EDITORIAL

From social casework to low-intensity psychosocial interventions: Repositioning psychiatric social work in contemporary mental health care

Kamlesh Kumar Sahu
Associate Professor of Psychiatric Social Work, Department of Psychiatry, Government Medical College & Hospital, Chandigarh, India

ABSTRACT

The persistent mental health treatment gap has increased interest in psychological and psychosocial interventions (PSI) that can extend care beyond specialist services. The World Health Organization (WHO) has promoted scalable and low-intensity interventions such as Problem Management Plus (PM+), Self-Help Plus (SH+), Thinking Healthy and Step-by-Step, using structured strategies, task-sharing, guided self-help and stepped care. Although these approaches are relatively recent in global mental health, several of their underlying principles have longstanding parallels in professional social work, particularly social casework, psychosocial casework, problem-solving, task-centred and strengths-based practice. This editorial examines the relationship between these traditions and contemporary low-intensity psychosocial interventions and considers their implications for Psychiatric Social Work (PSW). Low intensity refers to reduced specialist input, not reduced professional skill or responsibility. PSWs, with expertise in psychosocial assessment, casework, family intervention, rehabilitation and community practice, are well positioned to contribute to the delivery, adaptation, supervision and evaluation of such interventions. However, effective task-sharing requires competency-based training, supervision, risk assessment, fidelity and clear pathways for referral and escalation. Integrating the intervention traditions of social work with contemporary evidence-based and scalable approaches may strengthen the role of PSW in accessible, community-oriented mental health care.

Keywords: Social casework; psychosocial intervention; low-intensity intervention; scalable intervention; task-centred practice; task-sharing; stepped care

INTRODUCTION

The global mental health system continues to confront a substantial mismatch between the population need for mental health care and the availability of adequately trained professionals. This mismatch is particularly evident in low- and middle-income countries, where specialist services remain unevenly distributed and are frequently concentrated in urban and tertiary-care settings. India is no exception. The National Mental Health Survey (NMHS) conducted during 2015–2016 estimated an overall treatment gap of 84.5% for mental morbidity, highlighting the considerable unmet need for mental health care.[1] Among common mental disorders, the treatment gap was estimated at 80.4%.[2]

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Increasing the specialist workforce is essential, but specialist expansion alone is unlikely to close such a large gap. Consequently, contemporary global mental health has increasingly explored approaches that can extend evidence-based interventions through primary care, community services, trained non-specialists, peer workers, group-based interventions and guided self-help.

The World Health Organization (WHO) has increasingly used the concept of scalable psychological interventions to describe interventions that can be delivered with less reliance on specialist human resources.[3] Its portfolio includes interventions such as

Corresponding Author:
Dr. Kamlesh Kumar Sahu
Level – V, Block – E, Department of Psychiatry
Government Medical College and Hospital
Chandigarh - 160030, India.
Email: withkamlesh@gmail.com

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Thinking Healthy, Problem Management Plus (PM+), Self-Help Plus (SH+) and Step-by-Step.[4-7] PM+, for example, combines problem-solving counselling, behavioural activation, stress management and strengthening of social support in a brief structured format.[4] SH+ uses a group-based stress-management approach supported by pre-recorded audio and illustrated materials and can be delivered by trained and supervised non-specialist facilitators.[5]

These developments are important. However, from the perspective of Psychiatric Social Work, another question deserves attention:

How new are these approaches to professional social work?

The answer is complex. The terminology, manuals, evidence base and delivery architecture of contemporary low-intensity interventions are relatively new. Yet many underlying principles - problem solving, goal setting, social support, strengths, task orientation, environmental resources, brief intervention, and collaborative helping have deep roots in professional social work and social casework.[8-11]

This editorial argues that the emergence of low-intensity psychosocial interventions should therefore not be understood simply as another opportunity for Psychiatric Social Workers to acquire a new intervention package. It provides an opportunity to reconnect the historical intervention traditions of social work with contemporary evidence-based mental health care and reposition Psychiatric Social Work within scalable, community-oriented and stepped mental health systems. Although low-intensity psychosocial interventions have emerged within a contemporary global mental health context, several of their underlying intervention principles have longstanding parallels in the historical development of professional social work, particularly psychosocial casework, problem-solving casework, task-centred practice and strengths-based approaches.[8-11] The contemporary low-intensity movement therefore presents Psychiatric Social Work with an opportunity not merely to adopt new intervention models, but to critically examine, reclaim and reposition its own intervention traditions within evolving evidence-based mental health systems.

