International Journal of Science and Research Archive
eISSN: 2582-8185
Cross Ref DOI: 10.30574/ijsra
Journal homepage: https://ijsra.net/

(REVIEW ARTICLE)

From assessment to recovery: Psychotherapy-informed psychiatric team care in low-resource settings

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International Journal of Science and Research Archive, 2026, 19(03), 251-269

Publication history: Received on 29 April 2026; revised on 06 June 2026; accepted on 08 June 2026

Article DOI: https://doi.org/10.30574/ijsra.2026.19.3.1295

Abstract

Mental health services in low-resource settings face a persistent mismatch between population need, specialist workforce capacity, continuity of care, and access to evidence-based psychological and psychiatric interventions. This narrative review examines psychotherapy-informed psychiatric team care as a pragmatic model for improving assessment, treatment planning, safety, adherence, functioning, and recovery in resource-constrained health systems. The review synthesizes clinical, service-delivery, psychotherapeutic, psychopharmacological, neurodevelopmental, public mental health, and quality-improvement literature, with particular attention to relevance for Thailand, South Asia, Southeast Asia, and other low- and middle-income settings. Across the evidence, effective care depends less on isolated specialist activity and more on coordinated multidisciplinary practice, culturally responsive formulation, structured risk assessment, family involvement, stepped psychosocial interventions, task-sharing, medication monitoring, and reliable follow-up. Psychoeducation, motivational interviewing, parent-mediated intervention, behavioural activation, cognitive and interpersonal approaches, and recovery-oriented care can be adapted for routine psychiatric settings when supported by clear protocols, supervision, referral pathways, and quality-improvement methods. The review argues that psychotherapy-informed team care provides a clinically realistic bridge between biomedical psychiatry and person-centred recovery, particularly where specialist services are scarce. Strengthening this model may improve early detection, therapeutic engagement, safety, adherence, and functional outcomes while supporting more equitable and sustainable mental health systems.

Keywords: Task-Sharing; Cultural Adaptation; Stepped Interventions; Primary Health Integration; Quality Improvement

1. Introduction

Mental, neurological, and substance-use disorders are major contributors to disability, premature mortality, family burden, reduced productivity, and social exclusion worldwide [1]. Although effective pharmacological, psychological, social, and rehabilitative interventions exist for many psychiatric conditions, access to timely and continuous care remains uneven, particularly in low-resource settings [1], [2]. In many low- and middle-income countries, mental health systems are expected to respond to depression, anxiety, psychosis, substance-use disorders, neurodevelopmental conditions, perinatal mental health problems, neurocognitive impairment, and psychiatric complications of medical illness with limited specialist staffing, restricted service infrastructure, inadequate medicines, fragmented referral pathways, and persistent stigma [2], [3], [4], [5]. These challenges are highly relevant to Thailand, South Asia, Southeast

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Asia, and comparable health systems where psychiatric services must often operate across public hospitals, primary care, community services, private clinics, families, schools, and informal care networks.

The traditional model of psychiatric care has often placed diagnosis and medication at the centre of clinical activity. Accurate diagnosis and rational psychopharmacology remain essential, especially in severe mental illness, mood disorders, substance-use disorders, neurodevelopmental disorders, and neuropsychiatric presentations [6], [7], [8], [9]. However, diagnosis alone does not usually produce recovery. Many patients require engagement, explanation, motivation, behavioural change, family support, medication adherence, relapse prevention, functional rehabilitation, and continuity of care. In low-resource settings, these therapeutic tasks cannot be left only to specialist psychotherapists or psychiatrists. They must be embedded into the ordinary work of psychiatric teams, primary care clinicians, nurses, psychologists, social workers, community health workers, caregivers, and peer supporters.

Psychotherapy-informed psychiatric team care offers a practical way to bridge this gap. The term does not imply that every patient receives full formal psychotherapy. Rather, it means that psychiatric care is delivered with therapeutic attention to formulation, alliance, meaning, culture, motivation, coping, family systems, safety, adherence, functioning, and recovery. In this model, psychoeducation, motivational interviewing, behavioural activation, cognitive and interpersonal principles, parent-mediated intervention, problem-solving approaches, relapse-prevention planning, and supportive counselling are adapted to the realities of routine clinical practice [10], [11], [12], [13]. Such interventions may be brief, structured, culturally adapted, and delivered by trained members of a multidisciplinary team under appropriate supervision. This is particularly important where specialist psychotherapy is scarce, expensive, urban-centred, or separated from general psychiatric services.

A psychotherapy-informed approach must begin with assessment. Effective care requires more than symptom listing. It requires careful psychiatric history, mental status examination, physical and neurological screening where indicated, assessment of substance use and medical comorbidity, suicide and violence risk formulation, functional assessment, family and cultural formulation, and identification of barriers to engagement [14], [15], [16], [17]. This is especially important because psychiatric presentations may be complicated by neurological conditions, road traffic injury, sickle cell disease, epilepsy, Parkinson's disease, metabolic disease, medication adverse effects, trauma, pregnancy, adolescence, and social adversity [18], [19], [20], [21], [22]. In low-resource settings, missed neuropsychiatric and medical contributors may lead to ineffective treatment, avoidable harm, repeated admission, family distress, and loss of trust in services.

Team-based care is therefore not a luxury but a clinical necessity. Psychiatric teams can improve outcomes when they combine structured assessment, shared care planning, medication monitoring, psychosocial intervention, family engagement, and reliable follow-up. Evidence from low-resource psychiatric settings highlights the importance of health-seeking behaviour, stigma reduction, psychoeducation for psychosis, motivational approaches for alcohol-use disorder, parent-mediated intervention for autism spectrum disorder, metabolic monitoring during antipsychotic treatment, and quality-improvement methods for patient and staff safety [10], [11], [12], [13], [23], [24], [25], [26]. These findings support a pragmatic model in which biomedical psychiatry, psychotherapy, public mental health, and service improvement are not competing traditions but complementary parts of the same recovery pathway.

The relevance of this model is particularly strong for Thailand and neighbouring Asian settings. Mental health care in these contexts must be clinically competent, culturally respectful, family-sensitive, affordable, and adaptable to both urban and rural realities. Patients and families may move between biomedical services, traditional explanations, religious interpretations, private care, community supports, and informal advice before reaching specialist psychiatric treatment. A rigid model that separates psychiatric diagnosis from psychological meaning, family context, and social recovery is unlikely to meet these needs. Conversely, a context-responsive model can preserve scientific standards while adapting communication, intervention intensity, family involvement, and follow-up to local realities.

This narrative review examines psychotherapy-informed psychiatric team care as a practical model for moving from assessment to recovery in low-resource settings. It synthesizes literature on psychiatric assessment, primary care integration, psychopharmacology, psychotherapy-linked interventions, neurodevelopmental disorders, perinatal and adolescent mental health, substance-use disorders, psychosis, neurocognitive impairment, patient safety, and quality improvement. The review aims to propose a clinically usable assessment-to-recovery pathway that can support multidisciplinary teams in Thailand, South Asia, Southeast Asia, and other low- and middle-income settings.

2. Materials and methods

2.1. Review design

This manuscript was designed as a narrative review and evidence synthesis. The review was developed to examine how psychotherapy-informed psychiatric team care can support assessment, treatment planning, safety, continuity of care, adherence, functioning, and recovery in low-resource mental health systems. A narrative approach was selected because the topic is clinically broad, interdisciplinary, and service-oriented, covering psychiatric assessment, psychotherapeutic principles, psychopharmacology, neurodevelopmental care, substance-use disorders, perinatal and adolescent mental health, neuropsychiatry, patient safety, and health-system improvement. The purpose was not to conduct a meta-analysis, but to integrate clinically relevant evidence into a practical framework for psychiatric teams working in Thailand, South Asia, Southeast Asia, and comparable low- and middle-income settings.

