NOMINATION

HEARING

BEFORE THE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

GERALD L. KLERMAN, OF MASSACHUSETTS, TO BE ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

OCTOBER 26, 1977

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NOMINATION

WEDNESDAY, OCTOBER 26, 1977

U.S. SENATE,
COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The committee met, pursuant to notice, at 10:45 a.m., in room 4232, Dirksen Senate Office Building, Senator Harrison A. Williams, Jr. (chairman) presiding.

Present: Senators Williams, Pell, Javits, Hatch, and Chafee.

The CHAIRMAN. We will come to order and begin our hearing on Dr. Gerald L. Klerman, nominee to be Administrator of the Alcohol, Drug Abuse, and Mental Health Administration and ask Dr. Klerman to come forward.

This nomination is to fill the post that was created by act of Congress. When was that, Doctor?

Dr. KLERMAN. 1970, by this committee.

The CHAIRMAN. 1974.

Dr. KLERMAN. Pardon me.

The CHAIRMAN. We welcome you and are pleased to have this hearing as rapidly as we were able to. We have a confused schedule around here but this was possible and we are pleased to have your hearing on confirmation now. We will insert at this point the biographical sketch of Dr. Klerman in the record.

[The biographical sketch of Dr. Klerman follows:]

March 1974

GERALD L. KLERMAN, M.D.

SUMMARY OF CURRICULUM VITAE

Dr. Klerman is Professor of Psychiatry at Harvard Medical School, Boston, Massachusetts, and is on the staff of the Psychiatry Service of the Massachusetts General Hospital where he is Director of the Stanley Cobb Laboratories for Psychiatric Research. His main professional activities involve research and teaching in clinical psychiatry with emphasis upon depression and related affective disorders, psychopharmacology, and the evaluation of mental health programs.

He has taught at Yale where he was Associate Professor of Psychiatry (1965-68) and where he served as Director of the Connecticut Mental Health Center (1967-69). In 1970, he became Superintendent of the Erich Lindemann Mental Health Center in Boston, Massachusetts, until 1976.

Among his honors is the Hofheimer Prize of the American Psychiatric Association, which was awarded in 1969 for his role as one of the Principal Investigators of the NIMH Collaborative Study of Phenothiazine Treatment of Acute Schizophrenia. Other honors include Phi Beta Kappa, Sigma Xi, Alpha Omega Alpha, an Honorary M.A. from Harvard University, and Honorary Membership in the Society Royale de Medecine de Mentale de Belgique.

Dr. Klerman is active in many professional societies, among which are the American College of Neuropsychopharmacology and the American Psychiatric Association, and serves on the editorial boards of a number of professional journals, including the Archives of General Psychiatry and Psychopharmacologia. He is also a consultant to the National Institute of Mental Health, the Food and Drug Administration, and to other professional groups. His main commitment is to further the development of scientific bases for clinical psychiatry through controlled evaluations of psychopathology, treatments, and mental health programs.

March 1976

CURRICULUM VITAE

GERALD L. KLERMAN, M.D.

CURRENT MAJOR POSITION:	Professor of Psychiatry Harvard Medical School Boston, Massachusetts
	Director Stanley Cobb Psychiatric Research Laboratories Massachusetts General Hospital Boston, Massachusetts
MAILING ADDRESS:	Department of Psychiatry Massachusetts General Hospital Boston, Massachusetts 02114
CURRENT CONSULTATIVE APPOINTMENTS:	American Medical Association Council on Drugs (1967-present) Chicago, Illinois
	National Institute of Mental Health Clinical Research Branch (1970-present) U.S. Department of Health, Education, and Welfare Washington, D.C.
	The Medical Letter (1968-present) Drug and Therapeutic Information, Inc. New York, New York
	Veterans Administration (1974-present) Cooperative Studies Evaluation Committee Washington, D.C.
EDITORIAL BOARD MEMBERSHIPS:	Archives of General Psychiatry Community Mental Health Journal (1964-71) International Journal of Psychiatry (1965-72) Journal of Psychiatric Research Psychiatric Opinion Psychopharmacologia Massachusetts Journal of Mental Health (1970-73)

HONORS:

Alpha Omega Alpha

American Psychiatric Association
Lester N. Hofheimer Prize for Research (1969)

Phi Beta Kappa

Sigma Xi

Societe Royale de Medecine Mentale de Belgique
·Honorary Member

PREVIOUS CONSULTATIVE APPOINTMENTS:

Boston State Hospital, Boston, Massachusetts
·Research Consultant (1960-66)

Food and Drug Administration, Washington, D.C.
U.S. Department of Health, Education, and Welfare
·Consultant (1971-75)
·Chairman, Advisory Committee on Neuropharmacology (1973-75)

National Institute of Mental Health, Bethesda, MD
U.S. Department of Health, Education, and Welfare
·Consultant (1961-69)

Research Foundation for Mental Hygiene, Albany, NY
·Consultant (1961-66)

Veterans Administration Hospital, New Haven, Conn.
·Consultant (1965-66)

World Health Organization, Geneva, Switzerland
·Temporary Advisor, Scientific Group on Research in Clinical Psychopharmacology, Section on Mental Health (1966)

PROFESSIONAL SOCIETY MEMBERSHIPS:

American Association for the Advancement of Science
American College of Neuropsychopharmacology
·Chairman, Committee on Education and Training (1968-70)
·Charter Fellow (1970)
·Chairman, Government-Industry Liaison Committee (1976-)
American Medical Association
American Psychiatric Association
·Member, Drug Reactions Commission (1964-67)
·Chairman, Committee on Research Aspects of Community Mental Health Centers (1966-68)

(PROFESSIONAL SOCIETY MEMBERSHIPS -continued):

American Psychopathological Association
- ·Chairman, Membership Committee (1968-72)
- ·Member, APPA Council (1968-74)
- ·Vice-President (1974-75)
- ·President-Elect (1976-)

American Sociological Association
Section of Medical Sociology
American Society for Clinical Pharmacology and Therapeutics
Boston Psychoanalytic Society and Institute
- ·Member of Research Committee (1974)
- ·Affiliate Member (1974-present)

Collegium Internationale Neuro-Psychopharmacologium
Connecticut Medical Society
Group for the Advancement of Psychiatry
- ·Member, Committee on Research (1960-73)
- ·Contributing Member (1973-present)

Institute of Society, Ethics and the Life Sciences
- ·Fellow

Massachusetts Medical Society
Massachusetts Psychiatric Society
- ·Member, Committee on Residency Training (1972-75)

PERSONAL:

Born: December 29, 1928

Married: four children

Home Address: 21 Hammond Street, Chestnut Hill, Massachusetts 02167

Home Telephone: (617) 244-1909

EDUCATION:

High School of Science, Bronx, New York (1942-46)

A.B. (with Distinction in Sociology and Anthropology)
Cornell University, Ithaca, New York (1946-50)

M.D., College of Medicine, New York University, New York, New York (1950-54)

M.A. (Honorary), Harvard University, Cambridge, Massachusetts (1970)

CLINICAL TRAINING IN MEDICINE AND PSYCHIATRY:

First Medical Division (Columbia University Service), Bellevue Hospital, New York, New York
- Medical Intern (1954-55)
- Assistant Resident Physician, including three months on Second Neurological Division (1955-56)

Massachusetts Mental Health Center (Boston Psychopathic Hospital), 74 Fenwood Road, Boston, Massachusetts
- Medical Intern (1956-57)
- Resident Psychiatrist (1957-58)
- Chief of Service (1958-59)

CLINICAL EXPERIENCE:

National Institute of Mental Health, Bethesda, Maryland (1959-61)

Massachusetts Mental Health Center, 74 Fenwood Road, Boston, Massachusetts
- Principal Psychiatrist, Research (1961-65)
- Assistant Director of Psychiatry (1962-65)

Connecticut Mental Health Center, 34 Park Street, New Haven, Connecticut
- Director of Clinical Services (1965-67)
- Director (1967-69)

Erich Lindemann Mental Health Center, Government Center, Boston, Massachusetts
- Superintendent (1970-76)

RESEARCH EXPERIENCE:

"NIMH-PSC Collaborative Study of Phenothiazine Treatment of Acute Schizophrenia", Co-Principal Investigator. National Institute of Mental Health, Bethesda, Maryland (1959-64)

"Clinical-Metabolic Studies of Affective Disorders", Project Director and Co-Principal Investigator. PHS Grant, MH-04586. Massachusetts Mental Health Center, Boston, Massachusetts (1961-65)

"Drug Treatment in Outpatient Depressions", Principal Investigator. PHS Grant, MH-13738. Yale University, School of Medicine, New Haven, Connecticut (1966-74)