From social casework to psychosocial intervention

Social casework has historically occupied a central position within professional social work. Its development was closely associated with attempts to understand and intervene in difficulties experienced by individuals within their social relationships and environments.

Florence Hollis's influential work, *Casework: A Psychosocial Therapy,* explicitly conceptualised casework within a psychosocial framework, emphasising the interaction between the individual and the social environment.[8] This historical orientation is particularly relevant to Psychiatric Social Work because mental health problems rarely exist independently of family relationships, interpersonal experiences, social circumstances and environmental conditions.

The casework tradition consequently developed an intervention orientation that combined understanding of the individual with attention to relationships and social context. This is conceptually different from an exclusively symptom-oriented model of care.

Over time, professional social work also developed more structured and focused approaches. Task-centred casework, associated particularly with Reid and Epstein, introduced a time-limited, problem-focused model in which the worker and client collaboratively identify problems and undertake specific tasks towards their resolution.[9] Subsequent applications demonstrated the relevance of task-centred approaches to a variety of social and psychosocial problems, including interpersonal difficulties and mental health-related concerns.[10]

These developments are strikingly relevant to contemporary low-intensity interventions.

The terminology has changed. The evidence base has expanded. Intervention manuals have become more standardised. Delivery has increasingly involved non-specialist workers, digital platforms and stepped-care systems.

But the basic question remains familiar: *What is the person's current problem, what resources are available, what can realistically be changed, and what focused intervention can help the person move towards improved functioning?*

What exactly is a low-intensity psychosocial intervention?

The term low-intensity psychosocial intervention should be understood carefully.

"Low intensity" does not mean that an intervention is unimportant, simplistic or professionally inferior. Rather, it generally refers to an intervention configuration that requires less intensive specialist input, often through shorter contacts, structured materials, group formats, guided self-help, digital delivery or appropriately trained non-specialist providers.[3]

This needs to be distinguished from several related concepts.

Brief intervention: A brief intervention primarily refers to *duration or number of contacts*.

Low-intensity intervention: Low intensity refers more broadly to the *amount and configuration of professional or specialist input.*

Scalable intervention: Scalability refers to the ability to extend an intervention to larger populations without requiring a proportional expansion of specialist resources.[3]

Task-sharing: Task-sharing involves the redistribution of defined intervention functions among appropriately trained workers.

Guided self-help: Guided self-help combines self-directed intervention material with some degree of professional or trained-helper support.

Stepped care: Stepped care refers to organising services so that individuals receive an intervention appropriate to their level of need, with escalation to more intensive care when necessary.

These concepts overlap but are not interchangeable.

A brief intervention may be delivered by a specialist and therefore not necessarily be low intensity. Conversely, a low-intensity intervention may extend over a longer period through guided digital or self-help formats.

This conceptual distinction is important for Psychiatric Social Work because it prevents the profession from being reduced to the role of a provider of "short interventions." The relevant issue is not simply how many sessions are delivered but what type of intervention is appropriate, who delivers it, with what competencies, under what supervision and within which level of care.

Psychological versus psychosocial interventions

Another distinction deserves attention: *psychological interventions* versus *psychosocial interventions*.

Psychological interventions primarily target psychological processes such as thoughts, emotions, behaviour, coping and interpersonal functioning. Cognitive behavioural approaches, behavioural activation, interpersonal approaches and structured problem-solving interventions may fall within this broad domain.

Psychosocial interventions have a broader orientation. They may incorporate psychological strategies but also explicitly address social relationships, family systems, social support, environmental circumstances, functioning, rehabilitation and community resources.

The distinction is not absolute.

Indeed, contemporary WHO interventions demonstrate considerable overlap. PM+, for example, incorporates problem management, behavioural activation, stress management and strengthening of social support.[4] The 2023 systematic review of PM+ and Step-by-Step specifically described these interventions as low-intensity psychosocial interventions.[12]

This broader psychosocial orientation is particularly relevant to Psychiatric Social Work.