2.2. Evidence sources and selection

The evidence base included selected peer-reviewed articles, narrative reviews, clinical studies, randomized controlled trials, quality-improvement reports, and international guidance relevant to mental health care in low-resource settings. Particular attention was given to literature addressing primary care integration, mental status examination, neurological screening, risk assessment, depression care, antidepressant use, psychosis, psychoeducation, motivational interviewing, alcohol-use disorder, autism spectrum disorder, attention deficit hyperactivity disorder, neurocognitive impairment, perinatal depression, antipsychotic metabolic monitoring, patient safety, and quality improvement. Core manuscripts were selected because they provided locally generated or context-relevant evidence on psychiatric practice, psychotherapy-linked interventions, neuropsychiatric complexity, and service delivery in resource-constrained settings. Additional international sources were used where necessary to support broader global mental health, task-sharing, and health-system arguments.

2.3. Conceptual approach

The review was guided by an assessment-to-recovery perspective. This approach assumes that effective psychiatric care begins with structured assessment but must extend beyond diagnosis to include formulation, engagement, shared planning, psychosocial intervention, pharmacological care when indicated, family involvement, safety planning, follow-up, and functional recovery. Psychotherapy-informed care was understood as the use of therapeutic principles within routine psychiatric practice, including psychoeducation, motivational interviewing, behavioural activation, cognitive and interpersonal principles, supportive counselling, parent-mediated intervention, relapse prevention, and recovery-oriented communication. Team care was understood as coordinated work involving psychiatrists, psychologists, psychotherapists, nurses, primary care clinicians, social workers, occupational therapists, community health workers, caregivers, and other locally available supports.

2.4. Thematic synthesis

The included literature was reviewed thematically. Evidence was grouped into major clinical and service-delivery domains: psychiatric assessment and formulation; psychotherapy-informed psychiatric practice; team-based and task-sharing models; depression and antidepressant care; psychosis and adherence; substance-use disorders and harm reduction; neurodevelopmental disorders and family-mediated interventions; perinatal, adolescent, and family mental health; neuropsychiatric and medically complex presentations; patient safety and quality improvement; and cultural adaptation for Thailand, South Asia, Southeast Asia, and low-resource settings. These themes were then integrated into a proposed practical assessment-to-recovery pathway for multidisciplinary psychiatric teams.

2.5. Ethical considerations

This review used previously published literature and did not involve direct contact with human participants, animal subjects, personal clinical records, or identifiable patient information. Therefore, formal ethics committee approval and informed consent were not required. Ethical attention was nevertheless given to accurate representation of cited evidence, culturally respectful interpretation, and avoidance of recommendations that would be unrealistic, unsafe, or unsuitable for low-resource clinical settings.

3. Results and discussion

3.1. From assessment to formulation: Building the foundation of care

Psychotherapy-informed psychiatric team care begins with assessment, but assessment should be understood as more than the collection of symptoms for diagnostic classification. In low-resource settings, the first clinical encounter may be the only opportunity to establish trust, identify risk, detect medical or neurological contributors, engage the family, and develop a realistic care plan. For this reason, assessment itself should be therapeutic, structured, culturally sensitive, and oriented toward recovery from the beginning.

A practical assessment model should include psychiatric history, mental status examination, medication history, substance-use assessment, risk formulation, medical and neurological screening, family and social context, functional impairment, and the patient's own explanatory model of distress. This is especially important because patients may present first to primary care, emergency units, religious or traditional healers, private clinics, or family networks before reaching specialist psychiatric services. Integration of mental health assessment into primary health care is therefore essential for early detection, triage, referral, and continuity of care, particularly where specialist psychiatric services are limited [3], [6]. A structured approach also reduces the risk that depression, psychosis, substance-use disorders, neurodevelopmental problems, epilepsy, cognitive impairment, trauma-related symptoms, or medication adverse effects will be missed or mislabelled.

The mental status examination remains central to psychiatric practice, but it should not be separated from neurological findings and risk assessment. A patient presenting with agitation, confusion, withdrawal, hallucinations, poor sleep, aggression, or unusual behaviour may have a primary psychiatric disorder, an intoxication or withdrawal state, delirium, epilepsy, traumatic brain injury, metabolic disturbance, medication-related adverse effect, or a combination of these. Contemporary psychiatric practice therefore requires a minimum clinical dataset that links mental status findings with neuropsychiatric red flags, suicide and violence risk, physical health concerns, and a clear follow-up plan [7]. This is particularly relevant in settings where laboratory testing, neuroimaging, electroencephalography, and specialist neurological consultation may not be immediately available.

Formulation is the bridge between assessment and intervention. A diagnosis may describe the disorder, but formulation explains why this person is suffering in this way at this time, what maintains the problem, what resources are available, and what intervention is most feasible. A useful formulation should include biological vulnerability, psychological meanings, family relationships, cultural explanations, socioeconomic stressors, substance use, medical comorbidity, safety concerns, and strengths. In Thailand, South Asia, Southeast Asia, and comparable low-resource settings, formulation should also consider stigma, family hierarchy, religious beliefs, migration, tourism-related stressors, rural–urban inequality, affordability of care, and patterns of help-seeking. This does not weaken scientific psychiatry; rather, it makes psychiatric care more accurate, acceptable, and actionable.

Assessment must also identify barriers to treatment engagement. Evidence from substance-use services shows that health-seeking behaviour is influenced by health-system factors, socioeconomic pressures, stigma, knowledge of mental illness, family attitudes, staff availability, and access to medicines [16]. These barriers are not secondary details; they may determine whether a patient attends follow-up, accepts medication, participates in psychotherapy-informed intervention, or returns only during crisis. Similarly, repeated psychiatric readmission may reflect not only illness severity but also poor continuity of care, weak discharge planning, limited family support, medication non-adherence, substance use, and inadequate community follow-up [18]. A good assessment therefore asks not only "What is the diagnosis?" but also "What will prevent this patient from recovering after leaving the clinic?"

Psychiatric assessment should routinely include physical health and medication safety. Patients receiving antipsychotic medication are at increased risk of metabolic complications, and simple measures such as weight, body mass index, waist circumference, and blood glucose monitoring are feasible even in resource-constrained outpatient settings [17]. This is clinically important because untreated metabolic illness can worsen quality of life, reduce adherence, increase cardiovascular risk, and undermine confidence in psychiatric treatment. Safety-oriented assessment should also include medication side effects, pregnancy considerations, alcohol and drug use, neurological symptoms, sleep, pain, and chronic medical illness.

Neuropsychiatric complexity requires particular attention. Neurocognitive impairment has been reported among children with sickle cell disease and among adult road traffic accident victims, with consequences for school functioning, daily living, quality of life, and rehabilitation needs [19], [20]. Nonconvulsive status epilepticus may present with altered consciousness, confusion, behavioural change, or cognitive disturbance rather than obvious convulsions, creating a risk

of misdiagnosis as a primary psychiatric condition when neurological assessment is incomplete [24]. Parkinson's disease and other neurodegenerative conditions may also present with mood, cognitive, behavioural, sleep, and functional symptoms that require integrated neuropsychiatric assessment and treatment planning [25], [26]. These examples show why psychotherapy-informed care must remain medically alert and diagnostically disciplined.

Assessment is also the point at which teams identify the most appropriate level of care. Some patients require urgent admission, medication initiation, detoxification, neurological referral, safeguarding action, or crisis intervention. Others may benefit from brief psychoeducation, behavioural activation, motivational interviewing, family meetings, structured follow-up, or referral to psychological therapy. For children and adolescents, assessment must include development, school functioning, caregiver capacity, family stress, and safeguarding concerns. For perinatal and adolescent mental health, risk assessment should include depression severity, self-harm, intimate partner violence, social support, pregnancy-related stressors, and access to maternal care [21]. In each case, the goal is not merely to assign a diagnostic label, but to match the intervention to the person, family, risk level, and available resources.

For multidisciplinary teams, a shared formulation can prevent fragmented care. Psychiatrists, psychologists, nurses, primary care clinicians, social workers, occupational therapists, and community health workers may each see different aspects of the same patient. Without a shared formulation, care may become divided into separate medication, counselling, nursing, social, and risk tasks. With a shared formulation, the team can agree on the working diagnosis, risk level, psychological maintaining factors, family role, physical health priorities, medication plan, psychosocial intervention, crisis plan, and follow-up responsibility. This is the first step in moving from assessment to recovery.

