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Short report

The acceptability and feasibility of task-sharing for mental healthcare in low and middle income countries: A systematic review

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ABSTRACT

Task-sharing has frequently been proposed as a strategy to overcome human resource shortages in order to scale up mental health care. Although evidence suggests this approach is effective, to date no review has been conducted to assess its acceptability and feasibility among service users and health care practitioners. This review summarises current findings and provides evidence-based recommendations to improve the success and sustainability of task-sharing approaches. All study designs were included and both qualitative and quantitative data were extracted and reviewed using a comparative thematic analysis. In total, 21 studies were included, nine of which were of strong or adequate quality and twelve of unknown quality. The review highlighted that task-sharing is not an outright solution for overcoming human resource shortages in low and middle income countries. A number of factors need to be considered in order for task-sharing to be acceptable and feasible, for example the incidence of distress experienced by the task-sharing workforce, their self-perceived level of competence, the acceptance of the workforce by other health care professionals and the incentives provided to ensure workforce retention. As the main barrier to addressing these is a lack of resources, an increased investment in mental health care is essential in order to ensure that task-sharing interventions are successful and sustainable.

Introduction

According to the most recent WHO report, neuropsychiatric conditions contribute to approximately 14% of the global burden of disease (World Health Organisation, 2008). Furthermore there remains a substantial treatment gap, (Kohn, Saxena, Levav, & Saraceno, 2004) despite the existence of a wide range of treatments with proven effectiveness in low and middle income countries (LMIC) (Patel et al., 2007).

A major barrier to scaling up services is a shortage of human resources, for which task-sharing has been proposed as a strategy (Kakuma et al., 2011). Task-sharing is the process by which tasks are delegated to less specialised workers in order to use human resources more efficiently and increase capacity and health care coverage within a constrained budget. For mental health, non-specialist health and other workers have been trained to contribute to the detection, diagnosis, treatment, and prevention of various mental disorders (Kakuma et al., 2011). Preliminary results from a Cochrane review of the effectiveness of task-sharing interventions for mental health in LMIC have shown that individuals with no mental health background can deliver psychological treatments effectively with relatively little training and continued supervision (Van Ginneken et al., 2011, 2013).

To date no review has been conducted to assess the acceptability and feasibility of task-sharing mental health care. Feasibility may be challenged by factors such as time-constraints and number of workers available whilst the approach may not be acceptable to service users, carers and health care providers since mental health care is often complex and sensitive. This review summarises current findings and highlights barriers which tasking-sharing will need to overcome if it is to be scaled up as a strategy to reduce the treatment gap for mental disorders.

Methods

A full description of the methods is available in Supplementary File 1. In brief, five electronic databases were searched combining the concepts *non-specialist workforce* AND *mental disorders* AND *LMIC* and relevant organisations and experts were contacted. Titles and abstracts were screened and the full text copies of all potentially

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relevant studies examined to determine whether they met the pre-specified inclusion criteria. Both English language peer-reviewed and grey literature was included using any study design which assessed the feasibility and acceptability of task sharing for mental health care in LMIC. Data were extracted using a standard data extraction form and the methodological quality of each included study was assessed using a standardised checklist. A comparative thematic approach was used for data synthesis of both qualitative and quantitative data (Marston & King, 2006). This involved coding the themes described in the extracted data, grouping the codes into themes, analysing these themes in relation to the review question, and inferring implications and recommendations.

Results

Characteristics of included studies

A total of seventeen articles describing twenty-one studies met the eligibility criteria and were included in the review. Supplementary File 2 presents the flow chart for included studies and Supplementary File 3 provides full details of all included studies including a summary of their findings and quality assessment. Fifteen studies were published in peer-reviewed journals, while six were grey literature. Nearly all studies were conducted in either Africa or South Asia. The task-sharing interventions included identification, screening or referral in eleven studies, a counselling intervention in sixteen studies, a classroom-based intervention in four studies, the prescription of medication in four studies and home visits in seven studies. Multi-dimensional interventions, which included a range of task-sharing interventions, were most common with twelve of the twenty-one included studies focusing on this type of intervention. Over half of the studies used community health workers (CHW) for task-sharing whereas para-professionals and non-specialist nurses were each employed in six studies and paramedics, social workers, medical officers and recovered service users in one study each. The research methods in twelve studies were assessed to be of unknown quality because they provided insufficient detail. The remaining nine studies were either of strong or adequate quality. Study quality was not used as a criterion for inclusion in the review because quality could not be accurately appraised and because the appraisal of qualitative research is contentious. However during data synthesis, codes were refined using only adequate or strong data. Weak data were then inspected for additional themes but none were found. This suggested the final comparative thematic analysis was comprehensive.

