Bridging Gaps in Mental Health: 10 Research Priorities

King Baudouin
Foundation
Working together for a better society

Bridging Gaps in Mental Health:
10 Research Priorities

The MIND10 project by the Fund for Mental Health Research,
King Baudouin Foundation and
the Center for Contextual Psychiatry, KU Leuven

Mental health and caring for it: it affects us all. Globally, an estimated one in four people will experience psychological problems at some point in their life. Add to that the people around them, who are also impacted, and we can confidently state that most of us are directly affected by mental health and its treatment. Mental wellbeing and mental health are also prominent themes in both traditional and new media.
Mental illness is a major cause of personal and social disruption, loss of quality of life, and loss of talents that could otherwise benefit society. As such, it accounts for a significantly larger share of the disease burden than physical conditions with high mortality rates, such as cardiovascular disease, cancer and infectious diseases.

Wanted: research!

Research is essential if we are to properly understand and address the major and massive challenges in mental healthcare. Research doesn't only deepen our knowledge of mental illnesses, their causes and the underlying mechanisms. It also teaches us how we may be able to prevent them, which interventions and treatments work, how they work, for whom they do and don't work, in what circumstances, how best to organise the sector, etc. In short, research is urgently needed to underpin effective policy and improve healthcare practices. The broad spectrum ranges from fundamental research to clinical and practice-oriented research. This also requires sufficient and targeted funding.
This raises a problem: too little research is being carried out into mental health, as this report highlights.

There are blind spots, and scientific research questions don't always match the needs of patients, their families and care providers. Research agendas are often drawn up without any structured dialogue with or involvement of these groups.
As a result, important issues remain unexplored and a gap emerges between the research carried out and needs on the ground: what is actually needed to improve the quality of daily life and work for patients and care providers?

The MIND10 project: stakeholders in conversation

To help bridge the gap, the Fund for Mental Health Research was established within the King Baudouin Foundation.
The Fund recently joined forces with KU Leuven, leading to the MIND10 project, whose results you can read about in this report. We invited patients, their family members, care providers, researchers and policymakers from across Belgium to work together to identify crucial research questions.
The aim was to arrive at a common list of 10 questions whose importance was recognised by all parties.
Listening to the voices of stakeholders and facilitating a conversation between them seems obvious.
In practice, such discussions, which carefully consider different perspectives and interests, are rarely organised.
But this approach yields valuable results. By involving parties who are usually less visible, new insights and relevant questions emerge. This promotes the involvement of citizens and professionals in research, enables resources to be used more effectively, and increases the social relevance of the research, which in turn motivates the researchers themselves.

Project call

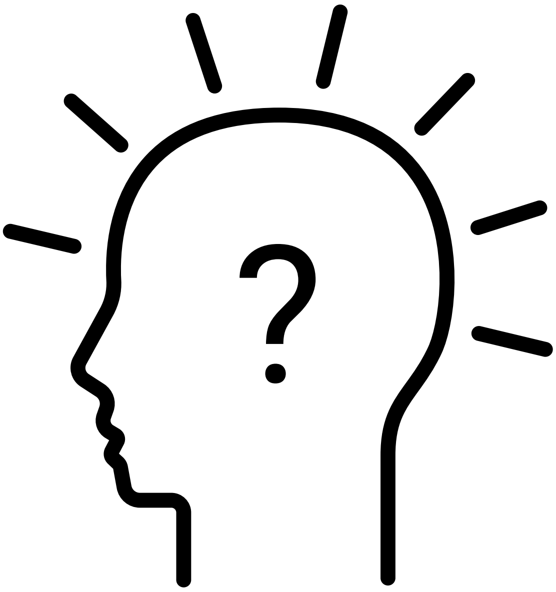
The top 10 research questions resulting from this project form the basis for the first call for research projects from the Fund. The Fund is making available a budget of €1.6 million to support mental health research that meets the needs of patients, their families and care providers. Of course, researchers, policymakers and other funders in the field of mental health are invited to use this report to focus their priorities.

We are sincerely grateful to the many people who contributed to this project. We would particularly like to thank those who took part in the surveys and workshops. This list of research priorities has been compiled thanks to their commitment, dedication and openness.

I.

WHAT IS THE PROBLEM?

The importance of research into and about mental health and its care is beyond dispute. However, investigation of the research points to three problems: underfunding, imbalances and insufficient transfer of theory into practice.

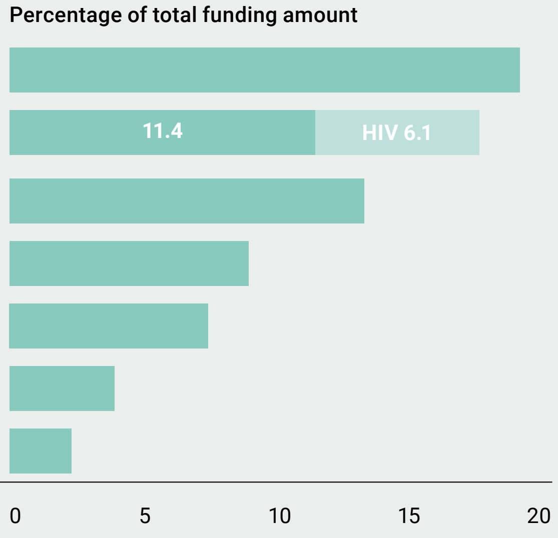


Global research: underfunding

Despite the immense impact of the issue of mental health and its care, there is a striking lack of funding for research. We know this thanks to a study of more than 75,000 research grants and their distribution in approximately 35 countries. This study indicates that, compared to other – physical – illnesses, scientific research into mental health is severely underfunded around the world. Only a fraction (7.4%) of the available budget is allocated to this (Figure 1). This amounts to approximately 50 cents per person per year.