In practical terms, the minimum assessment-to-formulation package for low-resource psychiatric teams should include: presenting problem and timeline; mental status examination; suicide, self-harm, violence, neglect, and safeguarding risk; substance-use screening; medication and physical health review; brief neurological screen where indicated; functional assessment; family and social context; cultural explanation of illness; strengths and protective factors; provisional diagnosis; shared formulation; and a written care plan. Such a package is realistic, teachable, auditable, and adaptable to different levels of care. It provides the foundation for psychotherapy-informed psychiatric teamwork because it transforms the first encounter into a structured pathway toward safety, engagement, treatment, and recovery.

3.2. Psychotherapy-informed psychiatric practice

Psychotherapy-informed psychiatric practice does not require every clinical contact to become formal psychotherapy. Rather, it means that psychiatric care is delivered with deliberate attention to therapeutic relationship, explanation, motivation, emotional containment, behaviour change, family context, relapse prevention, and recovery. In low-resource settings, this distinction is important. Many services do not have enough specialist psychologists or psychotherapists to provide full manualized therapy to every patient, but every psychiatric team can still deliver care in a psychologically informed manner. This approach allows therapeutic principles to be embedded into ordinary assessment, prescribing, nursing care, discharge planning, family meetings, and follow-up.

The therapeutic alliance is the first intervention. Patients and families may approach psychiatric services with fear, shame, uncertainty, financial pressure, or previous negative experiences of care. Some may understand distress through spiritual, moral, social, or physical explanations before accepting psychiatric language. A psychotherapy-informed team therefore avoids beginning with correction or confrontation. It first listens to the patient's account, acknowledges suffering, explains symptoms in understandable language, and invites collaboration. This is particularly important in Thailand, South Asia, Southeast Asia, and other low-resource settings where family involvement, respect for authority, stigma, religion, and community reputation may strongly influence treatment engagement.

Psychoeducation is one of the most practical psychological interventions for psychiatric teams. It can help patients and families understand diagnosis, expected course, warning signs, medication effects, relapse risk, sleep, substance use, stress, and the importance of follow-up. In first-episode psychosis, psychoeducation is clinically attractive because early engagement may influence adherence, relapse prevention, family response, and functioning. Evidence from a randomized controlled trial among treatment-naïve patients with first-episode psychosis showed improvement over time in adherence, symptoms, and functioning, although psychoeducation did not demonstrate a statistically significant additional effect over treatment as usual during the follow-up period [13]. This finding is useful rather than disappointing. It suggests that psychoeducation should not be treated as a magic intervention, but as one component of broader care that must also address motivation, socioeconomic barriers, family support, access to medicines, and continuity.

Motivational interviewing is particularly relevant for substance-use disorders, medication ambivalence, lifestyle change, and engagement with follow-up. Its value lies in helping patients explore ambivalence without coercion. Rather than simply instructing a patient to stop drinking, take medication, attend clinic, or change behaviour, the clinician helps the patient identify personal goals, discrepancies between current behaviour and desired life, and realistic next steps. In hospitalized patients with alcohol-use disorder, motivational interviewing combined with treatment as usual did not show a statistically significant added benefit over treatment as usual, although substantial short-term harm reduction was observed overall [14]. This again supports a pragmatic interpretation: brief motivational approaches may be useful, but their impact depends on timing, patient readiness, discharge support, social environment, and continuity after admission.

Behavioural activation and problem-solving approaches are especially useful where formal cognitive behavioural therapy is not available. Patients with depression, anxiety, chronic medical illness, substance-use problems, or social withdrawal often benefit from structured encouragement to resume meaningful activities, improve sleep-wake rhythm, reduce avoidance, rebuild routines, and identify solvable practical problems. Depression guidance for general clinical practice supports the use of psychotherapy, behavioural activation, cognitive behavioural therapy, interpersonal psychotherapy, pharmacotherapy, or combined approaches depending on severity, comorbidity, risk, patient preference, and available resources [10]. In low-resource settings, these interventions can often be simplified into brief clinical tasks: identify one avoided activity, agree on one small behavioural goal, review progress at follow-up, involve a trusted family member when appropriate, and adjust the plan according to response.

Family work is central to psychotherapy-informed psychiatric care. Families often provide transport, money, supervision, medication reminders, crisis response, childcare, and emotional support. They may also unintentionally maintain distress through criticism, overprotection, stigma, fear, or misunderstanding. A brief family meeting can therefore be highly therapeutic. It can explain the condition, reduce blame, clarify warning signs, assign practical roles, discuss medication and safety, and agree on what to do if relapse occurs. In neurodevelopmental disorders, family-mediated care is even more central. Evidence from brief parent-mediated intervention for autism spectrum disorder showed meaningful gains in functional language and social communication, with better outcomes associated with attendance and parent fidelity [15]. This supports a wider principle: when specialist services are scarce, empowering caregivers through structured guidance can extend therapeutic benefit beyond the clinic.

Supportive counselling remains valuable when delivered with discipline and purpose. It should not be dismissed as "just talking." Good supportive work validates distress, strengthens coping, reinforces adaptive behaviour, encourages treatment adherence, reduces isolation, and helps patients tolerate uncertainty. For patients with psychosis, severe depression, chronic illness, trauma, grief, disability, or family conflict, supportive counselling may be the most feasible and acceptable psychological intervention available. It is especially useful when combined with clear psychiatric assessment, medication review, risk planning, and follow-up.

Psychotherapy-informed practice also improves prescribing. Medication discussions should include the patient's beliefs, fears, previous experiences, financial capacity, likely side effects, expected time to response, and what the patient should do if symptoms worsen. Antidepressant and psychotropic prescribing should not be reduced to drug selection alone; it requires explanation, monitoring, adherence support, and review of comorbid conditions [9], [10], [12]. Similarly, antipsychotic treatment should be accompanied by metabolic monitoring, side-effect review, and shared planning because physical health problems may reduce adherence and worsen long-term outcomes [17]. In this sense, prescribing itself becomes a therapeutic conversation.

In team settings, psychotherapy-informed care should be shared rather than restricted to one professional. The psychiatrist may provide diagnosis, medication planning, risk formulation, and overall coordination. The psychologist or psychotherapist may provide structured psychological intervention. Nurses may deliver psychoeducation, adherence support, sleep advice, substance-use screening, and relapse monitoring. Social workers may address family conflict, safeguarding, social welfare, and community reintegration. Primary care clinicians may monitor physical health, identify relapse early, and maintain continuity. Community health workers or peer supporters may reduce stigma, support follow-up, and help patients remain connected to care. This distribution of therapeutic tasks is consistent with task-sharing and integrated care models in low-resource mental health systems [3], [5], [6].

However, psychotherapy-informed care must remain safe and supervised. Brief psychological interventions should be matched to patient need, risk level, cognitive capacity, language, culture, and clinical stability. Patients with severe suicidality, violence risk, delirium, intoxication, withdrawal, mania, severe psychosis, catatonia, nonconvulsive status epilepticus, or major medical instability require urgent clinical management before routine psychological work. Team

members should know when to provide brief intervention, when to consult, and when to refer. Supervision, documentation, and clear referral pathways protect both patients and staff.

The practical goal is to make every contact therapeutic without making every contact complicated. A five-minute explanation of medication, a respectful discussion of stigma, a brief motivational question, a family safety plan, a behavioural activation task, or a relapse-prevention reminder can change the direction of care. In low-resource settings, psychotherapy-informed psychiatric practice is therefore not an optional luxury. It is a realistic method for improving engagement, adherence, safety, family participation, and recovery within the ordinary work of psychiatric teams.

3.3. Team-based care and task-sharing in low-resource systems

Psychotherapy-informed psychiatric care is most effective when it is delivered through a coordinated team rather than through isolated professional activity. In low-resource settings, the shortage of psychiatrists, psychologists, psychiatric nurses, occupational therapists, social workers, and trained counsellors means that no single professional group can meet the full range of mental health needs. Team-based care and task-sharing therefore become practical necessities rather than optional service innovations [3], [5], [6].

Task-sharing means that selected mental health activities are delivered by non-specialist or less-specialized providers with appropriate training, supervision, referral pathways, and clinical governance. In psychiatric care, this may include screening for depression, anxiety, alcohol use, suicide risk, treatment adherence, relapse warning signs, medication side effects, and social problems. It may also include psychoeducation, brief behavioural activation, motivational conversations, family engagement, appointment reminders, physical health monitoring, and community follow-up. These tasks do not replace specialist care; they extend the reach of specialist care and allow psychiatrists and psychologists to focus on complex assessment, diagnosis, treatment planning, supervision, and risk management.

