OPINION**FIRST OPINION**

Why do discussions about ‘brain health’ ignore mental illness?

The divide between mental illness and neurological disorders is a scientific and strategic error

Adobe

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Governments, industry, and philanthropies are investing in neuroscience at an unprecedented scale, and the ambition behind this impetus is a noble one: to reduce the growing burden of brain diseases and extend healthy cognitive life. We fully support this movement's push for "brain health" to mirror successful frameworks established for cancer and heart health that prioritize early screening and aggressive preventive treatments, making it possible to act before irreversible damage sets in.

Even as this agenda gains momentum, however, a critical blind spot is emerging. As governments refocus their policies to tackle conditions like Alzheimer's disease and other neurodegenerative disorders, mental illness is often being sidelined as a secondary concern rather than as a primary component of brain health. This artificial divide is a scientific and a strategic error.

In many ways, the focus on Alzheimer's disease is understandable. Worldwide, more than 55 million people live with Alzheimer's and other dementias, a number that continues to grow with the rapid aging of the global population. This is undoubtedly a public health crisis.

If the goal of the brain health movement is to solve the Alzheimer's crisis, primary risk factors must be addressed, and many of these are psychiatric in nature. For instance, chronic depression, substance use disorders, and other untreated serious mental illnesses are not just comorbidities but significant drivers of cognitive decline and late-life neurodegeneration, and psychiatric symptoms like depression, anxiety, and psychosis are increasingly recognized as core, rather than secondary, features of major neurological conditions.

Psychiatric symptoms often precede memory or motoric loss and are associated with faster cognitive decline, increased institutionalization, and higher mortality rates. Such symptoms often impair a patient's quality of life as much as, or even more than, the primary neurological deficits. Indeed, in many countries, nursing home

admissions for dementia result more often from psychiatric symptoms than from cognitive changes.

Early-life psychiatric illness is a significant, modifiable risk factor for later-life neurodegenerative disorders. Although often underappreciated, depression is associated with a comparable, and sometimes higher, risk for dementia than cardiovascular health, which has has long been considered a key modifiable risk factor. In fact, leading health bodies, including the Lancet Commission, now recognize depression as one of the most significant contributors to the global dementia burden.

From a biological standpoint, chronic psychiatric conditions act like a constant stressor that erodes the brain's structural integrity. Data have demonstrated that mental illness can wreak havoc on the brain. When these disorders are inadequately treated, they leave neurons more susceptible to a "second hit" — the specific pathological shifts that trigger Alzheimer's disease or other neurological conditions — much like a weakened foundation is less able to withstand a storm.

For example, certain psychiatric illnesses have been shown to cause atrophy, or shrinkage, of parts of the brain. This reduces levels of transcription factors (proteins which help determine which genes are turned on or off) and places the brain in a "vulnerable" position. Subsequent "insults" (like exposure to growing levels of Alzheimer's or Parkinson's disease-associated misfolded proteins that rise during aging) facilitate degeneration of these neurons.

Adequately treating the psychiatric illness can slow the subsequent development or progression of major neurodegenerative disorders. Indeed, emerging evidence suggests that early detection and aggressive treatment of psychiatric symptoms may improve long-term outcomes by delaying the onset of clinical neurodegeneration and mitigating the cumulative biological stress that accelerates brain aging.

In short, ignoring the brain's psychiatric foundation — what many would consider "mental health" — while simultaneously focusing on saving memory in late life is like trying to treat the symptoms of severe cardiovascular illness after having ignored a lifetime of hypertension.

For decades, neurology has been viewed as the domain of "organic" disease, including conditions visible on scans or under a microscope, while psychiatry has been cast as the realm of behavior, shaped *mainly* by environment or psychology rather than biology. That distinction is not scientifically defensible. The fundamental processes governing brain health — genetics, neural and synaptic plasticity, and neuroinflammation — do not respect the arbitrary boundaries drawn between neurology and psychiatry. Bipolar disorder is as biological a disorder as multiple sclerosis, and schizophrenia is as disruptive to neural circuits as many neurological conditions.