The contribution of PSW should not be conceptualised merely as delivering a psychological technique to a person. It should involve understanding the person-in-environment, identifying psychosocial determinants of distress, mobilising family and community resources, addressing barriers to functioning and connecting psychological change with social recovery.

Are low-intensity psychosocial interventions new to social work?

In one sense, yes.

Contemporary interventions such as PM+ and Step-by-Step are highly structured, manualised

and supported by an emerging empirical evidence base. Their implementation within global mental health systems represents a relatively recent development.[3,12]

In another sense, however, their underlying principles are not entirely new to social work.

Professional social work has long incorporated:

- problem identification;
- goal setting;
- collaborative intervention;
- strengths and resources;
- problem solving;
- social support;
- interpersonal relationships;
- family intervention;
- environmental modification;
- task orientation;
- time-limited intervention; and
- attention to social functioning.

Task-centred casework, for example, is explicitly described as a time-limited problem-solving approach in which the client and social worker work jointly on identified problems.[9,10]

Similarly, solution-focused brief therapy has become an established social work practice model, drawing upon strengths, collaboration and a focus on solutions and preferred futures.[11] Franklin has specifically highlighted the importance of strengths-based and solution-focused brief therapy within health and mental health social work.[11]

Therefore, the contemporary low-intensity movement may be understood partly as a reconfiguration and standardisation of intervention principles that have long existed within professional social work, combined with new evidence, delivery mechanisms and implementation science.

This does not mean that PM+ or other WHO interventions are simply social casework under another name. They are not. Their theoretical foundations, manuals, evidence base, training requirements and delivery models differ. The point is instead that there is substantial conceptual compatibility that deserves systematic exploration.

Problem-solving: an important bridge

Problem solving provides one of the clearest bridges between social casework and contemporary low-intensity intervention.

PM+ incorporates problem-solving counselling as one of its central strategies.[4] WHO describes PM+ as combining problem-solving counselling with behavioural activation, stress management and strengthening social support.[4]

Problem-solving, however, has long been relevant to social work intervention.

The task-centred model conceptualised intervention around identified problems and specific tasks.[9,10] In both approaches, the aim is not necessarily to explore every aspect of a person's life in depth, but to identify manageable areas where intervention can produce meaningful change.

This convergence offers an important research opportunity for Psychiatric Social Work.

Can the profession develop structured, evidence-informed brief psychosocial interventions derived from established social work practice models, while incorporating contemporary evidence-based psychological strategies?

This question deserves systematic empirical investigation.

Strengths, solution-focused practice and low-intensity care

Low-intensity interventions also have conceptual links with strengths-based and solution-focused approaches.

Solution-focused brief therapy deliberately adopts a strengths orientation and focuses on the construction of solutions rather than prolonged analysis of problems.[11] Its collaborative and time-limited nature has made it relevant across diverse social work practice settings.

This is important because the language of “low intensity” can sometimes unintentionally imply a deficit model: less therapist time, fewer sessions and less professional involvement.

A strengths-based social work perspective offers a different framing.

The objective is not simply to reduce professional input but to increase the capacity of individuals, families and communities to participate actively in their own recovery.

Guided self-help, behavioural activation, problem-solving and social-support strategies can therefore be conceptualised not merely as

resource-saving mechanisms but as methods for increasing participation, autonomy and access.

Evidence for low-intensity psychosocial interventions

The growing evidence base should nevertheless be interpreted critically.

Schäfer and colleagues conducted a systematic review and meta-analysis of WHO's PM+ and Step-by-Step interventions, including 23 studies involving 5,298 participants.[12] The review found a small-to-medium favourable effect on distress indicators (standardised mean difference [SMD] −0.45; 95% confidence interval [CI] −0.56 to −0.34) and a small favourable effect on positive mental health outcomes (SMD 0.31; 95% CI 0.14–0.47).[12]

However, the authors also identified substantial between-study heterogeneity, and the certainty of evidence was rated very low across outcomes.[12] The findings therefore support the potential value of these interventions but do not justify treating them as universally effective or as substitutes for more intensive interventions.