A practical team model should define the contribution of each professional group. Psychiatrists usually lead diagnostic formulation, psychopharmacological planning, management of severe mental illness, complex risk, legal issues, and coordination of care. Psychologists and psychotherapists provide structured psychological assessment and therapy where available, while also training other staff in basic therapeutic communication. Nurses are central to observation, medication support, psychoeducation, sleep and substance-use screening, crisis containment, and follow-up. Primary care clinicians can detect common mental disorders, monitor physical health, continue stable prescriptions, and refer complex cases. Social workers, occupational therapists, community health workers, family members, and peer supporters can address social reintegration, disability, stigma, home environment, adherence, and functional recovery.

The strongest team-based systems are built around shared information. A patient should not receive separate and disconnected psychiatric, nursing, psychological, social, and medical plans. Instead, the team should agree on a shared working diagnosis, formulation, risk level, treatment goals, medication plan, psychosocial intervention, family role, follow-up schedule, and crisis response. The minimum shared dataset should include mental status findings, neuropsychiatric red flags, suicide or violence risk, substance use, physical health concerns, medication changes, family concerns, and the named person responsible for follow-up [7]. This is especially important during transitions from inpatient to outpatient care, from specialist services to primary care, or from emergency assessment to community follow-up.

Team-based care also improves safety. Psychiatric services must manage risks related to self-harm, violence, absconding, medication adverse effects, diagnostic error, coercion, staff safety, and unsafe discharge. Quality-improvement approaches can help teams identify system weaknesses, redesign workflows, test small changes, and monitor whether safety improves over time [8]. A PDSA quality-improvement study in a Zambian mental health facility highlighted the importance of structured safety and security management for protecting both patients and healthcare workers [27]. This is directly relevant to low-resource services where staff may work under pressure, infrastructure may be weak, and safety incidents may arise from gaps in communication, staffing, environment, or escalation procedures.

Task-sharing must be accompanied by supervision. Without supervision, it can become unsafe delegation. Non-specialist providers need clear protocols for what they can manage, what they must document, when they should consult, and when they must urgently refer. Warning signs include active suicidal intent, severe violence risk, delirium, intoxication or withdrawal, severe depression with psychotic features, mania, catatonia, uncontrolled epilepsy, severe medication adverse effects, pregnancy-related risk, safeguarding concerns, and diagnostic uncertainty. In these situations, task-sharing should activate specialist involvement rather than delay it.

For Thailand, South Asia, Southeast Asia, and comparable low-resource settings, team-based care should also include families as partners. Families often provide the real continuity of care between appointments. They notice relapse early, support medication, manage finances, negotiate stigma, transport patients, and protect vulnerable relatives. However, families also need guidance. Without psychoeducation, they may misinterpret symptoms, blame the patient, over-restrict autonomy, discontinue treatment early, or seek help only during crisis. Brief, respectful family involvement can therefore improve engagement and recovery while remaining culturally acceptable.

The aim of task-sharing is not to simplify psychiatry, but to organize psychiatric care intelligently. A well-functioning team allows each worker to contribute within competence while maintaining specialist oversight. In low-resource settings, this model can improve access, continuity, adherence, safety, and recovery without requiring every patient to see every specialist. It turns scarce expertise into a shared clinical system.

3.4. Depression, anxiety and antidepressant care across primary and specialist services

Depression and anxiety are among the most common reasons for psychological distress in primary care, general medical practice, and specialist psychiatric services. In low-resource settings, many patients do not first present with sadness or worry. They may present with sleep disturbance, pain, fatigue, poor concentration, irritability, reduced work performance, alcohol use, family conflict, medically unexplained symptoms, or repeated visits for physical complaints. For this reason, depression and anxiety care must be integrated into ordinary clinical encounters rather than reserved only for specialist psychiatric clinics [6], [10].

A stepped-care approach is particularly suitable for low-resource systems. Mild depressive symptoms may respond to psychoeducation, behavioural activation, problem-solving, sleep advice, social support, and follow-up. Moderate symptoms may require structured psychological intervention, antidepressant medication, or combined treatment depending on severity, patient preference, comorbidity, risk, and availability of services. Severe depression, psychotic symptoms, bipolar risk, suicidal intent, marked functional impairment, treatment resistance, pregnancy-related complexity, or diagnostic uncertainty should prompt specialist referral or shared care [10]. This approach allows scarce specialist resources to be used where they are most needed while still offering early help to patients with less severe presentations.

Antidepressant care should be rational, individualized, and closely monitored. The choice of medication should consider the clinical pattern of symptoms, past response, side-effect profile, medical comorbidity, pregnancy status, suicide risk, drug interactions, affordability, and availability [9], [10], [11]. In many low-resource settings, inadequate dosing, short treatment duration, poor explanation, medication fears, and early discontinuation undermine treatment response. A psychotherapy-informed prescribing conversation should therefore explain the expected time to benefit, common side effects, duration of treatment, warning signs, and the importance of follow-up. This can reduce fear, improve adherence, and transform prescribing into a collaborative therapeutic act rather than a brief instruction.

Anxiety symptoms often coexist with depression, substance use, trauma, chronic illness, and neurodevelopmental disorders. They may also complicate antidepressant initiation, because early side effects may be misinterpreted as worsening illness. Patients should therefore receive simple explanations about anxiety physiology, breathing, sleep, avoidance, alcohol and caffeine use, and gradual return to valued activities. Where formal cognitive behavioural therapy is unavailable, brief cognitive and behavioural principles can still be used by trained clinicians: identifying triggers, reducing avoidance, scheduling activity, improving routines, and reviewing progress at each visit.

Depression care must also be medically alert. Antidepressants are used not only in psychiatric practice but also in neurological and general medical care, including depression associated with neurological illness, chronic pain, neuropathic pain, panic symptoms, migraine prevention, and other comorbid presentations [12]. This overlap is clinically useful but also requires caution. Psychiatric teams should assess neurological symptoms, cognitive change, substance use, sleep disturbance, medical illness, and medication interactions before attributing all distress to primary mood disorder. In medically complex patients, collaboration between psychiatry, primary care, neurology, obstetrics, paediatrics, and other services may be necessary.

Special attention is needed for adolescents, pregnant women, and families under social stress. Prenatal depression among teenage pregnant women is associated with psychosocial factors such as stress, social support, household income, education, marital status, and previous attempts to abort [21]. These findings support the need for early screening, non-judgemental assessment, family-sensitive care, and practical support alongside any pharmacological decision. In children and adolescents, depressive and anxiety symptoms may present through school problems,

irritability, behavioural change, somatic complaints, self-harm, or family conflict. Medication decisions should therefore be cautious, supervised, and combined with psychoeducation and psychosocial intervention.

The relationship between antidepressant use and neurodevelopmental disorders also requires careful interpretation. Evidence from a small local study suggested improvement in neurocognitive functioning among children with attention deficit hyperactivity disorder after fluoxetine therapy [22]. However, fluoxetine is not a standard first-line treatment for attention deficit hyperactivity disorder. Such findings are best understood as context-specific evidence from a setting where stimulant availability may be limited, and they should encourage further research rather than routine unsupervised substitution. In practice, teams should assess comorbid anxiety, depression, obsessive symptoms, trauma, sleep, and family stress before considering antidepressant treatment in neurodevelopmental presentations.

For low-resource psychiatric teams, the practical depression and anxiety package should include: brief screening; assessment of suicide risk and bipolarity; review of substance use and medical illness; severity-based care planning; psychoeducation; behavioural activation or problem-solving; rational antidepressant prescribing when indicated; early follow-up; adherence support; side-effect monitoring; family involvement where appropriate; and referral pathways for severe, complex, or treatment-resistant cases. This package is clinically realistic and compatible with primary care integration. It also reflects the broader principle of this review: effective recovery requires combining psychiatric diagnosis, medication, psychological intervention, family support, and continuity of care.

