THE MISSING HALF OF PREVENTION

We recognise mental health difficulties. But are we teaching people how to respond?

Mental-health difficulties place pressure on individuals, families, schools, workplaces and public services. Awareness has grown, access to support remains essential, and prevention is now a recognised priority. Yet knowing that help matters is not the same as knowing what to do when difficulty begins.

TWO COMPLEMENTARY PARTS OF A PREVENTION CULTURE

RECOGNISE & SUPPORT

Notice difficulty, reduce stigma, communicate openly and provide access to appropriate support and services.

LEARN & APPLY

Understand pressure, recognise behavioural patterns, consider options, take constructive action and learn from the outcomes.

The missing element is a learned, transferable and repeatable capability for responding to difficulties as they happen - independently where possible and with appropriate support where needed.

WHY PRACTICAL CAPABILITY MATTERS

How people interpret challenges, respond to pressure and learn from consequences can influence whether difficulties are resolved, prolonged or compounded. These are abilities that can be developed through education, supported practice and useful feedback.

Fear matters because it can influence perception, thought, feeling and action before we recognise its effect. STOP Fearing Fear® offers a shared language for understanding these responses, interrupting ineffective behaviour and acting towards a different outcome.

This is education, not therapy moved upstream. It complements mental-health awareness, good environments, timely support and clinical care. The proposal is to make earlier practical responses a familiar part of everyday life.

WHAT FOLLOWS

The national evidence, the capability gap, the case for population-wide and inclusive learning, and a practical invitation to explore wider educational development.

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THE NATIONAL PROPOSITION

Prevention is the policy.

Early self- or supported intervention must become part of our culture.

Britain has already made prevention a priority across healthcare, education and employment. The next opportunity is to turn that commitment into everyday capability, making early recognition and proportionate intervention a normal part of how people understand and respond to mental health difficulties.

In physical health, people routinely recognise difficulties and take proportionate early action, independently where possible and with appropriate support where needed. Mental health should have the same educational foundation. People need the practical capability to recognise when fear and pressure are influencing their thinking, behaviour and decisions, intervene earlier, choose more effective responses and learn from the outcomes and feedback.

STOP Fearing Fear® provides an existing, practice-developed and evidence-informed framework for teaching that capability through Behaviour, Fear and Resilience Education. Its purpose is not simply to help people recover from difficulties, but to develop their ability to **apply resilience** through deliberate action, constructive outcomes and learning. The national opportunity is to make Early Self-Intervention and supported early intervention familiar parts of everyday mental health culture, complementing existing prevention, professional support and clinical care.

SIX INSTITUTIONAL POSITIONS ON PREVENTION

WORLD HEALTH ORGANIZATION
"Protecting and promoting mental health requires coordinated action across all sectors."

NHS ENGLAND
"A fundamental shift towards prevention, treating people earlier and faster."

DEPARTMENT FOR EDUCATION
Curriculum teaching to promote resilience and social and emotional learning.

HEALTH & SAFETY EXECUTIVE
Employers have a legal duty to protect workers from work-related stress.

BRITISH PSYCHOLOGICAL SOCIETY
"We can prevent many more people reaching that stage by focusing on preventative services."

DEPARTMENT OF HEALTH & SOCIAL CARE
Earlier needs-led support for children, young people and adults.

SIX CONTINUING REALITIES

20.3%
CHILDREN 8–16
Probable disorder, England 2023

1.05m
CHILD REFERRALS
Active referrals, 2024/25

35%
STILL WAITING
Of referred children, Mar 2025

22.6%
ADULTS 16–64
Common conditions, 2023/24

£51bn
UK EMPLOYERS
Estimated annual burden

£300bn
WIDER BURDEN
England annual estimate

No endorsement is implied. Institutional positions illustrate policy context; figures describe demand and cost, not demonstrated programme impact.

Sources: WHO (2025); NHS England (2026); DfE; HSE; BPS (2025); DHSC (2026). Data and cautions on pages 3–4.

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CHILDREN AND YOUNG PEOPLE

Children: the problem is already here.

A rise in recorded mental-health difficulties is only part of the picture. England also faces substantial demand for children's services and long waits for help. More provision remains necessary. The preventive question is what we can teach children, and the adults around them, before a situation reaches that point.

CHILDREN AGED 8–16 IN ENGLAND | PROBABLE MENTAL DISORDER

12.5%	17.1%	20.3%
2017	**2020**	**2023**
Recorded prevalence	Recorded prevalence	Recorded prevalence

If the 2017–2023 average annual change continued unchanged, the arithmetic result would be approximately 25.5% in 2027. This is **an illustration, not a forecast**. NHS England reported no statistically significant change between the 2020 and 2023 waves.

SERVICE PRESSURE IS VISIBLE TODAY

1,048,965	35%	60,000+
ACTIVE REFERRALS	**STILL AWAITING**	**LONG WAITS**
Children in 2024/25	Treatment in March 2025	Over two years, March 2025

Referral figures include autism and other neurodevelopmental pathways. They describe service demand and waiting, not the number of children with a probable mental disorder. These measures should not be conflated.

