

A Rapid Review of the Roles of Community Rehabilitation Workers in Community-based Mental Health Services in Low- and Middle-Income Countries

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ABSTRACT

Purpose: *The term Community Rehabilitation Worker (CRW) encompasses a group of mid-level health workers introduced within healthcare systems to increase accessibility to health-care services for individuals within the community sphere. This study aimed to summarise the current knowledge on the role of community rehabilitation workers in community-based mental health services in low- and middle- income countries.*

Method: *Between the 10th and 17th of July, 2020, searches were conducted on the following databases: Cochrane, EbscoHost, Primo, and Pubmed. The search strategy identified 521 individual records, 4 of which were included in this review: 2 qualitative descriptive studies, 1 quantitative descriptive study and 1 conceptual study.*

Results: *Across the 4 studies, eight roles of community rehabilitation workers were identified in relation to mental health services: home visits, client illness management, referral, documentation and administration, client and family education, community education, intersectoral collaboration and mediation. There was no data found on the role of community rehabilitation workers in mental health services in low- and middle- income countries specifically, indicating a gap in research.*

Conclusion: *There is a need to improve knowledge and understanding of the roles and responsibilities of community rehabilitation workers where mental health service provision is concerned. The data summarised in this review could be utilised to educate health professionals regarding the role of community rehabilitation workers.*

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Key words: community rehabilitation workers, mental health services, roles, community-based, low- and middle-income countries

INTRODUCTION

Approximately 85% of the world's population resides in low- and middle-income countries (World Bank, 2020). These populations tend to face challenges with regard to provision of healthcare, especially that of mental health services. South Africa is considered to be a middle-income country (World Bank, 2020). Middle-income countries are those with a gross national income (GNI) between \$1 036 and \$12 535, whilst low-income countries are countries with a GNI of \$1 035 or less (World Bank, 2020). Although low-income countries and middle-income countries have differing GNIs, they both face the challenge of a high burden of disease due to mental illness (Rathod et al., 2017; World Bank, 2020). The burden of mental illness is a result of social factors such as poverty, famine, urbanisation, internal migration and crime (Allen et al., 2014). These are prevalent stressors that perpetuate the cycle of inequities in low- and middle-income countries.

Global economic recession has placed increasing pressure and limitations on government budgets, which are the main source of funding for public healthcare systems in low- and middle-income countries (Basu et al., 2012). Funding available to address mental illness in these countries is minimal due to already tight budgets being prioritised for the provision of somatic health services, both in public and private healthcare systems (Chisholm et al., 2007). The prioritisation of somatic health services has resulted in accessibility constraints in relation to mental health services for the majority of the populations in low- and middle-income countries utilising public healthcare systems (Chisholm et al., 2007). This results in a mismatch between the increasing need for mental health services and the persistent scarcity of resources in the form of finances, workforce and infrastructure allocated to mental health services (Rathod et al., 2017). There is a notably large treatment gap between those that require mental health services and those who receive these services in low- and middle-income countries (Wright and Chiwandira, 2016). This gap exacerbates the ongoing global burden of disability (Shidhaye et al., 2016). Furthermore, the mental healthcare services that are available are generally focused within tertiary psychiatric hospitals rather than at the primary healthcare level (Jack et al., 2014). This realisation has led to a growing international agreement that decreasing the treatment gap in low- and middle-income countries requires a task-shifting or task-sharing approach

and integration of mental health care into primary care (Lund et al., 2015). A task-shifting approach makes use of non-specialists/general health workers, such as Community Rehabilitation Workers (CRWs), who have been given mental healthcare training, to deliver mental health services within communities (Lund et al., 2015).

The concept of community rehabilitation workers dates back to 1957 (Lehmann and Sanders, 2007). Community rehabilitation workers are community-based rehabilitation (CBR) personnel who were first introduced in South Africa (SA) in 1986 to aid with the provision of CBR (CREATE,2015). The healthcare support personnel initially received foundational training. Thereafter, they were specifically trained as community rehabilitation workers to address, among other aspects, the basic health needs of persons with disabilities within both the somatic and mental health domains in rural communities of South Africa (Petrick et al., 2002).