"Psychiatric Utilization Review" Project, Co-Principal Investigator. NIMH Contract, PH-43-68-702. Yale University, School of Medicine, New Haven, Connecticut (1969-74)

(RESEARCH EXPERIENCE -continued):

"Drug Effects on Mood and Tension", Principal Investigator. FDA Contract, FDA-71-279. Massachusetts General Hospital, Boston, Massachusetts (1971-present)

"NIMH-CRB Collaborative Study of Long-Acting Fluphenazine", Principal Investigator. PHS Grant, MH-24976. Massachusetts General Hospital, Boston, Massachusetts (1973-present)

"NIMH-CRB Collaborative Depression Studies", Principal Investigator. PHS Grant, MH-23864; MH-21411. Massachusetts General Hospital, Boston, Massachusetts (1972-present)

PRIOR TEACHING EXPERIENCE:

Tufts University, School of Medicine, Medford, Massachusetts
·Assistant in Psychiatry (1957-59)

Harvard Divinity School, Cambridge, Massachusetts
·Instructor, University Project on Religion in Mental Health (1958-59)

Harvard Medical School, Boston, Massachusetts
·Teaching Fellow in Psychiatry (1956-59)
·Instructor-to-Clinical Associate in Psychiatry (1961-65)

Yale University, School of Medicine, New Haven Connecticut
·Associate Professor of Psychiatry (1965-70)

Smith College School for Social Work, Northampton, Massachusetts
·Guest Lecturer (summers 1968-73)

MEDICAL LICENSING and CERTIFICATION:

Diplomate: National Board of Medical Examiners (1955)

Licensed: New York (1955-present)
Massachusetts (1959-present)
Connecticut (1965-present)

Certified: American Board of Psychiatry and Neurology (1964)

Registered: Bureau of Narcotics and Dangerous Drugs

The CHAIRMAN. You have a statement, I understand.
Dr. KLERMAN. I have a brief statement, sir.

STATEMENT OF GERALD L. KLERMAN, M.D., PROFESSOR OF PSYCHIATRY, HARVARD MEDICAL SCHOOL, BOSTON, MASS.

Dr. KLERMAN. Mr. Chairman, Senator Javits and other members of the committee, I am honored to appear before you as President Carter's nominee to head the Alcohol, Drug Abuse, and Mental Health Administration, which is the major Federal agency charged with helping solve three of the Nation's foremost public health and human problems: alcoholism, drug abuse, and mental illness.

At various points throughout my career I have been a researcher, a clinician, a teacher, and an administrator, but throughout, I feel I have been committed to relieving the health problems of individuals and the consequent suffering of their families and their communities. All of my experience in medicine and in psychiatry has been devoted, at the same time, to seeking understanding of the causes of these disorders and new treatment approaches, and also to providing improved patient care in a variety of settings both public and private.

As a researcher, my investigations have emphasized depression and related disorders, including the depressions associated with or secondary to alcoholism and drug abuse. For many years I have been involved in studies of psychopharmacologic treatment and the evaluation of different forms of service systems.

In recent years, I have become interested in studies of psychosocial treatments, particularly individual modalities of psychotherapy. I am dedicated to the development and systematic evaluation of all forms of treatment, whether they be biomedical, pharmacologic, or psychosocial, and I support the delivery of treatment techniques whether by professionals, para-professionals, or by self-help groups; any procedure or any technique that can be shown to reduce or prevent mental disorder, alcoholism, or drug abuse.

Currently, as you know, I am professor of psychiatry at Harvard Medical School and I am director of the Stanley Cobb Laboratories for Psychiatric Research at the Massachusetts General Hospital. Previously I have been associated with health institutions at the municipal, State, and Federal level. My experience has included periods of service at a large city general hospital, Bellevue Hospital in New York City. I have also worked at Federal mental hospitals including St. Elizabeth's Hospital here in Washington and I have been a consultant to VA hospitals.

In recent years I have been involved in community and neighborhood service programs. I have directed the Connecticut Mental Health Center for 2 years in New Haven and I was superintendent of the Erich Lindemann Mental Health Center in Boston for 6 years, and at those two facilities there were a variety of providers; medical, nonmedical, professional, and nonprofessional.