3.5. Psychosis, adherence and recovery-oriented follow-up

Psychosis requires more than symptom control. In low-resource settings, patients with hallucinations, delusions, disorganized behaviour, agitation, social withdrawal, or impaired insight often present late, after family distress, traditional help-seeking, police involvement, substance use, school or work disruption, or crisis admission. A psychotherapy-informed team approach should therefore combine early assessment, risk formulation, medication, psychoeducation, family engagement, physical health monitoring, and follow-up.

First-episode psychosis is a particularly important point for intervention because early experiences of care may shape later adherence, trust, relapse risk, and recovery. Psychoeducation can help patients and families understand symptoms, treatment, warning signs, relapse prevention, sleep, substance use, and the importance of continuing care. Evidence from a randomized controlled trial in treatment-naïve first-episode psychosis found improvement over time in adherence, symptoms, and functioning, although psychoeducation did not add a statistically significant advantage over treatment as usual during the follow-up period [13]. This finding supports a realistic interpretation: psychoeducation is important, but it must be combined with accessible medication, family support, motivational work, socioeconomic awareness, and reliable follow-up.

Medication adherence in psychosis is strongly influenced by insight, side effects, family beliefs, stigma, cost, service accessibility, and previous experience of coercion or hospitalization. Teams should explain the reason for medication, expected benefits, likely adverse effects, relapse risks, and what to do if treatment is interrupted. Antipsychotic prescribing should also include physical health monitoring, especially weight, waist circumference, body mass index, and blood glucose, because metabolic complications may reduce adherence and worsen long-term outcomes [17]. In this sense, adherence work is both psychological and medical.

Recovery-oriented follow-up should begin before discharge or before the end of the first crisis contact. The team should identify who will supervise medication, who will bring the patient to review, what warning signs should trigger urgent contact, and what social or occupational goals are realistic. Readmission studies from psychiatric settings suggest that repeated admission may reflect not only illness severity but also weak continuity, poor discharge planning, substance use, limited support, and medication non-adherence [18]. Follow-up should therefore focus on both relapse prevention and functional recovery.

Psychosis also illustrates why cultural and family formulation matters. Rare presentations such as induced delusional disorder, or folie à deux, show how delusional beliefs may spread within close relationships and become intensified by isolation, dependency, fear, religious interpretation, and family systems [28], [29]. These cases remind psychiatric teams that psychosis is not experienced by an individual alone. It can reshape family behaviour, child safety, help-seeking, community response, and legal risk. Culturally respectful assessment should therefore distinguish spiritual or cultural beliefs from fixed pathological delusions while still acting decisively when there is neglect, violence, severe risk, or impaired reality testing.

Risk assessment in psychosis should include suicide, violence, neglect, exploitation, self-care, child protection, substance use, command hallucinations, persecutory beliefs, access to weapons, medication non-adherence, and family capacity. However, risk assessment should not become a purely defensive exercise. It should lead to a practical safety plan: who will monitor the patient, where the patient will stay, how medication will be obtained, when review will occur, and what the family should do during deterioration. Structured handover and shared minimum datasets can improve safety during transitions between emergency care, inpatient units, outpatient clinics, primary care, and community follow-up [7], [8].

For low-resource teams, the practical psychosis care package should include early recognition; assessment of medical, neurological, and substance-related causes; antipsychotic treatment when indicated; psychoeducation; side-effect and metabolic monitoring; family meetings; relapse-prevention planning; substance-use intervention; risk and safeguarding plans; and named follow-up. The goal is not only reduction of hallucinations or delusions, but restoration of safety, dignity, relationships, functioning, and continuity of care.

3.6. Substance use disorders: motivational care, harm reduction and continuity

Substance use disorders are common, recurrent, and strongly shaped by social context, stigma, family response, poverty, comorbidity, and service accessibility. In low-resource settings, patients may present late, often after medical complications, family conflict, occupational decline, violence, legal problems, or psychiatric admission. Care should therefore move beyond detoxification alone and include assessment of motivation, psychiatric comorbidity, physical health, risk, family support, relapse triggers, and continuity after discharge.

A psychotherapy-informed approach is especially relevant because ambivalence is central to substance-use disorders. Many patients want relief from consequences but remain uncertain about reducing or stopping use. Motivational interviewing provides a respectful method for exploring this ambivalence, strengthening personal reasons for change, and reducing confrontation. Evidence from hospitalized patients with alcohol-use disorder showed substantial short-term harm reduction overall, although motivational interviewing did not produce a statistically significant additional benefit over treatment as usual [14]. This supports a practical conclusion: brief motivational work is useful, but it should not be isolated from medication, withdrawal care, family involvement, discharge planning, peer or community support, and follow-up.

Health-seeking behaviour is another key issue. Evidence from substance-use services shows that treatment access is influenced by health-system factors, staff attitudes, availability of medicines, socioeconomic barriers, stigma, family beliefs, and knowledge of mental illness [16]. These factors are clinically important because they influence whether patients seek help early, complete treatment, return for review, or present only during crisis. Psychiatric teams should therefore ask not only about the substance used, quantity, frequency, withdrawal, and complications, but also about what has delayed care, who supports recovery, what the patient fears about treatment, and what practical barriers may prevent follow-up.

Substance-use assessment should be integrated into all psychiatric care. Alcohol and drug use can worsen depression, anxiety, psychosis, sleep disturbance, impulsivity, aggression, self-harm, medication non-adherence, and readmission risk. It may also mimic or mask psychiatric syndromes. A patient presenting with agitation, hallucinations, mood instability, cognitive impairment, or poor adherence should therefore be assessed for intoxication, withdrawal, dependence, polysubstance use, and medical complications. This is particularly important in settings where emergency, inpatient, outpatient, and primary care services may not share information reliably.

Harm reduction is a realistic and humane principle in low-resource practice. While abstinence may be the safest goal for many patients, some individuals initially require gradual reduction, safer use planning, withdrawal management, relapse prevention, family support, and repeated engagement. Harm reduction does not mean clinical permissiveness. It means reducing immediate danger while continuing to support longer-term recovery. This may include reducing heavy drinking days, preventing withdrawal complications, addressing violence risk, improving nutrition and sleep, treating comorbid depression or psychosis, involving family safely, and arranging early post-discharge review.

Continuity of care is often the weakest point. Patients may improve during admission or crisis contact but relapse when they return to the same environment without follow-up, medication support, social stability, or coping strategies. Repeated readmission may reflect weak discharge planning, limited community follow-up, poor adherence, ongoing substance use, and inadequate family support [18]. A simple discharge plan should identify relapse triggers, warning signs, emergency contacts, medication arrangements, follow-up date, family role, and one realistic recovery goal.

For low-resource psychiatric teams, the practical substance-use care package should include screening; assessment of intoxication, withdrawal, dependence, psychiatric comorbidity, medical complications, and risk; brief motivational intervention; harm-reduction planning; family engagement when safe; treatment of comorbid mental illness; relapse-prevention advice; and named follow-up. The aim is not only to stop or reduce substance use, but to restore safety, dignity, functioning, family stability, and connection to care.

3.7. Neurodevelopmental disorders and family-mediated interventions

Neurodevelopmental disorders require a family-centred and developmentally informed approach. In low-resource settings, children and adults with autism spectrum disorder, attention deficit hyperactivity disorder, intellectual disability, language delay, behavioural difficulties, or learning problems may present late because of stigma, limited specialist services, school exclusion, family uncertainty, or misinterpretation of symptoms as poor discipline or spiritual problems. Psychiatric teams should therefore combine diagnostic assessment with psychoeducation, caregiver guidance, school collaboration, and realistic functional goals.

Autism spectrum disorder illustrates the importance of moving beyond diagnosis toward practical intervention. A diagnosis may help families understand the child's difficulties, but recovery-oriented care must also address communication, behaviour, daily routines, caregiver stress, school participation, and social functioning. Evidence from brief parent-mediated intervention showed meaningful improvement in functional language and social communication among children with autism spectrum disorder, with outcomes influenced by session attendance and parent fidelity [15]. This supports a practical principle for low-resource settings: when specialist therapy is scarce, trained caregivers can become therapeutic partners if they receive structured, understandable, and supervised guidance.

