary activities. "We need a listening ear. Let's go for a coffee...a ride... We need to be listened to."
- Several participants asked for capacity building: "Provide training on how to run support groups. We need training on PSS and then we can help within our groups as well."

Training community members in basic psychosocial support so help isn't seen only as the domain of "health workers" can reduce stigma and widen supportive ecosystems. This aligns with task-shifting/sharing (TS/S) by embedding support in everyday networks (peers, volunteers, frontline staff), not just clinics. These options complement, not replace, clinical care: they enable earlier engagement, reduce isolation, and make step-up care more feasible.

Furthermore, it's not just the act of listening that helps. Service seekers also explained the quality of their listening also matters. One participant mentioned,

> A service seeker stressed:
> "Healing process is skipped when the feelings are not validated...When we share a story, the listener says they I went through the same. This makes us shut down and feel like the situation is nullified. Compassionate and empathetic listening is especially important without being told that we are being tested and that there are others who are suffering more than us too. We do not want to talk when that is said."

Peer support training can therefore offer a beneficial pathway for increasing the support individuals feel, even without increasing specialist care providers. This approach is reinforced by the WHO Pyramid for an Optimal Mix of Mental Health Services, which places informal community care as the second tier of support, immediately after self-care and before specialized services. Just as first aid training has empowered the public to respond to physical emergencies, PFA and BPS training can equip communities to respond compassionately and appropriately to emotional distress.[101]

Rather than creating new structures, existing community groups can be used as platforms for psychosocial support. These include:

- women's collectives,
- youth clubs,
- parenting groups,
- religious gatherings (see Strategic Priority 4), and
- school associations.

Training peer leaders or focal persons in these spaces to identify distress, offer support, or refer individuals appropriately builds on established trust networks.

> As one service provider reflected:
> "You know, women by nature and how we were socialized and, you know, through generations and what we have seen is we tend to share with our close relatives or close friends. So those friends actually support and, you know, motivate to get help also."

Respecting existing help-seeking norms is key to successful community engagement.

Evidence Spotlight: Why Peer and Lay Support Matters

- Close social ties drive recovery. A systematic review on schizophrenia recovery found that support from close neighbors is uniquely important in Asian contexts; a scoping review in LMICs likewise identified social relationships as key facilitators of recovery.[102]
- Peer support delivers broad gains. Whether offered by people with lived experience or lay helpers, peer support has been shown to instill hope, improve engagement, build self-confidence, enhance quality of life, and ease pressure on formal services.[103]
- Providers see peers as "bridge-builders." A global study of mental health workers in LMICs reported generally positive attitudes toward lay/peer supporters, who were viewed as enhancing trust and uptake; risks (e.g., misinformation, negative role modeling) can be managed by balancing local adaptation with core peer-support values.[104]
- Skills gaps limit can often informal help. Many community members want to help but "don't know how." Without basic skills, informal support can inadvertently delay or deter formal help-seeking.[105]
- Gatekeeper training such as Programs like QPR (Question–Persuade–Refer) improve recognition of warning signs, empathetic responses, and referral behaviors; systematic reviews show immediate gains in knowledge, confidence, and intervention skills, including in culturally adapted versions for Indigenous/minority groups.[106]
- Psychological First Aid (PFA) & Basic Psychosocial Skills (BPS) are scalable. Low-cost courses (e.g., Supporting People in Difficult Times used in Timor-Leste, Nepal, Sri Lanka) teach active listening, emotion regulation, referral awareness, and supportive communication.

3.3.8 Use TSTS to Build Follow-up Support After Accessing Specialised Services

Participants frequently highlighted gaps in follow-up care:

> A service provider shared:
> "There is a lack of well-established community-based support services. Support networks for both patients and families are weak. This complicates the continuity of care and recovery process."

In the absence of structured follow-up, users often disengage after a single consultation. Training community-level providers to offer check-ins, medication reminders, or family psychoeducation can improve recovery outcomes and reduce relapse. This mechanism can also include basic progress monitoring and clear feedback loops back to specialists when needed.

3.3.9 Develop Certificate or Diploma Courses to Produce Qualified Community Support Personnel

The Maldivian health system largely produces specialist professionals. This is essential, but insufficient for the broader need for a trained community-based MHPSS workforce. One effective strategy to strengthen community-based care, and to facilitate task shifting and sharing, is to embed short-term certificate or diploma programs within established educational institutions. This approach offers greater sustainability and quality assurance than relying solely on sporadic training of laypersons or volunteers, which can be affected by entrenched cultural beliefs and stigma.

Integrating structured programs into formal education builds standardized, context-relevant skills and quality assurance nationwide. Alongside new local courses, reputable online options can be audited, vetted, and officially recognized, LMIC-developed curricula can be adapted (e.g., Johns Hopkins' Psychological First Aid, Supporting People in Difficult Times used in Nepal, Timor-Leste, and Sri Lanka). Hybrid or fully virtual delivery would maximize access for remote islands.

3.3.10 Support Non-Special Health Workers With Technological Tools

Technology can offer scalable, low-cost ways to enhance TS/S.[107]

Some options for this include:

- Introducing mobile apps for symptom screening, referral guidance, progress tracking, and self-care tips.
- Including built-in directories of nearby services or supervisors to support confident decision-making (see referral pathways recommendation in SP1, SP3 and Sp4).
- Using messaging platforms for ongoing supervision, peer support, or emergency consultation since the specialists are stretched too thin to provide individual supervision.
- Ensuring tools are accessible offline or in low-bandwidth settings and include privacy protections.
- Adapting a digital version of the WHO's Ensuring Quality in Psychological Support (EQUIP) to ensure adherence to standards of care.

Examples of Successful Community-Based Mental Health Interventions Led by Lay Persons

The Friendship Bench – Zimbabwe

- Context: Urban, low-resource settings.
- Approach: Trained grandmothers to deliver problem-solving talk therapy on park benches outside primary health clinics.
- Impact: Reached over 70,000 people, replicated in Malawi, Kenya, and New York City.
- Key Insight: Cultural trust and simplicity in delivery foster wide reach and community acceptance.

Atmiyata Project – India

- Context: Rural communities in Maharashtra.
- Approach: Trained community volunteers ("Atmiyata Champions") to identify emotional distress and provide basic psychosocial support.
- Impact: Reduced treatment gap for depression and anxiety, widely accepted across age and gender groups.
- Key Insight: Lay-led support is effective and culturally appropriate in rural settings.

The BasicNeeds Model

- Context: Implemented in Ghana, Kenya, Uganda, India, Nepal, and other countries.
- Approach: Integrated mental health care with livelihoods and community mobilization.
- Impact: Improved both mental health and economic outcomes for people with severe mental illness, demonstrated low dropout rates and long-term sustainability.
- Key Insight: Combining psychosocial care with economic empowerment enhances recovery and retention.

StrongMinds

- Context: Urban settlements, focused on women with depression.
- Approach: Delivered group interpersonal psychotherapy (IPT) through trained community health workers.
- Impact: 80% of women recovered after one therapy cycle, improvements were seen in parenting, social cohesion, and household stability.
- Key Insight: Non-specialist-led group therapy can produce scalable outcomes when supported by a structured design and supervision.