Out of these experiences and exposures I have developed an increasing awareness of and compassion for patients with all forms of illness. I find it hard to separate mental or physical illness. The mind/body dualism is not of my liking. Patients' needs are medical, psychological, social, and economic, and the needs of patients and their families with these afflictions are the responsibility of ADAMHA, and I look forward eagerly to the challenges involved in directing the

Federal agency involved in helping reduce or prevent these difficult and widespread problems.

This is a young agency. It is a novel design in public administration and Federal health program. It was created, in large part, through the initiative of this Senate committee and the individual members of this committee who have been devoted to strengthening programs in these three areas.

I regard this agency as innovative in that it combines within one administrative organization research, training, treatment, and prevention. I intend to support the autonomy and independence of the three Institutes where appropriate and, at the same time, seek opportunities to promote areas of cooperation among the Institutes in the programs of alcoholism, drug abuse, and mental health. Finding the balance between the autonomy and independence of the Institutes and areas for cooperation will be a major challenge.

I look forward to working with the committee as a member of this administration and I am confident that it will be a period of further progress.

I will be pleased to answer your questions.

The CHAIRMAN. Thank you very much, Dr. Klerman.

The mission or function of this post is described basically in the law. The purpose is to act for the Secretary in supervising the functions of the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse in order to assure: one, that the programs carried out through each institute receive appropriate and equitable support; and two, that there is cooperation among the Institutes in the implementation of such programs.

You end with a statement that you intend to continue the autonomy and independence of the three individual Institutes while at the same time promoting cooperative endeavors among alcoholism, drug abuse, and mental health programs. I wonder if you could, in a bit more comprehensive way, describe the Administrator's role as you see it. Just how would you approach this coordination, and how would you work with the Institutes. Recognizing their autonomy, how deeply would you be involved in policy that lead to programs?

I would like to have, if we can, just a sense and a feel of your understanding of the role being talked about.

Dr. KLERMAN. Over the summer I have been involved as a consultant during the process where the nomination has been reviewed by the administration before coming here, so I have had some opportunity to learn of the background and program of the Institutes and the organization of the Department of Health, Education, and Welfare. Some of the activities that will be expected of me are involved with the specific and unique programs of the individual Institutes as required by law to support and strengthen them; for example, to work with the individual Institute Directors and their staff in strengthening their program or interpreting their programs to the Assistant Secretary for Health, Dr. Richmond, or to the Office of the Secretary, Mr. Califano.

I have already participated and will continue to do so in the Secretary's desire to review current programs in alcoholism, with the desire to look to future initiatives. In part, I expect to serve as a liaison between the Office of the Surgeon General and the Assistant Secretary and the specific Institutes. A similar kind of process, for example,

is underway in that the President's Office of Drug Abuse programs is involved in a review of existing programs in drug abuse as was described in the President's message on drug abuse, and there has been a series of coordinating and review efforts out of the Secretary's office which have involved particulary the staff of NIDA, the National Institute on Drug Abuse.

My role here, I believe, has been supportive in liaison to help clarify issues and to bring together the appropriate person within the institute or to make liaison with other agencies, such as NIH and FDA, or staff in the Secretary's office, or the office of the Assistant Secretary for Health.

The other large area has to do with promoting cooperation, as was also specified in the legislation. There are a number of specific areas where one by one, cooperative opportunities have been reviewed and discussed. Some of these are already underway. As examples, the National Institute on Drug Abuse and the National Institute for Alcoholism and Alcohol Abuse have some common programs for career teachers in medical schools to increase the awareness of medical students and the faculties of medical schools as to the problems unique to and common or different from alcoholism and drug abuse. That is one example of common programs.

There has also been some attempt to seek common research programs for those clients and patients who simultaneously are involved in use or abuse of both alcohol and certain drugs.

The President's Message on Drug Abuse also directed the Secretary to consider the possibility of coordination or cooperation for intramural research programs. There is a special set of problems around the National Institute on Drug Abuse because its Addiction Research Center, now located at Lexington, Ky., must move for complicated reasons, which we could discuss. We are also very keenly aware that the intramural research facilities available for alcoholism are woefully inadequate and major steps must be made to obtain more resources for it, either separately, or, if desirable, in cooperation with our other intramural research program. This is both a short-term and a long-term objective.

The CHAIRMAN. When you say "intramural" do you mean within the institute itself?

Dr. KLERMAN. Yes. The research activities of the three Institutes, as you know, are divided into the intramural—those which take place under the aegis of the Government itself—often within the Washington area—and the other part, the extramural, where Federal funds are dispersed through grants or contracts to universities, hospitals and research institutes where the research projects are conducted by nongovernmental facilities and agencies.

