Cochrane Cameroon

World Mental Health Day

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This document has been prepared by Cochrane Cameroon to provide **healthcare professionals** with evidence-based data on the management of mental health. Enjoy your read!

EDITORIAL

Mental health is a major public health issue worldwide, affecting millions of people and having a significant impact on societies and economies. Here are some key figures from the World Health Organisation (WHO):

1. **Depression**: Approximatively **280 million** people around the world suffer from depression, making it one of the most common mental disorders. Depression is the leading cause of disability worldwide and contributes significantly to the global burden of disease (WHO, 2022).
2. **Suicide**: Around 700,000 people die by suicide each year, which represents one person every 40 seconds. Suicide is the fourth leading cause of death among young people aged 15-29 (WHO, 2021).
3. **Anxiety disorders:** Anxiety disorders affect around **301 million** people worldwide, including **58 million** children and adolescents (WHO, 2022).
4. **Schizophrenia:** Schizophrenia affects around **24 million people** worldwide, or approximately **1 in 300 people** (WHO, 2022).
5. **Economic impact:** Mental disorders cost the global economy an estimated **$1 trillion each** year in lost productivity. This is largely due to the impact of disorders such as depression and anxiety on people's ability to work and function in their daily lives (WHO, 2020).
6. **Access to care:** More than **75%** of people suffering from mental disorders in low- and middle-income countries do not receive any treatment or support. Lack of adequate mental health services, stigma and discrimination are major barriers (WHO, 2021).
7. **Impact of COVID-19:** The pandemic has exacerbated mental health problems, with a **25%** increase in cases of anxiety and depression worldwide, according to a 2022 WHO study. These statistics reveal the scale of the global mental health crisis and highlight the need for urgent action to improve mental health services, strengthen prevention and combat stigma.

Why was this summary produced?

This summary was produced to provide up-to-date evidence on the management of mental health.

What is a systematic review?

A summary of studies that answers a clearly formulated question and uses systematic and explicit methods to identify, select and critically appraise relevant studies. Data from different studies are extracted and can be analysed together using meta-analysis techniques.

THE SITUATION OF MENTAL HEALTH IN CAMEROON

Cameroon faces many mental health challenges, such as limited access to psychological care services, insufficient awareness and persistent stigma. Mental health accounts for around 2% of public health expenditure, which is relatively low given the prevalence of mental disorders such as depression and schizophrenia in the country (Nguimfack, 2021). According to Fokoua (2019), there are still few specialist staff, with only 0.06 psychiatrists per 100,000 inhabitants, which is well below WHO recommendations.

According to Atangana (2020), infrastructure is also limited, with most services concentrated in large cities such as Yaoundé and Douala, leaving rural populations with little or no support.

In addition, perceptions of mental disorders are often influenced by cultural and religious beliefs, resulting in treatments that rely on traditional practices rather than contemporary medical approaches. (Mbono,2022).

To address this situation, action is being taken to improve mental health care. For example, in 2016 the National Mental Health Programme was set up to train more professionals and raise public awareness of these issues. (Ngando, 2021).

SUMMARIES OF SYSTEMATIC REVIEWS

1. Mental Health First Aid as a tool for improving mental health and well-being

Why was this review important?

Mental health first aid is defined as 'the help provided to a person who is developing a mental health problem, experiencing a worsening of a mental health problem, or is in a mental health crisis' The first aid is given until appropriate professional help is received or the crisis resolves.' Mental Health First Aid (MHFA) is a training programme that aims to teach mental health first-aid strategies to members of the public. MHFA training works in a cascade model; accredited instructors deliver training to equip trainees with mental health first aid skills. Once trained, a trainee offers mental health first aid to people within their workplace, organisation, or community. MHFA training is designed to increase knowledge about mental health problems, and thereby reduce stigma often attached to these. Trainees learn how to provide immediate help to recipients and how to signpost to services.

Who will be interested in this review?

Individuals considering MHFA training
Employees and employers
Policy and decision-makers

What questions did this review try to answer? What is the impact of Mental Health First Aid (MHFA) training on mental health and well-being, mental health service usage, and adverse effects in individuals within the community in which MHFA training is delivered?

