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Guest Editorial

A better future for mental health science

Lynsey Bilsland and Niall Boyce

Summary

This editorial suggests ways in which mental health science reform could yield more robust research and faster clinical progress. These include better animal and other models, a shift to transdiagnostic and clinically pragmatic classification systems, improved measurement, mission mapping and an entrepreneurial mindset aimed at taking advances rapidly to scale.

Keywords

Anxiety- or fear-related disorders; depressive disorders; experimental design; neuroscience; psychotic disorders/schizophrenia.

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'There's nothing wrong in trying to be a science, trying to posit a theory of the mind, trying to map "mental disorder" or trying out different treatments. But that is where we're at: in the very low foothills of anything approaching a scientific discipline.'[1] The words of *The Times* columnist Matthew Parris, published in August 2024, understandably provoked outrage at what was perceived to be an ignorant and ill-informed dismissal of the field of mental health.[2] However, besides correcting the clear inaccuracies expressed in Parris's article, we as the mental health science community also have a duty to ask why an experienced journalist would engage in such a sweeping condemnation of our work.

It is not our intention as authors to single out Parris; his distrust of the field is not unique. Such criticism can stem in part from a lack of knowledge and rigorous, balanced research. It may also have deeper roots in general mental health-related scepticism, whether driven by a politically radical view of psychiatry and allied professions as a form of social control, or a more right-wing suspicion of benefits claimants. As a clinical and scientific endeavour, mental health faces constant questioning of its legitimacy; however, the field must not respond to this with a purely defensive attitude. Such a stance, first, means that we as a field can neglect to champion the many advances that have transformed people's lives and, second, it distracts us from the hard work of rethinking and reorganising ourselves so that these advances arrive with greater speed, and are delivered with greater efficiency and compassion to those who so badly need them.

There are key foundational issues. To take one example, the question as to which animal models are appropriate to aid understanding and develop new treatments in mental health science has long been acknowledged.[3] Modelling even readily measurable conditions such as tumours with animal models can be challenging; complex mental health disorders such as schizophrenia, with its mixture of delusions and hallucinations, presents another order of difficulty. However, rigorous cataloguing and evaluation of such models remains to be done, and alternatives to circumvent the use of animal models, such as the use of artificial intelligence, are yet to be substantially explored. Another foundational issue is that of classification of mental health problems. The extent to which any system – old or new, categorical or transdiagnostic – advances or hinders practice and research needs to be carefully considered. If a single system that combines scientific validity with clinical utility is not attainable, the field at least needs to consider how multiple systems designed for different purposes can be meaningfully integrated with each other to maximise research value and ensure a clear research-to-clinic pipeline.

While addressing foundational questions, mental health science also needs to strive for urgent impact. In the quest for new and better treatments, we need to ask hard questions about how precisely treatments can be improved: which symptoms are not being addressed, which side-effects are intolerable, what is perceived as a worthwhile benefit and how can it be measured?[4] Which of the available and emerging treatment modalities are preferred, and in which combinations? The voice of lived experience will be key to answering these questions.

Having clearly defined these missions, the field needs to map out the ways in which they can be achieved in a way that retains focus but allows space for innovation. Such an approach – adopted in other fields including oncology and dementia research – will allow us to crowd in advocacy, research, investment and other engagement in a way that delivers results.[5,6] Focusing on the end goal means devising and funding large-scale, definitive trials, developed with insights from lived experience and measured using commonly accepted and robust metrics that will give us the confidence to move innovation into practice, or to understand and move on quickly from failure. We need to encourage an entrepreneurial mindset in the mental health science community such that individuals are not kept waiting unnecessarily for new treatments that work. Publication of results in peer review journals – even prestigious titles such as the *BJPsych* – is a key part of the research process. However, it should not be the end goal. Research that simply inhabits an axis defined by funders, laboratories, journals and conferences is not research that is making a difference in the world. The field needs to break out into the continuous development and refinement of effective products and their delivery to, and in collaboration with, the people who need them. This approach needs to apply globally, creating a new world in which 'global mental health' represents the exchange and adaptation of ideas and movement of innovation freely in all directions, not simply the export and scaling-up (for example, via task-shifting) of pre-existing models of treatment.

Finally, we need to ask for more and demand better. While a recent *Lancet Psychiatry* editorial argued that 'successful treatments are available [and] the key challenge is how to make existing treatments available and acceptable to all those in need', we as authors argue that mental health science and practice do not need to alight on either development of new treatments or service delivery as the 'key challenge'.[7] It is possible that the meagre resources historically allocated to mental health research and treatment have instilled an either–or attitude. However, we see no reason why prevention, treatment and service delivery should not all be addressed by different sectors of the mental health community, working in their individual areas of expertise but joining collectively to demand resources and encourage investment.

We, the authors of this commentary, are addressing many of these issues through our work at Wellcome. However, we invite others to join us in our efforts to reform and reinvigorate the field

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and stimulate the investment it both needs and deserves.[8] We at Wellcome are creating a step-change in early intervention for anxiety, depression and psychosis. We invite readers to engage with our strategy, funding calls and other activities to catalyse the field.[9]

The growing burden of mental health problems creates an undeniable sense of urgency. However, we must respond to this urgency not only with a plethora of individual clinical and research initiatives, but also with systemic and structural changes that will increase the chances of success. The best response to criticism of our field is not words, but rather positive results.

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The authors both work in the mental health solutions programme at Wellcome, UK. They have no other interests to declare.

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