Prevention and mental health:

Understanding the evidence so that we can address the greatest health challenge of our times

A resource for policymakers, health professionals, mental health advocates and their families and friends

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Introduction

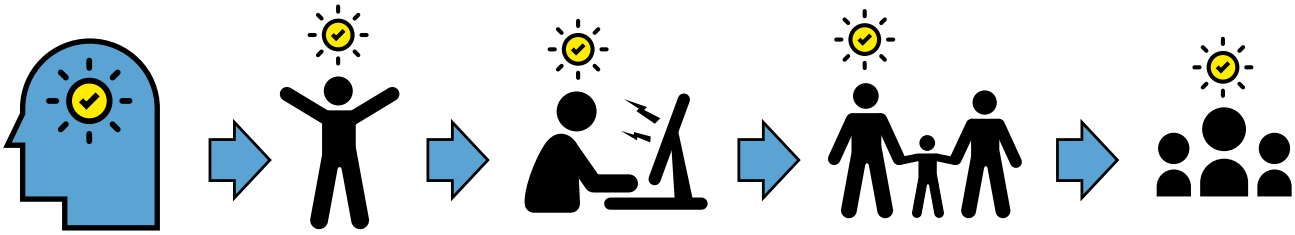
Mental health should be valued and understood as a key that allows us to unlock a wide range of health and social advantages. When this resource is damaged, it leaves us unable to reach our collective potential.

No other group of health conditions comes close to mental health problems in relation to the prevalence, persistence and breadth of damage that can be caused, requiring the most urgent public health commitment of our generation.

So much has changed in recent decades about how we view and treat mental health. Now is the time to build on this positive change and join the call that makes the most sense: preventing mental health problems.

An immense challenge

We all have mental health. But not all of us live with good mental health.



When we experience good mental health, we can make full use of our abilities, cope with the normal stresses of life and play a full part in our families, workplaces and communities, as well as among friends.

Despite our mental health being such an important personal and social resource, the extent of mental health problems in the population means that too many of us are struggling, rather than thriving and reaching our full potential.

Depression is the number one cause of disability worldwide. Anxiety disorders follow closely, making number six on the list.

Every week, one in six of us faces a common mental health problem such as depression or anxiety. If it's not ourselves, it's our children, parents, siblings, colleagues or neighbours.

Every day, hundreds of thousands of us feel limited and disabled by symptoms of stress, low mood, unusual thoughts, anger, poor concentration, and lack of sleep.

Every day, thousands of us get through the day battling thoughts that life is not worth living. And some of our fellow citizens – every single day – will reach their lowest point and take their own

lives, seeking relief from what they thought were permanent problems.

But, in reality, many of these problems could have been managed with professional help.

We have learnt so much about preventing people from reaching these crisis points in the last 70 years. For instance, we know that a combination of reduced stigma, clinical help, social support and personal intervention makes the biggest difference in people's lives.

Yet, we haven't achieved the necessary societal change or implemented the right solutions to support this. Can our healthcare systems cope with millions of people needing urgent help because they are experiencing distress every week?

The answer is no.

Now, we need to do all that we can to prevent people from reaching crisis point in the first instance by taking action in our workplaces, schools and homes, and for those within our communities that have the least power to influence change.

And, to do that, we need to understand that prevention is possible.

Every week, one in six of us faces a common mental health problem.

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Depression is the number one cause of disability worldwide.

Prevention is possible

To learn how we can prevent mental health problems, we need to search for answers to this fundamental question: what causes mental health problems?

This question has received various responses over the centuries. From evil spirits to brain abnormalities, and from our genes to chemical imbalances in our bodies, many explanations have been put forward, only to be disproved or found to be lacking and partial.

Traditionally, there has been a focus towards the biomedical model of mental health. This means that many theories sought to prove that mental health problems were caused solely by a chemical imbalance in the brain, irrespective of context or events.

Based on this, experts classified (and many still do) mental health problems as a brain disorder resulting from faulty genes or a problem with the way a brain develops and functions.

Forty years and millions of pounds of investment later, we have been unable to find consistent patterns in our genes or a single biomedical test specific for any mental health problem.

We now know that our genes do not set our destiny. Poor mental health is also not a case of being born with a 'deficiency'.

Our biology is important, as it shapes the way our bodies respond to what happens to us. However, having a purely biomedical approach does not consider the effect of the environment on our mental health.

And we know that, although some mental health problems are partly influenced by genetics, genes play a much smaller role in shaping our health than our social circumstances.

In almost all cases, our genes do nothing more than carry a slight risk. What is more important to look at is the wide range of social, economic, family and emotional factors that interact with our genes and our biology.

These factors can make us more or less likely to develop a mental health problem.

This is the case for common mental health problems like depression, anxiety and OCD,

"With the right approach, mental health problems of all kinds can be prevented."

as well as severe and chronic mental health problems like psychosis and bipolar disorder.

If we understand this key evidence, we will be able to succeed in following the much-needed fundamental change in attitudes clearly suggesting that, with the right approach, mental health problems of all kinds can be prevented.