Community rehabilitation workers are community-based public health workers who receive foundational training aimed at addressing the quality of life of communities (Lehmann and Sanders, 2007). The community rehabilitation workers' cadre is fundamental to the provision of primary health care (PHC), as community rehabilitation workers increase the accessibility of healthcare services for individuals within the communities they serve (Lehmann and Sanders, 2007). Pallas et al. (2013) go on to stress that the role of community rehabilitation workers in the provision of primary health care is valuable in the context of low- and middle- income countries.

The advantages of recognising community rehabilitation workers in a task-shifting approach include: improved accessibility to care and health education and a reduction in stigma surrounding mental illness in communities (Lund et al., 2015). Unfortunately, there is limited knowledge on, and understanding of, the role of community rehabilitation workers, particularly in the scope of mental healthcare provision (Stacciarini et al., 2012). Thus, it is possible that with an increase in knowledge of the role of community rehabilitation workers the aforementioned advantages could be realised.

Objective

This rapid review aims to provide a summary of the current available knowledge regarding the role of community rehabilitation workers within community-based

mental health services in low- and middle- income countries. This review could inform students in healthcare, staff that train community rehabilitation workers and health professionals on the role of community rehabilitation workers. Clarifying the role and contribution of community rehabilitation workers within this review, could help to promote further investment of resources and interest in the area of CBR and the community rehabilitation workers who are tasked with delivering this care. A holistic understanding of the role of community rehabilitation workers in mental health services may inspire better collaboration between the various sectors to better serve the population in need. This review will also be appropriate within the South African context; its focus within low- and middle-income countries will help to inform mental healthcare provision in South Africa.

The research question therefore is:

What are the roles of community rehabilitation workers in community-based mental health services in low- and middle- income countries?

METHOD

Study Design

Rapid review was used as a form of knowledge synthesis, where systematic review processes were utilised in a streamlined manner. Reviews utilise systematic analysis and critical appraisal which greatly reduce bias (Hoffmann et al., 2013; Tricco et al. and World Health Organisation, 2017). Rapid reviews are used as a practical approach to provide actionable and relevant current evidence as well as identify research gaps that can be targeted in future (Tricco et al. and World Health Organisation,2017).

Search Strategy

The reviewers conducted the search between July 10th and July 17th, 2020. The search was conducted on the following multidisciplinary medical and public health databases: Cochrane, EbscoHost (CINHAL, AFRICA WIDE, MEDLINE), Primo, and Pubmed. The databases were searched using the following keywords: “Role” AND “Community-based Services” OR “Community-based Rehabilitation” AND “Community Rehabilitation Workers” OR “Community Rehabilitation Facilitators” OR “Community-based Disability Workers” OR

“Community Health Workers” OR “Village Health Workers” AND “Mental Health Services” OR “Mental Health Care” OR “Psychiatric Services”.

Study Selection

The process began by ensuring that any duplicate articles of the initial search results were removed. Search results were then screened according to the selection criteria, with the intention of erring on the side of inclusion where there was doubt of a study’s status. This ensured that no potentially relevant pieces of research were prematurely excluded. The initial stage of screening excluded sources based upon dates, language, country and data type. The next stages of screening involved exclusions based upon title, and then abstract screening. The inclusion criteria were then once again applied to the full texts of the studies, to conclude screening and finalise the selection process (see Table 1).