FIGURE 1

Health Category	%
Cancer and neoplasms	**19.0**
Infection	**17.5**
Neurological	**13.2**
Cardiovascular/Stroke/Blood	**8.9**
Mental Health	**7.4**
Metabolic and endocrine	**3.9**
Respiratory	**2.3**



Global investment in research into mental health compared to other illnesses
(adapted from "*The Inequities of Mental Health Research Funding*" by Woelbert et al., 2020)

Imbalances in research

There is a second problem: the limited funding for mental health research is unevenly distributed. This results in certain issues, research areas and age groups being systematically overlooked. International research shows that, compared to research into substance use and depression, the following conditions receive significantly less funding, despite their considerable social impact: self-harm, suicidal tendencies, eating disorders, conduct disorder, obsessive-compulsive disorder, bipolar disorders and personality disorders (Figure 2). Self-harm and suicidal tendencies, for example, account for a significant proportion of years of life lost due to mental illness, but research into these issues receives significantly less funding.

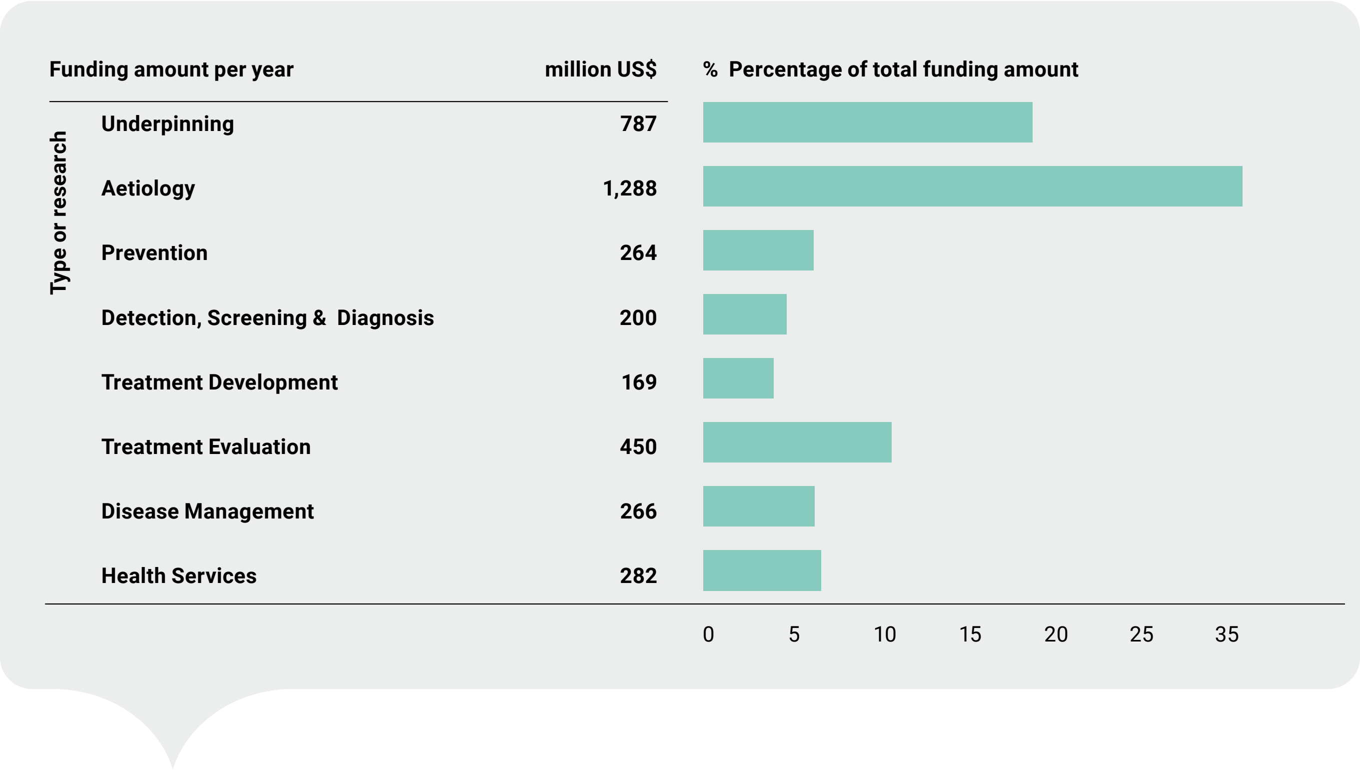
There is a second imbalance in current global research funding: more than half of the funds are spent on fundamental medical research (Figure 3), such as research into genetics or brain imaging. Its importance is beyond dispute, but this research does not directly benefit people with mental health issues, their family and carers, and any benefit is often only in the long term. More practice-oriented research is severely underfunded. This includes research into prevention, detection, treatment, health literacy and recovery, as well as healthcare provision and organisation. These themes are crucial for bridging the gap between scientific insights and real impact in healthcare practice.