This is not to say that we could or should put an end to all mental health problems. We know that mental ill-health will always be part of life.

But the causes of poor mental health can be addressed to prevent such high numbers of people from developing a mental health problem. This means that we can also support people living with and without mental health problems to stay well and prevent people from relapsing or reaching crisis points.

The causes of mental health problems

A singular approach to what causes mental health problems is simplistic and not backed by evidence. We know it is a combination of factors.

Even if we look at the biological changes among those of us who experience symptoms, it is important to ask what causes those.

In some cases, it will be our stress levels, a chronic experience of discrimination, a lack of exercise or sleep, unhealthy eating habits, or an experience of trauma.

And, in turn, we have to ask: What makes us stressed? What increases the chances that we'll be discriminated against? What shapes our opportunities to be active or sleep well? What determines our choices of what we eat? What exposes us to a higher chance of experiencing trauma?

The answers lie in the circumstances in which we are born, grow, live, work and age. These either enable us to thrive, or don't.

So, beyond our genes, our mental health is fundamentally shaped by two sets of circumstances:

1) The deeply personal experiences that define us. Our mental health can be influenced by our family, our relationships and how we see ourselves.

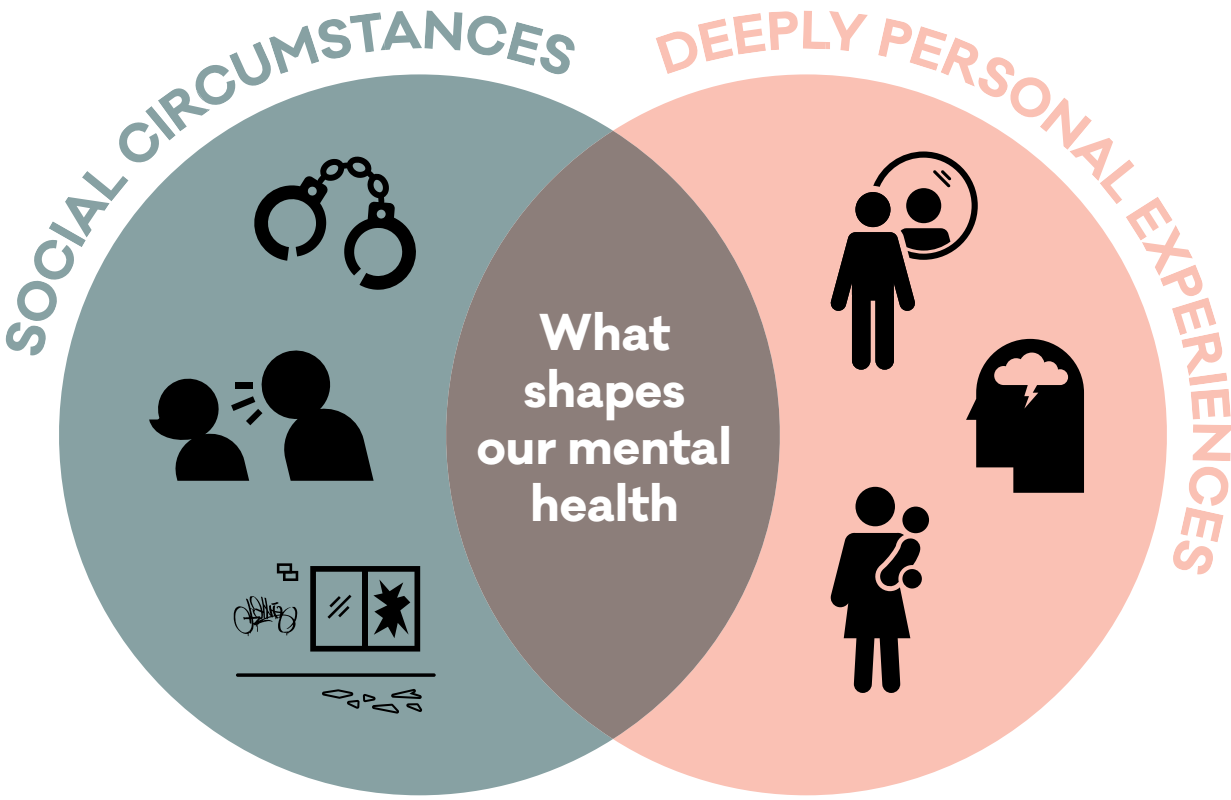
2) The social circumstances we find ourselves in. This includes poverty, violence and employment.

This interaction of our biology and our circumstances is key to our health. And it can either protect our mental health or be a risk to it.

However, there are factors affecting this interaction that are not controlled by us as individuals and instead come from our environment.

The conditions in which we are born, grow, live, work and age are shaped by our social and physical contexts and health services. These, in turn, are affected by the distribution of money, power and resources at global, national and local levels.

Among others, they include things such as income and wealth, family and



household structure, social support and isolation, education, occupation, discrimination, neighbourhood conditions, and social institutions.

Mental health is complex. There is not, nor will there be, any biomedical test that can predict what combination of personal history and current circumstances determines a person's unique state of wellbeing.

