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VIEWPOINT

Reducing Common Mental Disorder Prevalence in Populations

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The burden of common mental disorders (CMDs), including major depressive and anxiety disorders, is substantial. CMDs contribute to lowered work productivity, family dysfunction, substance misuse, suicide, and reduced life expectancy. The point prevalence of CMDs has been stable since the 1980s,[1] although expenditures on mental health care and drug therapy have increased dramatically.[2] Given failure of increased treatment to lower CMD prevalence, some have called for reconceptualizing the diagnosis of CMDs and investing in new research to improve treatment.

New approaches to CMD diagnosis and treatment are clearly needed, but a paradigm shift in CMD prevention and its evaluation is also needed to lower CMD prevalence on a population basis. We need to consider organizational reforms in treatment delivery for the subset of patients at highest risk of relapse and chronicity as they contribute most to the point prevalence.[3] For high-risk patients, clinicians need to assume greater responsibility for teaching relapse prevention skills while ensuring long-term continuity of care to minimize relapse risk. These changes would reorient mental health care from diagnosis and short-term treatment to long-term management of higher-risk patients.

Lack of progress in reducing prevalence has led some to propose mental health promotion and mental disorder prevention programs. However, trials of universal, selective, and indicated prevention programs report weak to modest effectiveness.[4] Prevention typically involves psychological therapies targeting motivated people with subthreshold symptoms, rarely addressing the strongest determinants of risk. Preventive interventions are usually short term (with outcomes assessed for no more than 1-2 years) and effects tend to decrease over time, with the methodologically strongest trials reporting the smallest effects and poor uptake in disadvantaged high-risk groups.[4,5] However, there are preventive interventions with promising long-term effect.[5,6] These include programs to support and promote effective parenting and family bonding, addressing depression among pregnant or postpartum women (eg, Mothers and Babies; Reach Out, Stand Strong),[6] prevention of substance misuse, enhancement of resilience and social-emotional competencies in children, and relapse prevention for high-risk persons with history of CMD recurrence. To date, these promising preventive programs have not been widely and consistently implemented.[6]

Achieving meaningful CMD prevention results on a population basis is likely to require multifaceted, longer-term, structurally integrated, consistently funded programs that foster psychosocial competencies. Acquisition of social and emotional skills (eg, social-emotional learning) requires long-term training, practice, and exposure. Successful initiatives often target multiple levels of society, including individuals, classes and curricula in schools, and entire communities.[5,7]

Important determinants of CMDs include high negative affectivity and related avoidant coping; poor attention and behavioral control; major adverse childhood experiences (physical maltreatment, sexual abuse, neglect, and trauma); long-term difficulties characterized by long-term threat, loss, entrapment, and humiliation; and distal factors driving proximal risks including poverty, unfair inequality, discrimination, and social isolation. With sustained institutionalization, population-level prevention targeting improved parenting and social-emotional skills may benefit multiple outcomes other than CMD burden because poor parenting and skill deficits predict not only CMDs, but general adult mental and physical health, income and professional attainment, general well-being, and successful marital and family relationships.[8]

Reevaluation of CMD prevention depends on rigorous, long-term controlled research. However, if sustained robust preventive interventions require structural integration into schools and other community institutions, then randomized clinical trials of short-term standalone interventions will not suffice. Rigorous evaluation of promising CMD preventive interventions for population-level effect requires substantial and sustained integration in educational, familial, social welfare, and workplace settings. Without larger investment and substantial integration into social institutions, it will not be possible to determine how effective CMD preventive interventions could be in lowering CMD burdens on a population basis. Thus, research methods to evaluate large-scale, long-term community programs are necessary, rather than only short-term randomized trials.[5]

Based on available research, the effectiveness of community-level CMD preventive interventions are likely to depend on 3 factors:

1. Embedment in major social institutions (family, childcare, school, workplace) including sustained implementation and adequate funding. Embedment provides prolonged exposure to change determinants that are difficult to modify. Two forms of embedment are critically important. The first is political embedment, whereby local and national governments structurally implement prevention programs, activities, and strategies in institutions such as schools, communities, health care facilities, and workplaces, rather than through mental health professionals alone. The second is cultural embedment integrating prevention activities into the social norms of

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day-to-day life. An example of cultural embedment is the implementation of smoking prevention interventions in diverse public settings that dramatically reduced the prevalence of tobacco use.[9]

2. Start early in life and consistently target major determinants of CMD risk, especially those that predict recurrence and chronicity. Risk factors for chronicity and recurrence are the major drivers of CMD prevalence. Because recurrent and chronic CMDs typically have precursors in childhood and adolescence, starting early in life is crucial to alter negative cascading developmental pathways. This may best be achieved by simultaneously targeting poor parenting and children's maladaptive personality traits and life skills. Possible approaches include parent-child clinics fostering improved parenting and school-based educational programs targeting high-risk behaviors and enhancing resilience. Through community integration, preventive services may avoid stigma and ideally become an accepted, normal part of life.
3. Combine universal and indicated prevention, including population-level measures. Indicated preventive intervention should augment universal approaches that may be insufficient for some groups, families, and children.

Implementing these 3 criteria will require long-term investments in educational settings, family support systems, and community services. However, evidence has not yet established that such long-term investments will be cost-effective. Insufficient scientific evidence creates an impasse: large investments may not occur without compelling proof of effectiveness, but evaluation of effectiveness cannot begin without long-term investments. Societal changes in regulation of tobacco use did not await evidence from prevention trials. Rather, epidemiologic research on the effects of tobacco use and secondhand smoke guided public policy changes along with surveillance of changes in tobacco use after implementation of tobacco-use restrictions, turning out to be far more cost-effective than individual behavioral interventions.[9]

Overcoming this impasse for CMD prevention requires a paradigm shift. Given that CMD prevention initiatives may need to be fully embedded in societal institutions over long periods of time, randomized clinical trials are not likely to be the best research design for evaluating effectiveness and may need to be augmented by research designs appropriate for long-term evaluation of community-based programs. Innovative pragmatic research designs are needed that draw on population databases including electronic health care data, educational data, and governmental data on dependency, income, and criminal justice status, among others. Such data could be used to compare outcomes in regions investing in CMD prevention to control areas, for example.

In sum, there is a strong case for investing in embedment of CMD prevention in institutions that provide sustained community-based, integrated services to help families and young people develop resilience to prevent CMDs and produce broader individual and societal benefits. In addition to a focus on diagnosis and treatment, mental health services should pay increased attention to prevention of relapse and recurrence. Together, these CMD prevention initiatives may achieve large reductions in CMD prevalence and burdens, where large expansion of mental health treatment has not. Investments in community-based preventive services and large-scale reforms of mental health services should be evaluated through population-based research that guides these initiatives and assesses which investments are yielding commensurate benefits.

ARTICLE INFORMATION

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