Where SP1 improves access to specialized care, and SP2 strengthens providers, SP3 fills the gap inbetwen by catching problems early, reducing avoidable referrals, and keeping routine needs in community settings. By putting early response, non-specialized support, and clear pathways in place, it reduces stigma, shortens waits, and prevents drop-off between screening and care. Structured task shifting and sharing builds local capacity so primary care and community actors can offer brief, evidence-informed help and follow-up, while specialists focus on complex needs. In short, SP3 does what SP1 and SP2 cannot do alone: lower demand for specialized services, stop solvable problems from escalating, close the gap between identification and care, and keep help local and timely.

Strategic Priority 4

Take a Public Health Approach to Mental Health

Too many Maldivians reach care only at the breaking point. Behind each crisis is a web of family stress, school pressure, stigma, costs, and distance that current service models often overlook. Providers and seekers alike noted that many struggles begin at individual, family, and community levels, yet few interventions address these causes directly. They also described pathways and care that did not align with how problems were understood whether through medical, cultural, or religious frames.

SP4 shifts the focus from individual treatment to population-level prevention and promotion. It builds health literacy, counters stigma and misinformation, and normalizes early help-seeking. Where SP3 strengthens community-based delivery, SP4 changes the conditions around people by growing community resilience, knowledge, and capacity to cope and adapt, so people know what to do, where to go, and feel safe doing it before problems escalate.

4.1 Reframe the Dialogue on Mental Health

Reframe public mental health messaging around well-being, resilience, and lived experience rather than diagnostic categories.

Current public conversations about mental health in the Maldives often default to low-literacy, moral, or "techno-moral" frames. For example, labeling distress as "attention seeking," "lack of faith," or blaming phones and discipline, rather than acknowledging stress, relationships, environment, and biology. These narratives stigmatize people as lazy or irresponsible, shift blame onto caregivers (often mothers), and normalize punitive responses to children's behavior instead of assessment and support. In small communities, distrust of "outsider" professionals, fear of gossip, and fragile confidentiality further deter help-seeking. The result is delayed care, escalation from manageable problems to crises, and greater burden on families and a limited health system. A public-health reframing, centered on early recognition, practical support, and community pathways, would be more accurate, less shaming, and far more effective.

The following recommendations move the discussion beyond knowledge for its own sake, toward priorities that improve lives: early support, usable skills, and community-level solutions.

4.1.1 Shift Awareness Raising from "Mental Health Literacy" to "Living Well"

Current conversations around mental health in the Maldives tend to focus primarily on disorders. Reframing mental health awareness around daily functioning, emotional well-being, and resilience can help reduce stigma, increase engagement, and improve outcomes, especially for those hesitant to access formal care. Especially if it is presented as one of the components of health, the same way physical health, weight, nutrition and other such topics are discussed.

- Instead of focusing on pathology, this framing emphasizes concepts like managing stress, adopting daily well-being practices, building emotional resilience, and supporting others. This language does not isolate mental health in its own separated silo but feels neutral and relevant.
- Both groups of participants valued psychosocial support delivered through skill-building or practical interventions, such as parenting, youth development, or faith-based well-being programs, rather than purely clinical pathways. (See SP1)

> A service provider shared:
> "Even if the wife wants help, the husband will stop her. But if we talk about parenting, it's easier."

- This approach also supports male engagement. When framed as care for family, spiritual growth, or positive masculinity, well-being becomes a culturally congruent way for men to access support. Similarly, children and youth may benefit from school-based or peer-led programs focused on life skills and emotional development.

4.1.2 Move Away from Western Diagnostic Labels

A key finding from the data was that while mental health literacy is essential, disorder-focused conversations often made it difficult to meaningfully engage participants. Even medical professionals reported struggling to explain diagnoses to service users, as noted earlier under Strategic Priority 2.

Although more visible conditions like anxiety or ADHD are commonly discussed, service providers in this study noted that fundamental concepts such as emotional regulation, self-care, and coping remain poorly understood:

> A service provider stated:
> "People only learn about the disorders that are popular online."

Service providers also observed that many people used and understood mental health challenges more in culturally meaningful language and physical symptoms rather than psychological symptoms.

> A service provider shared:
> "The complaint would be headache, 'I can't sleep', 'I have body pain'. I will ask 'fikurukuranee'? Meaning are you worried/overthinking?"

Instead:

- Community-level messaging should focus on relatable, functional experiences such as feeling overwhelmed, difficulty coping, trouble sleeping, or changes in eating habits, rather than clinical labels.
- Culturally grounded language should replace technical terms. For example, phrases like "feeling down" or "heavy heart" may resonate more than "depression" and cause less stigma.

Evidence Spotlight: Limits and Risks of Diagnostic Labeling

- Labels are double-edged. Diagnostic categories can help some people and caregivers make sense of difficulties and access services, but growing evidence links labels to stigma, identity foreclosure, and discrimination, particularly for children and adolescents.[108]
- Cultural fit matters. Western labels that don't align with local understandings can be reductionistic (e.g., "autistic child," "depressed person") and may worsen self-esteem, fuel stereotype threat, and deter help-seeking.[109]
- The social costs of labelling are real. Labels can trigger prejudice, unequal treatment, and therapy avoidance; labels then shape identities, particularly in children and adolescents, who may grow up believing that the diagnosis defines them.[110]
- Administrative incentives to label can distort practice. While diagnostic categories may be necessary in administrative contexts (such as applying for funding through NSPA or Aasandha) in therapeutic or social settings, their impact is largely negative. In the Netherlands, requiring formal diagnoses for school provisions drove a sharp rise in ADHD labeling; shifting to lump-sum funding for "any child in need" reduced diagnoses, suggesting clinicians had been compelled to label just to unlock support.[111] Psychiatric diagnoses do not reliably guide treatment decisions or predict outcomes across contexts; overreliance can crowd out individualized, functional formulations.[112]
- Context-sensitive communication works better. Evidence from similarly dispersed geographies in Pacific Island settings recommends shifting away from Western diagnostic criteria toward locally resonant language and functional descriptions that focus on supports, strengths, and needs.[113]

4.1.3 Embrace Religious and Spiritual Meaning-Making as Support and Strength

Many service providers in the study cited challenges in getting individuals to fully participate in therapeutic processes because it seemed to clash with their spiritual and cultural beliefs. Additionally, service seekers also said that people considered low faith to be associated with mental health issues.

It is undeniable that religious beliefs and cultural frameworks strongly shape how mental health is understood and approached in the Maldives, similar to many other contexts. Challenging deeply held, personal and important belief systems can often prove counterproductive to the intention to get as many people as possible support as early as possible.

A cross-cutting intervention that can have a strong impact across all Strategic Priorities (reducing barriers to access, improving service delivery, and strengthening community-based care through task shifting and sharing) is to invest in programs and activities that foster buy-in from influential community leaders, particularly those affiliated with religious or cultural institutions.

Dismissing local belief systems risks alienating individuals from formal care. Instead, many global contexts have found success by positioning religious and spiritual pathways as complementary to clinical services. Encouraging people to maintain their faith-based practices while also accessing professional support can reduce hesitancy, resolve internal conflicts, and promote mutual respect between service providers and service seekers.

Evidence Spotlight: Faith, Mental Health and Recovery

- Religiosity shapes meaning and help-seeking: Among Arab Muslims, moderate to high religiosity strongly influenced how mental disorders were conceptualized; many used traditional healing and supernatural explanations (e.g., jinn, curses) both as belief and as a strategy to avoid stigma attached to mental illnesses in community settings.[114]
- Spirituality can be a recovery asset: A large review of recovery among people with schizophrenia in Asian cultures found that participation in religious activities increased hope and often catalyzed recovery.[115] A scoping review across low- and middle-income countries identified spirituality as both a facilitator and an indicator of recovery.[116]
- Different lenses, same domain: In Hong Kong, service users and professionals agreed spirituality matters for well-being, but users emphasized love, care, and meaning, while professionals focused on support and symptom management, signaling a communication gap.[117]

Integrating spiritually sensitive care (shared language, respectful inquiry about beliefs, optional collaboration with faith leaders) to harness strengths which will reduce stigma and improve engagement is important.