FIGURE 2

Funding amount per year	milion US$	Median grant value $
Not disease-specific	**1,660**	154,000
Substance use and dependence	**701.9**	494,928
Depression	**319.1**	157,496
Autism spectrum disorders	**252.0**	153,281
Psychosis	**175.1**	334,678
Schizophrenia	**162.8**	229,338
Anxiety disorders	**97,7**	289,596
Other neurodevelopmental disorders	**82.7**	133,530
Posttraumatic stress disorder	**57.2**	338,508
Suicide	**54,1**	104,000
Attention-deficit hyperactivity disorder	**43.9**	180,568
Bipolar disorders	**32.7**	391,342
Eating disorders	**24.6**	167,882
Conduct disorder	**16.0**	437,624
Obsessive compulsive disorder	**11.5**	222,760
Personality disorders	**6.9**	80,968
Self harm	**6.6**	163,358
Other mental health conditions	**3.4**	56,763

Global investment in research into mental health per condition
(adapted from "*The Inequities of Mental Health Research Funding*" by Woelbert et al., 2020)

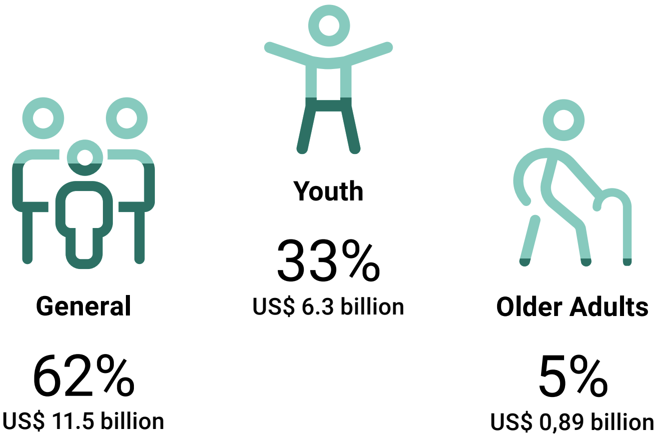
FIGURE 3



Annual global investment in research into mental health
(adapted from "*The Inequities of Mental Health Research Funding*" by Woelbert et al., 2020)

The third and final imbalance: age groups (Figure 4). Most investment goes into research into mental health in adults. Other age groups – babies, children, young people and seniors – systematically receive less attention. A notable observation in this regard is that the majority of mental disorders (approximately 75%) develop before the age of 24. This is therefore the stage at which prevention and early intervention are particularly beneficial and cost-effective. 33% of global funding is spent on research on young people and their mental wellbeing.

FIGURE 4



Distribution of research funds per age group (adapted from "*The Inequities of Mental Health Research Funding*" by Woelbert et al., 2020)

Insufficient transfer

Finally, in addition to underfunding and the three imbalances noted above, there is the problem of research transfer, again according to Woelbert et al. This begins with the research community and its assessors and funders valuing fundamental science more than research into practical solutions that directly benefit patients and the healthcare system as a whole.
This leads to a gap between existing research and its implementation: how do you put scientific insights into practice? How does this benefit mental health care?

Applications of research in everyday practice encounter obstacles such as:

- the lack of coordination between researchers, policymakers and healthcare providers;
- cultural and systemic differences that make it difficult to generalise findings and translate them to specific contexts;
- insufficient funding and appreciation for applied research that tests interventions in real-world contexts;
- insufficient involvement of end users in the design, implementation and evaluation of research.

Without well-targeted efforts to promote progress and bridge the gap between research and its implementation, promising research risks being confined to academic settings. In other words: the people who most need the insights from the research are not being adequately reached.

Research in Belgium

Until now, the figures have looked at the global picture.
What is the situation in Belgium? That was also recently studied: the Fund for Mental Health Research and the University of Leiden published a bibliographical analysis of the Belgian research field in 2024. Some of its findings:

- The dynamics in Belgium are comparable to the global figures mentioned above.
- Existing research focuses primarily on the above conditions (addiction problems, depression) and age groups (adults).
It focuses less on other conditions and vulnerable age groups.
- There is also a disproportionate focus on fundamental research here. In other words, there is much less practice-oriented research being conducted.

In Belgium, too, there is a need to better align research with the needs of the field and to determine research priorities.

II.

THE MIND10 PROJECT: CHOICES

The MIND10 project: what is it?

The Fund for Mental Health Research and KU Leuven joined forces for the MIND10 project. Implementation took place between February and June 2025 and was inspired by the Priority Setting Partnership model of the James Lind Alliance. Such projects aim to establish research priorities for a specific issue in a participatory process involving all stakeholders.
MIND10 offered patients, families and care providers the opportunity to identify the themes they believe should be prioritised in research into mental health and its care in Belgium. Researchers and policymakers were actively involved in the process in order to draw up a widely supported top 10 research priorities together. We describe the process in Part IV.

The MIND10 project: choices

The figures mentioned in Part I significantly influenced the substantive choices made in MIND10. The project systematically took into account and paid particular attention to mental health problems, research areas and age groups that are currently underrepresented in research.

This choice played a role from the outset, in recruiting participants and in designing the questionnaire. The following were particular points of attention:

- Recruiting participants from patient organisations, peer support groups and care provider contexts who are familiar with the needs of babies, children, adolescents and older people.
- Recruiting participants from patient organisations, peer support groups and care provider contexts who are familiar with the needs of people with conditions such as self-harm, suicidal tendencies, eating disorders, conduct disorders, obsessive-compulsive disorder, bipolar disorders and personality disorders.

Five categories

We defined five categories for collecting research questions. This choice is also based on figures from the existing research, which revealed needs for future research.

- Worldwide, more than half of the funding for research into mental health and its care goes to fundamental research (56%).
- Research into the prevention, diagnosis and treatment of mental health problems accounts for 17% of funding worldwide.
- Applied research, such as the evaluation of treatments and the management of health services, accounts for 12% of funding around the world.

The source for this data is Woelbert et al.