This distinction is particularly important for professional social work.

Evidence-based practice requires not only asking whether an intervention can work, but also:

- for whom it works;
- for which problems;
- under what circumstances;
- when it should not be used;
- who should deliver it;
- what level of supervision is required; and
- when the individual should be moved to a higher level of care.

India: from treatment gap to intervention opportunity

India provides a compelling context for low-intensity psychosocial interventions because of the scale of unmet mental health need. The NMHS estimated an overall treatment gap of 84.5% for mental morbidity.[1] For common mental disorders, the treatment gap was approximately 80.4%.[2] However, India should not be positioned merely as a country in which interventions developed elsewhere need to be imported.

The Indian experience with the *Thinking Healthy Programme* is particularly instructive. Fuhr and colleagues evaluated a peer-delivered version of the programme for perinatal depression in Goa.[13] Among 280 enrolled women with perinatal depression, remission at six months postpartum was higher in the peer-delivered intervention group than in the enhanced usual-care group (73% versus 60%; prevalence ratio 1.21, 95% CI 1.01–1.45).[13] The study also reported that the intervention was relatively inexpensive to deliver and potentially cost-saving through reductions in health-care, time and productivity costs.[13] This study demonstrates the feasibility of adapting evidence-based psychological intervention for delivery through a non-specialist or peer model in an Indian context.

For Psychiatric Social Work, the implication is broader than simply adopting existing programmes. India has the opportunity to develop and test its own culturally responsive low-intensity psychosocial interventions, drawing upon its established professional traditions and contemporary implementation science.

Psychiatric Social Work and the opportunity for repositioning

Psychiatric Social Work has traditionally occupied a distinctive position within mental health services.

Its professional domain encompasses psychosocial assessment, individual intervention, family intervention, social casework, community work, rehabilitation, social-resource mobilisation and attention to the social determinants of mental health.

These competencies are highly relevant to low-intensity psychosocial care. The PSW could potentially contribute as:

1. **A direct intervention provider:** PSWs with appropriate competency-based training could deliver selected structured low-intensity psychosocial interventions.
2. **An assessor and triage professional:** PSWs can contribute to determining whether a person is suitable for low-intensity intervention or requires more intensive specialist care.
3. **A family intervention professional:** Family relationships and social support are central components of psychosocial intervention and cannot always be addressed

adequately through individual symptom-focused approaches.

4. **A casework specialist:** Traditional casework skills can complement structured intervention by helping individuals translate intervention goals into practical changes within their social environment.
5. **A community practitioner:** PSWs can potentially facilitate integration of interventions into primary care, community mental health, rehabilitation and social-care settings.
6. **A supervisor and trainer:** With appropriate additional training, PSWs can contribute to workforce development, supervision and fidelity monitoring.
7. **A researcher:** PSWs are particularly well positioned to investigate the psychosocial outcomes of these interventions, including family functioning, social support, functioning, quality of life, stigma and social participation.

From casework to focused psychosocial intervention

This raises an important question about the future of social casework.

Traditional casework can be comprehensive and may require considerable assessment and intervention over time. Contemporary mental health systems, however, also require *focused and proportionate interventions.*

Rather than viewing these approaches as competing models, Psychiatric Social Work could conceptualise them along a continuum:

Comprehensive psychosocial assessment

↓

Psychosocial formulation

↓

Brief/focused social casework

↓

Task-centred or solution-focused intervention

↓

Structured low-intensity psychosocial intervention

↓

Guided self-help/digital intervention

↓

Step-up to specialist or intensive intervention when required

This should not be interpreted as a rigid hierarchy. Different individuals may enter the continuum at different points.

A person with relatively uncomplicated psychosocial distress may benefit from a focused intervention. Another person with severe mental illness, significant suicide risk, complex trauma, severe functional impairment or substantial family dysfunction may require comprehensive multidisciplinary intervention from the outset.

The key principle is therefore *proportionate intervention based on need*, not universal low-intensity care.

Low intensity does not mean low skill

One of the most important messages for Psychiatric Social Work is that low intensity should never become synonymous with low skill.