Evidence Spotlight: Mosque-based and Faith-adapted Interventions

A systematic review found that culturally inclusive, faith-sensitive programs in Muslim communities can overcome trust or communication barriers, increase engagement, and improve mental health outcomes.[118]

- Islamic Trauma Healing: Programs delivered with Islamic teachings (e.g., among Somali men and women) produced significant reductions in PTSD, depression, somatic symptoms, and improved general well-being.
- Addiction recovery: Spiritually adapted psychoeducational interventions for substance use increased participants' knowledge and improved attitudes toward recovery.
- Mosque as a health hub: Mosque-based mental health promotion improved mental health literacy and reduced stigma in Muslim communities.

Partnering with imams and mosque institutions can expand access, reduce stigma, and provide trusted, community-embedded pathways, especially when linked to formal services for stepped care.

- For example, after a national disaster in the USA, 22 imams (most without formal Western psychotherapy training) provided essential support via Islamic teachings and informal counseling, demonstrating an indigenous psychosocial model.[119]

Case Example: A Survey of Islamic Religious Leaders and Community Leaders Regarding Muslim Mental Health First Responder Training

Context:

In 2020, a pilot Islamically integrated mental health training program was delivered to a 498 community leaders and Islamic religious leaders in the United States across several mosque communities. The training focused on increasing awareness of common mental health issues, equipping participants with basic skills in recognition, support, and referral, and clarifying the ethical boundaries of pastoral counseling.[120]

Objectives of Training:

- To empower participants to identify signs of mental distress in their communities.
- To build understanding of their supportive but non-clinical role.
- To strengthen collaboration between religious leaders and mental health professionals.

Outcomes Observed:

- The overwhelming majority (80%) appreciated the Islamically integrated approach, stating it changed their perceptions, attitudes, and beliefs about mental health.
- 92% of participants said they would recommend the training to other clergy colleagues.
- The training helped reduce misconceptions about mental illness and encouraged imams to shift away from viewing distress solely through a spiritual lens.
- Participants gained a clearer understanding of the distinction between spiritual counselling and psychological intervention, enabling safer and more effective community support.

Participants reported increased confidence in making timely referrals to professional mental health services when needed.

4.2 Choose Skills and Resilience Over Disorder Awareness

Equip individuals and communities with practical tools to manage stress and daily challenges, reducing reliance on clinical care.

Raising awareness about mental health disorders alone does not equip people to cope with or manage their experiences. As evidenced in this study, even when individuals are aware they need support, many are unable to access care due to barriers such as stigma, financial constraints, limited availability of service providers, and a lack of localized support systems. Furthermore, the origins of many mental health and psychosocial challenges are also tied to a lack of skills rather than awareness.

> A one young service seeeker indicated:
> "Most people will do something by themselves, we have seen condition going from bad to worse because people don't know how to deal with these kinds of things. Lack of knowledge, awareness, and not enough community care or real parenting skills."

Therefore, it is essential to shift focus toward helping individuals build practical coping strategies and skills to navigate daily stressors and emotional challenges. The emphasis should be on "teaching people how to cope, not just what it's called." The World Health Organization's pyramid of ideal mental health care in communities (references at the start of the recommendations) also underscores self-care as the most common and foundational strategy for managing mental well-being.

Some skills that people will find useful in everyday life, regardless of whether they are currently experiencing a mental health condition or not, are:

Distress tolerance skills Being able to adapt to new situation Grounding techniques Present moment awareness Creating personal coping plans Problem-solving and goal-setting Daily recovery habits Body-mind connection awareness (e.g., nutrition, hydration, movement) Sleep hygiene Anger management	Repairing relationships after conflict De-escalation techniques Conflict resolution Setting boundaries Navigating social relationships Movement and exercise Being able to ask for help Understanding signs of common mental health issues Healthy routines Suicide awareness and basic safety planning

Promoting these practices helps to normalize mental health coping strategies and integrate them into daily routines and language, reinforcing a "living well" approach rather than one focused solely on "mental illness." Importantly, when individuals adopt these practices consistently, they are more likely to manage early signs of distress effectively. Over time, this can lead to a significant reduction in the number of people whose mental health concerns escalate, as they will already be using early-intervention self-care tools to protect, maintain, and improve their well-being, reducing reliance on specialized services.

A service provider shared:
"Even if the wife wants help, the husband will stop her. But if we talk about parenting, it's easier."

4.2.1 Disseminate These Via Trusted Daily Touchpoints

For skill-building initiatives to be effective and widely adopted, they must be introduced through familiar, trusted, and frequently encountered channels. Just as public health behaviors like handwashing and social distancing were repeatedly reinforced through daily spaces during COVID-19, mental health skills must also be embedded into everyday life to promote habitual use.

Schools are particularly well-positioned as key touchpoints for such dissemination. They bring together students, parents, teachers, sports coaches, administrative staff, and even local authorities, making them an ideal setting to promote mental well-being across multiple levels of the community.

Another daily touchpoint can be the mosque. Some participants directly recommended that mental health awareness be conducted in mosques, noting that this could help challenge the belief that mental health challenges stem from weak faith or insufficient prayer. One service user even expressed a preference for religious support over psychiatric intervention:

> A service provider revealed:
> "When I consulted a psychiatrist, he recommended that I take medication, which I refused since I have worked in the field. I found support from a religious figure who had faced similar challenges, and he advised me on religious healing, which proved beneficial for me."

This reflects findings from global research as well. For instance, mosque-goers in one study expressed a desire for mosque-based support groups, mental health activities, virtual resources, involvement of community social workers, and family-focused services.[121] See also Section 4.1.3 for further discussion on the role of religious institutions in mental health promotion.

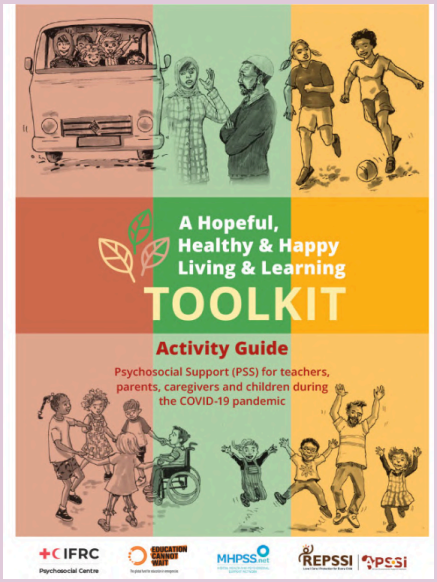
Evidence Spotlight: Building Resilience in Schools

- Resilience improves academic and mental health outcomes. Research consistently links resilience training with better coping skills, emotional regulation, and problem-solving, enhancing psychological, social, and academic growth.[122]
- Resilience-Based Programs (RBPs) increase students' study skills, motivation, engagement, and interpersonal relationships, with measurable gains reported by students, teachers, and parents alike.[123]
- Physical health benefits: School-based resilience programs have also been shown to lower rates of childhood obesity, illustrating the wide-reaching impact of well-being interventions.[124]
- Early adolescence is a critical window. Long-term, curriculum-integrated programs are most effective at building lifelong emotional strength and preventing escalation of distress.[125]
- Practical resilience skills help students navigate everyday challenges, reducing anxiety and improving concentration.[126]
- Embedding resilience and social-emotional learning into all aspects of schooling (academic, social, and community) creates a culture of well-being. Studies show that integrating counselling, social skills training, and community engagement within education improves student awareness, understanding, and sustained attention to mental health.[127]

Evidence-Based Toolkits that Can Be Used in Schools.