The five research categories are:

1. Prevention

Prevention encompasses preventing mental health problems and promoting mental wellbeing. It means we try to prevent mental health problems from developing while working to strengthen mental wellbeing. In terms of research, this could involve, for example, research on people without a diagnosis or how to help people develop healthy behaviours and thus reduce the risk of mental health problems. This includes research that focuses on promoting physical activity and its effects, sleep and stress regulation, as well as research that focuses on reducing bullying behaviour or preventing drug use.

2. Detection

Detection involves recognising, identifying, diagnosing and predicting mental health problems. This could be research into better screening methods in schools, developing and evaluating tools for early detection, or ways to improve the recognition of signs of emerging mental health problems.

3. Treatment

This category concerns the establishment and development of therapies and testing how well they work, how much they cost, for whom they work best and what side effects they have. Research may focus on comparing treatments, such as cognitive behavioural therapy and group therapy, or developing and evaluating new therapies, including digital therapies, using apps or virtual reality interventions. It may also involve research into how to better tailor treatments to specific target groups, such as young people, the elderly or people with multiple conditions.

4. Health literacy and recovery

Research into health literacy and recovery examines how people deal with their mental health issues, and the impact on relationships, education and work, and on an economic and physical level. It also looks at what supports people socially and how they recover. There is also the question of how the impact of mental health issues can differ, depending on an individual's social position. Consider people living in poverty. What is needed to improve their quality of life, what support can families receive, how can we better understand what helps people to participate in society again? This raises questions such as: what support do people need in their daily lives? What helps people to cope better with an illness and not be hindered by its consequences? How can we better support and guide people who have become unemployed due to illness return to the labour market? How can people regain a sense of identity and purpose? How can people feel connected to their community again?

5. Healthcare provision and organisation

Research into healthcare provision and organisation examines how mental healthcare is delivered and how we can improve the quality of this care and the related policy. This could involve research into reducing or eliminating waiting lists, or how to make healthcare more accessible to those who find it difficult to access, such as people in poverty or people with a migrant background. It may also concern how care providers can collaborate more effectively or innovative ways of organising care, such as the use of e-health platforms.

III.

RESEARCH QUESTIONS AND PRIORITIES: THE TOP 10

What follows in Part III is the result of the three-step process described in Part IV: the top 10 research questions identified as priorities. The 10 questions are ranked equally. We present them in the order of the five categories.

1

How do we organise and implement mental health prevention programmes that are widely accessible and efficient for everyone, with a focus on socially vulnerable people?

What is the issue?

The prevention of mental health problems is receiving increasing attention. However, many initiatives remain difficult to access for people in socially vulnerable circumstances, such as people in poverty, people with a migrant background, young people without a network and socially isolated older people. There are also financial barriers, linguistic and cultural differences, inadequate digital skills and opportunities, and a mistrust of social services.

These are precisely the groups that are often at higher risk of mental health problems and would benefit most from prevention. Because many prevention programmes are established without much input from the target groups, their content does not properly reflect their reality. In addition to being inaccessible, they are often inappropriate, which undermines their effectiveness and exacerbates existing forms of inequality in the field of mental health.

Education – from primary to higher – can play a dual role in this issue. It is a unique environment for reaching virtually all children and young people, and it trains future healthcare professionals, for example in applying evidence-based prevention strategies.

This leads to the research question of how an inclusive approach can be successful in the design, organisation and implementation of mental health prevention programmes, ensuring that everyone is reached, particularly people from the groups mentioned here.

2

How can families, schools and other informal support actors work better with the professional care sector with a view to early recognition of mental health problems, raising awareness and referral?

What is the issue?

What is informal support? This refers to individuals and organisations that, without having a formal care mandate, can play an important role in the mental wellbeing of people of all ages. They are part of their daily lives and are often the first point of contact when concerns arise. They may be teachers, youth group leaders, sports coaches, community centre workers, volunteers in associations, etc.

Early recognition and intervention are crucial: the sooner signs are noticed and addressed, the greater the chance of timely and appropriate help and the lower the risk of a problem worsening in the long term. In this initial phase, schools and other informal support networks play a key role alongside families. They are often closest to children, young people and others in vulnerable situations and can be the first point of contact when problems arise.

This is not self-evident. These actors often feel they do not receive sufficient support and/or are not sufficiently skilled to recognise signs of mental “unwellness” or to deal with them appropriately. They often do not have the time, availability or resources to do so. Furthermore, there are barriers to cooperation with professional support services in terms of communication, responsibility, expertise and mutual trust. Due to this combination of factors, many signals remain unnoticed and the referral process can be difficult.

By working towards shared responsibility between informal and professional care, we can make mental healthcare more accessible and take more preventive action.

Research is needed into strategies to make it easier for informal actors to involve professionals at an early stage. How can we implement this? How can we strengthen cooperation with professional care providers while taking into account people’s capabilities, roles and capacity? Consider joint training programmes, consultation structures, shared tools and clear agreements.

It goes without saying that families and other loved ones can also play a role in this.

3

How can we detect and treat mental health problems in older people more quickly and effectively?

What is the issue?

Mental health problems in older people are still often overlooked. This is because the catch-all phrase "it's just part of ageing" is used too often, resulting in psychological complaints such as depression, anxiety and confusion being recognised late or not at all. A second problem is that older people are less likely to mention their complaints: out of embarrassment about what they consider to be taboo, because they also see it as "part of ageing", and because physical problems predominate in medical consultations.