Acceptability

Satisfaction with services

Fourteen studies investigated satisfaction with services amongst participants and their families. Two studies revealed an initial wariness towards the services provided by both participants (Pereira, Andrew, Pednekar, Kirkwood, & Patel, 2011) and their families (Balaji et al., 2012) in India. However participants became less hesitant after reassurance whilst families became more accepting after realising that CHWs were from their local community and efforts were made to build rapport. Participant satisfaction with services was overwhelmingly favourable (Climent, de Arango, & Plutchick, 1983; Jordans, Keen, Pradhan, & Tol, 2007; Jordans et al., 2011; Naved, Rimi, Jahan, & Lindmark, 2009; Petersen, Ssebunnya, Bhana, & Baillie, 2011).

In a number of studies, CHWs (BasicNeeds Lao PDR, 2008; BasicNeeds Sri Lanka, 2008; BasicNeeds Uganda, 2008) and paramedics (Naved et al., 2009) were specifically commended by participants for their work. However, in two studies which detailed the implementation of a collaborative stepped care intervention for common mental disorders (CMDs) in India, participants felt that interpersonal therapy was unacceptable due to time and travel constraints, a preference for medications and concerns about confidentiality (Chatterjee et al., 2008; Pereira et al., 2011).

Satisfaction of need

Nine studies provided findings about participants' satisfaction with having their needs met, although these were limited and variable. In four of these studies the task-sharing intervention was considered useful by participants or their families (Chatterjee et al., 2008; Climent et al., 1983; Naved et al., 2009; Rahman, 2007). However a four country evaluation of the integration of psychosocial counselling into rehabilitation services in Burundi, Indonesia, Sri Lanka and Sudan demonstrated that satisfaction of needs and problem reduction varied significantly between countries (Jordans et al., 2011). The study also showed that satisfaction with services can occur without satisfaction of need and vice versa, with some countries reporting high levels of satisfaction of need despite not being satisfied with the service itself.

Acceptability to service users

The personal characteristics of the individual delivering the intervention were considered important both by service users and other service providers in promoting the acceptability of the intervention. People with schizophrenia and their caregivers in India felt that the acceptability of CHWs depended on their personality, educational background, experience or knowledge and in some cases gender (Balaji et al., 2012), while women who had been abused in Bangladesh also valued the personal qualities of the paramedic counsellors (Naved et al., 2009). Managers in Nepal felt that female counsellors would be more acceptable to the local population (Jordans et al., 2007) whilst members of a primary health care team in India believed that participants had found CHWs acceptable because of their polite, friendly nature (Pereira et al., 2011). Stakeholders involved in the same intervention in India suggested the counsellor be called an 'advisor' in local languages to improve acceptability (Chatterjee et al., 2008).

Many of the task-sharing workforces in the included studies were from the community that they worked in, and this added to the perceived acceptability of the workforce (BasicNeeds Uganda, 2008; Chibanda et al., 2011). In South Africa, nurses felt that this position in the community made them best suited to provide interventions for depression and emotional problems (Petersen et al., 2011). Whilst in Zimbabwe, CHWs that were selected to deliver a problem-solving therapy felt that their existing role conducting health promotion visits prevented concerns being raised about the possibility of illness disclosure (Chibanda et al., 2011) as was the case in India amongst people with schizophrenia and their caregivers (Balaji et al., 2012).

Acceptability to health care providers and stakeholders

Only one article directly explored the acceptability of task-sharing to the workforce. Findings indicate that across four countries conducting the same intervention, 33–55% of classroom-based intervention facilitators and 5–47% of counsellors experienced distress when delivering the intervention, though reasons for this distress were not explored (Jordans et al., 2011). Indirect evidence on the acceptability of task-sharing to those carrying out the intervention comes from another study which highlighted the importance of support and supervision as a method of helping CHWs who had reported feeling depressed or stressed when they first started delivering mental health care interventions (Petersen et al., 2011).