The huge amounts of funding that have gone into this narrow biomedical model mean that we've missed opportunities to invest in addressing the roots of poor mental health and to reduce the rates of diagnosis.

One integrated model of mental health

We now need to focus on one model that pulls together the biological, psychological, social and environmental factors.

For instance, when we look at early experiences in childhood, a mix of these different factors can work together to either protect or pose a risk to mental health later in life.

Some children may be more genetically vulnerable to stressful experiences. This means they may be more likely to be affected by events such as being involved in an accident or shame-based parenting.

This interaction between their genetic susceptibility and circumstances (including powerful experiences like childhood abuse) can have knock-on effects on their biology by causing their brain to become over- or under-reactive.

Further down the line, a stressful life event such as losing a job may be more likely to trigger depression or anxiety as a response than someone who did not experience these personal circumstances.

However, this also means that there may be key opportunities to prevent this from happening by introducing protective factors – for instance, equipping parents to nurture their children in a non-judgemental way, ensuring a reliable adult presence at school, or providing professional and peer support early.

Or, in another example, factors like childhood adversity, living in deprived neighbourhoods, discrimination, and life events like bullying can bias the way we interpret what happens to us.

Subsequent stress or adult adverse life experiences can impact the hormonal balance in our bodies and result in misinterpreting the importance of non-dangerous events or developing biased thinking.

For instance, a friendly neighbour may be seen as scary or intimidating because the brain has adapted to protect us in a difficult environment by becoming more reactive. These fear or danger responses sometimes evolve to become paranoid ideas that can be triggered even in safe situations.

Symptoms of psychosis (like such paranoid

ideas) or obsessions and compulsions might, again, be expected responses to childhood adversity.

It is clear that, if we can tackle the risk factors and maximise the protective factors, we can achieve this critical mission of reducing the number and severity of mental health problems. We can also improve resilience to those bumps in the road that aren't readily preventable.

BIOLOGY
Our genes and the ways they are expressed

ENVIRONMENT
The places we live and work, and the relationships we have

EXPERIENCES
The things that happen to us - especially in our early life

Our life events

Distress tends to find us at times when we are most vulnerable. It often bites during times of change.

This can be a bigger change such as leaving our family home for the first time, or a smaller one such as changing jobs. The change can be negative, such as being made redundant, or even positive, such as becoming a parent. The changes can also be physical, such as a serious diagnosis like cancer, or something more common, like not getting enough sleep.

It's at times like these when we turn to our fundamental protective factors: our knowledge around mental health, our emotional awareness, our education, our family and friends, our hobbies and our talents.

There are several evidence-based ways – simple or more complicated – that serve the same purpose of protecting our mental health. Yet, many of us have either never received this information or were given it in a way we couldn't understand or apply to our own lives.

As a result, we were never given the chance to thrive.

And then there are life events that cause powerful impacts on our mental health.

Traumatic experiences can be defined as experiences that we perceive as serious or life-threatening and that have lasting negative effects on our wellbeing. This can be a single event, such as being involved in a road accident, or a series of events, such as prolonged abuse.

Further, experiences of adversity – such as living in a deprived neighbourhood or being discriminated against – can turn into trauma if the person believes they are alone in their experiences or excluded from the rest of society.

Trauma is a powerful factor linked to mental health problems. The experience of traumatic events is overwhelming to our brain. In normal circumstances, we can form full memories of a specific event – for instance, memories of enjoying ourselves and blowing out birthday candles at a celebration.

On experiencing a traumatic event, however, our brain instead often records

"Many of us were never given the chance to thrive."

separate fragments of the event. This could be in the form of images, sounds and physical sensations, without much context behind them.

When we re-experience these sensations that remind us of the event, they then become triggers of the past to trigger fear or danger responses, expose us to extreme stress, or lead us to unhealthy behaviours.

Like life changes, triggers are very important to our mental health, as they can throw us off balance even when we have been taking good care of ourselves.

It is important to understand that our experiences of these life events lead to genuine biological changes to our nervous system, and, further, often shape who we are as individuals and the roles we go on to play in our families and communities.

Arguing for preventing mental health problems can be seen as an attempt to disregard those who have already recovered from or experienced such trauma. This is not the case. Our societies are largely shaped by, and our attitudes have been largely shifted thanks to, such survivors of trauma.

But the scale of the problem is so big, and the risk to our lives so grave, that prevention is the only reasonable solution to invest more in if we are to enable a diverse and evolving world.

We need to understand how such life experiences are central to who we are.

