Rethinking funding priorities in mental health research


Summary

Mental health research funding priorities in high-income countries must balance longer-term investment in identifying neurobiological mechanisms of disease with shorter-term funding of novel prevention and treatment strategies to alleviate the current burden of mental illness. Prioritising one area of science over others risks reduced returns on the entire scientific portfolio.

Declaration of interest

Some authors work in research areas (e.g. optimising interventions for people with mental illnesses) that could receive additional funding if the recommendations for realignment of funding priorities made in the article were implemented. Specific conflicts of interest: R.L.-F., National Alliance on Mental Illness, Eli Lilly & Co, American Psychiatric Association, Cambridge University Press, UpToDate and American Psychiatric Publishing Inc.; D.B., Pfizer, Roche, Takeda, Amgen; M.F.H., Otsuka, Education Development Center, Policy Research Associates; A.I.R., Medavante, Takeda, Eli Lilly & Co, Santium Inc.

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The USA and other high-income countries have an ongoing need to examine these priorities. Despite spending more than any other country on healthcare (4271 US dollars annually/person), the USA ranks 37th in global health outcomes and fails to serve even half of its residents needing mental health services.3 In recent years, the NIMH funding allocation has prioritised neurobiological mechanisms of mental illness, searching for neurobiological mechanisms of mental illness, treatments for mood disorders in older adults and underserved populations.4

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Mental health research funding is a form of social investment. As with any investment portfolio, diversification is a prudent strategy. A disproportionate investment in neuroscience is as imprudent as investing only in growth stocks and neglecting less risky investments that yield immediate albeit potentially more modest benefits. Publicly funded government agencies are custodians of research for the public good. A diversified research portfolio, balanced between longer- and shorter-term pay-outs, has the advantage of demonstrating to stakeholders a present and steady payoff in improvements to routine practice. Fortunately, the services-research end of the NIMH portfolio provides such examples today. When outgoing NIMH Director Insel gave his final top ten list of best mental health research stories for the year, his pick for number one was from the services-research portfolio, noting, ‘this year we saw a spectacular example of how to move research into practice . . . The Recovery After an Initial Schizophrenia Episode (RAISE) project developed a patient-centred, multi-element treatment approach for optimising outcomes after a first episode of psychosis.’ Although NIMH support for projects like RAISE continues, those funding levels are dwarfed by neuroscience-related investments. As presented at open access Council meetings, yearly total investment in non-HIV/AIDS services and interventions research since 2012 comprises ~15% of the NIMH budget, with basic and translational neuroscience research accounting for the remaining 85%.

To prioritise one area of science over others risks compromising the overall return-on-investment. Neuroscience is one road to improving mental health, but overenthusiasm for this area means losing opportunities for advancements in mental health through research in areas such as developing sustainable interventions to overcome disparities in access to effective treatment and outcomes; crafting technologies and implementation strategies to disseminate scalable, cost-efficient interventions; devising approaches to empower people to overcome barriers to engagement and retention in treatment; and deploying preventive interventions to reduce the burden of mental illness, including clarifying how to implement best practices in suicide prevention, especially given the dramatic rise in suicide. Scalability of prevention interventions is key. Solutions may leverage technological advances, such as mHealth-based counselling, computer and web-based resources and collaboration with caregivers – such as teachers, clergy and primary care providers – who are first points-of-contact for those in need.

When NIMH leaders sought to illustrate the limited impact of mental health research on public health, they compared the multiple-decade decline in cardiovascular mortality with an increasing suicide rate, citing our limited understanding of mechanisms and the lack of new treatment agents as barriers to progress. Yet, epidemiological explanations of the decline in cardiovascular mortality find that lifestyle changes affecting risk factors (such as smoking) account for 44–76% of decreased mortality, whereas novel treatments account for 23–47%. Research on how to develop and implement preventive (including early-detection) mental health interventions could have similarly salutary effects. For instance, a substantial proportion of children's emotional impairments and poor school functioning could be alleviated by improving parenting skills, learning environments and habits of daily living. Prevention research should also identify strategies for mitigating the effects of social determinants and physical environments triggering mental illness. Pursuing these opportunities would result in a more diversified portfolio of intervention development, dissemination and implementation than currently exists.

In sum, too often our mental health research funding neglects immediate public health needs to focus on future discoveries, reflecting the drive for technological solutions for disorders that are unequally distributed and partly socially determined. Time frames for such payoffs have previously been consistently underestimated, underscoring the prudence of keeping a healthy portion of the research portfolio invested in projects with shorter-term benefits.
health. The recent distribution of funding from NIMH suggests that these concepts need increased attention, priority and dollars.

Next steps

We call for an increase in public discussion of how to apportion funding resources across mental health research domains, as broad participation by stakeholders can lead to new policy priorities. This conversation should be fostered within national and international health organisations, government funding agencies such as the NIMH, and professional journals and organisations as well as in public forums, legislative hearings and political debates. These discussions must address thorny details, such as what proportion of the budget should be allocated to what research areas; the near-term public health consequences of particular priorities; and how to leverage inter-agency collaborations to attain a robust and sustainable public health impact. The conversation should be international in scope. The NIMH can contribute to, and benefit from, the global discussion on funding policy conducted by organisations like the Roadmap for Mental Health Research and Well-Being in Europe, the Global Mental Health Initiative, Horizon 2020 and Grand Challenges Canada. Paramount in these discussions must be alleviating the terrible burden that individuals and families living with mental illness face every day. As Harry Hopkins, co-architect of the 1940s New Deal, replied to members of Congress who opposed allocating federal funds to lift the economy out of the Great Depression, claiming that the economy would sort itself out ‘in the long run’: ‘People don’t eat in the long run, they eat every day’.

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References