There is desire to be, as part of the President's Message and also general policy, a long-term review of planning for what are the needs not only of the three Institutes in ADAMHA but also of NIH. Dr. Frederickson, Dr. Richmond, and I have begun such discussions and one of the key issues that came up was the special needs of the three Institutes. And the question is, how can there be cooperation? Also, what are the unique needs that will require special facilities and special programing? This discussion is in the very early stages.

The CHAIRMAN. You mentioned within the Institutes developing effort to advance alcoholism studies at medical schools?

Dr. KLERMAN. Yes.

The CHAIRMAN. And you also included drugs in that as an educational effort at medical schools?

Dr. KLERMAN. Yes. It is my understanding that the two Institutes have already cooperated on funding what are called career teacher positions to augment the faculties of the schools of medicine to increase their capabilities for teaching medical students about these two fields, and that this has been an area of existing cooperation.

The CHAIRMAN. Alcoholism has now been found to fit the medical definition of disease?

Dr. KLERMAN. Yes.

The CHAIRMAN. Has drug addiction been similarly described?

Dr. KLERMAN. Particularly the consequences of drug addiction and drug dependence have very serious medical consequences that varies from drug to drug, like heroin, barbiturates, cocaine. Each of these substances will have different effects on the nervous system, on the muscular system, perhaps on the liver and intestinal system, and also on the social and psychological functioning of the individual who becomes habituated or addicted.

The CHAIRMAN. How many medical schools have developed any curriculum to deal with these areas?

Dr. KLERMAN. Career teacher programs, which are jointly funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), were first funded in fiscal year 1972. Since that time, 47 grants have been awarded to 46 schools of medicine and 1 school of public health.

A recent evaluation of the career teacher program indicated that curriculum hours devoted to alcohol and drug abuse have increased from a pregrant average of 12.4 hours for medical school undergraduates to a current 73.6 hours, of which 57 have been developed by the career teacher. By comparison, a survey of nonparticipating medical schools indicate that they currently have an average of 6.2 hours of alcohol and drug abuse curriculum.

The CHAIRMAN. That is one of the efforts at the institute?

Dr. KLERMAN. Yes.

The CHAIRMAN. Research has been fundamental to your professional career.

Dr. KLERMAN. Yes.

The CHAIRMAN. I would consider as I read your history here it is basic research in these areas of understanding health problems.

Dr. KLERMAN. I have also been mostly concerned with what might be called applied research, trying to understand which treatments work for which types of individuals and, also how to understand the impact of illness on families and communities. I have not worked in the laboratory. I am not experienced in laboratory research in chemistry or experimental psychology. I've been involved in what's called clinical or applied research.

The CHAIRMAN. And this is basically an evaluation of methods of treatment; is that right?

Dr. KLERMAN. Yes.

The CHAIRMAN. This leads us into a lot of confusion that did exist raising out of some of the research that evidently was contracted by the NIAAA. Was it research? Maybe that is the first question. That

Rand Report has been interpreted by many in many ways and probably by many who haven't read the full Rand report. You were asked to review the report as I recall. I wonder if you could get us on a solid foundation at last, at least for me. What was the basic research method of the people that undertook this study for Rand and NIAAA?

Dr. KLERMAN. As you say, the NIAAA gave, as I recall a contract to the Rand Corp. in Santa Monica to do what is called a secondary analysis of the data collected by the Alcohol Treatment Centers, the ATC program. By that it is meant, I think, in the 1960's a series of grants and contracts had been given to a large number of treatment centers specializing in alcoholism.

The CHAIRMAN. Private centers?

Dr. KLERMAN. They vary; some went private, community, and also included hospitals, county facilities, medical schools. They used a variety of techniques, including antabuse, hospitalization, counseling, liaison with AA. Part of the program was that all the clients and patients served were recorded as to their background characteristics; age, sex, years of drinking and their clinical characteristics; types of symptoms.

The CHAIRMAN. Are these ATC's set up for research or treatment?

Dr. KLERMAN. Treatment. These were treatment settings supported by funds appropriated by the Congress. A sample of the patients treated were followed up at 18 months to ascertain what were the outcomes; how many of them were improved; how many of them were working; how many of them had a change in their family relations.

The main method used in this was the patients' reports as to their functioning on the job, in the family, what their symptoms were as to intestinal symptoms, sleeping, nervousness, and alcohol consumption at different points.