Table 1: Inclusion and Exclusion Criteria

| Inclusion | Exclusion |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Time frame: Articles published within the last 20 years | |
| Articles only from low- and middle-income countries. *See list of countries (World Bank, 2020) in Appendix A | |
| Publication/data types to be included: peer-reviewed academic articles | Publication type to be excluded: grey literature such as opinion pieces, conference papers, government reports, policy statements, dissertations and pamphlets |
| Articles that have one of the key terms: community rehabilitation workers (or community-based disability workers or community health workers or community rehabilitation facilitators or village health workers) and mental health services (or mental health care or psychiatric services) in the title | Duplicate articles from the same study |
| The review will be limited to full text articles written in English, or readily available in an English translation | |
| Quantitative and qualitative research articles | |

Screening Process

After the screening of the full texts, the articles that remained were then critically discussed and evaluated with an external reviewer acting in a supervisory

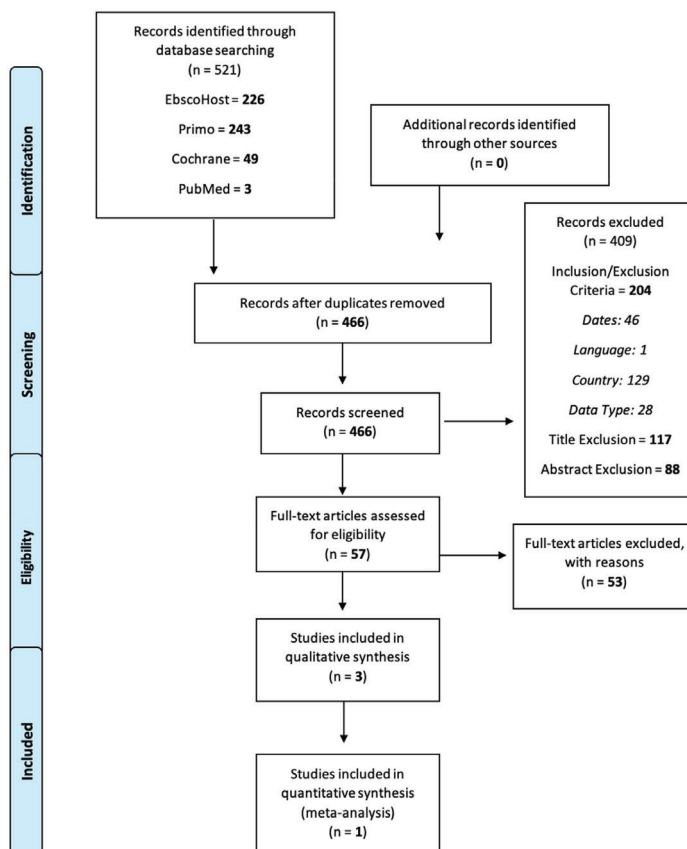
position. Following this consultation, additional articles were excluded based upon their appropriateness to the topic of the review. This resulted in the final selection of four articles.

Types of Studies

Systematic reviews were prioritised for inclusion, as these can provide extensive information pertaining to the research topic. Additionally, both qualitative and quantitative studies have been included in the review. Study designs positioned higher up in the hierarchy of evidence have more rigorous methodology, which can minimise the effect of bias on the results of the study (Hoffmann et al., 2013).

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement (PRISMA) flow chart was used by the reviewers to track article inclusions and exclusions (see Figure 1).

Figure 1: PRISMA 2009 Flow Diagram



Data Extraction

The data extraction process aimed to highlight the critical information from each included study that was most relevant to the topic of the review. In this rapid review, data extraction was undertaken by a group of six reviewers using a data extraction form. The data extraction form was developed by the reviewers to include the following criteria: author, date, country, aim, methodology, population, specific roles of community rehabilitation workers, and level of evidence of each study. The pertinent information was then utilised in analysis and evidence synthesis.

