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Title: Preventive Global Mental Health: finding a balance of preventive and care policies and practices through creative interdisciplinary research

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Background

A recent WHO report demonstrated a 33-year difference in life expectancy between high- and middle/low-income countries.[1] Smaller but significant losses of life-years are also found in high-income countries. The presence of mental illness increases mortality risks generally, especially in those with multiple long-term conditions. Preventing and treating mental illness, alongside tackling social determinants can reduce health inequalities, poorer life chances, and mortality. Alongside these, commercial and political drivers require preventive policies and practices.[2]

Structural disadvantage and greater life-time exposure to risk factors are found in the most marginalised populations, requiring more tenacious, structurally and culturally competent care that is necessarily trauma-informed. For example, black and minority ethnic populations and migrants have a higher incidence of psychotic disorders, largely due to the social and environmental modifiable influences, including social determinants and multiple adversities.[3] Black patients are also more likely to be involuntarily treated under the powers of mental health legislation of the respective countries. Asylum seekers and refugees are more likely to have experienced war and conflict, persecution and traumatic incidents. Life-time adversity, poverty, racism, discrimination, stigma, marginalisation and exclusion add to the future risks of multiple long-term conditions as well as mental illnesses; explaining premature mortality found amongst the most marginalised with severe mental illness.

Prevention evidence

Prevention of mental illness and reducing ineffective and coercive care have been proposed for decades,[4] yet little progress has been made due to the allocation of resources to

emergency and immediate care rather than prevention. This is compounded by the complexity of preventive interventions when applied earlier and over the life-course in non-health settings. The strongest evidence for prevention for mental health[5] comes from *universal prevention* in schools and in the perinatal period, focusing on improving nutrition and physical activity, and reducing tobacco use and bullying. Even dementia is partly caused by modifiable risk factors, which, if effectively targeted, could prevent over 40% of cases. *Selective* interventions targeting specific high-risk groups include depression related to trauma and adversity, and risks related to parental mental illness: the risk of developing a mental illness could be decreased by 40-50% amongst children whose parents have a mental illness. *Indicated* interventions for individuals with early indicators of poor health include CBT to reduce transition to psychosis, alongside support to prevent relapses such as advance choice documents. Interventions in adolescence provide a good return on investment for group-based CBT for mild depression, preventing suicide attempts in high-risk groups, and universal prevention of anxiety and depression in low-income and lower-middle income countries. There is much evidence for parenting and health visiting programmes to protect children's health and development.

Complex Preventive Interventions

We propose a global research, policy and practice shift to *care and preventive* interventions that are culturally and geo-politically competent, and cognisant of social, cultural, environmental, commercial and political determinants. This requires a shift in balance away from individual, brain, and body-based disease models, towards longer term culturally competent, eco-social and syndemic preventive approaches that take account of complex systems. For example, in Pakistan, the 'Thinking Healthy' programme delivered simplified

culturally adapted CBT by ‘lady health workers’, leading to a 50% reduction in perinatal depression.[6] We are developing co-designed resources across the lifespan, for example, including a prototype *serious game* to support young people at the intersection of multiple vulnerabilities including adverse childhood experiences; such work can benefit from drawing on creative arts expertise, lived experience, schools, parents, charities and as well as formal health systems.[7] Interdisciplinary and cross-sector research is required to develop preventive policies and interventions, impacting across conventions of universal, selective, and indicated scenarios, in the following areas:

- Maternal and early years
- Children and Adolescents: recognising and preventing adverse childhood experiences as care and preventive interventions
- Working populations and work stress, sickness, and multiple long-term conditions
- Multiple long-term conditions and ageing well, including dementia and neuropsychiatric conditions
- Urbanisation, air quality, and climate change
- Climate change, natural disasters, rising temperature and threats to water supplies
- Conflict, displacement and war around the world
- Developing research infrastructures in communities
- Integration of health and social care and prevention
- AI for improving literacy and as components of interventions
- Care in communities and multisector prevention
- Reducing coercion in vulnerable people with neurodiversity (ND), SMI and psychosis

Under-representation in research of marginalised and minoritized populations, especially those with multiple conditions and care needs is common and fails those populations. This applies globally, and even in high-income countries. Research must include people with more complex identities or positioned at the intersections of multiple disadvantages by age, sex, gender, ethnicity/race, class/caste, neurodiversity, and place. Interventions are often developed in isolation from the potential beneficiaries, meaning interventions are insufficiently complex nor sufficiently flexible to meet the needs of those living in precarity and poverty. Geopolitical contexts shape adversity and structural disadvantages, for example, by urban, rural and coastal spaces, as well as the Global North and South. Country specific attitudes towards mental illness, and stigma, will determine prioritisation of spend, for example, into war, conflict, and defence as opposed to health or protections for vulnerable groups.

For the development of inclusive complex interventions, we propose interdisciplinary, participatory, and co-design research.[8] These approaches ensure resources are not wasted on research that repeats exclusionary practices and compounds epistemic injustices by ignoring the voices of those most in need. Unlike large trials and systematic reviews, participatory research and co-design require a more paced and flexible process to authentically collaborate, share power, and together define the priorities with the intended beneficiaries. The approach fosters support for vulnerable groups to participate and overcomes mistrust of health agencies and authorities. Digital methods of communication abound, but our experience is co-design and trust building are less complete without personal face to face conversations, in which power is shared, within flatter structures of research delivery. We avoid formal institutional locations, to instead undertake these

creative conversations in neutral community settings (schools, arts galleries, museums, community centres). We recommend *experience-based co-design* involving participatory creative non-verbal methods, such as photovoice and creative arts, to enable more people to participate and evolve their thoughts and views over time.[9] This is especially important for those with limited literacy, neurodivergent identities, and traumatised populations for whom narrating traumatic incidents is not easy. The methods are superior in developing appropriate interventions to empower and incite participants to take actions, compared with research that only meets the researchers pre-conceived questions and notions of knowledge gaps.

Ethical Dilemmas

Whether co-designed interventions later undergo randomised trials will depend on the urgency (e.g. preventing maltreatment or coercive care), and the perceived or documented harms of the intervention. Evolving interventions to support those with existing diagnosed illness or symptoms may cause excessive concern about vulnerability and potential harms, requiring trials and longer-term monitoring. These traditions and safeguards can work against the more rapid evolution of co-designed and culturally relevant interventions to urgently address massive inequalities. Existing research and institutional processes are structurally implicated in epistemic injustices that compound inequalities. Can we afford to retain an individualistic disease model that requires expensive and lengthy academic pipelines for the testing of every complex intervention? We must tackle poor, coercive, or absent care with some urgency, building fair research infrastructures through distribution of resources, alongside creative shifts in research paradigms informed by lived experience.

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