Conceptually, then, the field of brain health must recognize that it is not confronting fundamentally different categories of disease. Rather, the field must embrace shared biological vulnerabilities that manifest in different ways. A brain that cannot regulate mood or perception is not, by any meaningful definition, a healthy one.

While dementia rightfully commands attention for its devastating late-life impacts, it behooves us to remember that mental illnesses are "the chronic diseases of the young." They often strike during critical early years in ways that fundamentally shape — and in many cases alter — the trajectory of education, employment, and social stability. Treating these disorders has an enormous impact on public health that is entirely separate from their potential later association with developing Alzheimer's disease and related dementias.

Psychiatric conditions account for a disproportionate share of global disability precisely because they strike early and persist. Failing to adopt a more inclusive concept of brain health represents a massive loss of human potential and, moreover, carries staggering economic and societal costs. Consider, for instance, that the overrepresentation of serious mental illnesses among the homeless and incarcerated is a visible testament to our failure to treat these brain disorders early and effectively.

Recognizing this gap is only the first step. To truly advance brain health, policy and research efforts must evolve in three key ways: comprehensive screening, research into improved treatment and preventive measures, and unified national (and international) priorities.

First, thorough screening efforts should be used to evaluate emotional regulation and affective resilience as rigorously as memory or movement, echoing the rigorousness of screening methods in, for instance, cancer, cardiovascular diseases, and diabetes. This is particularly important because meta-analyses of early intervention initiatives across the world have observed significant reductions in relapse rates and psychiatric hospital admissions. Importantly, early intervention also appears to result in improved functional recovery, not just symptomatic recovery.

For example, longitudinal Danish studies found that, five years post-diagnosis, patients enrolled in early intervention programs were significantly less likely to require supported housing and demonstrated improved social functioning, including greater engagement in vocational or educational activities.

Second, the same precision-medicine approaches that are now transforming oncology must be applied to mental illness, identifying biomarkers early enough to alter disease trajectory. In contrast to many other fields, psychiatry still diagnoses complex conditions such as depression, bipolar disorder, schizophrenia, and autism solely through clusters of behavioral symptoms observed in clinical settings.

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As just one example, two people receiving a diagnosis of major depressive disorder may have very different underlying biological mechanisms driving their illness, and very different responses to the same treatment. This is critically important because most existing treatments for psychiatric conditions (including major depressive disorder and schizophrenia) involve a significant delay in efficacy. Personalized treatments could help the field move beyond symptom suppression and toward functional remission, optimizing the probability of therapeutic success and eventually evolving into improved prevention.

Third, and perhaps most importantly, mental illness must be a central component of every major brain health initiative. The success of recent government initiatives for Alzheimer's disease — most notably the National Alzheimer's Project Act and the BOLD Infrastructure for Alzheimer's Act — along with parallel efforts in Europe, Canada, and Japan provide a powerful blueprint for how coordinated federal action

can yield tangible public health benefits. By elevating Alzheimer's to a national priority, these efforts catalyzed a historic surge in National Institutes of Health funding, resulting in markedly increased clinical trials for novel therapeutic candidates and the validation of first-generation blood-based biomarkers that will, in time, revolutionize early diagnosis and treatment.

Furthermore, the 2013 G8 Dementia Summit driven by then-U.K. Prime Minister David Cameron led to the formation of the landmark dementia discovery fund that is having a major impact on dementia research. Applying this same level of sustained, bipartisan commitment to serious mental illness would undoubtedly mirror these results. By establishing similar national frameworks for research and care infrastructure, mental health treatment can go from crisis management to a proactive, biologically based era of recovery and functional independence.

The brain and mind are one system. It is time for our policies — and our priorities — to catch up.

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