The CHAIRMAN. The ATC did this?

Dr. KLERMAN. That's right. And these data, as I recall, were recorded on various kinds of forms and were sent to a central facility. The Rand Corp. did a secondary analysis. That is, it was not involved in seeing the individual clients or the individual centers. It was involved in doing statistical analysis of the data that had been collected in a computer bank.

I think it is important to acknowledge that the program was a treatment program across the Nation and that in this particular study the main source of data was the patients' and clients' reports as to their self definition and their degree of improvement or change.

The report was a complicated one and it is a very thick document which I think is worthy of reading, but it requires careful attention because some of the statistical techniques are complicated and have been subject to criticism by specialists in the field of statistics. One of the important findings is that a large percentage of patients at 18 months are in remission. Over 55 percent of the patients are working, have a reduction of symptoms and are not drinking. That is a gratifying treatment result. It indicates that the treatment of alcoholism is a hopeful condition and that at 18 months, 55, or so, percent of the patients in these programs are doing well. They have returned to useful and gainful employment and have not continued to have the kinds of symptoms, such as tremulousness, nausea, vomiting, muscle cramps or sleep disturbance that led to their seeking treatment.

There is also a finding that they could not by their statistical techniques determine that any one treatment did better than another treatment in doing better than this 55 percent improvement rate at 18 months. That has caused a certain amount of controversy within the field because different proponents of specific treatments feel that there are unique benefits from one treatment or another.

The third finding, among others, which is most controversial is that, as I recall, about 10 percent at follow up of the subjects reported that they had been resuming some form of alcohol ingestion without deleterious consequence. I want to emphasize this is self report data. There is no independent validity; that is, other people did not go in and observe whether or not what they said about themselves was in fact accurate.

This report was published and has generated a moderate to a large amount of controversy. Dr. Noble asked me, as one of a number of persons, to review the report as to the type of research methodology and also as to what might be future steps that the Insitute might take to verify the findings or to extend them to other forms of evaluation of the treatment program.

My comments to him were based upon his request that I serve as a researcher who had done other studies of the evaluation of treatments, particularly treatments of mental disorder. My feeling now, as I have written to you and the members of the committee, is that while such research is valuable it should not change what is the existing policy of NIAAA, that treatment programs should continue to promote abstinence among alcoholic individuals as the most prudent, useful and valued goal for the outcome of clinical treatment programs. That is the policy of NIAAA. Dr. Noble and I have discussed it on a number of occasions, and I feel that it is a useful and a principal policy and I see no reason to change that.

The CHAIRMAN. The policy goal is total abstinence; is that right?

Dr. KLERMAN. As part of clinical treatment.

The CHAIRMAN. As far as method of treatment?

Dr. KLERMAN. The Institute is committed to promoting a series of methods of treatment; in-patient and out-patient, sometimes the use of antabuse, the use of different kinds of psychotherapies with groups, sometimes the use of antabuse, where there is a particular problem or where people may have alcohol plus drug problems—particularly in the methadone area. There is also the phenomenon of what is called alcoholism plus depression which is quite common and there are research efforts underway to explore the value of anti-depressant drugs for patients who are both alcoholic and depressed.

Then, there are also the value of supporting various self help groups, both such as AA or other forms of groups. The Institute has been committed to a pluralistic program of supporting a variety of treatment approaches.

The CHAIRMAN. I would think that one of the major missions is an ongoing evaluation system and method of evaluation. This is part of your background. I am just wondering how—mindful of the autonomy of the Institutes and your background of evaluation research—you are going to protect yourself from being part of the day-to-day policy development in this area, evaluation of treatment systems that are being promoted by your institutes. Do you see a role for yourself?

Dr. KLERMAN. This is an area that I have a particular personal interest. It is also an area where the Secretary of HEW and the Assistant Secretary have indicated the importance of what's called treatment assessment and treatment outcome research both for individual disorders and across the board. It becomes pressing as there is planning for national health insurance that if there is to be coverage under national health insurance for various kinds of treatments, whether they are medical treatments, surgery, or psychotherapy that those treatments evidence that they are, in fact, efficacious and safe, and that applies to all the types of disorders that we are responsible for. It also applies to surgery, to drug treatment of other conditions.