Which studies were included in the review? We searched for randomised controlled trials (clinical studies where people are randomly put into one of two or more treatment groups) that examined MHFA training published up to June 2023.
We included 21 studies with 22,604 participants.

What did the evidence from the review tell us? The main outcome of interest was the effect of MHFA training on the mental health and well-being of individuals at a time point between six months and a year. We included three comparisons: MHFA versus no intervention; MHFA versus an alternative intervention designed to improve mental health literacy; and MHFA versus an active control, for example training in physical first aid. We only found very low-certainty evidence regarding this outcome, and it is not possible to draw any firm conclusions. The evidence we found only related to our comparison of MHFA with no intervention. We did not find any evidence relating to mental health service usage or adverse effects at the same time point.

What are the limitations of the evidence? We are not confident in the evidence, firstly because there were problems in the way in which the research had been carried out which might bias their results. Secondly, there were variations in the results from different studies that we could not explain. Thirdly, because many studies did not include large number of participants, we were not able to obtain precise results that would tell

us whether MHFA training was better than the interventions to which it was compared. The lack of evidence around adverse effects is a limitation, as we cannot assume that any type of intervention does not have the potential to cause harm.

What should happen next ? Further research is needed to better understand the possible effects of MHFA.

Citation: Richardson R, Dale HE, Robertson L, Meader N, Wellby G, McMillan D, Churchill R. Mental Health First Aid as a tool for improving mental health and well-being. Cochrane Database of Systematic Reviews 2023, Issue 8. Art. No.: CD013127. DOI: 10.1002/14651858.CD013127.pub2.

2. Do psychological and social interventions promote improved mental health in people living in low and middle-income countries affected by humanitarian crises?

Key message

– We did not find enough evidence in favour of interventions for promoting positive aspects of mental health in humanitarian settings. Larger, well-conducted randomised studies are needed.

Mental health during a humanitarian crisis

A humanitarian crisis is an event, or series of events, that threatens the health, safety, security, and well-being of a community or large group of people, usually over a wide area. Examples include wars and armed conflicts; famine; and disasters triggered by hazards such as earthquakes, hurricanes, and floods. People living through a humanitarian crisis may experience physical and mental distress and experience highly challenging circumstances that make them vulnerable to developing mental disorders, such as post-traumatic stress disorder, depression, and anxiety. The estimated occurrence of mental disorders during humanitarian crises is 17% for depression and anxiety, and 15% for post-traumatic stress disorder.

What are psychological and social interventions?

Psychological and social interventions (also called psychosocial) recognise the importance of the social environment for shaping mental well-being. They usually have both psychological components (related to the mental and emotional state of the person; e.g. relaxation) and social components (e.g. efforts to improve social support). They can be aimed at promoting positive aspects of mental health (e.g. strengthening hope and social support, parenting skills), or prevent and reduce psychological distress and mental disorders.

What did we want to find out? We wanted to know if psychosocial interventions could promote positive mental health outcomes in people living through humanitarian crises in low- and middle-income countries, compared with inactive comparators such as no intervention, intervention as usual (participants are allowed to seek treatments that are available in the community), or waiting list (participants receive the psychosocial intervention after a waiting phase).

What did we do? We searched for studies that looked at the effects of psychosocial interventions on positive aspects of people's mental health in low- and middle-income

countries affected by humanitarian crises. In these studies, we selected those outcome measures representative of positive emotions, positive social engagement, good relationships, meaning, and accomplishment. This is in line with the definition of mental health given by the World Health Organization, according to which mental health is "a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community." We looked for randomised controlled studies in which the interventions people received were decided at random. This type of study usually gives the most reliable evidence about the effects of an intervention.

What did we find? We found 13 studies on mental health promotion with a total of 7917 participants. Nine studies were with children and adolescents (aged seven to 18 years), and four were with adults (aged over 18 years). Four studies were carried out in Lebanon; two in India; and one study each in the Democratic Republic of the Congo, Jordan, Haiti, Bosnia and Herzegovina, the occupied Palestinian Territories (oPT), Nepal, and Tanzania. The average study duration was 18 weeks (minimum 10 weeks, maximum 32 weeks). Trials were generally funded by grants from academic institutions or non-governmental organisations. The studies measured mental well-being, functioning, and prosocial behaviour (a behaviour that benefits other people or society as a whole), at the beginning of the study, at the end of the intervention, and three or four months later. They compared the results in people who did and did not receive the intervention.