Furthermore, access to specialised mental healthcare for older people cannot be taken for granted. This is due to structural barriers, such as mobility problems, underdiagnosis in primary care and a lack of appropriate care models. There is another factor in the background: the underrepresentation of older people in mental health policy and research. Yet alongside this observation – the limited attention paid to older people in relation to mental healthcare – demographic figures indicate that our society is ageing.

How can we achieve faster detection and treatment of mental health problems in older people? How can we combine this with care that is tailored to their specific needs and improves their quality of life? It is already clear that raising awareness among care providers is a priority, as is the structural reinforcement of elderly care within the mental health sector. Older people can be made aware of mental health issues in themselves and those around them, enabling them to recognise and report these issues more quickly.

4

In a society that is diverse in many ways, how can we better tailor care to people's individual needs, even when complex issues are involved?

What is the issue?

Mental healthcare is faced with an increasing diversity of backgrounds, requests for assistance and care needs. It often proves difficult to provide adequate, tailored care, especially when people are struggling with multiple problems. Consider psychological vulnerability combined with addiction issues, poverty, trauma or physical health problems. Such complexity calls for a holistic approach that views people as a whole and does not treat them solely on the basis of a "label" or "diagnosis".

Cultural diversity is playing an increasingly important role in the healthcare landscape. Existing forms of assistance and communication or expectations regarding care do not always match the reality of people with a migrant background or other cultural reference frameworks. This can lead to misunderstandings, reduced adherence to treatment and even a failure to seek help. There is a need for research into strategies to better align care systems and practices with the diversity of people who need care, taking into account the unique context, values, needs, vulnerabilities, etc of each individual. The aim is to guarantee good, accessible, inclusive and appropriate mental healthcare.

5

How do we establish a culture of evidence-based practice as the norm in mental healthcare?

What is the issue?

Evidence-based practice refers to the systematic application of care interventions based on the best scientific evidence available at the time. This is combined with the individual clinical expertise of healthcare providers and takes into account people’s values and preferences, as well as contextual factors (costs, available resources, etc). Evidence-based practice is a cornerstone of high-quality care.

It appears not to be straightforward to implement evidence-based practice broadly and sustainably in mental healthcare. As a result, research findings are slow to find their way into practice, or only do so in a fragmented manner. Care providers sometimes experience tension between standard guidelines and the unique situations of the people in their care.

There is sometimes uncertainty or even resistance in the sector when it comes to using scientific “evidence”, partly due to a lack of training, time or resources. There is also a perception that this approach can be too rigid or distant from reality. If that is the case, people are more likely to work on the basis of their own experience, intuition or practical feasibility.

How can we achieve a learning healthcare system in which new knowledge is structurally and systematically integrated into practice, and in which evidence-based working is the norm? This requires a cultural shift. Structural, cultural and psychological barriers must be identified and removed, and effective strategies are needed. These could include training, leadership, reflection practices, knowledge sharing, quality assurance criteria, etc.

6

How can we embed recovery principles, such as self-management and participation, in mental healthcare, in order to give people long-term support in their recovery and reintegration? What role can the social environment play?

What is the issue?

People are increasingly encouraged to take an active role in their recovery, with a view to social reintegration. Self-management and participation are crucial, and the process involves much more than the traditional reduction or control of symptoms. How can you actively apply the principles of recovery within mental healthcare? This has not yet been sufficiently researched.

It is also clear that a person’s social environment – family, friends, wider networks – can play an important role in supporting recovery and preventing relapse. This potential involvement and the opportunities it offers are not yet sufficiently integrated into care provision.

In other words, this is a two-pronged question, in which both the formal care system and the informal social environment play a key role. The aim is to examine how mental healthcare and people’s own environment can provide systematic and sustainable support for the recovery process and their reintegration into society.

7

How can we better define the profiles of loved ones of people with mental health issues in order to offer them more personalised support?

What is the issue?

The loved ones of people with mental health issues often play a crucial role in the recovery process. However, they rarely receive structural support themselves. Their experiences and needs vary greatly: some like to be actively involved in the care process, others struggle with feelings of powerlessness, overload, shame and isolation, while others prefer to keep their distance.

There are forms of support available, but they tend to be generic and do not take sufficient account of the diversity within the broad group of “loved ones”. A young adult who cares for a parent with a mental illness has different needs than the partner of someone in crisis, or the parent of a child with addiction problems or suicidal thoughts.

The concept of “loved ones” itself is also diverse. It refers to family members and relatives as well as friends, colleagues and neighbours. By definition, they can also play a role in aftercare, long-term recovery and reintegration into society. Their involvement aligns seamlessly with the more relational and recovery-oriented approach that is gaining ground in mental healthcare.

Research is needed to gain a better understanding of the diverse profiles of loved ones – their resilience, needs, coping strategies, etc – and their relationship with the person with mental health needs. How can support be more targeted and tailored to what really helps? How can we avoid overburdening people and promote their long-term involvement?

8

How can we involve loved ones more in the care process, using better implementation strategies?

What is the issue?

Loved ones – family members, partners, close friends, colleagues – can play a crucial role in the recovery process of people with mental health issues. They can provide emotional support, help to follow up on treatments and act as a bridge to professional help. Research shows that involving loved ones has positive effects, on both the individuals themselves and their relationship with care services. However, in practice, it appears difficult to structure this involvement in a systematic and effective manner.

Many care providers want to collaborate with family members but encounter obstacles such as lack of time, uncertainty about privacy and a lack of guidance or overarching vision. Policies and training programmes also recognise the added value of family involvement. For their part, families often feel they are not sufficiently recognised or listened to.