This was initiated by Mr. Isbister, my predecessor. He had already begun a process of reviewing what was called treatment assessment research, looking for both common features as well as to preserve the unique features of individual programs. There are certain common features that cut across all evaluation of treatment conditions just as there are certain unique features that have to be respected for individual conditions whether they pertain to alcoholism, depression, children's disorders, or phobia, as the case may be.

The CHAIRMAN. From any questions that I might ask it will be obvious that I am not a researcher and don't know anything about the professional scientific approach to an understanding of the effects from any given line of professional treatment.

Treatment in all of these three areas really involves what I would describe as a social service, a service to people to bring them back into societal existence and out of their exclusion, whether it is alcohol, drugs or mental illness. It is, I would describe it, a social service.

Any of the institutes embarked upon treatment to evaluate the effects is not for you who are scientific a controlled experiment, is it? You are observing in the social scene and seeing the effects on an individual of a given course of treatment. It is not like Lexington where you could control the whole works; that is what I am saying.

Dr. KLERMAN. That's right. One important research area is the study of persons in their natural settings; in their family and in their work in the community. One of the important outcomes, as you indicate, is the extent to which they are able to resume meaningful social functioning.

The CHAIRMAN. It would seem to me that that Rand approach of taking a form back from the former patient, now called a client, is subject to no compelling hard, clear conclusion. You are taking a person's interpretation of himself rather than objective observation of the person in society.

Dr. KLERMAN. I think that's a very valid criticism, Senator. I think that any future research on the outcomes, particularly social functioning, should include objective observers, whether they are the family or the person's employer or community members. Yes, I think that's a valid limitation of those methods.

The CHAIRMAN. It seems to me that this will be most important, this whole area of understanding the treatment in terms of its effect. When we get to national health insurance the coverage can be defined and I would think the coverage would be in terms of the nature of the treatment.

Dr. KLERMAN. It is my hope and one of the things we will strive for, to be sure is that any program of national health insurance include

in its so-called benefits package a variety of treatment approaches for the needs of alcoholics and persons with drug problems and the different forms of mental illness. One of the goals of such treatment would be exactly what you have identified, the return of such persons to social functioning at a meaningful level of participation.

The CHAIRMAN. Somewhere in something I read of yours—I believe it is your statement—you talked about the varieties of methods of treating alcoholism; through medication and other treatment approaches. I am not familiar with this. Is there work going on at the institute, NIAAA, research in drug treatment?

Dr. KLERMAN. I would have to go back and talk more in detail with Dr. Noble, but at different times medication such as antabuse has been used. In addition, medication such as tranquilizers—Librium and Valium—have been used by many persons in the treatment of alcoholism and various other medications have been advocated. It is unclear as to the extent to which they are useful. It is very clear that no one medication can be recommended for all such individuals, that alcoholism as a condition or disease has within it a great variety of sub types and we do not know at this point how to classify those sub types. Medication is only one technique and no one that I know has proven that any one particular medication is useful for more than a fraction of the sub types. But I do not know the details of it. I would have to talk to Dr. Noble and his staff before I could answer your question as to how much research is being currently supported on the use of medication or has been in the past.

The CHAIRMAN. Certainly in mental health this is an area where you have background and considerable——

Dr. KLERMAN. My own personal background is more detailed and I would be better able to answer your questions about the use of medication in mental disorders, and there are major differences I am learning in the needs of treatment for alcoholism, drug abuse, and for the different forms of mental disorder.

The CHAIRMAN. As far as third party payment is concerned, what is the national picture in these three areas? Is there any general pattern developing of third party coverage for alcohol, drugs or mental illness?

Dr. KLERMAN. Depending on whether you're an optimist or a pessimist, the glass is half full or half empty. Compared to the past there has been gradual and steady improvement in the sense that an increasing percentage of the third party payment programs, both private and public, have extended their benefit package to include coverage of mental disorders and alcoholism. However, the rate of progress is nowhere near what those of us in the field would consider optimum, and it is also true that alcoholism ranks lower than, say mental illness.

Hospitalization benefits or outpatient benefits in many third party payees are still less liberal and less inclusive for alcoholism services overall. I do not know the exact percentages. Again, that could be obtained from Dr. Noble and his staff and I could respond to that if you so wish. It is disappointingly low.

The CHAIRMAN. But, at any rate, does it hinge pretty much to where there is coverage to the certification of an institution?