Schools can make use of existing, evidence-based resources to strengthen students' problem-solving, coping, and stress management skills.

One example is the Tilli Kids toolkit, developed using behavioral science principles to teach core socio-emotional skills to children. This toolkit has been adapted for use in various global contexts, including Sri Lanka.



Another resource is the Healthy, Happy, Hopeful Living Toolkit, developed during the COVID-19 pandemic to promote psychosocial well-being among children. It explores key competencies such as:

1. Self-awareness
2. Self-management
3. Social awareness
4. Relationship skills
5. Decision-making

The toolkit includes a teacher's guide, caregiver's guide, and separate activity guides tailored for use with children and families. With a wide range of ready-to-use activities, it is well-suited for immediate integration into classroom and home settings.

4.3 Focus Mental Health Campaigns on Targeted Audiences

Design tailored outreach that addresses the unique needs of specific population groups, especially those often excluded.

Broad, positive mental health messaging, such as "take care of yourself today," "prioritize self-care," or "depression is a real illness," may not always provide people with meaningful guidance or actionable steps for support and management. Instead, targeted campaigns can be a more effective strategy, especially when developed around specific groups or commonly presented issues. Audiences such as mothers, children, men, or persons with disabilities can benefit from messaging that directly addresses their unique challenges and needs, based on available data.

Designing campaigns that specifically reach these groups can significantly improve both access to care and quality of life. These campaigns should use communication methods and terminology that are familiar and accessible to the target audience and clearly indicate where persons with visual or auditory impairments can seek support.

Even within mainstream health campaigns, targeting can still occur in terms of the support offered.

Every Mind Matters (EMM) was a publicly funded England-wide campaign (launched 2019) which offered accessible, online guidance for anxiety, low mood, sleep, and stress. Although the campaign was called Every Mind Matters, indicating broad relevance, most users turned to it for help with personal and immediate concerns. Qualitative evaluation reported EMM was easy to use and personalized, the interactive "Your Mind Plan" quiz and follow-up emails were especially valued, with some users calling the tools "life-changing."[128] Population evaluations found small but positive gains in stress, depression, anxiety self-management knowledge, sleep literacy, self-efficacy, and mental-health vigilance, campaign awareness correlated with lower stigma and greater confidence in help-seeking.[129]

Health Promotion and Persons with Disabilities

Broad mental-health messaging often misses persons with disabilities (nearly 6.8% of the Maldivian population), who already face exclusion from SDG areas like health, education, employment, and safety, especially people with cognitive or mental impairments, those outside Malé, and working-age adults and children.[130]

Most health promotion and prevention materials were in complex Dhivehi, posted mainly online, offered in a single format, and lacking basic accessibility.

Service seekers from the community shared:

- "We need digital accessibility guidelines and social media non-text content, mostly images, need to be accessible. Information is currently shared on social media and websites which is not accessible."
- "The content out there is not disability friendly. No success stories or referral points or figures or events. No disability history here."
- "There are many types of disabilities. Dyslexia fonts, hearing and visual disabilities. So information does not reach the people who need it most."

These accounts point to structural exclusion, not individual failings. Single-channel, non-accessible outreach (no alt text, captions, sign language, large print, dyslexia-friendly layouts) creates an information gradient that leaves low-literacy households and people with specific access needs information-poor by design, increasing reliance on intermediaries such as Artificial Intelligence (AI) chatbots and rumor, and delaying care.

Co-designing campaigns with persons with disabilities and representative organizations, routine accessibility audits before release, and basic accessibility training for communications teams would make messages usable for intended audiences, add social proof (success stories and clear referral points), and reduce inequities in access to MHPSS.

4.3.1 Increase Impact by Integrating Mental Health Messaging & Support to Other Health Interventions

Mental health promotion ideally should not be a standalone effort. Integrating mental health and psychosocial support into existing health and advocacy initiatives can extend reach, normalize conversations, and improve overall outcomes. In the Maldives, practitioners have already acknowledged this need. For example, a study on patients hospitalized with COVID-19 concluded that establishing clear communication to identify emotional distress and support mental well-being should be a central component of patient care.[131]

Examples of such integration from other settings include:

- Delivering mental health screenings and simplified cognitive-behavioral therapy within HIV clinics has been shown to significantly reduce depression and alcohol use, improve social functioning, and lower stigma among people living with HIV. It also boosts provider confidence in addressing mental health concerns.
- Mental health has also been integrated into infectious disease prevention and treatment work, strengthening both physical and mental health outcomes.

Such efforts:

- Enhance patient education on mental health
- Increase screening and early identification
- Reduce stigma by making mental health "part of the routine"
- Improve both uptake and outcomes through earlier intervention.

4.3.2 Use Evidence-Based Frameworks to Design Health Campaigns

Campaigns aimed at changing knowledge, attitudes, and practices often fall short of their intended outcomes when they are not grounded in strong evidence or guided by appropriate frameworks. Using established theories and existing research to design these campaigns is therefore essential. Frameworks such as the Theoretical Domains Framework (TDF) and the Behavior Change Wheel (BCW) are among the most widely used tools for planning mental health campaigns and behavior change interventions.[132]

4.3.3 Utilize Trusted and Commonly Used Platforms

A 14-year review of health messaging of one practitioner in the Maldives found that radio, particularly Voice of Maldives (VoM), has historically been the dominant platform for public health awareness. These methods can still continue to reach people despite the emerging role of social media. Blending traditional broadcast media with newer digital channels is therefore essential to reach diverse demographic groups. Syntheses of the literature suggest that health education for adolescents is most effective when it integrates digital and critical health literacy, creating programs that are both engaging and informative.[133]

Service providers in this study also observed that many community members access information through platforms like Facebook and podcasts, suggesting that government-led agencies such as the Health Protection Agency (HPA) or Ministry of Health (MoH) could consider sharing evidence-based key health messages "living well" campaigns through these channels.

4.4 Actively Promote Psychosocial Support (PSS) and Alternative Support Pathways

Expand visibility and uptake of non-clinical care options through community mapping and clearer guidance.

In the Maldives, like in many other neighboring countries, the concept of psychosocial support (PSS) gained traction primarily in the aftermath of the 2004 tsunami, when it was introduced as part of humanitarian crisis response efforts.[134] As a result, PSS seems to have remained largely associated with disasters and emergencies, rather than being understood as a routine and integral part of the mental health system.

This framing has limited the visibility, uptake, and development of psychosocial interventions as viable, everyday support options for individuals facing mental distress. Many participants in this study expressed that even for mild to moderate concerns, such as relationship problems, work-related stress, or emotional struggles, people tend to seek out psychiatrists or go without support altogether, often because they are unaware of other available options or unsure of where to turn.