Family-mediated intervention should be simple, respectful, and feasible. Caregivers can be taught to use short instructions, predictable routines, visual cues, play-based interaction, positive reinforcement, communication opportunities, and calm responses to distress. The goal is not to turn parents into therapists, but to help them use therapeutic strategies during ordinary daily life. Psychiatric teams should also assess caregiver burden, parental mental health, family conflict, financial stress, and school support, because these factors influence whether home-based strategies are sustained.

Attention deficit hyperactivity disorder also requires careful assessment and contextual management. Children may present with inattention, impulsivity, hyperactivity, emotional dysregulation, poor school performance, peer conflict, sleep problems, or family frustration. In low-resource settings, stimulant medication, behavioural therapy, educational support, and specialist child psychiatry may not be consistently available. Evidence from a local study suggested improvement in neurocognitive functioning after fluoxetine therapy among children with attention deficit hyperactivity disorder, although such findings should be interpreted cautiously because fluoxetine is not a standard first-line treatment for attention deficit hyperactivity disorder [22]. The more important clinical message is that teams should assess comorbid anxiety, depression, trauma, sleep disturbance, family stress, and learning difficulties before selecting treatment.

Adults with autism spectrum disorder are also at risk of being overlooked. Adult presentations may include social communication difficulties, restricted routines, sensory sensitivities, dependence on family, anxiety, depression, behavioural crises, occupational impairment, or complex comorbidity [23]. A psychotherapy-informed approach should avoid forcing neurotypical expectations onto the patient. Instead, it should support communication, predictability, autonomy, emotional regulation, family understanding, and reasonable functional goals.

For low-resource psychiatric teams, the practical neurodevelopmental care package should include developmental history, family interview, school or occupational history, assessment of communication and adaptive functioning, screening for epilepsy and medical comorbidity where indicated, evaluation of caregiver stress, psychoeducation, parent-mediated strategies, school liaison, behavioural planning, and follow-up. The central aim is not merely symptom reduction, but improved functioning, participation, caregiver confidence, and quality of life.

3.8. Perinatal, adolescent and family mental health

Perinatal and adolescent mental health are central to psychotherapy-informed psychiatric team care because distress during these periods affects not only the individual patient but also infants, partners, caregivers, schools, families, and future developmental outcomes. In low-resource settings, perinatal depression, adolescent depression, anxiety, trauma, substance use, self-harm, family conflict, and social adversity may remain hidden because of stigma, limited screening, poverty, gender expectations, and fear of judgement. Psychiatric teams should therefore approach these presentations with clinical seriousness, cultural sensitivity, and practical family-centred planning.

Teenage pregnancy illustrates the overlap between mental health, family systems, social vulnerability, and reproductive health. Evidence from a comparative study of prenatal depression among teenage pregnant women showed that depression was associated with psychosocial and contextual factors, including stress, social support, household income, education, marital status, and previous attempts to abort [21]. These findings support a broad assessment model that goes beyond depressive symptoms alone. Clinicians should ask about safety, self-harm, intimate partner violence, family response, housing, school disruption, financial pressure, shame, substance use, access to antenatal care, and available emotional support.

A psychotherapy-informed team can offer brief but meaningful interventions even where specialist perinatal services are unavailable. These may include psychoeducation about depression and anxiety, emotional validation, problem-solving, sleep and routine advice, safety planning, strengthening of social support, partner or family meetings where appropriate, and referral for obstetric or social support. Medication may be required for moderate to severe depression, high-risk presentations, psychosis, or persistent impairment, but prescribing should be integrated with informed discussion, monitoring, and collaboration with maternal health services [10].

Adolescent mental health also requires developmentally sensitive care. Young people may present with irritability, school refusal, risk-taking, self-harm, somatic complaints, family conflict, poor concentration, substance use, or behavioural problems rather than clearly verbalized depression or anxiety. Assessment should include family relationships, bullying, trauma, sexual and reproductive health, substance use, academic stress, online behaviour, sleep, neurodevelopmental problems, and suicide risk. Where possible, clinicians should balance confidentiality with family involvement, safeguarding duties, and the adolescent's emerging autonomy.

Families can either protect recovery or unintentionally worsen distress. In many Asian and low-resource settings, family authority, social reputation, religious beliefs, and gender roles may strongly shape help-seeking and adherence. Respectful family engagement can reduce blame, improve understanding, support follow-up, and strengthen safety. However, clinicians should avoid assuming that family involvement is always protective; where violence, coercion, abuse, or severe conflict is present, the team must prioritize safety and safeguarding.

For low-resource psychiatric teams, the practical perinatal and adolescent care package should include routine screening for depression, anxiety, self-harm, substance use, trauma, and family violence; assessment of social support and caregiving capacity; psychoeducation; brief problem-solving or behavioural activation; family involvement when safe; referral to antenatal, paediatric, school, or social services; and clear follow-up. The aim is early detection, emotional containment, safer families, improved functioning, and prevention of avoidable deterioration.

3.9. Neuropsychiatry and medically complex presentations

Psychotherapy-informed psychiatric care must remain medically disciplined. In low-resource settings, psychiatric symptoms may be caused, worsened, or mimicked by neurological disease, traumatic injury, epilepsy, metabolic disturbance, chronic pain, infection, medication adverse effects, substance use, and other medical conditions. If these contributors are missed, patients may receive inappropriate treatment, families may lose trust in services, and preventable disability may worsen.

Neurocognitive impairment is a particularly important example. Children with sickle cell disease may experience cognitive difficulties affecting school performance, attention, memory, daily functioning, and quality of life [19]. Adult road traffic accident victims may also experience neurocognitive deficits that affect behaviour, emotional regulation, occupational functioning, family relationships, and rehabilitation needs [20]. These presentations may be misinterpreted as poor motivation, depression, personality change, substance use, or primary psychosis unless teams deliberately assess cognitive and neurological functioning.

Epilepsy and altered states of consciousness also require careful attention. Nonconvulsive status epilepticus may present with confusion, behavioural disturbance, reduced responsiveness, agitation, cognitive change, or unusual mental-state findings rather than visible convulsions [24]. In settings where electroencephalography and specialist neurology are not easily available, psychiatric teams should maintain a high index of suspicion when presentations are acute, fluctuating, atypical, treatment-resistant, or associated with neurological signs.

Parkinson's disease and other neurodegenerative conditions further illustrate the need for integrated care. Motor symptoms may dominate clinical attention, but non-motor features such as depression, anxiety, sleep disturbance, cognitive impairment, apathy, psychosis, impulse-control problems, pain, and autonomic symptoms may significantly

affect quality of life [25], [26]. Psychiatric teams should therefore consider both neurological and psychological dimensions when planning care, especially where medication interactions and side effects may complicate treatment.

Medical complexity also affects prescribing. Antidepressants may be used in neurological and general medical contexts, including depression associated with neurological illness, chronic pain, neuropathic pain, panic symptoms, and migraine-related presentations [12]. Antipsychotics require metabolic monitoring because weight gain, glucose dysregulation, and cardiovascular risk may undermine both physical health and adherence [17]. In children with attention deficit hyperactivity disorder, context-specific evidence around fluoxetine and neurocognitive improvement should be interpreted cautiously and should not replace careful assessment of standard treatment options, comorbid anxiety, depression, sleep, trauma, and learning difficulties [22].

For low-resource psychiatric teams, the practical neuropsychiatric care package should include brief cognitive screening where feasible, neurological history, medication review, substance-use assessment, physical health checks, identification of red flags, family collateral history, and clear referral pathways. Red flags include acute confusion, fluctuating consciousness, seizures, focal neurological signs, head injury, rapid cognitive decline, new late-onset psychosis, fever, severe headache, abnormal movements, and sudden personality change. Psychotherapy-informed care remains valuable in these cases, but it must be combined with diagnostic caution, medical collaboration, and safe follow-up.

3.10. Safety, quality improvement and ethical psychiatric care

Psychiatric care in low-resource settings must be therapeutic, but it must also be safe. Safety is not limited to preventing suicide or violence. It includes diagnostic safety, medication safety, physical health monitoring, safe prescribing, safeguarding, confidentiality, respectful communication, staff safety, safe discharge, and continuity of care. Psychotherapy-informed teams should therefore combine compassion with structure, because poorly organized care can harm patients even when individual clinicians are well-intentioned.