WHY THIS MATTERS FOR EDUCATION

Children can learn to recognise fear, interpret behaviour, consider consequences and develop the capability to respond more deliberately. Teachers, parents and carers can use shared language to understand escalating situations and support greater autonomy as children develop.

This would be a structured progression, introduced early and reinforced in lessons, relationships and everyday interactions - **not a one-off assembly**. It would sit alongside safeguarding, appropriate specialist support and statutory teaching. A child should not need a diagnosis before learning how to respond to ordinary difficulty.

Evidence and context: NHS England children and young people's mental health survey (2023); Children's Commissioner (2026); DfE schools and colleges.

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ADULTS, EMPLOYMENT AND THE ECONOMY

Pressure is costly long before crisis.

Poor mental health affects decisions, relationships, retention, public-service capacity and the quality of work undertaken while people remain present. Better clinical access and healthier conditions are vital. So is the ability to recognise deteriorating responses and act earlier.

COMMON MENTAL-HEALTH CONDITIONS | ADULTS AGED 16–64, ENGLAND

15.5%	18.9%	22.6%
1993	**2014**	**2023/24**
Recorded prevalence	Recorded prevalence	Recorded prevalence

Among adults aged 16–24, recorded prevalence was 25.8% in 2023/24, compared with 17.5% in 2007. These findings describe population trends; they do not estimate the impact of STOP Fearing Fear®.

DISTINGUISH COSTS; DO NOT DOUBLE-COUNT THEM

£51bn

UK EMPLOYER BURDEN | DELOITTE 2024

Estimated annual costs of poor employee mental health: approximately **£24bn presenteeism**, **£20bn turnover** and **£7bn absence**. These are productivity and employment costs, not NHS treatment expenditure.

£300bn

WIDER ANNUAL BURDEN | ENGLAND

The Centre for Mental Health estimates approximately £110bn economic costs, £130bn monetised human costs and £60bn health and care costs, including informal care. This estimate overlaps with employer costs; it cannot be added to the £51bn figure.

HSE separately reports **22.1 million working days lost** to work-related stress, depression or anxiety in Great Britain in 2024/25. Not all losses are preventable, and responsibility must not be placed solely on individuals: safer systems, fair working conditions, timely support and learned capability need to work together.

Evidence and context: NHS adult psychiatric morbidity survey (2023/24); Deloitte (2024); Centre for Mental Health (2024); HSE 2024/25.

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THE PREVENTIVE CAPABILITY GAP

What does “earlier” mean in practice?

People are advised to manage stress, build resilience, seek help early and prevent mental ill health. These messages matter, but advice is not the same as capability. What can someone actually do when a difficulty is happening and fear is influencing their response?

PREVENTION NEEDS MORE THAN AWARENESS

Stage One: everyday development and maintenance. **Stage Two:** early self- or supported intervention when a particular difficulty is happening. **Stage Three:** clinical assessment, diagnosis or treatment when clinically indicated. These are distinctions of responsibility, not labels attached permanently to people.

STAGE 1	STAGE 2	STAGE 3
MAINTENANCE	**EARLY RESPONSE**	**CLINICAL CARE**
Everyday learning	Self- or supported intervention	Specialist responsibility

The objective is not to move therapy upstream. It is to make recognition, proportionate action and the judgement to seek appropriate help familiar skills wherever non-clinical early intervention is suitable.

THE EDUCATIONAL MECHANISM ALREADY EXISTS

Perception › Pre-Cognitive Fear › Thought (linked to memory) › Feelings › Action › Outcome › Feedback

The Behaviour Cycle explains how responses, outcomes and feedback shape future behaviour. Fear can narrow attention and bring familiar worries to mind before we notice it, influencing interpretation before action. Sometimes the danger is real. Poorly resolved Fear Cycles can repeat and stack, adding pressure and limiting recovery. This pathway does not explain every mental-health condition.

STOP interrupts fear-driven behaviour. **GO** is deliberate action towards a different outcome and feedback. The MetaSTOP Method® supports consideration of options and preparation for action; repeated use can strengthen practical capability.

WHAT THE CAPABILITY LOOKS LIKE

RECOGNISE EARLIER

A young person notices an angry reaction before acting.

RESPOND DELIBERATELY

A manager or carer spots their own escalating response and changes approach.

Source: STOP Fearing Fear® Framework and MetaSTOP Method®.

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EQUALITY, INCLUSION AND NATIONAL RELEVANCE

Identically Different

Different identities. Shared underlying mechanisms.

Age, gender, ethnicity, neurotype, culture, upbringing and individual circumstances influence the pressures people face, how threats are perceived and what resources or support are available. These differences are real and significant. They help shape personal experience and identity; they cannot be reduced to one behavioural explanation.

THE SHARED FOUNDATION

STOP Fearing Fear® proposes that, beneath these differences, people can be taught a common functional understanding of how perception, fear, thought, feelings, action, outcomes and feedback interact. Experience and repeated feedback can reinforce expectations of what is manageable. The framework describes that shared educational architecture; it does not claim that neurological functioning is identical in every person.