In any case, the standard question of whether we should involve loved ones in care is giving way to the question of how we can do so in a sustainable and systematic manner. More insight – and therefore more research – is needed into effective implementation strategies to embed existing and possibly new knowledge about family involvement more firmly in mental healthcare practice. How do we translate existing and new insights into everyday reality?

9

How can we promote access to and continuity of care? How can we improve cooperation between actors within and outside mental healthcare?

What is the issue?

Many people experience discouragingly high barriers in their search for appropriate mental healthcare. These may be waiting times and distances, financial barriers, fragmentation in the healthcare landscape or insufficient coordination between care providers and institutions. All of this also increases the pressure on the people around them.

Continuity of care means that care is provided without interruption, tailored to the individual and their changing needs. Achieving this requires structural and smooth cooperation between care partners. In practice, this often goes wrong: crucial information is lost or not passed on, agreements are unclear and follow-up is not guaranteed.

Actors outside the professional mental healthcare sector also play an essential role in the broader care network surrounding an individual, such as loved ones, teachers, social workers and general practitioners.

Good, structural communication and cooperation between mental healthcare providers and these external actors is crucial to ensure accessibility and continuity of care.

With these in place, a sustainable and integrated care system can develop that is tailored to people’s personal circumstances and needs and takes a holistic approach, addressing somatic complaints as well as the psychosocial context and considers the connections between them.

There is a need for research into how we can move towards better accessibility and greater continuity, in a holistic approach to care. Related to this: how can actors within and outside mental healthcare work together more effectively, with this threefold objective in mind?

10

What causes long waiting times, what is the impact of waiting, and how can we reduce it?

What is the issue?

Waiting times in mental healthcare in Belgium are a long-standing and persistent problem. Many people with mental health issues have to wait weeks or months before receiving appropriate help; sometimes waits exceed a year. The consequences are clear: worsening conditions, more crisis situations, a feeling of abandonment or hopelessness among the people waiting and those around them.

The causes are complex and multiple, and they reinforce each other. In general, there is a shortage of care staff in relation to needs, insufficient continuity within the care pathway, inefficient organisation of healthcare provision and insufficient structural coordination between levels of care. The lack of accessible intermediate forms of temporary support also plays a role. In any case, these intermediate forms are not an ideal option, as they may even perpetuate the issue.

More than just treating the symptoms – making the wait more bearable – there is a need for systemic change. Can we refine our knowledge of the interrelated causes and better understand the psychological and social impact of waiting times in order to also highlight the urgency of the issue? Research can provide targeted sustainable solutions, such as alternative care models, improved triage and investments in prevention and primary care, to make the system more accessible and dynamic.

IV.

HOW WE ARRIVED AT THE TOP 10: THE PATHWAY

Step 1:
inventory of research questions

60 key representatives

For step 1, 60 key representatives from across Belgium were recruited. A total of 67 Brussels, Flemish and Walloon organisations active in mental healthcare were contacted: organisations representing the interests of patients, family members and carers, and organisations from the formal and informal care and welfare network. This was done by email and telephone.

The aim was for the 60 representatives to present the perspectives of the three most important stakeholder groups: patients, their family members and care providers. They were therefore the voice of a broader group within mental healthcare and not simply representing themselves. The number was in line with previous prioritisation projects by the King Baudouin Foundation; recruiting 60 people was also feasible within the time available.

The key representatives do not work at policy level. However, they do have practical experience and a strong connection with the group they represented in this project. Each organisation was asked to nominate the most suitable person, and each representative was encouraged to speak to their constituents with a view to submitting research questions (see below).

Representative

When searching for participants, the aim was to achieve representation and diversity of age, region, language and the various parties involved. Particular attention was paid to people from organisations working with conditions and age groups that are underrepresented in existing research (Yegros, Aerts & Vandenberghe, 2023; Woelbert et al., 2020). These include conditions such as self-harm, suicidal tendencies, eating disorders, conduct disorders, obsessive-compulsive disorder, bipolar disorder and personality disorders. The age groups in question were babies, children, adolescents and the elderly.

Another goal was to achieve the broadest possible representation of the various care settings: primary, secondary and tertiary care, psychiatric and general hospitals, mobile teams, sheltered housing organisations, umbrella organisations and other relevant contexts.

Number of key representatives	French-speaking	Dutch-speaking	Total
Patients	3	14	**17**
Family members	8	5	**13**
Care providers	12	18	**30**
Total	**23**	**37**	**60**

Towards a list of research questions

The 60 representatives were given an online questionnaire and asked to formulate what they considered to be crucial questions in the five broad categories outlined above. For prevention, for example, questions included: What would you, and the group you represent, like to know more about in terms of preventing mental ill health and promoting mental wellbeing? What do you consider to be important issues or uncertainties in the field of preventing mental health problems and promoting mental wellbeing that should be further investigated or better implemented?

These are the five categories:

- Prevention
- Detection
- Treatment
- Health literacy and recovery
- Care provision and organisation

Submissions were reworked into clear research questions and supplemented with input from two sources:

- questions from the Science Shop (KU Leuven Engage) [1], which originate from non-profit, local or social organisations;
- a concise literature review by the Center for Contextual Psychiatry at KU Leuven.

The list of 769 unique research questions (in dutch) can be consulted here.

	Patients	Family members	Care providers	Science Shop	Literature study	Total
Prevention	33	20	66	0	17	**136**
Detection	32	30	42	0	14	**118**
Treatment	40	31	52	1	18	**142**
Health literacy and recovery	57	53	52	7	10	**179**
Care provision and organisation	48	48	82	4	12	**194**
Total	**210**	**182**	**294**	**12**	**71**	**769**

---

[1] The Science Shop is an initiative of KU Leuven Engage, UGent, UAntwerp and VUB. It focuses on answering questions from society – often from non-profit, local or social organisations. It does so by converting these questions into research questions for students or researchers, with the aim of building bridges between academic research and social needs.