What are the results of our review? There is not enough evidence to make firm conclusions. In children and adolescents, psychosocial interventions may have little to no effect in improving mental well-being, functioning, and prosocial behaviour, but the evidence is very uncertain. For the adult population, we found encouraging evidence that psychosocial interventions may improve mental well-being slightly, but there were no data on any other positive dimensions of mental health. Overall, for both children and adults, we are not confident that these results are reliable: the results are likely to change when further evidence is available.

What are the limitations of the evidence? The main limitation of this review is that we cannot guarantee that the evidence we have generated is trustworthy. This is a direct consequence of the small amount of data that addressed our research question. By conducting analyses from such a small pool of data, we cannot be sure that the changes in outcomes are related to the interventions provided, rather than due to the play of chance. Furthermore, people in the studies were aware of which treatment they were getting, and not all the studies provided data about everything that we were interested in.

How up to date is this evidence? We included evidence published up to January 2023.

Citation: Papola D, Prina E, Ceccarelli C, Cadorin C, Gastaldon C, Ferreira MC, Tol WA, van Ommeren M, Barbui C, Purgato M. Psychological and social interventions for the promotion of mental health in people living in low- and middle-income countries affected by humanitarian crises. Cochrane Database of Systematic Reviews 2024, Issue 5. Art. No.: CD014300. DOI: 10.1002/14651858.CD014300.pub2.

3. Mental health support in the community for refugee children and adolescents in high-income countries

Refugee children and adolescents who have settled in high-income countries are at risk of mental health problems due to the many challenges they face before, during, and after migration.

Key message

The evidence to date is not of sufficient quantity or quality to recommend what interventions should be implemented in practice. It is necessary for existing mental health support programmes and interventions for child refugees and asylum seekers to be evaluated so that they can add to the evidence on what works to support mental health in this population.

What did we want to find out? We aimed to assess the evidence for mental health promotion, prevention, and treatment taking place in the community for refugee children and adolescents living in high-income countries. Some programmes or interventions may focus on mental health promotion (to improve mental health) through community-building and social support, while others may focus on the treatment of mental health problems with individualised specialist care.

What did we do? We searched for studies in online databases and registries on 23 February 2021. Studies of any design were eligible as long as they included child or adolescent refugees aged 18 years or younger and evaluated a community-based mental health intervention in a high-income country.

What did we find?

We included 38 studies with a wide range of study designs, participant characteristics, and interventions. Three studies used a randomised controlled trial design where the treatments people received were decided at random; these usually give the most reliable evidence about treatment effects. We used these studies to assess the effectiveness of interventions and the acceptability as indicated by the occurrence of adverse events.

What were the limitations of the evidence? There were important limitations relating to the quality of the included trials. There was no evidence on the acceptability of interventions. Data on effectiveness, relating to symptoms of mental health problems, psychological distress, and behaviour, showed no evidence of a difference in effectiveness between the intervention group and the waiting list control group (where the intervention was not delivered until after participants in the intervention group had completed the treatment) for any of the three studies.

Citation: Soltan F, Cristofalo D, Marshall D, Purgato M, Taddese H, Vanderbloemen L, Barbui C, Uphoff E. Community-based interventions for improving mental health in refugee children and adolescents in high-income countries. Cochrane Database of Systematic Reviews 2022, Issue 5. Art. No.: CD013657. DOI: 10.1002/14651858.CD013657.pub2.

4. Shared decision-making interventions for people with mental health conditions

Shared decision-making interventions or care as usual: which works better for people with mental health conditions?

What are mental health conditions? There are many mental health conditions. They are generally characterised by a combination of abnormal thoughts, perceptions, emotions, behaviour, and relationships with others. Access to health care and social services capable of providing treatment and social support is key.

What did we want to find out?

Shared decision-making is an approach to consumer-professional communication where both parties (e.g. patients or their carers, or both, together with their clinician) are acknowledged to bring equally important experience and expertise to the process. In this approach, both parties work in partnership to make treatment recommendations and decisions.

This approach is considered part of a broader recovery and person-centred movement within the behavioural health field. The focus on recovery and individual responsibility for understanding and managing symptoms in collaboration with professionals, caregivers, peers, and family members is also fundamental to this approach.