Where Behaviour Cycles remain poorly resolved, fear-led responses may repeat and compound pressure. The activating conditions, intensity, capacity for recovery and consequences vary across people and settings. Yet the pattern of unresolved difficulty and accumulating strain provides a useful cross-population focus for early education.

Universal in foundation. Equitable in access. Adapted in delivery.

THE EQUALITY PRINCIPLE

A population-wide foundation does not mean that everyone must learn in the same way. Materials, pace, communication, accessibility, reasonable adjustments and supported application must reflect different ages, abilities, neurotypes and circumstances. Inclusive education is meaningful only when people can use what they learn.

A NATIONAL RESPONSIBILITY, NOT A DIAGNOSIS GATEWAY

Targeted provision, specialist assessment, safeguarding and clinical treatment remain essential. The policy opportunity is complementary: make foundational Preventive Mental Health Education available before diagnosis or crisis is the threshold for attention. A shared capability can be introduced widely, with additional support wherever it is needed.

National implication: The case is not for replacing targeted services with a universal programme. It is for adding a teachable preventive foundation across education and public life, while ensuring the routes into it are equitable.

Population-wide access should be the starting point; accessible teaching and proportionate support make that access meaningful.

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A NATIONAL EDUCATIONAL OPPORTUNITY

Teach it early.
Reinforce it throughout life.

The opportunity is continuity, not another isolated awareness message. People could encounter a coherent educational foundation repeatedly, with understanding and application developing across age, experience and responsibility. The content would remain recognisable; its delivery would change with context.

A PROGRESSIVE SCHOOL PROGRAMME

STOP Fearing Fear® emerged from educational study and frontline teaching, and developed through intensive crisis intervention and later adult work. The national proposition begins with existing practice-developed material, rather than an unbuilt idea or a claim to an accredited national curriculum.

Across approximately 11–13 years of education, learners could revisit the relationship between fear, thought, behaviour, consequences, needs and feedback. Teaching would develop from early recognition and supported responses towards increasing autonomy, judgement and applied resilience. Classroom instruction would be reinforced through ordinary routines, relationships, challenge, reflection and constructive feedback.

THE SAME FOUNDATION, DIFFERENT RESPONSIBILITIES

FAMILIES, CHILDREN'S SERVICES & CARE

Shared understanding of escalating behaviour, adult responses, co-regulation and the development of autonomy without removing necessary support.

HEALTH & ADULT SOCIAL CARE

Earlier recognition of behavioural change, communication and proportionate support alongside clinical, social-care and safeguarding responsibilities.

POLICE, EMERGENCY SERVICES & DEFENCE

Fear literacy, reciprocal escalation, judgement and applied resilience within operational procedures and established duty-of-care requirements.

EMPLOYERS, LEADERS & PUBLIC SERVICES

Recognising pressure before visible failure, improving decisions under stress, and complementing safer working systems and appropriate support.

A RESPONSIBLE ROUTE TO DEVELOPMENT

National adoption would require partnership with relevant educators, practitioners, specialist bodies and public institutions. Early work could define learning outcomes, accessible formats, delivery standards, safeguarding and evaluation before any larger implementation or licensing decision.

Context: DfE schools and colleges; WHO education guidance (2025); DWP Keep Britain Working (2026); STOP Fearing Fear® speaking and training materials.

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THE PROPOSITION AND NEXT STEP

The framework exists. Let us make the capability familiar.

Created by Paul Martin, STOP Fearing Fear® is a practice-developed, evidence-informed framework for Preventive Mental Health Education. It draws on more than 25 years of education and frontline crisis intervention. The behavioural models, MetaSTOP Method®, publications, educational resources and training applications already exist.

THREE AREAS FOR A FIRST GOVERNMENT DISCUSSION

01 **National relevance**

Could a common layer of Behaviour and Fear Literacy complement existing prevention, education, health and employment responsibilities?

02 **Educational development**

How might progressive school learning, professional development and accessible adult education be adapted across settings?

03 **Public value and evaluation**

What collaboration, safeguarding standards, delivery requirements and independent educational evaluation would responsible development require?

AN INITIAL DISCUSSION, NOT A FUNDING REQUEST

We welcome a conversation with an appropriate government contact about national relevance and potential routes to development. The initial request is for dialogue, not endorsement or immediate funding. Any later collaboration, commissioning or licensing would follow suitable processes.

EVIDENCE, SAFEGUARDING AND INTELLECTUAL PROPERTY

The immediate proposition is a legitimate educational offer, not a claim of independently proven national clinical outcomes, reduced diagnoses or guaranteed savings. Wider adoption would set educational objectives, assess what is learned, protect safeguarding and public value, and evaluate implementation quality. Proposed future assessments based on the 7 Needs and 5 Methods of Fulfilment® are not yet validated predictive instruments.

INVITATION: AN INITIAL CONVERSATION

Could we discuss how practical Preventive Mental Health Education might be developed more widely, and how STOP Fearing Fear Services Ltd could contribute?

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