Step 2:
to an initial prioritisation of the research questions

Step 2 aimed to establish an initial prioritisation or targeted ranking of the 769 research questions. The objective was to select the most urgent and relevant within each of the five categories in order to arrive at a shortlist of 20 to 25 questions per category. This would result in a total of 100 to 125 questions. Researchers and policymakers, as well as patients, family members and care providers, were invited to indicate which questions they believed deserved priority, based on their own expertise, organisation and perspective. Various forms of expertise were brought together to ensure that the final priorities are both supported and achievable.

Reducing and reformulating

Based on a thematic analysis, questions with overlapping content were grouped into broader, less specific questions.
The aim was to respect the voice of each questioner as much as possible, to preserve the original idea of each question and to avoid duplication and unnecessary details. Questions submitted by only one person or without substantive similarities to others were not retained. In total, less than 3% of the questions submitted were eliminated for the next round, primarily because they were too specific and would only appeal to a limited group of researchers. For example, there were originally 142 questions in the Treatment category. Only four of these were eliminated. The final list contained 103 questions, divided into five categories.

Ranking by participation and representation

The 103 research questions were then sent to the patients, families and care providers from step 1, to policymakers with diverse competences and a broad view of the field, and to researchers from various disciplines and healthcare contexts who are active in categories and conditions where research is underfunded. They were all invited to indicate how important they considered each question to be, on a scale of 0 (no priority at all) to 10 (very high priority). As in step 1, they were asked to discuss with their constituents beforehand in order to solidify their representative role in setting priorities.
A total of 35 valid responses were recorded.

Number of participants per group	French-speaking	Dutch-speaking	Total
Patients	2	4	**6**
Family members	1	2	**3**
Care providers	4	7	**11**
Researchers	2	7	**9**
Policymakers	0	6	**6**
Total	**9**	**26**	**35**

The shortlist: selection criteria

The final selection of 20 to 25 questions (four or five per category) was based on a combination of criteria:

- The score given by the 35 respondents on the ranking questionnaire. This was the most important criterion.
- The origin of the question. Questions raised by different groups in step 1 were given extra weight. If both care providers and patients and/or family members asked the same or very similar questions, this was considered an indication of a widely shared social relevance. Such questions certainly reflect shared concerns within mental healthcare.
- The scope of the question. Some were a compilation of several questions from step 1. Such overarching formulations were given priority because they brought together multiple needs and voices in a single clear, widely supported research question.
- Gaps in the literature. Finally, a supplementary literature analysis indicated the extent to which certain questions have already been investigated. Questions for which the least scientific literature was found received extra attention. This gave the most neglected research topics more opportunities.

The shortlist of 24 selected research questions formed the starting point for the workshops in step 3. This was the distribution according to the five categories:

Research category	Number of research questions in the shortlist
Prevention	5
Detection	5
Treatment	5
Health literacy and recovery	5
Care provision and organisation	4
Total	**24**

The 24 in focus

Some of the 24 questions were slightly reworked at this stage to make them more precise methodologically or more relevant in terms of policy. Existing literature was taken into account.
For example, one original question was: “How can family members and loved ones be effectively involved in all phases of the treatment process?” The wording was edited to: “How can we improve implementation strategies aimed at involving loved ones in treatment?” (In this report, the wording has been slightly adjusted for linguistic reasons.) There is already a considerable amount of literature on how loved ones can be involved in treatment programmes. However, it often proves difficult to apply that knowledge in practice. The modified question shifts the focus to better embedding existing insights in healthcare practice.

Step 3:
towards a top 10, in workshops with end users and experts

After prioritising research questions in the ranking list, the selection was refined and validated in three interactive workshops. The workshops brought together the various parties involved to arrive at a widely supported top 10 research priorities based on the shortlist of 24 questions.

Workshops: objectives

- Identifying what stakeholders consider the most important and urgent research priorities.
- Delivering a widely supported list of priorities as a basis for future research funding and policy initiatives.

Composition and structure

Participants in steps 1 and 2 were asked if they would also like to participate in the workshops (step 3). The aim was to create an inclusive and safe environment in which everyone felt free to express their views. The sessions were led by experienced, independent moderators and conducted in Dutch and French, with simultaneous translation during the plenary part. This allowed everyone to participate actively.

- **Workshop 1:** Patients, family members and care providers
- **Workshop 2:** Researchers, policymakers and care providers
- **Workshop 3:** A mixed group of participants from workshops 1 and 2

Attendees	Workshop 1	Workshop 2	Workshop 3
Patients	2		1
Family members	3		2
Care providers	1	3	0
Researchers		4	1
Policymakers		4	1
Total	**6**	**11**	**5**

Method and process

At the start of workshops 1 and 2, participants worked in small groups on the shortlist of 24 research questions. They formulated their thoughts on questions such as:

- Are the research questions clearly formulated?
- Is any additional input or clarification required?
- Which questions do you think deserve the highest priority?

The concerns were shared and discussed in plenary. Finally, each group distributed “priority points” across the research questions. For each category, eight to 10 such points could be distributed across at least three questions. After the quantitative processing of the results, a plenary discussion took place to jointly validate the priorities and make adjustments where necessary. Research questions with the highest priority points were selected, with a minimum of one and a maximum of four questions per category.