To address this gap, it is essential to actively map, strengthen, and promote alternative care pathways. This includes raising public awareness about the range of support services that already exist within the country, such as community-based organizations, qualified counsellors, and trained psychosocial practitioners. These providers are often more accessible, culturally attuned, and appropriate for early or non-clinical interventions. By positioning PSS as a legitimate and trusted component of the broader care system, not only during crises but as part of everyday well-being, the mental health response can become more responsive, less stigmatized, and better aligned with the diverse needs of the population.

Include Caution about AI-tool Use for Mental Health Support when Promoting Psychosocial Support and Services

Some participants in this study described turning to AI platforms for psychosocial support and mental health advice. As one service seeker shared, "AI systems are a private chatbot, so there is no fear of leaking. It's 24/7 available. It gives good answers that are easy for you to digest and make sense." Youth participants also echoed this use of AI for support as they mentioned, "We usually ask friends or check online what kind of help we need or we can get. We can type anything online these days and get answers from different AI systems as well as social media."

While privacy and confidentiality, immediate access, gaps in available services, and the clarity of AI-generated explanations can make AI a helpful complement for information, reflection prompts, or preparing questions for a clinician, they do not make AI a substitute for human care and may actually cause harm in the longer term.

The evidence spotlight in this section summarizes key risks and limitations of using AI for mental health support. Public health messaging should therefore include guidance on safer use. It should explain what AI can help with and what it cannot do, emphasize that AI is not for emergencies, and encourage people to verify advice with trusted others and qualified providers. It should advise users to avoid discussing specific methods of self-harm or suicide with AI, to set time limits for chats, to step away if they feel worse, and to seek immediate human support if they notice increased distress. It should also remind users about privacy risks, recommend using reputable services with clear safeguards, and encourage the involvement of family, peers, faith leaders, or community workers where appropriate. Clear, practical messages of this kind can help people benefit from supportive features while reducing the likelihood of harm.

Evidence Spotlight: Limits & Risks of Utilizing AI for Mental Health

- Studies have found that chatbots are less effective than trained providers and may reinforce stigma or suggest unsafe actions.[135]
- Most free tools operate outside formal services, so they lack clinical standards, supervision, and risk-management structures, with wide variability in quality.[136]
- Clear governance is required to set safety expectations, auditing, and escalation pathways; several high-profile incidents have already forced AI developers to tighten safeguards.[137]
- Recent high-profile incidents due to AI use for mental health support show that the model's safety can degrade in long exchanges. An initially safe conversation may later yield unsafe guidance, highlighting the need for session limits and monitoring.[138]
- AI tools cannot provide crisis care. Any self-harm or suicide risk warrants immediate human help and referral to emergency/helpline services.[139]
- Mirroring and validation can blur reality boundaries, amplify delusional or grandiose content, and destabilize regulation in vulnerable users. Effects differ across individuals, so screening and clear guidance are essential.[140]
- AI systems often present speculation as fact; unlike therapists, they are not reliably aware of what they don't know and cannot routinely probe, reframe, or challenge harmful beliefs within accountable supervision.[141]

4.4.1 Clarify When to Seek Specialized and Non-Specialized Help

From a public health perspective, empowering individuals to distinguish between situations that can be managed through self-help or community-based care and those requiring specialized intervention is essential. This not only enables early response but also helps reduce pressure on already overburdened mental health systems. Therefore, a key focus of mental health education should be on when to seek help, not just how (the latter is addressed in detail under referral pathways and protocols). In the Maldivian context, this distinction is especially critical due to the high dependence on specialized service providers.

Education efforts should introduce a tiered system of care, guiding individuals on where to turn based on the nature and severity of their concern. This includes informal or peer support (e.g., trusted friends, family), community-based PSS providers, online or non-specialist counsellors, trained psychotherapists or psychologists and psychiatrists and hospital-based care.

Covid-19 Four-Tier Interventional Model

The Covid-19 four-tier interventional model from the Department of Psychiatry and Human Behavior and HR at Sidney Kimmel Medical College. Dept. = Department, EAP = Employee Assistance Program.

Source: The authors, adapted from the forYOU program, University of Missouri.
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

Clear messaging about the types of support available and what to expect at each level can reduce confusion and stigma, while fostering a greater sense of control and confidence in navigating mental health needs. In practice, this approach ensures that those experiencing distress can access an appropriate level of support, even when specialized services are limited or delayed. See an example of a tiered model in the image above.

Example 1: Using a "Traffic Light" System to Help Individuals Understand the Tier of Support They Need to Access

The traffic light model is a simple and effective visual tool to help community members and frontline workers assess the severity of emotional distress and determine when to seek additional support:[142]

- Green (Safe or Normal): Refers to everyday stressors that most people experience such as feeling anxious before an exam, sad after a disagreement, or overwhelmed on a busy day. These are temporary, manageable states that typically improve with rest, support from friends and family, or basic self-care.
- Yellow (Warning): Indicates that someone may need extra psychosocial support. This includes persistent sleep disturbances, increased irritability, difficulty concentrating, or withdrawal from regular activities. These signs might last longer than expected, recur frequently, or begin to affect daily life. At this stage, speaking to a trusted adult, teacher, counselor, or PSS worker is recommended.

- Red (Act Now): Refers to more serious signs of distress requiring immediate or specialized intervention, such as ongoing suicidal thoughts, panic attacks, hallucinations, or complete inability to carry out daily tasks. Individuals in this category should be referred promptly to trained mental health professionals.

This model can be promoted in schools, workplaces, religious institutions, or clinics as a basic mental health literacy tool to help communities recognize early signs and make timely decisions.

Example 2: Guiding Questions on Duration, Impact, and Intensity to Determine the Need for Specialized Support

Another approach is to use simple screening posters that help people and their support networks understand when symptoms cross the threshold from "common experiences of stress or distress" to "severe experiences of stress or distress." Simple guiding questions can be used to help people self-assess and understand whether they do require specialized support.

- Duration: If emotional or psychological difficulties (such as sadness, low energy, or anxiety) continue for more than two weeks without signs of improvement, this may indicate the need for further support.
- Guiding question: "Have you felt this way for more than two weeks?"

- Impact on Functioning: When distress begins to interfere with daily life, it's a sign that support may be needed.
- Guiding question: "Are you still able to do your usual activities, like studying, working, socializing, or taking care of yourself?"

- Intensity: Certain symptoms, such as suicidal thoughts, extreme mood changes, or feeling detached from reality, require immediate professional help. Encouraging people to watch for these warning signs and connect with available services or helplines can ensure timely response. These should be accompanied by local referral pathways or helpline numbers.

Using such tools in community settings, including primary care centers, mosques, women's groups, and youth spaces, can empower non-specialists to support timely help-seeking while avoiding unnecessary pathologization of mild distress.

4.4.2 Encourage Sharing Stories to Normalize Help Seeking

Humans are inherently drawn to stories, we use them to make sense of our experiences and influence others' understanding of the world around us. When used intentionally, storytelling can be a powerful tool in shifting public attitudes toward mental health and help-seeking.

> A service seeker expressed:
> "Social media, like Instagram, TikTok. Success stories might go viral."

Sharing personal experiences of navigating emotional challenges, when done in ways that protect privacy and uphold confidentiality, can help break stigma and create connection.