Early years

- Parental neglect
- Family facing adversity
- Child poverty

- Positive parenting
- Nurturing home environment
- Strong attachment

Childhood

- Abuse
- Parental divorce
- Malnutrition
- Adverse Childhood Experiences

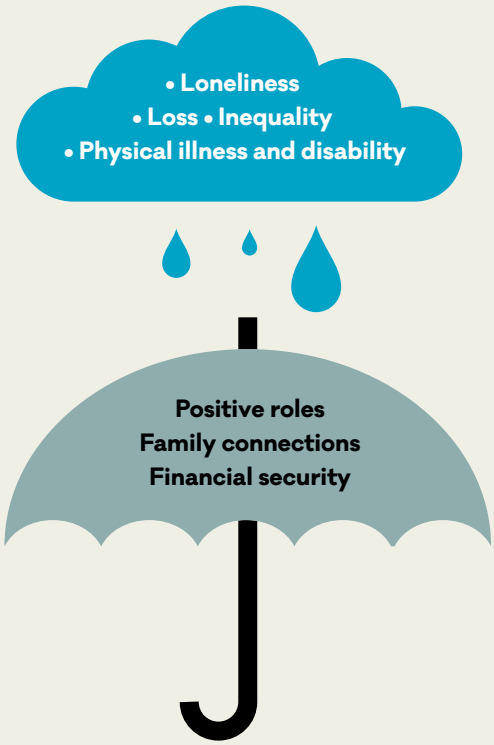
- Good education
- Supportive parenting
- Emotional literacy
- Communication skills

Teens

Early Adulthood

Adulthood

Later years



It's personal

Even for the small minority of us living with high levels of positive mental health, days of low mood, stressful tasks at work or struggles with a change in our circumstances will be familiar.

None of us will lead a long life without having felt limited by our mental health at some point, for a shorter or longer period.

However, despite these universal experiences, it remains a fact that mental health is affected by a range of social and environmental factors that interact with our own biological susceptibility and family circumstances. This makes the experience of a mental health problem very personal to each of us.

In mental health, perhaps more than in any other area of health, we face the contradiction of ultimately being the experts in our own mental health, but also being limited by our understanding of our own experiences. This can be compounded if we don't talk about mental health. We may go for years bottling up our emotions and ignoring serious symptoms.

Our community (as defined by our ethnic or socioeconomic background) may ignore or underestimate the causes and impact of mental health problems in another community. And our political beliefs may lead us to underestimate the role of social inequalities in enabling people to flourish.

Mental health is a big part of our identity and it affects many of the aspects of our day-to-day lives: our relationships, our work and our education. We know that children with mental health problems have worse educational outcomes, adults with high levels of stress are less productive at work, and people who are experiencing a mental health problem are more likely to feel lonely and isolated.

When it comes to our mental health, we are on a spectrum. It's not just a simple yes/no diagnosis. Our mood, stress levels, wellbeing and how we act fluctuate depending on the circumstances in our lives. And this is the case even for those who live with a diagnosis of a long-term mental health problem.

Our wellbeing can move between a point of struggling and a point of thriving.

On a fundamental level, this personal experience is about our quality of life.

Quality of life

To have a better chance of addressing the challenge of poor mental health in our societies, we need to understand an important fact: that the healthier we are mentally, the healthier we will be physically as well. But remember – mental health is a very personal experience.

This personal view is called 'self-rated health'. Evidence clearly links how we say our health is (e.g. poor, okay or excellent) with a number of different conditions and overall mortality.

In other words, the worse we consider our personal health to be, the more likely we are to be experiencing a variety of problems and, in fact, to die younger.

It is important to note that our own perceptions of health and wellbeing do not exist in a vacuum, but have a complex relationship with our socioeconomic situation (e.g. our income, savings and quality of housing), our environment (e.g. how safe we feel in our neighbourhood and the mood of our close friends and family), and our physical health (especially our levels of activity, any addictions and our diet).

In an important milestone, in the mid-1990s, the 'Global Burden of Disease' initiative (the most comprehensive effort to record health statistics and identify trends) reframed how it measured the outcome of a health condition beyond the traditional focus of how many people die because of a condition, towards a focus on the years of productive life lost due to disability.

Mental ill-health went from being almost invisible in global public health statistics to topping global surveys on the conditions causing the biggest impact on people's lives. This was a revolution in our understanding, as it brought mental ill-health into the spotlight. The historical marginalisation of mental health, though – in terms of how much is being invested in research, understanding and services addressing problems – has been persistent.

With a focus on prevention, we are more able to take a holistic view of mental health that includes issues of disability and the connection to our physical health.

One health

This relationship between mental and physical health is one of extremely high importance. We know that mental and physical health interact in several direct and indirect ways.

For example, mental health problems sometimes affect our ability to make decisions, which can affect our ability to access good information on, or act to improve, our health. For instance, we know that smoking and lack of physical activity are more common among people experiencing mental health problems.

Further, mental and physical health interact with each other via indirect routes, such as employment. Poor mental health may lead to loss of productivity, then loss of wages, hence reducing access to healthier foods. Or stress at work can lead to lack of sleep, which has negative physical health results.

Another important route of interaction is through our relationships and social life. People experiencing mental health problems are more likely to feel, and indeed be, lonely or socially isolated. Both loneliness and social isolation strongly impact our physical health and have been found to be linked with increased risk of early death.

In public health, these relationships in which one health problem increases the risk of another one is usually called a mediation factor. Research shows that approximately 1 in 20 of all physical health problems we may currently experience are a direct or indirect result of a past or current mental health problem.

The costs of mental, neurological and substance abuse problems (which often start as a self-medication attempt for mental distress) account for 9 out of the 20 leading causes of the years people live with a disability around the world.