Four reviewers, working in pairs, were tasked with extracting relevant information from the four chosen articles, with each pair extracting data from two articles, respectively. The remaining two reviewers were responsible for overseeing this process and ensuring consistency in the approach to data extraction. These two reviewers were required to critically examine all four articles to ensure no pertinent information was neglected during the data extraction process. The purpose of the two reviewers overseeing the data extraction process was to ensure confirmability and neutrality of extracted data and prevent any oversight of information (Ghafouri and Ofoghi, 2016). Any disagreements that occurred between reviewers during the data extraction process would be resolved through discussion and consensus between the six reviewers. When no consensus was possible, an external reviewer acted in a supervisory position by addressing any disagreement and facilitating resolution of the issue. This seventh person was also the corresponding author for this review.

Assessment of Methodological Quality

The methodological quality of the four included studies was assessed by all six reviewers. The quantitative study and the shortest qualitative study were each assessed by one reviewer respectively (two reviewers). Each of the two more extensive qualitative studies was assessed by a pair of reviewers respectively (four reviewers). Within each pair, the two reviewers worked separately to assess the same longer article and then combined their assessments to formulate one final critical appraisal for each study. The Critical Appraisals Skills Programme (CASP) was used to assess the studies. The use of appraisal tools was a means of standardisation across the four separate studies to ensure correlation of the papers in relation to the research question.

To minimise any systematic errors or deviations from the truth, the reviewers utilised several strategies to mitigate risk bias (Viswanathan et al., 2017). All six reviewers were involved in data extraction, critically appraised sources, and compiled findings together. This was done with the intention to enhance the confirmability of this review and subsequently reduce the risk of bias (Ghafouri and Ofoghi, 2016). Secondly, the reviewers engaged in reflection and documentation of all processes undertaken during the review, to ensure all decisions were taken note of and the review process was appropriately tracked in detail. This also ensured that the reviewers were held accountable to their own biases and how this may have influenced the review findings. Reflexive analysis is a beneficial tool to minimise risk of bias and ensure researchers are aware of their own influence on the data findings (Ghafouri and Ofoghi, 2016).

The CASP was used as a means of appraising the quality of each source. Particular focus was placed upon question 6 in the CASP for qualitative research - "Has the relationship between the researcher and participants been adequately considered?" - in order to note the influence of any bias held by the researchers, as well as potential influences they may have had on the results of the study. Additionally, the reviewers considered the extent to which the authors of each article analysed and documented their methodology and data analysis process, to further analyse potential risk of bias.

The reviewers utilised a hierarchy of evidence to finalise selection of studies according to their position on the hierarchy, with the intent of prioritising studies found higher up on the hierarchy where this was possible. Studies higher up in the hierarchy of evidence generally have a more rigorous methodology, which can minimise the risk of bias (Hoffmann et al, 2013).

Data Analysis - Synthesis of Results

The process of data analysis focused on making sense of the critical information extracted from each article using a data extraction form created by the reviewers. A content analysis of the roles of community rehabilitation workers from each article was performed through the systematic classification of coding and identifying themes within the data (Abdulkareem et al., 2018). A detailed, in-depth analysis of the themes and categories of the roles and functions was used to provide a rich description of the roles of community rehabilitation workers. Once these themes were summarised, the evidence was then organised to formulate a discussion and draw conclusions.

RESULTS

Literature Search

The reviewers conducted the search between July 10th and July 17th, 2020. The search was conducted on the following multidisciplinary medical and public health databases: Cochrane, EbscoHost (CINHAL, AFRICA WIDE, MEDLINE), Primo, and Pubmed. The databases were searched using the following keywords: “Role” AND “Community-based Services” OR “Community-based Rehabilitation” AND “Community Rehabilitation Workers” OR “Community Rehabilitation Facilitators” OR “Community-based Disability Workers” OR “Community Health Workers” OR “Village Health Workers” AND “Mental Health Services” OR “Mental Health Care” OR “Psychiatric Services”.

Study Selection

The initial search yielded a total of 521 articles. Duplicates were removed, leaving the article count at 466. The articles’ titles and abstracts were then screened utilising the inclusion and exclusion criteria, which left a total of 57 articles. The full texts of the remaining 57 articles were then read and assessed for eligibility based upon each study’s relevance to the research question. This resulted in 4 articles being included in the rapid review.