Evidence Spotlight: Hopeful Narratives Reduce Suicide Risk

- **The Papageno effect describes how media that highlights recovery, coping strategies, and help-seeking (rather than crisis or fatal outcomes) can lower suicidal ideation and promote resilience. Stories of people choosing alternatives to suicide normalize help-seeking, increase perceived options, and counter hopelessness which are key drivers of risk.[143]**

- **In a longitudinal study, Twitter users engaging with coping stories led to measurable improvements such as lower stress and depressive expressions, with increased emotional expression, content diversity, and platform engagement.[144]**

In the Maldivian context, mental health literacy could benefit from campaigns that encourage the sharing of anonymized, relatable stories about accessing support, particularly through non-specialized or informal sources. These could include peers, youth groups, school counsellors, mosque leaders, or PSS providers. Such narratives can help normalize help-seeking and demonstrate that support does not always have to come from formal clinical systems.

4.5 Address Silence Around Criminalized and Highly Sensitive Issues

Promote safe, confidential pathways for individuals with issues that are highly stigmatized or carry legal risks to access support.

A persistent challenge in mental healthcare in any nation is the criminalization of certain behaviors that are, at their core, public health issues. Substance use, self-harm, and diverse sexual orientations are often treated as criminal or moral failings, rather than as health-related concerns. Below accounts from participants from this study also points to many related issues,

Service seekers revealed:

"People who use drugs are not treated as humans. Some islands will proudly say there would be none in our community. That is only because that person is no longer allowed to be part of that island community. They will ask that person to leave. So, there are no such issues in that community!"

"Especially if it is a girl. People will know. Information leaks easily. Confidentiality is a big issue."

"If someone tries to help him, others say not to interact with him, warning they might get drawn into drugs."

"For children, they will share as much as the provider asks about the situation. But in the case of drugs, since it is a crime, they might be hesitant."

Criminalization and local norms suppress help-seeking even when people want to recover. Reports that an island "has no such issues" often signal social expulsion rather than low need: people who use drugs are pushed out, families fragment, continuity of care breaks, and planners misread low visibility as low prevalence. Gendered risks intensify this, women and girls face fragile confidentiality and reputational harm, leading to hidden use and crisis-point entry. Potential helpers are also deterred by "guilt by association," closing informal pathways (friends, neighbors, faith groups). For adolescents, the criminal status of substances further limits disclosure where providers hear only as much as asked, blunting early assessment and intervention.

Evidence Spotlight: Criminalization and Access to Care

Criminalization of addiction is linked to large, untreated mental illness and substance use burdens, diverting government funds into mass incarceration and costly crisis interventions rather than prevention and care.[145]

- **In LMICs, treatment gaps remain extreme. For alcohol use disorders alone, an estimated 82.7% receive no treatment.[146]**
- **Stigma and punitive policies persist despite advances in addiction science, reducing help-seeking and continuity of care for people with substance use disorders.[147]**
- **Criminal penalties and social sanctions similarly affect people who self-harm and those who are LGBTIQ+, compounding mental, physical, and social inequities and pushing help-seeking to crisis points.[148]**

Systems oriented around criminal justice (vs. health) generate revolving-door cycles: late presentation, acute interventions, and re-entry, escalating costs and worsening outcomes.

These patterns suggest practical shifts that do not depend on legal change. Instead, programs could,

- Decouple help-seeking from punitive responses:
    - Use plain-language confidentiality scripts, display privacy notices, adopt service charters that spell out what is confidential, what triggers mandatory reporting, and how data are protected.
- Create low-stigma, early entry points:
    - Offer women-only and youth-friendly hours, private entrances and discreet scheduling, provide confidential helplines and online chat, add peer-befriending, "walk-and-talk" check-ins, and embed screening in primary care with warm referral.
- Lower the social cost of helping:
    - Train "community supporters" (peers, youth workers, faith or community leaders) in Psychological First Aid or Basic Psychosocial Skills with clear boundaries, supervision, and referral criteria, publicly frame helping as protective, not permissive (see SP3).
- Tailor engagement for young people:
    - Use developmentally appropriate scripts, caregiver guidance, and rapid pathways to family-based support (when safe) so youth can seek advice without self-incrimination.

Measurement should track what criminalization and stigma push out of sight such as reasons for non-disclosure, drop-off between first contact and referral, expulsions or forced relocations, and gender-disaggregated time-to-care. Sharing aggregate, de-identified recovery stories can counter the "no cases here" narrative and rebuild hope. In short, the researchers of this study infer that reframing these issues through a public-health lens by protecting confidentiality, opening low-visibility entry points, and enabling safe community support can narrow treatment gaps without requiring debate on legal reform.

4.5.1 Introduce Private Screening or Coping Tools

When public messaging around criminalized or highly sensitive issues require larger systemic changes, confidential tools can provide a safer alternative for early recognition and help-seeking.

Self-Administered Tools

Evidence indicates that when self-administered, screening tools can help reduce stigma, normalize mental health symptoms, and support shared decision-making between patients and providers.

Several brief self-assessment tools commonly used in primary care include:

- the Generalized Anxiety Disorder 7-item scale (GAD-7) for anxiety,
- the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) for trauma,
- the Alcohol Use Disorders Identification Test - Consumption (AUDIT-C) or the CAGE questionnaire for alcohol use, the Drug Abuse Screening Test (DAST-10) or CAGE Adapted to Include Drugs (CAGE-AID) for substance use,
- the Patient Health Questionnaire-9 (PHQ-9) for depression, and
- the Columbia Suicide Severity Rating Scale (C-SSRS) for suicide risk.

These tools:

- Avoid clinical terminology.
- Help users reflect on the severity and duration of symptoms.
- Can link users to confidential helplines, chat services, or peer supporters.

Most importantly, they can be embedded in Digital Mental Health Assessment (DMHA) apps, and even in public spaces such as public bathrooms, mosques, school nurse's office, youth centers, school health portals or community clinics, in the form of QR code posters.

QR codes can link to:

- Anonymous self-check-ins. (e.g., "How are you feeling today?").
- Support chat platforms.
- Low-risk coping guides.
- Lists of "safe to talk" service providers.

4.5.2 Capitalize on the Nation's High Digital Literacy Rates by Utilizing e-Mental Health Tools

Several service providers highlighted the usefulness of the Health Information System (HIS), noting that having all relevant patient information consolidated in one place made their work significantly easier. This reflects the broader potential of technology to address challenges in the mental health system, particularly around remote assessment, symptom monitoring, and treatment compliance.[149] Research shows digital mental-health platforms are feasible to deploy.[150] This recommendation also has relevance in Strategic Priorities 3 and 4.

Given the Maldives' high digital literacy rates, expanding the use of e-mental health tools presents a promising opportunity. One valuable addition could be a publicly available, culturally adapted Digital Mental Health Assessment (DMHA) app. These tools can help individuals better understand their mental health status, increase early identification, and encourage help-seeking, without requiring immediate face-to-face contact.

DMHAs could also serve as a low-cost solution to support early response in community settings where training staff across various referral points may take time (see Strategic Priorities 1 and 3).

- For instance, any teacher, community worker, or health aide could suggest the app as a first step for someone showing signs of distress. Because these assessments are completed privately via mobile phone app, they may help overcome common concerns around stigma, discrimination, and confidentiality, particularly in close-knit island communities where sharing distress openly with a health center staff member might be challenging.
- In one study evaluating a DMHA, users reported that even a brief results report encouraged them to seek professional support and affirmed that completing the tool was worthwhile.[151]
- In addition, research suggests that integrating subtle e-health tools alongside conventional treatment can help tailor care to individuals' daily lives and promote better outcomes.[152]

While questions remain regarding data privacy, long-term efficacy, and system-level adoption, digital tools still offer a scalable, innovative strategy to expand access and ease the burden on overstretched services.