Of course, protecting mental health is not – and should not be – just down to us as individuals. It can be incredibly difficult to work on ways of protecting our mental health if we are struggling with our wellbeing.

For this reason, laws exist in several countries around the world that class diagnosed long-term mental health

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problems, on a par with long-term physical health problems, as disabilities. In general terms in public health, considering mental illness diagnoses as disabilities has been a fundamental progressive step in giving people certain rights.

In the past few decades, we've learnt to ask to be vaccinated to prevent infectious diseases, we've got used to talking about family planning and contraception to protect our personal health, we've grown to consistently follow laws to wear seatbelts to prevent injuries, and we've moved to not smoking indoors in order to prevent cancer.

We've made incredible progress to prevent simple or severe problems facing our physical health, and reduced the numbers of childhood deaths for children under 5 years old.

Our next milestone is to make the same progress for our mental health. At a deep, fundamental level, our mental health is a mediator of our overall good health. And nothing helps our health more than investing in structures that fully and freely allow and empower us to develop ourselves as social beings with a sense of purpose, value and belonging.

It is clear that we need to invest more in the relationship of our internal personal factors with the societal factors that shape our lives. This is well understood in physical health when talking, for example, about prevention of heart disease or lung cancer. However, globally, mental health still lags behind physical health in terms of spending and funding.

We need to understand better what prevention means.

The meaning of prevention

When we talk about prevention, we don't follow the narrow sense of the term.

We know that mental health problems affect millions of us, in our families, communities and workplaces. We all have mental health that will fluctuate in response to life events. It would be unwise to suggest that prevention is only for those who currently feel 'in good health'.

We define prevention in the 'public health' (the health of the population as a whole) sense of the term. Under this lens, there are three types of prevention.

1. Primary prevention: preventing problems before they emerge

Primary prevention focuses on stopping problems before they emerge. Primary prevention is relevant to all of us – often whole societies or nations – so solutions targeting primary prevention are called 'universal'.

Examples of universal solutions include a national anti-stigma campaign that makes sure we all follow the same standards when talking about mental health, or teaching school children about emotions and mental ill-health from a young age.

Universal solutions neither discriminate nor focus – rather, their aim is to protect. We can all identify non-mental-health-related universal solutions already in our lives, as they include things like banning smoking in buildings and making it compulsory to wear seatbelts in the car.

Often, a universal approach will aim to protect the most vulnerable members of a community in a non-stigmatising way, thus benefitting everyone. For example, mandating that all buildings have an accessible entrance means that people using wheelchairs can access a space, but this is also handy for those carrying a suitcase or delivering a large package.

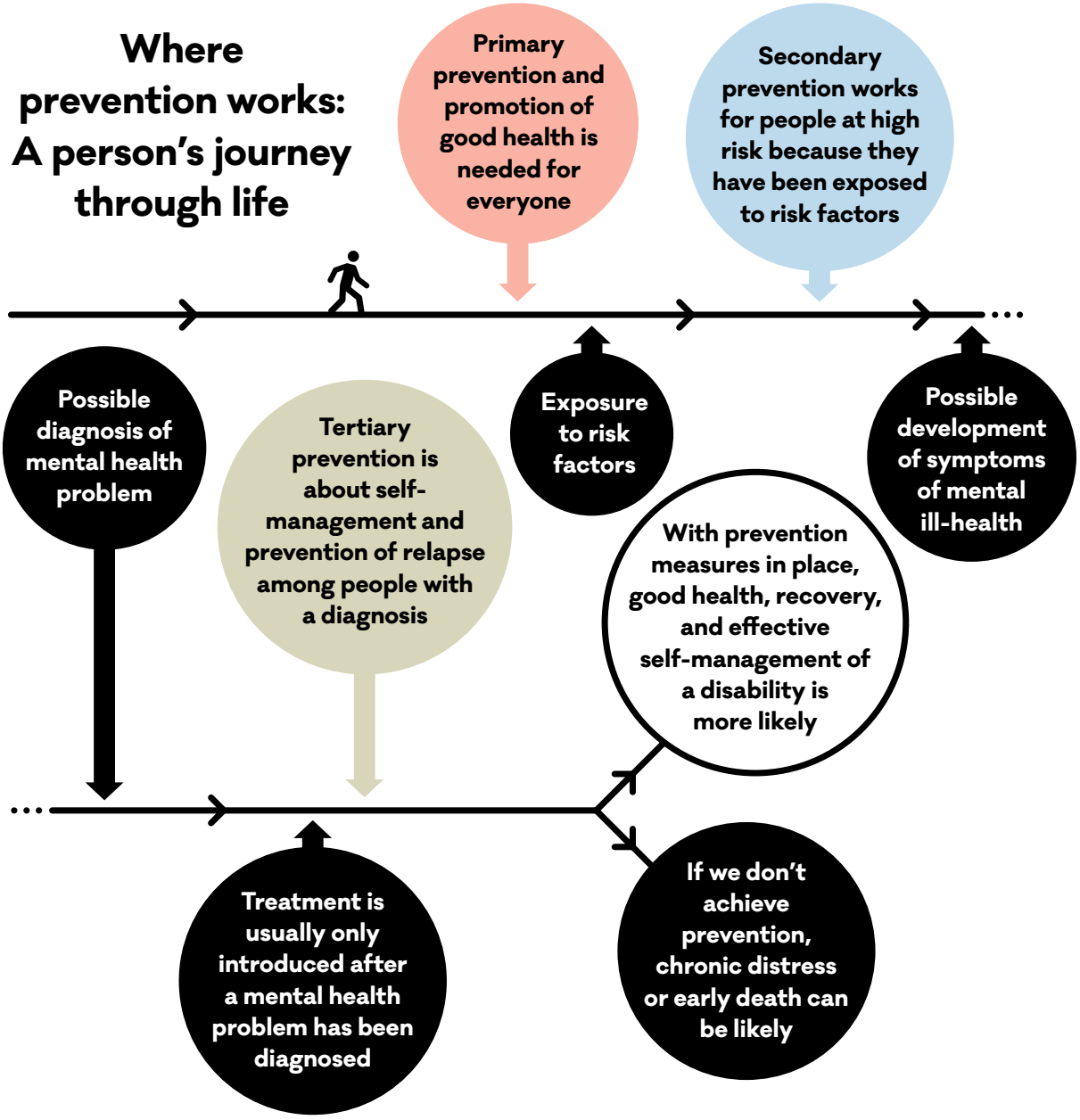
We need social and political changes in our society that can benefit everyone, including education and reducing socioeconomic inequality across places and nations.