Quality improvement provides a practical method for strengthening psychiatric systems. Rather than waiting for large reforms, teams can identify local problems, test small changes, review outcomes, and adapt practice. This is particularly useful in services facing staff shortages, overcrowding, weak infrastructure, fragmented documentation, and limited specialist availability. Quality-improvement approaches can support safer handover, improved risk assessment, better follow-up, clearer escalation procedures, metabolic monitoring, and more reliable documentation [8].

Medication safety is a major priority. Antidepressants, antipsychotics, mood stabilizers, sedatives, and medications used in medically complex patients require careful indication, explanation, monitoring, and review. Patients receiving antipsychotics should be monitored for metabolic complications, including weight gain and glucose dysregulation, because these problems can worsen long-term health, reduce adherence, and increase cardiovascular risk [17]. Prescribing should therefore be linked to psychoeducation, side-effect monitoring, shared decision-making, and follow-up rather than being treated as a one-time event.

Risk assessment should be structured but not mechanical. Suicide, self-harm, violence, neglect, exploitation, absconding, substance use, safeguarding concerns, and medical deterioration should be assessed in relation to the patient's diagnosis, history, current mental state, family context, and available supports. The purpose of risk assessment is not simply to record risk but to produce a practical plan. A useful plan should identify warning signs, protective factors, family or caregiver roles, medication arrangements, emergency contacts, review dates, and clear thresholds for urgent reassessment [7].

Staff safety is also part of ethical psychiatric care. Psychiatric teams often manage aggression, intoxication, psychosis, severe distress, family conflict, and high-risk behaviour under difficult conditions. A PDSA quality-improvement study in a mental health facility highlighted the importance of structured safety and security management for protecting both patients and healthcare workers [27]. This is directly relevant to services where environmental risks, communication gaps, overcrowding, and unclear escalation pathways may contribute to preventable incidents.

Ethical care also requires respect for dignity, autonomy, confidentiality, and cultural meaning. Involuntary care, family involvement, restraint, seclusion, medication refusal, disclosure of risk, and safeguarding decisions are ethically complex. Teams should use the least restrictive safe option, explain decisions clearly, document reasoning, involve families appropriately, and avoid coercion where collaborative care is possible. At the same time, respect for culture should not prevent action when there is serious risk, abuse, neglect, delirium, severe psychosis, intoxication, or medical instability.

For low-resource psychiatric teams, the practical safety and quality package should include structured assessment, written care plans, risk and safeguarding protocols, medication monitoring, physical health checks, safe handover, discharge planning, staff escalation pathways, incident review, and small-cycle quality improvement. Safe psychiatric care is therefore not separate from psychotherapy-informed practice. It is the system that allows therapeutic care to remain trustworthy, ethical, and sustainable.

3.11. Cultural adaptation for Thailand, South Asia and LMIC practice

Psychotherapy-informed psychiatric team care must be culturally adapted without abandoning scientific standards. In Thailand, South Asia, Southeast Asia, and other low-resource settings, patients may understand mental distress through biomedical, spiritual, religious, family, moral, social, or economic explanations. These explanatory models influence when people seek help, whom they consult first, whether they accept medication, how families respond to illness, and whether follow-up is maintained. Culturally responsive care therefore begins by asking how the patient and family understand the problem before offering psychiatric explanation or treatment [4].

Cultural adaptation is not the same as simply translating clinical language. It requires attention to family structure, stigma, gender expectations, religion, migration, poverty, education, health literacy, rural–urban inequality, and affordability. A patient may not reject psychiatric care because of "poor insight"; they may fear shame, cost, family judgement, loss of employment, or being labelled as dangerous. Similarly, families may delay treatment not because they are uncaring, but because they are attempting to interpret symptoms through the resources and beliefs available to them.

In many Asian and low-resource contexts, families are central to care. They often provide transport, money, supervision, medication reminders, emotional support, childcare, and crisis response. Family involvement can therefore improve adherence, safety, and recovery. However, family involvement must be clinically thoughtful. It may be harmful when there is violence, coercion, abuse, severe conflict, confidentiality risk, or forced treatment decisions. The task of the psychiatric team is to involve families where helpful, protect the patient where necessary, and document the reasoning clearly.

Psychotherapy-informed care should also respect traditional and religious help-seeking without allowing unsafe delay. Some patients may consult religious leaders, traditional healers, community elders, or informal advisors before reaching psychiatric services. A respectful clinician does not need to ridicule these pathways. Instead, the team can acknowledge the family's efforts, explain the psychiatric formulation, and build a shared plan that preserves dignity while addressing risk, medication needs, psychological support, and follow-up.

For Thailand and tourist-facing clinical settings, cultural adaptation also includes care for migrants, expatriates, travellers, and workers separated from their usual support systems. These patients may present with anxiety, depression, substance use, trauma, relationship crisis, psychosis, medication interruption, or cultural dislocation. Teams should assess language, insurance, legal status, emergency contacts, continuity of medication, family communication, and safe repatriation or referral when needed.

The practical cultural adaptation package should include respectful enquiry into explanatory models, language-sensitive communication, family mapping, stigma assessment, affordability planning, flexible psychoeducation, attention to religion and traditional help-seeking, and culturally realistic follow-up. The aim is not to dilute psychiatric care, but to make evidence-based care acceptable, understandable, and usable in the patient's real world [1], [2], [3], [4].

3.12. Proposed assessment-to-recovery pathway

Based on the reviewed literature, psychotherapy-informed psychiatric team care can be organized as an assessment-to-recovery pathway. This pathway is not intended to replace local protocols or specialist guidelines. Rather, it provides a practical structure that low-resource psychiatric teams can adapt to outpatient clinics, inpatient units, emergency settings, primary care, private clinics, community services, and family-centred care. The pathway emphasizes that recovery does not begin after treatment; it begins at first contact, when the team establishes safety, trust, formulation, and a realistic plan.

The first step is access and engagement. Patients may enter care through primary care, emergency units, families, schools, religious networks, traditional healers, private clinics, or hospital admission. The team should therefore reduce shame, listen respectfully, identify urgent risk, and explain the purpose of assessment. Early therapeutic engagement is essential because mistrust, stigma, cost, poor health literacy, and fear of coercion may prevent follow-up.

The second step is structured assessment and triage. This includes psychiatric history, mental status examination, substance-use assessment, physical health review, brief neurological screening where indicated, medication history, suicide and violence risk assessment, and identification of safeguarding concerns [6], [7]. Patients with delirium, severe withdrawal, catatonia, acute psychosis, active suicidal intent, severe violence risk, seizures, pregnancy-related risk, or medical instability require urgent escalation.

The third step is shared formulation. Diagnosis remains important, but the team should also identify psychological meanings, family context, cultural explanation, social stressors, strengths, barriers to care, and functional goals. This formulation should guide the care plan rather than remain a theoretical exercise [4]. The fourth step is intervention matching. Depending on need and available resources, intervention may include psychoeducation, behavioural activation, motivational interviewing, family meetings, parent-mediated strategies, medication, metabolic monitoring, risk planning, referral, or admission [10], [13], [14], [15], [17].

The fifth step is continuity and recovery monitoring. Before the patient leaves the clinic, ward, or emergency unit, the team should clarify medication arrangements, warning signs, family or caregiver role, review date, crisis contact, and one realistic recovery goal. This is particularly important because readmission and relapse may reflect weak discharge planning, poor adherence, substance use, limited family support, and inadequate follow-up [18]. The final step is quality-improvement feedback. Teams should review missed appointments, incidents, readmissions, medication safety, family feedback, and barriers to care in order to improve the pathway over time [8], [27].

Table 1 summarizes the proposed assessment-to-recovery pathway and demonstrates how psychiatric assessment, psychotherapy-informed intervention, medication safety, family involvement, continuity of care, and quality improvement can be organized into a practical sequence for low-resource clinical teams.