Sometimes it also involves a 'decision aid', such as videos, booklets, or online tools, presenting information about treatments, benefits and risks of different options, and identifying ways to make the decision that reflects what is most important to the person.

The process of shared decision-making may often also involve decision coaching by someone who is non-directive and provides decision support that aims to prepare people for discussion and the decision in the encounter with their practitioner.

We wanted to find out if shared decision-making interventions were better than care as usual for people with mental health conditions to improve:

• clinical outcomes, such as psychotic symptoms, depression, anxiety, and readmission;

• participation or level of involvement in the decision-making process.

We also wanted to find out if shared decision-making interventions were associated with any unwanted (harmful) effects.

What did we do? We searched for studies that examined shared decision-making interventions compared with care as usual in people with mental health conditions. We compared and summarised the results of the studies and rated our confidence in the evidence, based on factors such as study methods and sizes.

What did we find? We found 15 studies involving 3141 adults, from seven countries: Germany, Italy, Japan, Saudi Arabia, the Netherlands, the UK, and the USA.

Care settings included primary care, community mental health services, outpatient psychiatric services, specialised outpatient services such as post-traumatic stress disorder clinics, forensic psychiatric services, and nursing home wards.

The mental health conditions studied were schizophrenia, depression, bipolar disorder, post-traumatic stress disorder, dementia, substance-related disorders and multiple

clinical conditions, including personality disorder. Care providers included family carers, clinicians, case managers, nurses, pharmacists, and peer supporters. Three studies used an interprofessional collaboration.

When people with mental health conditions receive shared decision-making interventions, we do not know if their clinical conditions change. They may feel that they participated more in decision-making processes compared with those receiving usual care, although we are uncertain about this when participation was measured in other ways or at later time points after the consultation.

People who take this approach probably improve some, but not all, aspects of their satisfaction with received information compared with those receiving usual care.

Although it is often suggested that shared decision-making takes a lot of time, we found that there is probably little or no difference compared with usual care in the length of consultation.

We are uncertain about whether shared decision making-interventions change outcomes such as recovery, carer satisfaction, healthcare professional satisfaction, knowledge, treatment/medication continuation, carer participation, relationship with healthcare professionals, length of hospital stay, or possible harmful effects.

Further research is needed in this area. Longer term follow-up is also needed to better determine the impact of shared decision-making on: perceptions of quality of life; impact on frequency and severity of crises, hospitalisations, or both; stability of key functions of life, work, housing and overall health; and satisfaction with decision-making.

The review is up to date as of January 2020.

Citation: Aoki Y, Yaju Y, Utsumi T, Sanyaolu L, Storm M, Takaesu Y, Watanabe K, Watanabe N, Duncan E, Edwards AGK. Shared decision-making interventions for people with mental health conditions. Cochrane Database of Systematic Reviews 2022, Issue 11. Art. No.: CD007297. DOI: 10.1002/14651858.CD007297.pub3.

5. Does stopping smoking improve mental health?

Smoking and mental health

Some health providers and people who smoke believe that smoking helps reduce stress and other mental health symptoms, like depression and anxiety. They worry that stopping smoking may make mental health symptoms worse. However, studies have shown that smoking may have a negative impact on people's mental health, and stopping smoking could reduce anxiety and depression.

Why we did this Cochrane Review

We wanted to find out how stopping smoking affects people's mental health. If stopping smoking improves mental health symptoms, rather than worsening them, then this may encourage more people to try to quit smoking and more health professionals to help their patients to quit. It may also discourage people from beginning to smoke tobacco in the first place.