This can be extended to how we talk about health and illness. In mental health, ensuring that the language we use is thoughtful and appropriate (e.g. on days

when we struggle, saying "I am feeling low" instead of "I am so depressed") respects those who experience disabling symptoms while enabling an inclusive community. Mirroring this with our actions and legislations goes a step further to apply a protective 'filter'. We'll talk more about our language later on.

2. Secondary prevention: prevention for people exposed to inequality

Secondary prevention is the type of prevention that focuses on the people who share characteristics that place them at a higher risk of developing a mental health problem. Secondary prevention solutions are often called 'targeted' or 'selective'.



Examples of targeted solutions include enabling support for those who are lonely or marginalised, giving access to higher-quality education for young people who are excluded from schools, or ensuring quick access to support for those who have experienced trauma or have been victims of hate crime.

A range of characteristics we are born with place us at an increased risk of developing mental health problems. In public health, these are called 'inequalities' because they mean that certain groups of people face an unequal risk of becoming unwell. They can include being LGBT+ (as we know that this group of people might face a higher chance of being bullied) or having a physical health condition like diabetes (where we know that there is a much higher chance of developing a mental health problem like depression).

Tackling inequalities in our communities means that we need to look into all these social, economic, environmental and other factors and invest a higher amount of energy in engaging people who are not traditionally helped through universal approaches. These targeted solutions are often aimed at people who are experiencing some symptoms of distress, and they are about intervening when it matters most.

Reducing poverty and inequality is fundamental if we are to make meaningful progress in prevention.

3. Tertiary prevention: prevention that goes to a deeper level

The third layer of prevention is called tertiary. This type of prevention has a lot to do with our quality of life once we have experienced a problem, and also with reducing the risk of recurrence. Solutions in tertiary prevention focus on people who are already affected by mental health problems, and are often called 'indicated' solutions.

Indicated solutions aim to reduce symptoms that can be disabling, limit complications of an illness, reduce the risk of relapse, and empower people experiencing problems to manage their own symptoms as much as possible.

Even though tertiary prevention works with people who may have a diagnosis, it is seen as distinct from treatment, but complementary in that the goal of reducing the severity of an illness and the risk of relapse is shared. Indicated solutions tend to be set in communities rather than clinical settings.

Often, the aim is to shift the focus of control from the clinician to the person who is using services in terms of identifying what works best for them in their circumstances.

So, in many ways, prevention is a lot about our personal experience of illness within our societal context.

Investing in prevention

To address mental health problems, we would need a concentrated effort as a society, tackling those persistent inequalities with prevention and early intervention (i.e. provision of support when we show early symptoms of mental ill-health).

This is the case for both common and more serious and rare mental health problems.

The three types of prevention are not in competition or clashing in scope. Rather, to tackle an issue as common and widespread as mental health problems, we need whole society plans that invest in all layers of prevention.

Working together at the level of national government, local authorities, and bigger or smaller third-sector organisations, we need to be focusing efforts on rolling out universal solutions that protect everyone, while enabling targeted and indicated solutions supporting those at risk or experiencing problems.

