

Short Review

Reform of the National Institute of Mental Health: A Proposal

Colin A. Ross* MD

The Colin A. Ross Institute for Psychological Trauma, TX, USA

*Corresponding author: Colin A. Ross, The Colin A. Ross Institute for Psychological Trauma 1701 Gateway, #349 Richardson, TX, USA. Phone: 972-918-9588 FAX: 972-918-9069

Received: January 12, 2025; Accepted: January 20, 2025; Published: January 27, 2025

Abstract

In the United States, the primary federal agency for funding mental health research is the National Institute of Mental Health (NIMH). For decades, the NIMH has prioritized research on genetics, biomarkers and related aspects of biological psychiatry, with no meaningful yield. It is time for a radical reorganization, restructuring and reconceptualization of NIMH spending.

Keywords: National Institute of Mental Health, Mental health, Research funding

The 2025 budget of the NIMH will be over 2 billion dollars [1]. After decades of focus on genetics, brain chemistry, biomarkers and related elements of biological psychiatry, and tens of billions of dollars spent, biological psychiatry in its current form has yielded zero findings of direct clinical relevance. The idea that there is an “underlying pathophysiology” to mental illness has been countered by a large body of NIMH-funded, published evidence – by the failure to find anything. Rather than continuing to fund endless efforts to identify biological causes of mental illness, it is time to rethink the paradigm and set a distinctly different research agenda.

This view is consistent with a statement made on the American Psychiatric Association website: “many factors contribute to the risk of mental illness, such as depression. Except in rare cases, genes determine just a small percentage of the risk of illness or response to medication. Age, lifestyle, general health, psychiatric symptoms and severity, and co-occurring conditions are usually more important factors in drug response.” [2]

Simple logic and common sense can tell you that the search for genes contributing to mental illness is futile. For example, genome-wide association studies (GWAS) currently involve tens of thousands of patients and tens of thousands of controls. Rather than demonstrating the advanced nature of such research, these numbers demonstrate that it is time to give up on that line of investigation. The huge numbers are required in order to find anything of statistical significance in a given study. The findings are difficult or impossible to replicate from one GWAS to another, and the overall conclusion is that there are hundreds of risk genes, each contributing less than 2% to the clinical picture, as stated in DSM-5 [3]. The same set of risk genes has been identified for schizophrenia, bipolar disorder, depression and autism, proving that there is no genetic specificity to DSM-5 diagnostic categories.

The promise in grant applications and the psychiatric literature is the hope that – with just a few more years of research – something will be found, resulting in a truly scientific personalized psychiatry in which medications will be prescribed to target specific genetic dysregulations. If there are hundreds of risk genes then hundreds of medications targeting the functions and products of those genes would be required and an individual patient would require dozens of medications given that each genetic abnormality only accounts for under 2% of the clinical picture. Each medication will cost the patient thousands or tens of thousands of dollars per year.

The entire enterprise is guaranteed to fail. It is time to give up on it.

If asked, I would recommend the following reforms to the NIMH:

1. Stop funding biological psychiatry in its current form.
2. Prioritize psychological and social causes of mental illness, and psycho-social treatments.
3. Stop all efforts to de-stigmatize mental disorders by saying they are brain diseases.
4. Mandate that measures of childhood trauma be included in all funded research. This should include psychological, social, cultural and economic forms of trauma.
5. Set ICD-11 complex-PTSD as the ruling paradigm: a poly-diagnostic response to complex psychological and social trauma accounts for a substantial proportion of serious mental illness.
6. Dismantle negative attitudes towards dissociative disorders by requiring them, and dissociative symptoms, to be measured in the majority of funded studies. Pair this with explicit efforts to de-stigmatize borderline personality disorder and conceptualize it as an adaptation to psychological trauma – set this as a research funding priority (see 2 above).

7. Provide extensive public education about the reforms.
8. If the reforms are met with bureaucratic, committee and procedural barriers, withdraw funding until the NIMH and its bureaucracy complies.
9. No reduction in the overall NIMH budget, only a re-allocation of resources.

If a reform at all resembling the above was adopted, the predicted response of organized psychiatry would be to decry it as anti-scientific and to say it was setting mental health back 50 years. Actually, it would transfer the focus to scientific study of the psychosocial aspects of mental health – and thereby correct an extreme imbalance that has dominated psychiatric research funding for decades [4].

References

1. Torrey F, Simmons WW, Dailey L (2023) The NIMH research portfolio: An update. *Primary Care Companion CNS Disorders* 25(4), 23m03486. [[crossref](#)]
2. <https://www.psychiatry.org/news-room/apa-blogs/genetic-testing-to-improve-psychiatric-medication>.
3. American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. American Psychiatric Association, Washington, DC, p. 494.
4. Ross CA, Pam A (1995) Pseudoscience in Biological Psychiatry. Blaming the Body. John Wiley & Sons, New York.

Citation:

Ross CA (2025) Reform of the National Institute of Mental Health: A Proposal. *J Neurol Neurocrit Care* Volume 8(1): 1-2.