Table 2 below illustrates the characteristics of the studies that were included (Binken et al., 2009; Como and Batdulam, 2012; Chebolu-Subramanian et al., 2019; Ortega and Wenceslau, 2020). All four of the countries in which the studies were based are middle-income countries; thus none of these studies represent low-income countries (World Bank, 2020).

Table 2: Characteristics of Included Studies

| Author (year) | Country & World Bank Classification | Title | Study Design | Roles Identified |
|--------------------------|-------------------------------------|-------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|
| Binken and Miller (2009) | South Africa | The value of the service offered by the community rehabilitation worker | Qualitative descriptive study | 1. Direct client contact 2. Community education 3. Intersectoral collaboration 4. Not otherwise specified |

| | | | | |
|-----------------------------------|----------|-------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Chebolu-Subramanian et al. (2019) | India | A time motion study of community mental health workers in rural India | Quantitative descriptive study | <ol style="list-style-type: none"> 1. Identifying clients with priority mental health disorders 2. Counselling and following-up of identified clients 3. Conducting awareness meetings in the community 4. Screening clients 5. Coordinating with family members of identified clients 6. Referral of clients 7. Documentation and reporting of all activities. |
| Como and Batdulam (2012) | Mongolia | The role of community health workers in the Mongolian CBR programme | Qualitative descriptive study | <p>PHC activity roles:</p> <ol style="list-style-type: none"> 1. Health promotion and prevention 2. Early identification of health conditions 3. Primary and emergency care 4. Referral to higher level facilities <p>Various social roles which include:</p> <ol style="list-style-type: none"> 5. Involvement in social development projects 6. Disability awareness 7. Advocacy for the rights and social inclusion of people with disabilities <p>Role linked to the livelihood domain of the CBR matrix:</p> <ol style="list-style-type: none"> 8. Helping persons with disabilities to access disability grants and pension |
| Ortega and Wenceslau (2020) | Brazil | Challenges for implementing a global mental health agenda in Brazil: The "silencing" of culture | Conceptual study | <ol style="list-style-type: none"> 1. Provide PHC services 2. Mediators |

Risk of Bias

All studies remaining after screening according to the inclusion and exclusion criteria were classified as descriptive studies (level III) (Ackley et al., 2008).

Como and Batdulam's article (2012) indicated a high risk of bias. In addition to the researchers not considering the relationship between themselves and the participants, the authors did not reflect on how their own roles or potential personal biases may have influenced the study design and results. The study's

ethical considerations were also not sufficiently reported on, which attaches further bias to the study.

Articles by Binken and Miller (2009) and Ortega and Wenceslau (2020) indicated a moderate risk of bias. According to the CASP, these articles did not adequately explore the relationship between the researchers and participants.

The article by Chebolu-Subramanian et al. (2019) was of a low risk of bias. The study's data was collected by an observer external to the organisation involved in the study (the Foundation for Research in Community Health) to neutralise any personal bias.

Synthesis of Results

Based on findings within the literature, it was identified that community rehabilitation workers occupy several roles in the provision of mental health services in low- and middle- income countries. They are involved in home visits, client illness management, referral, documentation and administration, client and family education, community education, intersectoral collaboration, and cultural mediation. The findings are summarised below.

Home Visits

All the four included articles refer to home visits as one of the roles of community rehabilitation workers (Binken et al., 2009; Como and Batdulam, 2012; Chebolu-Subramanian et al., 2019; Ortega and Wenceslau, 2020).

Binken et al. (2009) highlighted the importance of home visits as a means of improving accessibility to healthcare services. The authors elaborated that by community rehabilitation workers facilitating care at home, there is a greater likelihood of successful rehabilitation that is contextually appropriate.