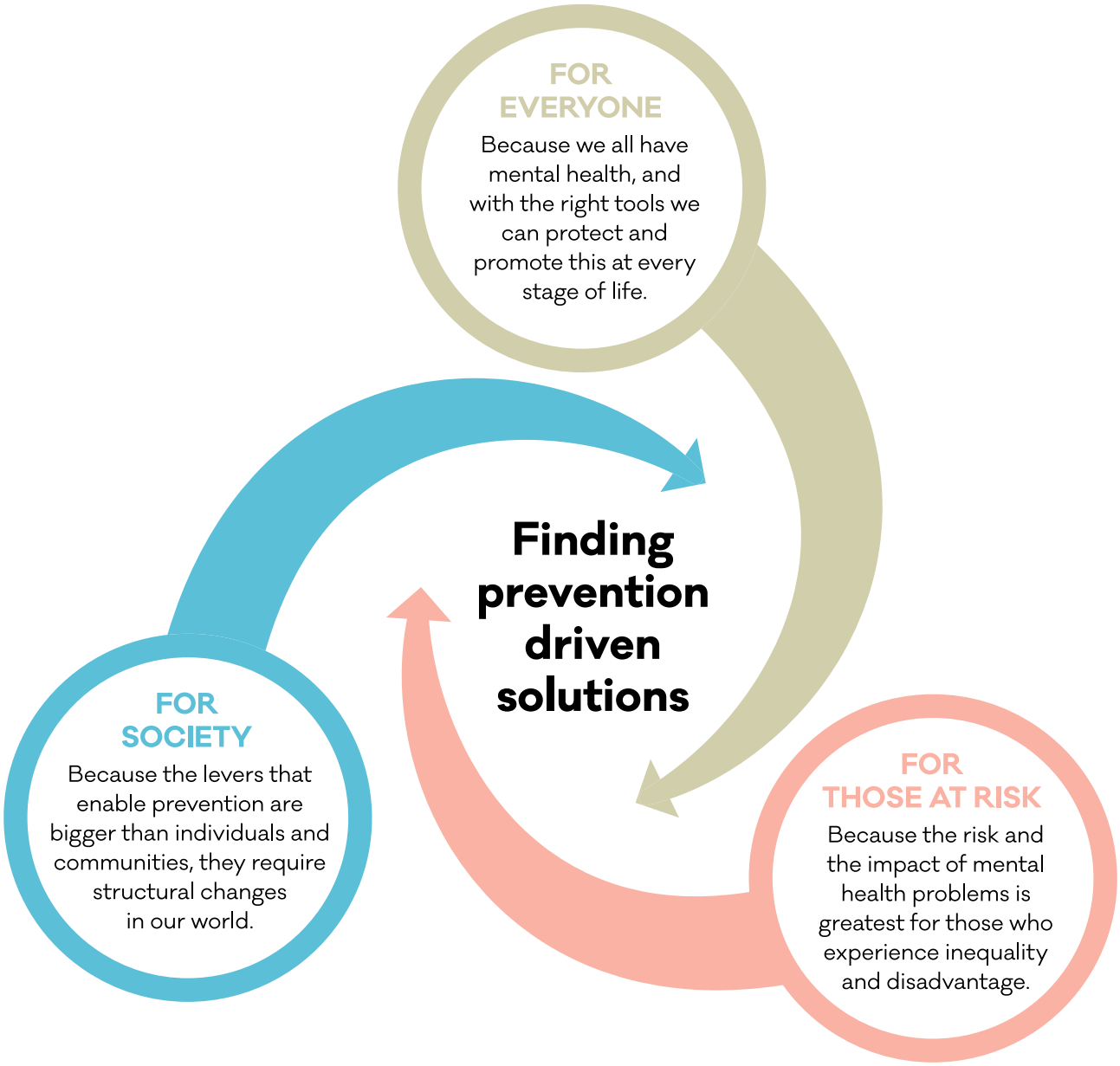
In public health, we call this holistic approach 'proportionate universalism'. This principle suggests that our actions should be universal (i.e. benefitting everyone), but with a scale that is proportionate to the level of disadvantage (i.e. more intensive for those experiencing higher risk or more severe problems).

Unfortunately, when it comes to mental health, there is no single vaccine that can protect us against distress or mental health problems.

But if we invest more energy and attention into the fact that mental health is actually a mediator of all good health in a community, then we can make great strides towards applying the education, resilience and policies needed to protect everyone's mental health.

And we will be able to reap the subsequent benefits in ourselves, our families, our environments and our economies. Successful prevention of poor mental health means better quality of life, improved physical health, reduced alcoholism, fewer suicides, and

a more holistic human contribution from everyone. It's hard to imagine a bigger contribution to human flourishing than successfully preventing the rates and severity of mental ill-health.



What is holding us back?

Building a society where mental health is everyone's business should be a no-brainer. Prevention is possible.

But it's a difficult personal goal because, often, our everyday stresses overwhelm us, and we tend to only understand the value of prevention once we have reached crisis point.

It's a hard political sell because it is achieved through concentrated, cross-government and long-term commitments that go beyond the average political cycles.

It's a high social aim because several of the determinants allowing prevention can only be shifted through addressing issues of social justice.

And it represents a big community shift because we've mystified mental ill-health diagnoses for centuries and we're still catching up on the stigma we've allowed to permeate our way of thinking.

The challenges are many. But not disheartening. We need to urgently start talking about prevention and mental health.