What did we do? We searched for studies that lasted for at least six weeks that included people who were smoking at the start of the studies. To be included, studies

also had to measure whether people did or did not stop smoking and any changes in mental health during the study.
We were interested in how stopping smoking affected:
- symptoms of anxiety;
- symptoms of depression;
- symptoms of anxiety and depression together;
- symptoms of stress;
- overall well-being;
- mental health problems;
- social well-being, personal relationships, isolation and loneliness.
Search date: we included evidence published up to 7 January 2020.
What we found
We found 102 studies in more than 169,500 people: some studies did not clearly report how many people took part. The studies used a range of different assessment scales to measure people's mental health symptoms.
Most studies included people from the general population (53 studies); 23 studies included people with mental health conditions; other studies included people with physical or mental health conditions, or long-lasting physical conditions, who had recently had surgery, or who were pregnant.
We combined and compared the results from 63 studies that measured changes in mental health symptoms, and from 10 studies that measured how many people developed a mental health disorder during the study.
What are the results of our review? Compared with people who continued to smoke, people who stopped smoking showed greater reductions in:
- anxiety (evidence from 3141 people in 15 studies);
- depression (7156 people in 34 studies); and
- mixed anxiety and depression (2829 people in 8 studies).
Our confidence in our results was very low (for depression), low (for anxiety), and moderate (for mixed anxiety and depression). Our confidence was reduced because we found limitations in the ways the studies were designed and carried out.
Compared with people who continued to smoke, people who stopped smoking showed greater improvements in:
- symptoms of stress (evidence from 4 studies in 1792 people);
- positive feelings (13 studies in 4880 people); and
- mental well-being (19 studies in 18,034 people).
There was also evidence that people who stopped smoking did not have a reduction in their social well-being, and their social well-being may have increased slightly (9 studies in 14,673 people).
In people who stopped smoking, new cases of mixed anxiety and depression were fewer than in those who continued to smoke (evidence from 3 studies in 8685 people). New cases of anxiety were also fewer (2 studies in 2293 people). We were unable to come to

a decision about the numbers of new cases of depression, as the results from different studies were too variable.

Key messages : People who stop smoking are not likely to experience a worsening in their mood long-term, whether they have a mental health condition or not. They may also experience improvements in their mental health, such as reductions in anxiety and depression symptoms.

Citation: Taylor GMJ, Lindson N, Farley A, Leinberger-Jabari A, Sawyer K, te Water Naudé R, Theodoulou A, King N, Burke C, Aveyard P. Smoking cessation for improving mental health. Cochrane Database of Systematic Reviews 2021, Issue 3. Art. No.: CD013522. DOI: 10.1002/14651858.CD013522.pub2.

6. An overview of systematic reviews on mental health interventions for involuntary migrants

Refugees, asylum seekers, and internally displaced persons are involuntary migrants, who have often experienced distress when forced to leave their home, on the journey, and in the process of settling in a host country or new environment. Mental health promotion, prevention, and treatments for mental health problems such as depression, anxiety, and post-traumatic stress disorder may work differently in these groups of people than for the general population. This overview of systematic reviews summarises the characteristics of reviews available on this topic, to help us determine which research questions are the most important to address in future Cochrane reviews.

We searched for systematic reviews and protocols of systematic reviews on mental health promotion, prevention, and treatment of mental health problems for refugees, asylum seekers, and internally displaced persons. Mental health promotion may, for example, involve a classroom-based well-being intervention for children. An example of prevention is trauma-focused therapy to prevent post-traumatic stress disorder. Treatment may, for example, include psychological therapy for depression. We found 23 systematic reviews and 15 protocols of reviews in progress. Together the 23 published systematic reviews included 336 references, 175 of which were unique studies. Reviews more commonly included refugees and asylum seekers than internally displaced persons, and were more frequently focused on adults than children. There was more attention on the treatment of post-traumatic stress disorder than there was for mental health promotion or prevention, or for the treatment of depression or anxiety. Studies of Cognitive Behavioural Therapy, Narrative Exposure Therapy, and integrative and interpersonal therapies were most likely to be included in reviews.

The quality of reviews was limited by a range of issues, many of which related to poor reporting of the review methodology.

The evidence available from systematic reviews may not match the need for evidence-based interventions for the mental health of involuntary migrants. Review authors should consider relevant groups such as internally displaced persons, children, and people with depression or anxiety, and relevant interventions such as those for mental health promotion or prevention, and treatments other than psychological therapy.

Citation: Uphoff E, Robertson L, Cabieses B, Villalón FJ, Purgato M, Churchill R, Barbui C. An overview of systematic reviews on mental health promotion, prevention, and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons. Cochrane Database of Systematic Reviews 2020, Issue 9. Art. No.: CD013458. DOI: 10.1002/14651858.CD013458.pub2.

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