The intervention may involve fewer specialist contacts, but the decision to select the intervention can require considerable professional judgement.

The provider must be able to:

- identify appropriate participants;
- conduct risk assessment;
- recognise contraindications;
- establish a therapeutic relationship;
- deliver the intervention with fidelity;
- recognise deterioration;
- monitor outcomes;
- engage families where appropriate;
- make timely referrals; and
- know when to step up care.

WHO's scalable intervention framework emphasises the need for appropriate training and implementation structures rather than simply transferring psychological techniques to untrained workers.[3]

Thus, the relevant principle is: *Lower intensity of intervention must not mean lower standards of professional competence.*

Task-sharing or task dumping?

Task-sharing has become a major component of global mental health strategies. Properly implemented, it can extend the reach of evidence-based care. But task-sharing also carries a professional risk.

If specialist responsibilities are transferred to workers without adequate training, supervision, resources or referral mechanisms, task-sharing can become task dumping.

This is particularly relevant to social work because PSWs may be asked to absorb additional responsibilities simply because they are already embedded within multidisciplinary and community services. Such expansion should instead be accompanied by:

- clearly defined competencies;
- standardised training;
- structured supervision;
- defined scope of practice;
- risk-management procedures;
- documentation standards;
- fidelity monitoring;
- outcome measurement;
- referral and back-referral pathways; and
- access to specialist consultation.

Task-sharing should therefore be understood as *responsibility matched with competency and support.*

Stepped care: where low intensity belongs

Low-intensity psychosocial interventions are most appropriately conceptualised within a *stepped-care system.*

The purpose of stepped care is not to keep individuals at the lowest possible level of treatment. It is to provide the *least intensive intervention that is reasonably expected to meet the person's needs*, while enabling timely escalation when it does not.

This distinction is crucial.

Low-intensity intervention should not delay specialist care for people with significant risk or complex clinical needs.

Conversely, requiring specialist intervention for every person experiencing mild or moderate distress may be neither feasible nor necessary.

Psychiatric Social Work is particularly well positioned to contribute to this continuum because the profession has historically worked across hospital, community, family, rehabilitation and social-care environments.

Digital interventions and the changing nature of casework

Digital delivery introduces another dimension.

Step-by-Step represents a guided digital adaptation of the PM+ approach, using behavioural activation together with strategies related to stress management and social support.[12] WHO has also expanded its work on psychological self-help interventions and digital approaches.[7]

Digital delivery can increase reach, but it does not eliminate the need for professional judgement.

Questions of digital literacy, language, privacy, accessibility, socioeconomic inequality, engagement and risk monitoring remain important.

For Psychiatric Social Work, digital mental health could create new forms of practice, including:

- digital psychosocial assessment;
- guided self-help;
- remote family intervention;
- digital follow-up;
- online psychoeducation;
- referral and service navigation; and
- community linkage.

Thus, the future of casework may not necessarily be face-to-face casework alone.

Cultural adaptation: from translation to transformation

One of the risks of global low-intensity intervention programmes is assuming that translation is equivalent to cultural adaptation.India's social and cultural diversity makes this particularly problematic.

Effective psychosocial intervention must consider:

- language;
- family structure;
- gender;
- socioeconomic circumstances;
- cultural explanations of distress;
- stigma;
- community resources;
- health-seeking behaviour;
- local idioms of distress; and
- social expectations surrounding mental illness.

Here, the social work perspective can make an important contribution.

The task is not simply to translate a manual. It is to understand *how the intervention interacts with the social world in which the person lives.* This is precisely where the person-in-

environment orientation of professional social work can strengthen contemporary low-intensity intervention.

Beyond delivering interventions: the role of Psychiatric Social Work

There is a danger that the discussion of low-intensity interventions may reduce PSWs to intervention deliverers.

The professional contribution can be considerably broader.

Psychiatric Social Workers can contribute to the entire intervention pathway:

Need identification → psychosocial assessment → formulation → intervention selection → intervention delivery → family/community engagement → monitoring → rehabilitation → referral and escalation → outcome evaluation

Such a role preserves the professional identity of PSW while enabling the profession to participate in contemporary models of scalable care.