In talking, it is perhaps not surprising that an area of health that has been so systematically stigmatised for so many decades has historically settled for a discriminatory vocabulary. Generations of people have grown up in societies that found terms like 'psycho', 'schizo', 'loony' and 'crazy' perfectly acceptable.

Stigma is not only an element of mental health, of course, but the extent to which it has permeated our language, compared to any other area of ill-health, is profound.

Many would argue that it is practice and not language that matters. But words are a barrier to people seeking help.

Our language is emotionally charged and it is evolving, and how we talk about mental ill-health in our immediate environment is critical. Therefore, being respectful and thoughtful in our mental-health-related language could do wonders for the automatic responses that our brains produce to words, and, hence, the emotions of the people around us.

Our emotions and our attitudes

Our evolution as human beings has left a complicated picture of how we express our emotions.

A lot of the activity happening in our brain triggers emotions that would have been normal and protective some tens of thousands of years ago.

For example, our ancestors got angry to protect themselves against a threat and cried to ask for help when they didn't have the words for it. But now we mostly understand 'negative' emotions as problematic.

It is true that we have come a long way in public mental health in recent years in terms of our attitudes around, and our efforts to tackle, the stigma of mental ill-health, but we are not there yet.

It remains true that several thousands of our fellow citizens experiencing symptoms of mental ill-health will not seek professional clinical help because of the stigma attached to mental health problems and the fear of being misunderstood.

Media, retailers and social media have been playing a role in the persistent use of stigmatising, stereotyping and offensive language. We are still exposed to unhealthy imaging and expressions. The potential of humour to help address stigma is welcome, but, as a rule of thumb, trivialising diagnostic terms should have no place in our societies.

For too long, most campaigning efforts in psychiatry and public health have focused on increasing the understanding of the biomedical model of mental illness (i.e. the physical, organic and biological aspects of illness).

We now know that social circumstances play a huge role in the development of mental health problems. Research shows that, while this increased understanding of the biology leads to greater acceptance of professional help, it hasn't really changed attitudes towards people with mental illness.

A greater understanding of the social circumstances that we grow and live in – that either expose us to risk or add protection to our mental health – is needed. We cannot change this understanding unless our language evolves. And this is rooted in how prevention works.

Making a start on prevention

It is clear that we must now personally and collectively do as much as we can to protect our mental health.

Getting better sleep, practising mindfulness, drinking less and exercising more are all helpful. Also, crucially, caring and doing things for others is important, whether that's through working on our relationships with family, letting go of old grudges, building positive and lasting friendships, reaching out to someone who may be lonely and being altruistic, engaging in acts of kindness, or volunteering.

If we stay open-minded, we can move from a very individualistic perspective on mental health to a collective, societal view.

But our individual actions are rarely enough. We need more efforts across society to empower everyone to be the change they'd like to see. We don't need to wait until we become unwell to change how we talk about mental health.

Little by little, through citizen activism and a new generation of celebrities willing to open up about their own experiences of mental health problems, our language is slowly catching up with the centuries of mystifying mental illness. We are now well beyond the times when we thought that, if we locked up people experiencing symptoms that we don't understand, then maybe they would stop existing.

We know that mental health problems exist in our homes and communities, that they are common, and that they can be addressed through prevention, timely treatment and concentrated societal effort. The weight of the evidence piles up, urging us to focus on the social and environmental factors and their influence on our mental health. We need far greater resources on research and policy change.

Let's invest in what will make the biggest genuine difference. Enable women and men to be educated mothers and fathers, protect children from neighbourhood trauma, educate adolescents to understand and manage their emotions, support adults experiencing excessive stress at work, build connections in our communities, reduce loneliness for older people, acknowledge and care for people

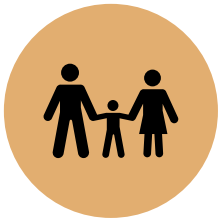
with suicidal thoughts, and empower people experiencing symptoms of mental ill-health to recover and self-manage. The faces of prevention are many. We have neglected those for too long.

Some of us will be working across the health sector and government to correct this inequality and help address the challenge. And all of us can start from our homes and communities when things get too much: be kind to ourselves and compassionate to our friends and this could go a long way. Mental health problems and distress can be prevented.

The challenge is immense, and the barriers are many. But not disheartening. So, let us look forward to the future and embrace this challenge of prevention. And, when we achieve the promised progress, we will look back and see that this was our time's greatest contribution to human flourishing.

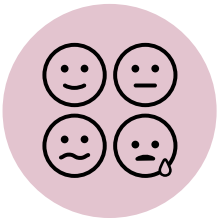
Join us in a future where we can all thrive with good mental health.

Let's invest in what will make the biggest genuine difference



Enable women and men to be educated mothers and fathers

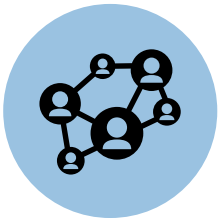
Protect children from trauma



Educate adolescents to understand and manage their emotions

Support adults experiencing excessive stress at work

Reduce loneliness for older people



Build connections in our communities

Acknowledge and care for people with suicidal thoughts

Empower people to recover and self-manage

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