The outcome of workshop 1 was a selection of 13 questions (two to four per category). Workshop 2 yielded a selection of 12 questions (up to four per category).
In preparation for workshop 3, the results of workshops 1 and 2 were processed both qualitatively and quantitatively. Suggestions, comments about ambiguities and other issues were also taken into account for the refinement, clustering and reformulation of the research questions. Eight questions scored highly in both workshops. The other two were selected from the five with the next highest scores (three from workshop 1 and two from workshop 2).

Workshop 3 brought together a mixed group of participants who had previously attended workshop 1 or 2 and were therefore familiar with the research questions and the process. The participants discussed, validated and refined the selection of the eight overlapping questions where necessary.
Individually, they provided final feedback on each question and confirmed it. They then worked in groups on the five additional questions, considering clustering, reformulation and which questions would make the final selection.
Based on a plenary discussion and vote, the participants ultimately selected the 10 final research questions, with the requirement that at least one from each category had to be included in the top 10. Attention was also paid to the clarity and focus of each question.

The top 10, the result of this three-step inventory, ranking and prioritisation process, can be found on pages 10 to 15.

V.

FINALLY: SOME INSIGHTS AND RECOMMENDATIONS

Finally, from the MIND10 project process, which resulted in the top 10 research priorities and questions, we have distilled a few key insights. These also include recommendations for mental healthcare in Belgium, which is making significant strides in terms of quality.

1

From knowledge to practice: implementation is a key challenge

The process made it clear that valuable knowledge and good practices often exist, but that they too infrequently find their way into the workplace. Bridging the gap between “knowing” and “doing” requires targeted implementation strategies, structural embedding of knowledge and good practices, knowledge sharing and a culture in which evidence-based practice is the norm.

2

Focus on target groups that may be particularly vulnerable

There is a need for structural attention in research and in mental healthcare as a whole for groups of people with their own demands and needs: young people, older people, people in socially vulnerable positions, people with complex mental health issues, and people with a migrant background and/or other cultural reference frameworks. The broader goal embodied in this: less inequality in health and more inclusive care.

3

Collaboration as the foundation of accessible and effective care and research

Effective mental healthcare relies on structurally embedded cooperation, both within the formal care chain and through informal networks: family, friends, schools and other community-based actors. Promoting this collaboration is crucial to stimulate prevention, improve continuity of care and strengthen recovery thinking. This requires clear structures and communication, and the assumption of shared responsibility.

The research itself is also best designed, conducted and evaluated in collaboration with all relevant disciplines and with partners from the field and from policymaking. This will generate the broadest support and the most impactful results.

The MIND10 project is intended to contribute to this.

REFERENCES

Woelbert, E., Kirtley, A., Herten-Crabb, A., McDaid, D., & Parkin, D. (2021).
The inequities of mental health research funding.

Yegros A., Aerts L., & Vandenberghe, A. (2023).
Identification and characterisation of Belgian mental health research published between 2018 and 2021.

Fund for Mental Health Research Steering Committee

PRESIDENT

Olivier Luminet, full professor, UClouvain

MEMBERS

Katrijn Ballet, secretary, ANBN vzw

Kirsten Catthoor, chair, Flemish Association for Psychiatry

Kathleen De Cuyper, research manager,
LUCAS KU Leuven - Care research & consultancy

Charles Kornreich, professor emeritus, CHU Brugmann

Dominique Nothomb, director, Center for Suicide Prevention

Tom Van Daele, research lead psychology and technology,
Thomas More University of Applied Sciences

Pierre Smith, public health scientist, IWEPS

Bruce Vrancken, advanced nurse practioner in mental health,
AZ Sint-Jan Bruges

Sofie Bekaert, head of programme, King Baudouin Foundation

FACILITATION OF THE WORKSHOPS

Miranda Maes

Tamara Alen

King Baudouin Foundation Working together for a better society

The King Baudouin Foundation's mission is to contribute to a better society in Belgium, in Europe and elsewhere in the world. The Foundation is an actor for change and innovation, serving the public interest and increasing social cohesion. It seeks to maximise its impact by improving skills in organisations and for individuals. It also stimulates effective philanthropy by individuals and corporations.
The Foundation's most important values are integrity and transparency, promoting solidarity, respect for diversity, pluralism and independence.

Our vision for the future is
- In Belgium, to anchor our activities, from the local to federal level;
- In Europe, to continue to position the KBF on the European stage;
- Internationally, to become a significant player in cross-border philanthropy, through the Myriad alliance for borderless giving created together with Myriad USA and Myriad CANADA, and through our partnership with Give2Asia.

The King Baudouin Foundation was set up in 1976, on the occasion of the 25th anniversary of King Baudouin's reign.

With thanks to the National Lottery and its players, and also to our many donors for their ongoing commitment.

Bridging Gaps in Mental Health:
10 Research Priorities

A King Baudouin Foundation publication
Rue Brederodestraat 21
B-1000 Brussels

Researchers
Julie Janssens, Center for Contextual Psychiatry, KU Leuven, Department of Neuroscience
Inez Myin-Germeys, Center for Contextual Psychiatry, KU Leuven, Department of Neuroscience

Editing
Patrick De Rynck

Translation
Sally Tipper

Advisory group
Fund for Mental Health Research Steering committee
(For the composition of the group, we refer to page 24)

Coordination King Baudouin Foundation
Laetitia Aerts
Ester De Doncker

Graphic design
signelazer.com

Legal deposit D/2893/2025/16
Order number 4012
October 2025

KU LEUVEN

Center for Contextual Psychiatry

kbs-frb.be   **because.eu**

Subscribe to our e-news

Facebook   YouTube   LinkedIn   Instagram