The profession should therefore move from the question: *"Can PSWs deliver low-intensity interventions?"* to a broader question: *"What distinctive psychosocial knowledge can Psychiatric Social Work contribute to the design, delivery, supervision and evaluation of low-intensity mental health care?"*

Research agenda for Psychiatric Social Work: The current movement provides a substantial research agenda.

Developing social-work-derived interventions: Can established approaches such as task-centred casework, problem-solving casework and strengths-based practice be systematically adapted into evidence-based brief psychosocial interventions?

Comparing intervention models: How do PSW-delivered interventions compare with peer, community health worker, digital and specialist-delivered models?

Identifying appropriate populations: Which individuals benefit most from low-intensity intervention, and which characteristics indicate the need for higher-intensity care?

Family outcomes: Can low-intensity psychosocial interventions improve family functioning, caregiver burden, communication and social support?

Rehabilitation and functioning: Can these interventions improve occupational, social and community functioning in addition to symptom outcomes?

Implementation science: What training, supervision and organisational arrangements are necessary for sustainable implementation within Indian mental health services?

Cost-effectiveness: Can low-intensity psychosocial interventions reduce the economic burden associated with untreated mental health problems without compromising quality of care?

Cultural adaptation: Which components should remain standardised and which can be adapted to local cultural and social contexts?

These questions place Psychiatric Social Work not merely at the implementation end of the research process but at the centre of intervention development.

Reclaiming the intervention identity of Psychiatric Social Work: There is perhaps a larger professional issue underlying this discussion.

For many years, professional social work has sometimes been described primarily in terms of *support, counselling, advocacy, case management and psychosocial assistance,* while more structured interventions have increasingly been associated with psychology and psychotherapy.

The emergence of low-intensity psychosocial interventions provides an opportunity to reconsider this division.

Social work has always possessed an intervention tradition. Psychosocial casework, task-centred practice, problem-solving approaches, strengths-based practice and solution-focused practice demonstrate that professional social work has a substantial history of structured intervention.[8-11]

The contemporary challenge is to translate this intervention heritage into the language of evidence-based practice, competency-based training, manualised interventions, implementation science and measurable outcomes. This should not mean abandoning the profession's psychosocial identity. It should mean strengthening it.

CONCLUSION

The movement towards low-intensity psychosocial interventions represents an important development in contemporary mental health care. WHO-supported interventions such as PM+, SH+, Thinking Healthy and Step-by-Step demonstrate how evidence-based psychological and psychosocial strategies can be delivered through brief, structured, scalable and task-shared models.[3-7] Evidence from PM+ and Step-by-Step is promising, although the existing evidence base remains heterogeneous and the certainty of evidence has been rated very low.[12]

For Psychiatric Social Work, however, the significance of this development extends beyond the delivery of another set of intervention manuals.

The principles underlying many contemporary low-intensity psychosocial interventions—problem solving, goal setting, strengths, social support, collaborative helping, task orientation and attention to social context—have substantial conceptual parallels within the historical traditions of social casework and professional social work.[8-11]

The opportunity is therefore not to replace social casework with low-intensity intervention.

Nor is it to convert Psychiatric Social Workers into low-cost providers of standardised psychological programmes.

The opportunity is to reconnect the intervention heritage of professional social work with contemporary evidence-based and scalable mental health care.

Psychiatric Social Work can contribute as a practitioner, assessor, family interventionist, community practitioner, trainer, supervisor, programme developer and researcher. It can help ensure that low-intensity care remains genuinely psychosocial, rather than becoming merely low-cost psychological care.

The future of mental health care will require interventions that are accessible without becoming superficial, scalable without becoming impersonal, structured without becoming culturally rigid, and low intensity without becoming low skill.

For Psychiatric Social Work, the question is therefore not whether the profession should move from casework towards low-intensity intervention.

Rather, it is whether *the rich intervention tradition of social casework can be reimagined, evaluated and repositioned as a central component of contemporary low-intensity and scalable psychosocial mental health care.* That may represent not a departure from the roots of Psychiatric Social Work, but a return to one of its central professional purposes: *helping people change, cope, function and recover within the social worlds in which they live.*

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