Client Illness Management

Community rehabilitation workers are responsible for the implementation of PHC activities at a community level, including early identification of health conditions, health promotion and disease prevention, as well as primary and emergency care (Como and Batdulam, 2012). The community rehabilitation workers' primary care services included counselling services and other forms of psychosocial support (Como and Batdulam, 2012; Chebolu-Subramanian et al., 2019). The provision of psychosocial support aids in the improvement of the client's confidence and

ability to participate more actively within the community, as well as for the prevention of worsening of illness or fatality (Como and Batdulam, 2012). Two articles (Como and Batdulam, 2012; Chebolu-Subramanian et al., 2019) reported that community rehabilitation workers are also responsible for screening of at-risk clients in the community which included prioritising those with mental health disorders.

Referral

Three of the four included studies highlight the important role of referral by the community rehabilitation workers (Binken et al., 2009; Como and Batdulam, 2012; Chebolu-Subramanian et al., 2019).

Como and Batdulam (2012) reported that community rehabilitation workers make referrals of people with disabilities to specialist health services and they coordinate with the appropriate health specialists to organise the needed consultations. Additionally, Como and Batdulam (2012) stated that community rehabilitation workers refer people with disabilities to the appropriate social and welfare services, to facilitate the provision of additional support for people with disabilities.

Documentation and Administration

Three of the four included studies indicated that community rehabilitation workers engage in the role of documentation and administration (Binken et al., 2009; Como and Batdulam, 2012; Chebolu-Subramanian et al., 2019).

Chebolu-Subramanian et al. (2019) stated that community rehabilitation workers spend a significant amount of their time on documentation and administration tasks, which they refer to as “non-value added but necessary activities”. This was echoed by Binken et al. (2009) who reported that documentation and administration activities occupy a large portion of community rehabilitation workers’ work day. Documentation in a prescribed format supports and allows for efficiency in, and coordination of, their community and client-centred activities and interventions (Chebolu-Subramanian et al., 2019). The type of documentation used included client record sheets, work activity record sheets and lists of the resources to which the community rehabilitation workers referred their client (Binken et al., 2009).

Client and Family Education

Three of the four included studies mentioned client and family education as major roles of community rehabilitation workers (Binken et al., 2009; Como and Batdulam, 2012; Ortega and Wenceslau, 2020). Psychoeducation is usually facilitated during regular visits to the clients' homes (Ortega and Wenceslau, 2020). Psychoeducation allows for the enhancement of the clients' knowledge and skills pertaining to management of their mental illness within the context of their home and community, thus improving their capacity for independence (Binken et al., 2009). In terms of provision of education, community rehabilitation workers assist the family in gaining insight into the nature of the mental illness of people with disabilities and how the illness influences behaviour (Binken et al., 2009; Ortega and Wenceslau, 2020). This results in developing better coping skills for the clients and caregivers or family.

Community Education

All four included studies indicated that community rehabilitation workers utilise community spaces to promote the integration and inclusion of people with disabilities through community activities. They conduct community education by means of community-orientated education meetings and initiatives (Binken et al., 2009; Como and Batdulam, 2012; Chebolu-Subramanian et al., 2019; Ortega and Wenceslau, 2020). Education meetings were intended to raise awareness about disability and encourage community members to become involved in community-based rehabilitation initiatives, including health promotion, disease prevention and stigma reduction in relation to mental illness (Como and Batdulam, 2012). The concept of advocacy for the rights related to social inclusion and empowerment of people with disabilities within the forum of community meetings, was stressed (Binken et al., 2009; Ortega and Wenceslau, 2020). These authors suggest that the promotion of the rights of people with disabilities and integration of these individuals into the community is facilitated by addressing the community members' predetermined attitudes toward disability and mental illness (Binken et al., 2009).