4.5.3 Promote Confidential Access for Sensitive or Criminalized Concerns

In addition to self-screening, individuals need quiet, safe spaces to reach out for help on their own terms. Incorporating a few confidential entry points can allow service users to obtain support without being identifiable.

Suggested approaches include:

Private Self-Learning Modules

- Provide mobile-friendly, stigma-free psychoeducation modules on topics such as stress management, emotional regulation, and self-soothing.
    - Avoid disorder labels.
    - Include prompts such as: "If this doesn't feel like enough, here's where to get help."

Confidential Peer Drop-Boxes

- In schools, workplaces, or religious centers, introduce anonymous "question boxes" where individuals can:
  - Request support or information.
  - Raise sensitive concerns.
  - Assign and train a trusted peer, counselor, or staff member to check responses regularly and respond with care. (Strategic Priority 3)

Train Trusted Community Figures

- Equip teachers, peer mentors, youth leaders, or religious figures to serve as confidential, non-judgmental points of contact. (Strategic Priority 3)
- Provide:
  - Basic psychosocial training.
  - Triage and referral guides.
  - Ongoing support or supervision.

Integrate Outreach into Broader Health Activities

- Combine mental health awareness and screening with existing health outreach efforts (e.g., nutrition campaigns, reproductive health checks) to destigmatize participation.

In addition, standard privacy safeguards could explain what information is confidential, what triggers mandatory reporting, how data is stored, and offer discreet contact options such as call-backs and privacy-respecting messaging.

These recommendations shift mental health from a crisis response to a shared public concern. By reframing messages around living well, teaching usable skills through trusted touchpoints, and targeting priority groups, SP4 reduces stigma and gives people clear, safe first steps. Clarifying when to seek specialized versus non-specialized help, and offering confidential options for sensitive issues, closes the gap between recognition and action. Implemented together, SP4 lowers late presentations, improves fit between people's explanations and available support, and strengthens the whole system by preventing problems earlier than SP1–SP3 can reach.

Conclusion

Together, the four Strategic Priorities aim to remove both practical and relational barriers that keep people from getting timely, appropriate mental health care.

- Strategic Priority 1 expands equitable access to specialised care by aligning services with what users value, clarifying pathways and provider information, simplifying Aasandha or NSPA processes, and supporting caregivers and confidentiality so trust, continuity, and outcomes improve across islands.

- Strategic Priority 2 strengthens the workforce by investing in provider wellbeing, practical client-facing skills, supervision, peer networks, and simple system fixes (clear paperwork, protected time, better tools, basic infrastructure), so good care is possible and sustainable in everyday practice.

- Strategic Priority 3 builds the missing middle component of the system by catching problems early, embedding non-specialised and community support, and structuring task shifting or sharing so primary care and local actors can manage routine needs while specialists focus on complex cases.

- Strategic Priority 4 reframes mental health as a public health and everyday wellbeing issue, shifting from crisis-only responses to prevention, practical coping skills, and context-sensitive communication that reduce stigma and give people clear, safe first steps to seek help.

Implemented together, these four priorities reduce avoidable pressure on specialist services, shorten waits, prevent escalation, improve user and provider experience, and move the Maldives closer to universal health coverage, SDG 3, and a system where people can reliably find help that fits their lives.

The shifts the system now needs

FROM CRISIS-FIRST TO EARLY, STEPPED CARE

Build triage, brief interventions, and community options so specialist time is used where it's most needed.

FROM OPAQUE TO NAVIGABLE PATHWAYS

Publish clear pathways, referral protocols, and a user-facing provider registry with costs, languages, access and booking.

FROM BIOMEDICAL TO RECOVERY-ORIENTED, CULTURALLY CONGRUENT CARE

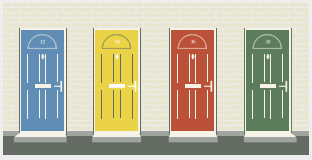
Pair clinical treatment with skills, psychoeducation, and relational supports.

FROM INDIVIDUAL EFFORT TO SUPPORTED TEAMS

Standardize supervision, peer supports, practical skills training (MI, SBIRT/BNI), and protected time to do them.

FROM AD-HOC SAFEGUARDS TO CREDIBLE PRIVACY

Update confidentiality protocols for small-island realities, make them visible to users and enforceable in practice.



FROM "ONE BIG HOSPITAL" TO MANY SMALL DOORS

Normalize low-visibility, everyday entry points (schools, primary care, parenting groups, peer/befriending, faith settings, helplines, vetted digital tools).

Low Cost, Low Intensity Changes

1. Provider Registry

Set up a basic, searchable registry of licensed MHPSS providers with specialties, languages, modality (in-person or remote), service fees, other costs and accessibility notes.

2. Practical Ethics

Add privacy notices and plain-language confidentiality scripts at all entry points, standardize an apology and remedial steps for breaches.

3. Brief Training for Frontline Staff

Two to 3-hour skills labs on teach-back, side-effect conversations, and first-session structure.

4. Peer Support for Providers

Launch monthly virtual peer chats for case discussion and mutual support, rotate facilitation, log actionable takeaways.

5. Information Visibility

Promote existing helplines and share disability-inclusive communication basics (alt text, captions, large print, informal Dhivehi).

6. Peer Support for Seekers

Equip two peer-led support groups with facilitator checklists, referral links, and supervision touchpoints.

7. Skill Development for Seekers

Shift the focus of planned awareness campaigns and sessions to teaching coping, management and wellbeing skills. Include clear and simple warnings about when to use AI chatbots for support and their limitations.

8. Triage through Awareness

Share simple posters and social media posts focused on “when to seek help” that helps individuals understand and differentiate between accessing daily support and specialised clinician support.

2-Year Priorities and Actions

1. Stepped-care pilots in two regions ☐

Add screening or triage at primary care, offer brief interventions, formalize “warm” referral to specialists.

2. Validate and adapt core tools. ☐

PHQ-9, GAD-7, SRQ-20, C-SSRS (and PC-PTSD-5/AUDIT-C/DAST-10 as needed), translate, train, and embed in HIS.

3. Provider well-being policy. ☐

Set caseload norms, minimum monthly supervision hours, access to debrief, and protected learning time.

4. Practical skills program ☐

Implement Motivational Interviewing, SBIRT or BNI labs with observed practice and feedback, job aids (plain-language sheets, scripts, checklists).

5. National Community of Practice. ☐

Include primary care, schools, social services, NGOs, and faith or community focal points, two thematic channels: referrals and continuous learning.

6. Support caregivers. ☐

Brief caregiver guides; routine early “family briefings”; respite or transport vouchers through NSPA or Aasandha; boundary-setting training for staff.

7. e-Mental health with guardrails. ☐

Digitize initial screening (self-administered), set governance for DMH tools, and clarify “not for crisis” rules.

8. Task sharing framework. ☐

Define roles, training, supervision, and data flows for non-specialist and community supporters.

What Measuring Success Might Look Like

ACCESS & TIMELINESS

- Average time from first contact to first appointment reduces.
- Number of first-episode/early-stage cases seen in primary care increases,
- No-show and drop-off rates between referral and first specialist visit decreases.

QUALITY & CONTINUITY

- 2+ follow-ups within 90 days increases.
- Unplanned crisis visits and inpatient days reduces.
- Validated screening tools used in ≥70% eligible encounters in primary care.

TRUST, PRIVACY & EXPERIENCE

- Reported confidentiality breaches reduces.
- User-reported trust or experience scores increases.
- Complaints resolved with documented remedial steps increases.