Table 1 Practical assessment-to-recovery pathway for low-resource psychiatric teams

Step	Main clinical task	Practical team action
1. Access and engagement	Reduce fear, stigma, and mistrust	Listen respectfully, explain the purpose of care, identify urgent risk, and involve family when appropriate.
2. Screening and triage	Identify severity and urgency	Screen for depression, psychosis, substance use, self-harm, violence, medical instability, and safeguarding concerns.
3. Structured assessment	Build diagnostic and risk understanding	Complete psychiatric history, mental status examination, substance-use review, medication history, and physical or neurological screening where indicated.
4. Shared formulation	Link diagnosis to context	Identify biological, psychological, family, cultural, social, and functional factors contributing to the presentation.
5. Care planning	Match intervention to need and resources	Agree on medication, psychosocial intervention, family role, referral, admission, or follow-up plan.
6. Psychotherapy-informed intervention	Make routine care therapeutic	Use psychoeducation, motivational interviewing, behavioural activation, supportive counselling, family work, relapse prevention, and parent-mediated strategies.
7. Medication and physical health monitoring	Improve safety and adherence	Explain treatment, monitor side effects, check metabolic risk, review response, and adjust care when required.
8. Continuity and relapse prevention	Prevent avoidable deterioration	Set a review date, identify warning signs, agree on an emergency plan, support adherence, and define recovery goals.
9. Recovery and functioning	Move beyond symptom reduction	Support relationships, work, school, daily routines, autonomy, dignity, and quality of life.
10. Quality-improvement feedback	Strengthen the system	Review incidents, readmissions, missed follow-up, documentation, safety concerns, and patient or family feedback.

This pathway shows that psychotherapy-informed psychiatric team care is not a separate service added after diagnosis. It is a way of organizing the whole clinical journey. In low-resource settings, the pathway helps teams convert scarce specialist expertise into structured, culturally responsive, safe, and recovery-oriented care.

4. Practical implications

This review has several practical implications for psychiatric, psychological, primary care, and community mental health teams working in low-resource settings. First, psychiatric services should treat assessment as the beginning of recovery rather than as a separate diagnostic activity. A structured first contact can identify symptoms, risk, comorbidity, family context, cultural meaning, treatment barriers, and functional goals. This allows teams to move quickly from diagnostic description to shared formulation and care planning.

Second, psychotherapy-informed care should be embedded into routine psychiatric practice. Even where formal psychotherapy services are scarce, teams can use brief psychoeducation, motivational interviewing, behavioural activation, supportive counselling, relapse-prevention planning, family meetings, and parent-mediated strategies. These interventions are feasible when they are brief, supervised, documented, and matched to patient need and risk.

Third, medication care should be delivered as a therapeutic process. Prescribing should include explanation, shared decision-making, side-effect discussion, adherence planning, physical health monitoring, and follow-up. This is particularly important for antidepressants, antipsychotics, medicines used in medically complex patients, and treatment plans involving children, adolescents, pregnant women, or patients with neurological comorbidity.

Fourth, services should strengthen team-based and task-sharing systems. Psychiatrists, psychologists, nurses, primary care clinicians, social workers, occupational therapists, community workers, families, and peer supporters should not work in isolation. They require shared documentation, clear roles, referral thresholds, supervision, and escalation pathways. Such systems can improve continuity, safety, and recovery while making better use of scarce specialist expertise.

Fifth, cultural adaptation should be treated as a clinical skill rather than an optional courtesy. In Thailand, South Asia, Southeast Asia, and other low-resource settings, care is more likely to be accepted when teams understand family roles, stigma, religious and traditional explanations, affordability, language, gender expectations, and local help-seeking pathways. Evidence-based care becomes stronger when it is communicated in a way that patients and families can understand, trust, and use.

Finally, quality improvement should be part of everyday psychiatric practice. Teams should review missed appointments, readmissions, safety incidents, medication monitoring, family feedback, and documentation gaps. Small, repeated improvements can make psychiatric care safer, more reliable, and more recovery-oriented even where resources remain limited.

Limitations of the review

This review has several limitations. First, it was designed as a narrative review and evidence synthesis rather than a systematic review or meta-analysis. Therefore, the literature was not selected through a formal systematic search strategy, and no pooled effect estimates were calculated. The purpose was to integrate clinically relevant evidence into a practical framework rather than to provide a comprehensive quantitative summary of intervention effectiveness.

Second, the reviewed evidence includes studies and reports from different clinical populations, service settings, and geographical contexts. Although this diversity strengthens the relevance of the review for low-resource mental health systems, it also limits direct comparison between findings. Evidence from one setting may not be fully generalizable to another without cultural, workforce, financial, and service-delivery adaptation.

Third, several included studies are context-specific and may involve relatively small samples, short follow-up periods, or service conditions that differ from those in Thailand, South Asia, Southeast Asia, and other low- and middle-income countries. As a result, the recommendations should be interpreted as practical guidance rather than definitive clinical protocols.

Fourth, the proposed assessment-to-recovery pathway has not yet been formally tested as an intervention model. Its value lies in organizing existing evidence and clinical reasoning into a usable structure for multidisciplinary teams.

Future research should evaluate its feasibility, acceptability, safety, clinical outcomes, cost implications, and adaptability across different low-resource settings.

Despite these limitations, the review provides a clinically grounded framework for integrating psychiatric assessment, psychotherapy-informed care, medication safety, family involvement, cultural adaptation, continuity of care, and quality improvement into routine mental health practice.

Future directions

Future research should evaluate psychotherapy-informed psychiatric team care as a structured service model in low-resource settings. Studies should examine whether assessment-to-recovery pathways improve early detection, adherence, symptom outcomes, functioning, patient satisfaction, family engagement, safety, and continuity of care. Feasibility and implementation studies would be particularly useful in primary care, outpatient psychiatry, inpatient units, community services, private clinics, and tourist-facing mental health settings.

Further work is needed to identify which brief psychological interventions are most acceptable, effective, and affordable when delivered by multidisciplinary teams. Psychoeducation, motivational interviewing, behavioural activation, parent-mediated intervention, supportive counselling, relapse-prevention planning, and family meetings should be tested in culturally adapted formats. Research should also clarify the level of supervision, training, documentation, and referral support required to make task-sharing safe.

There is also a need for stronger evidence from Thailand, South Asia, Southeast Asia, and comparable low- and middle-income settings. Locally generated studies should examine cultural explanatory models, stigma, family involvement, traditional and religious help-seeking, affordability, rural–urban differences, migrant and tourist mental health needs, and the integration of psychiatric care with primary health, maternal health, schools, and community services.

Future studies should also include health-economic evaluation. Low-resource systems require interventions that are not only clinically effective but also affordable, scalable, and sustainable. Cost-effectiveness, workforce requirements, medication availability, service accessibility, and patient out-of-pocket costs should therefore be assessed alongside clinical outcomes.

Finally, quality-improvement research should be embedded into routine psychiatric services. Teams should test practical changes in risk assessment, discharge planning, metabolic monitoring, appointment follow-up, family psychoeducation, and incident review. Such work can help transform psychotherapy-informed psychiatric care from a clinical ideal into a measurable and sustainable service model.

5. Conclusion

Psychotherapy-informed psychiatric team care offers a practical and clinically realistic approach for strengthening mental health services in low-resource settings. The central message of this review is that psychiatric care should not stop at diagnosis or medication. Effective recovery requires structured assessment, shared formulation, therapeutic engagement, rational prescribing, family involvement, risk planning, cultural adaptation, continuity of care, and quality improvement.

The proposed assessment-to-recovery pathway provides a usable framework for multidisciplinary teams working in Thailand, South Asia, Southeast Asia, and comparable low- and middle-income settings. It shows how ordinary clinical contacts can become therapeutic when teams use psychoeducation, motivational interviewing, behavioural activation, supportive counselling, family meetings, parent-mediated strategies, medication monitoring, and relapse-prevention planning within a safe and coordinated system.

In settings where specialist resources are limited, the goal should not be to separate biomedical psychiatry from psychotherapy, primary care, public mental health, or community support. Rather, these elements should be integrated into one coherent model of care. Such integration can improve early detection, adherence, safety, dignity, functioning, and recovery while making better use of scarce professional resources.

Psychotherapy-informed psychiatric teamwork is therefore not an additional luxury for well-resourced systems. It is a necessary, adaptable, and ethically grounded method for delivering humane, evidence-informed, and sustainable mental health care where the need is greatest.

Compliance with ethical standards

Disclosure of conflict of interest

The authors declare that they have no financial or non-financial conflicts of interest related to this manuscript.

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