Intersectoral Collaboration

Two of the four included studies noted that community rehabilitation workers are involved in intersectoral collaboration where they make links with other sectors, government departments and health structures (Binken et al., 2009; Como and

Batdulam, 2012). Common needs identified in a middle-income country include: financial security, safe housing, income-generating jobs and family support (Binken et al., 2009). Community rehabilitation workers need to collaborate with government departments and special services as they alone cannot address the above-mentioned needs (Binken et al., 2009). The sectors/services involved in this collaboration may include the governmental departments of social development, social welfare, financial services, labour and housing. Community rehabilitation workers are also responsible for collaborating with local government to collect and update demographic and socioeconomic data of the local community that is then provided to the department of health for government reporting, thus facilitating the monitoring of the local population's health indicators (Como and Batdulam, 2012).

Mediation

Two of the four included studies identified cultural mediation as an important role that community rehabilitation workers fulfil ((Binken et al., 2009; Ortega and Wenceslau, 2020). While Binken et al. (2009) noted mediation as a role of community rehabilitation workers, Ortega and Wenceslau (2020) outlined the importance of cultural competency as part of mediation in the work of community rehabilitation workers. Community rehabilitation workers utilise their cultural competency to take on the role of mediators between their community's beliefs and lifestyles and their own professional knowledge of scientific and medical practices within mental health (Ortega and Wenceslau, 2020). Community rehabilitation workers are described as social actors who have an in-depth understanding of local cultural idioms including beliefs, traditions, values and habits of the members of the community (Ortega and Wenceslau, 2020). Community rehabilitation workers mediate between traditional world views and biomedical treatment principles (Ortega and Wenceslau, 2020).

DISCUSSION

Summary of Evidence

In the four articles that were examined, there was some overlap in the various studies' discussions of the roles and functions that community rehabilitation workers engage in. Unfortunately, many articles that were screened for use within this review had to be excluded, due to the fact that many discussed

the 'ideal' role/practice of community rehabilitation workers in mental health services, and not the current reality of their practice. Within the four included studies it was discovered that there are many different forms of training and roles of community rehabilitation workers that are very specific to each country and/or distinct community. These differences appear to be why it is difficult to distinctly define a universal role of community rehabilitation workers in mental health services at a community level.

It became apparent during the data collection process that there is significantly more available information pertaining to the roles community rehabilitation workers play in somatic health than in mental health. A significant number of articles collected and screened during study selection had to be excluded from the review, as they covered community rehabilitation workers' roles solely in the provision of somatic health care. Only the four studies summarised in this review analysed their role within mental health care.

Analysis of the research findings suggested that community rehabilitation workers have significant potential to reduce the treatment gap in mental health services in low- and middle- income countries (Chebolu-Subramanian et al., 2019). With the concept of task-shifting, multidisciplinary teams would be able to collaborate with community rehabilitation workers to improve accessibility to mental health services in low- and middle- income countries (Chebolu-Subramanian et al., 2019).

During data synthesis, it was discovered that although the methodology included both low-income countries and middle-income countries, all of the included studies originated from middle-income countries (Mongolia, India, South Africa and Brazil). This reveals a gap in the research, as low-income countries are vastly under-represented. Therefore, the reviewers were able to summarise the roles of community rehabilitation workers in community-based mental health services in low- and middle-income countries, and not in both middle-income countries and low-income countries as originally planned.

It is suggested that collaboration between the multidisciplinary team and community rehabilitation workers will enable the latter to take on tasks such as basic preliminary screening, psychoeducation and follow-up care within the communities. Collaboration would also ease the burden on the health department, by ensuring that those who have been discharged from specialist mental healthcare facilities receive continuity of care and consistent illness

management at a community level. The aspiration is that if the hospital-based multidisciplinary team collaborates effectively with community rehabilitation workers, their role in continued community-based care will help to minimise pressure on health care and increase intersectoral collaboration.

Limitations

During the screening process only four articles were deemed relevant to the review; this resulted in a limited pool of information from which to make deductions and comparisons.

There were no included studies from low-income countries as all four selected articles were conducted in low- and middle-income countries. This lack of information pertaining to the role of community rehabilitation workers in mental health services in low- and middle-income countries resulted in a gap in the findings. Also, all articles written in languages other than English were not included. Therefore, it is possible that relevant articles were overlooked on the basis of language.

