Centre for Global Mental Health

The acceptability and feasibility of task-sharing mental health care in low- and middle-income countries: a systematic review

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Background: 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.

Method: 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 relevant studies were 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. This involved coding the themes described in the extracted data, grouping the codes into themes by looking for similarities and differences between and within them, analysing these themes in relation to the review question, and inferring implications and recommendations.

Country (Author, date)	Intervention	Task-sharing workforce	Study design	Quality assessment
Bangladesh (Naved, 2009)	Mental health counselling service for abused women	Paramedics deliver counselling.	Qualitative Quantitative	Strong Adequate
Burundi, Indonesia, Sri Lanka, Sudan (Jordans, 2011)	Multi-layered psychosocial care package for children in areas of armed conflict	Paraprofessionals: deliver classroom-based intervention for elevated distress, deliver problem-solving counselling for severe distress	Quantitative	Unknown
Colombia (Climent, 1983)	Delivery of mental health services in an urban health centre	Paraprofessionals: identify, refer to psychiatrist, carry out psychiatrist's recommendations, conduct home visits	Quantitative	Unknown
Ghana (BasicNeeds Ghana, 2008; BasicNeeds, 2008)	Multi-dimensional intervention to meet community's mental health service needs	Community health workers (CHW): identify mental disorders (MD), complete documentation, conduct home visits Nurses: identify MDs, make temporary diagnosis, prescribe some medications	Qualitative	Adequate
India (Balaji, 2012)	Collaborative community-based intervention for people with schizophrenia	CHW: deliver home-based counselling intervention	Qualitative	Unknown
India (BasicNeeds, 2008)	Integration of mental health services into primary care	Trained medical officers: diagnose MD, prescribe medications, make referrals, follow-up participants Social workers: deliver counselling, make referrals, follow-up participants Nurses: complete documentation	Qualitative	Unknown
India (Chatterjee, 2008)	Collaborative stepped care intervention for CMDs	CHW: screen for MD, case management, deliver psychosocial treatments	Qualitative	Unknown
India (Pereira, 2011)	Collaborative stepped care intervention for CMDs	CHW: screen for MD, case management, delivery of a range of psychosocial treatments	Qualitative	Adequate
Lao PDR (BasicNeeds Lao PDR, 2008; BasicNeeds, 2008)	Multi-dimensional intervention to meet community's mental health service needs	CHW: register participants, conduct home visits, assist with follow-up services, complete documentation Nurses: conduct physical examinations, complete documentation	Qualitative	Adequate
Nepal (Jordans, 2007)	Integration of psychosocial counselling into rehabilitation services	Paraprofessionals: deliver counselling	Qualitative	Strong
Pakistan (Rahman, 2008)	Psychological intervention for perinatal depression	CHW: deliver adapted cognitive behavioural therapy	Qualitative Quantitative	Adequate Unknown
South Africa (Petersen, 1997)	Referral system to facilitate access to and coordination of care	CHW and nurses: Identify MD, make referrals or manage by delivering counselling, complete documentation, conduct home visits	Qualitative	Unknown
South Africa & Uganda (Petersen, 2011)	Integration of mental health services into primary health care	South Africa: CHW: identify, manage and refer MDs, establish self-help groups, provide supportive counselling, provide specific psychological interventions Uganda: General health care workers and CHW: identify, manage and refer MDs	Qualitative	Adequate
Sri Lanka (BN Sri Lanka, 2008; BN, 2008)	Multi-dimensional intervention to meet community's mental health service needs	CHW: identify and refer MDs, register participants, lead self-help groups, conduct home visits, complete documentation	Qualitative	Adequate
Tanzania (BasicNeeds Tanzania, 2008; BasicNeeds, 2008)	Multi-dimensional intervention to meet community's mental health service needs	CHW: identify MDs, register participants, conduct follow-up consultations and home visits, complete documentation Nurses: Occasionally make diagnosis, prescribe medication, conduct follow-up consultations	Qualitative	Adequate
Uganda (BN Uganda, 2008; BN, 2008)	Multi-dimensional intervention to meet community's mental health service needs	CHW: identify and refer MDs, register participants at clinic, conduct home visits, complete documentation Nurses: register participants, in some circumstances prescribe medication Former participants: monitor, follow-up and counsel participants	Qualitative	Adequate
Zimbabwe (Chibanda, 2011)	Delivery of problem-solving therapy for CMDs	CHW: deliver adapted problem solving therapy	Qualitative Quantitative	Unknown Unknown

Implications for designing task-sharing interventions:

Before, during and after the implementation of an intervention, programme developers should:

1. Explore factors that affect the acceptability to participants and their families of using a task-sharing workforce to deliver an intervention.
2. Ensure that task-sharing interventions satisfy participant's need.
3. Explore the acceptability of the task-sharing workforce to managers and other health care professionals and consider methods of improving this.
4. Explore the acceptability of the intervention delivery to the task-sharing workforce, in particular whether they experience any distress, and consider ways in which this can be minimised.
5. Consult with stakeholders and the workforce to assess whether the workload is feasible and obtain their opinions as to how it could be made more so.
6. Consult with stakeholders and the workforce to develop an adequate and sustainable training and supervision system.
7. Consider incentives for the task-sharing workforce such as career progression, where it is not feasible to create sufficient monetary incentives.

Policy-makers should implement a clear policy framework which provides guidance on:

•Reimbursement and working conditions

•Training and supervision

•Management and accountability

Results: In total, 17 articles representing 21 studies were included. The findings relating to acceptability were summarised by four main themes: satisfaction with services; satisfaction of needs; factors affecting satisfaction; and acceptability to health care providers and stakeholders. Five themes emerged from the findings relating to feasibility: logistical challenges; availability of a task-sharing workforce; competency; workload; and training and supervision.

Conclusion: Task-sharing has become a widely adopted strategy to scale-up mental health care in LMIC following a number of large trials demonstrating its effectiveness. However to date little emphasis has been placed on evaluating the acceptability and feasibility of these interventions. This review illustrates the complexity of both acceptability and feasibility and the importance of exploring them in depth. It concludes that task-sharing is not an outright solution for shortages of mental health specialists in LMIC. For task-sharing to be successful and sustainable a number of factors need to be considered: 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 retention of the workforce. As the main barrier to addressing these is a lack of resources, it is clear that in order to ensure the acceptability and feasibility of task-sharing interventions, an increased investment in mental health care remains essential.

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