EQUITY

- Gap in access or wait times between Malé and outer atolls reduces.
- Utilization among women, youth, persons with disabilities, migrants increases.
- Percentage of services delivered outside Malé and via telehealth increases.

What Measuring Success Might Look Like

PROVIDER WELL-BEING & CAPABILITY

- Burnout or exhaustion scores decreases.
- Monthly supervision hours are met.
- Participation in CoP and skills learning sessions increases.

COST & BURDEN

- Average out-of-pocket per care episode reduces.
- Uptake of travel or lodging support increases.
- Caregiver strain reduces in pilot sites.

COMMUNITY & PREVENTION

- Number of active peer groups, school programs, and community hubs with referral protocols increases.
- Percentage of islands delivering co-designed “living well” literacy and skills sessions increases.
- Digital screening completions and completed call-backs increases.

The path forward is clear and achievable. Start by making care easier to find, safer to use, and closer to home. Equip providers with the practical skills and support they keep asking for. Pair treatment with recovery-oriented, everyday supports that people trust. Progress is possible without ideal circumstances being present. Meaningful gains can be made now with coordinated, incremental steps, even within current resources.

If each actor (ministries, providers, schools, councils, NGOs, and communities) carries a part of the work, the system can shift over time from crisis to care, from late to early, from fragile to resilient.

Change is possible, and it need not be complicated.

Let's begin.

The Team

The Asia Foundation
in Sri Lanka and the Maldives

- Roshan Shajehan
- Niluka Wickremesinghe
- Fathimath Waheeda (Co-investigator)
- Omella Outschoorn
- Rehan Meemaduma
- Husna Shiraz
- Kaushi Jayawardena (Principal Investigator)

The Maldivian Nurses Association

- Associate Professor Fathimath Shifaza
- Mariyam Shifaana Hussain (Co-investigator)
- Fathimath Ajna (Co-investigator)
- Sama Hussain

The enumerators
(in alphabetical order)

- Aishath Liziyan
- Aishath Rifa
- Aishath Sheneen Ibrahim
- Fathimath Ajna
- Hawwa Zimna
- Kaushi Jayawardena
- Mariyam Shifaana Hussain
- Rehan Meemaduma
- Sama Hussain

The Asia Foundation (TAF) is an international nonprofit organization working to solve the toughest social and economic challenges in Asia and the Pacific. Informed by more than 70 years of experience and deep local knowledge, TAF works with partners across more than 20 countries to improve lives and expand opportunities.

Maldivian Nurses Association (MNA) is the national professional voice of Maldivian Nurses, recognized nationally and internationally for promoting excellence in nursing through leadership, research, education, advocacy, and sustainable health care practice in collaboration with others to achieve optimum health of the community. MNA advocates for evidence-based practice and professional development while working to enhance healthcare outcomes in communities where geographic isolation makes comprehensive mental health support particularly critical. The association supports nurses providing frontline mental health care across the archipelago, where stigma and poor awareness around mental health at all levels pose ongoing challenges.

Appendix I: Participants

Service Providers		
Gender distribution	Male	8
	Female	10
Age	Range	23-62
Service type	Public sector	15
	Private sector	3
Years of experience	Average total years of experience	14.6
Roles	Direct Mental Health Service Providers (ex- Psychiatrists, Psychologists, Counselors, Crisis hotline operators)	11
	Medical & Clinical Staff (ex - Medical Officers, Nurses)	3
	Other Indirect Service Providers (ex - Managers / Directors, Customer Service, Community / Service Officers)	4
Total participants	Count	18

Service Seekers/Users		
Age category	Male	Female
18-29	20	32
30-39	11	15
40-49	2	19
50-59	1	6
60-69	0	2
70-79	1	0

Service Seekers/Users		
Gender distribution	Male	35
	Female	74
Age	Range	18-75
Total participants		109

Appendix II: Service provider questionnaire summary

These questions asked service providers and organizations to walk through what it is like to deliver mental health and psychosocial support in practice, from daily work to system-level barriers.

- Day-to-day work and case profiles - What a typical workday looks like, the most common mental health and psychosocial problems they see and which issues are hardest to work with or treat.
- Experiences of providing care - General experiences in supporting people's wellbeing and biggest challenges in delivering services, in their own words.
- Access and service delivery dimensions
    - Accessibility: What makes it hard for people to receive or even know about services (costs, outreach, health literacy, transport, distance).
    - Patient factors: Things about service users that complicate care (engagement, adherence, severity, family support, stigma, personality factors).
    - Facilities and resources: Gaps in physical space, privacy, labs, tools, diagnostic materials.
    - Workload and processes: Caseloads, working hours, intake/documentation burdens, follow-up systems, availability of localized/validated tools, accreditation demands.
    - Community context: Community understanding of mental health, local support options, financial assistance, networks for families and service users.
    - Policies and governance: How laws, policies, frameworks, coordination between state/non-state actors, and training systems make care harder or easier.
- Provider wellbeing, satisfaction, and support - How satisfied they feel in their role (interest, social acceptance of the profession, stigma toward providers, career prospects), what support they receive as practitioners (from family/friends, colleagues, institutions, supervision, peer support, interdisciplinary collaboration, work–life balance).
- Enablers - What helps them provide services well (personal qualities, self-care, good facilities/resources, supportive colleagues/family, policy support, access to information).
- Recommendations - What changes or supports are needed so they and other professionals can provide better mental health services.

- For organizations and indirect service providers: what a typical day looks like, the main issues they respond to, services they provide, challenges faced, gaps and needs, and their general recommendations for improving support to communities.

Appendix III: Service seeker and user questionnaire summary

These questions asked service users and seekers to walk through the entire help-seeking journey from their point of view.

- How problems are understood - What the person and their family think is "wrong" (e.g., mental illness, stress, spiritual causes) and how they name or describe it.
- Attitudes toward help-seeking - How easy or difficult it feels to ask for help, and what beliefs or fears (shame, blame, religious or cultural ideas) make seeking support harder.
- What support is needed and from whom - The kinds of help the person would need (emotional, practical, clinical, spiritual) and which people, services, or institutions they could turn to.
- Practical steps and system navigation - What the person actually has to do to reach help (steps taken, referrals, paperwork) and how clear or confusing that process is.
- Access dimensions
    - Information: Do people know where to go? Is available information clear and useful?
    - Distance: Where are services located? How far, how costly, and how long is the travel?
    - Availability: Opening hours, appointment systems, 24/7 access or not, and how this affects use.
    - Cost: Fees for services, travel, tests, medication, and whether cost changes the decision to seek help.
    - Time & efficiency: Waiting times, delays, repeated visits, and how these make people feel.
- Trust and experience of care - How much people trust providers and systems to help, fears about confidentiality, and whether this trust (or lack of it) affects using services. How people are treated based on gender, class, wealth, education, how they dress, or the type of problem, and how this shapes access.
- Stigma and social risk - Shame, gossip, labels, and the impact of living in small communities on willingness to seek help.
- Individual factors - Personal characteristics (confidence, communication skills, past experiences with services, knowledge of the system) that make access easier or harder.
- Coping without formal services - What people do to take care of themselves when they cannot or do not use formal services (self-help, family, peers, religious practices, etc.).
- Most significant barriers and enablers - What participants see as the single biggest obstacle and the single biggest enabler of access for a problem like the one discussed.
- Suggested changes - What they think needs to change in services, systems, or communities to improve access, plus any additional comments they wanted to add.

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