CONCLUSION

A total of eight roles that community rehabilitation workers have in relation to mental health services in low- and middle-income countries were identified. These roles are home visits, client illness management, referral, documentation and administration, client and family education, community education, intersectoral collaboration, and cultural mediation. However, there was no data found on the role of community rehabilitation workers in mental health services in low- and middle-income countries, indicating a significant research gap. Therefore, the reviewers would recommend further research to be conducted on community rehabilitation workers' role in mental health services in low- and middle-income countries. The data summarised in this review could be utilised to educate health professionals regarding the role of community rehabilitation workers. If their roles were better understood, community rehabilitation workers would have the potential to ease the current burden on health departments and improve accessibility to mental health services for those living within rural communities. The information could also be employed by teaching facilities that cover the training of community rehabilitation workers to provide evidence on the role of the community rehabilitation worker in mental health services. This would ensure better awareness and use of the services of community health workers,

and subsequently improve collaboration between the formalised health sectors and them.

Declaration of No Conflicting Interest

The authors report no conflict of interest.

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Appendix A

List of Low- and Middle-Income Countries (World Bank, 2020)

Low-Income Countries

| | | |
|--------------------------|---------------------------|----------------------|
| Afghanistan | Guinea-Bissau | Sierra Leone |
| Burkina Faso | Haiti | Somalia |
| Burundi | Korea, Dem. People's Rep. | South Sudan |
| Central African Republic | Liberia | Sudan |
| Chad | Madagascar | Syrian Arab Republic |
| Congo, Dem. Rep | Malawi | Tajikistan |
| Eritrea | Mali | Togo |
| Ethiopia | Mozambique | Uganda |
| Gambia, The | Niger | Yemen, Rep. |
| Guinea | Rwanda | |

Middle-Income Countries

| | | |
|------------------|-----------------------|-----------------------|
| Angola | Honduras | Papua New Guinea |
| Algeria | India | Philippines |
| Bangladesh | Kenya | São Tomé and Príncipe |
| Benin | Kiribati | Senegal |
| Bhutan | Kyrgyz Republic | Solomon Islands |
| Bolivia | Lao PDR | Sri Lanka |
| Cabo Verde | Lesotho | Tanzania |
| Cambodia | Mauritania | Timor-Leste |
| Cameroon | Micronesia, Fed. Sts. | Tunisia |
| Comoros | Moldova | Ukraine |
| Congo, Rep. | Mongolia | Uzbekistan |
| Côte d'Ivoire | Morocco | Vanuatu |
| Djibouti | Myanmar | Vietnam |
| Egypt, Arab Rep. | Nepal | West Bank and Gaza |
| El Salvador | Nicaragua | Zambia |
| Eswatini | Nigeria | Zimbabwe |
| Ghana | Pakistan | |
| Albania | Fiji | Montenegro |
| American Samoa | Gabon | Namibia |
| Argentina | Georgia | North Macedonia |
| Armenia | Grenada | Paraguay |
| Azerbaijan | Guatemala | Peru |
| Belarus | Guyana | Russian Federation |

| | | |
|------------------------|--------------------|--------------------------------|
| Belize | Indonesia | Samoa |
| Bosnia and Herzegovina | Iran, Islamic Rep. | Serbia |
| Botswana | Iraq | South Africa |
| Brazil | Jamaica | St. Lucia |
| Bulgaria | Jordan | St. Vincent and the Grenadines |
| China | Kazakhstan | Suriname |
| Colombia | Kosovo | Thailand |
| Costa Rica | Lebanon | Tonga |
| Cuba | Libya | Turkey |
| Dominica | Malaysia | Turkmenistan |
| Dominican Republic | Maldives | Tuvalu |
| Equatorial Guinea | Marshall Islands | Venezuela, RB |
| Ecuador | Mexico | |