Dr. KLERMAN. Yes; the institution must be certified and also the practitioners must be licensed or certified and there is a great deal of effort underway to develop certification criteria for facilities for the

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treatment of alcoholism under the Joint Commission for the Accreditation of Hospitals and also for the credentialing of various categories of workers in the field of alcoholism, counselors and other workers. That is underway and, again, I know that Dr. Noble and I discussed it yesterday, that vigorous efforts are underway to move that along as quickly as possible.

The CHAIRMAN. I will include the letter that you addressed to me in the record. It did help to clarify some of the confusion of interpretation of your evaluation of Rand and on that one point, policy goals and whether total abstinence at this point was basic policy and should continue to be. Your letter clarifies that and that is the situation, right?

Dr. KLERMAN. Yes.

The CHAIRMAN. I have just one question before I turn to Senator Javits. What are the Institute appropriation amounts? I think I have it here. Mental Health Administration, $117 million in the research budget. That was the current fiscal year. The NIAAA, $16 million in research. NIDA, $34 million.

It is frequently said that alcohol is a disease which is No. 3 or 4 in terms of its severity and dimension. It is the third ranking killer of people. I am just wondering whether these numbers here don't suggest that there is a disparity in the amounts of money that is going into research over at the three Institutes that you will be administering.

Dr. KLERMAN. I think Assistant Secretary Richmond when he testified here made the statement that alcoholism was a major public health problem and that it was undersupported. I would emphasize that and go further. I think, of the three Institutes, the research needs of NIAAA are way inadequate relative to the public health problem and I would think that if we could find a way to increase the appropriations for that over a long-term period I would like to see that figure increase dramatically.

I am disheartened by the level of appropriations. Some of the innovative programs that Dr. Noble and his staff have generated such as the clinical research centers will not be—the new ones—funded. I think that unless we get additional appropriations we will not be able to close the gap that you identify between this major public health problem and the current allocation of resources. They are not at all commensurate with the major public health problem and social problem that alcoholism does represent.

The CHAIRMAN. Those research figures and their relationship to program follows pretty much here.

Dr. KLERMAN. Of the three institutes, the Alcohol Institute is the most poorly funded. I would say that without hesitation, not only with regard to research but also with regard to training of various types of personnel, research, clinical, professional and paraprofessional and with regard to supporting of service programs at the State level and at the community level.

The CHAIRMAN. Program support, I have here, in 1977, NIAAA, $168 million, NIDA, $262 million, and NIMH, $500.7 million. Do you feel that this should be reviewed as to whether or not there is a disparity here that should move in the direction of correcting?

Dr. KLERMAN. Yes.

The CHAIRMAN. That is all I have for now.

Senator Kennedy and Senator Hathaway were distressed that they were retained on the floor and couldn't be here. They were very anxious to be here. Senator Kennedy particularly wanted to introduce you at the opening of these hearings.

Dr. KLERMAN. Being a resident of Massachusetts, I appreciate that comment.

The CHAIRMAN. Senator Javits?

Senator JAVITS. Dr. Klerman, there is a very grave concern, which will be expressed in the testimony shortly, that because you are a psychiatrist you are going to neglect the other branches of learning in this particular field; to wit, psychologists, nursing, and social workers. If we confirm you for this job, to what extent are you going to try to bring in these other disciplines in order to assist in this monumental endeavor which you would be undertaking?

Dr. KLERMAN. I am aware that that is a matter of concern. I have met privately with some of the officers of the American Psychological Association and some of the other professional groups. It is true that some of the major leadership positions are held by MDs who are psychiatrists. My own career through the years has involved numerous opportunities and experiences working with other professions. Many of my publications have been jointly authored with psychologists and with nurses and often members of those other professions have been the senior authors of those papers. For example, the Connecticut Mental Health Center and more recently, the Erich Lindemann Mental Health Center where I was the clinical director, for example, at the Erich Lindemann Mental Health Center was not an MD. The individual was a social worker who supervised medical personnel who ran in-patient units and out-patient clinics and it was a very useful and successful outcome.

With regard to ADAMHA, there are many psychologists and other nonmedical personnel in positions of major responsibility. The deputy directors of two Institutes are individually psychologists in NIAAA and in NIMH, and many of the division directors and branch chiefs are non-MDs.

There is a continuing review and discussion as to what is the appropriate balance. We have already discussed, and there has been discussion between Dr. Richmond and myself about what mechanisms we might use to bring more nonmedical personnel including psychologists, into other positions of leadership.

In the development of policy and program I believe that Mr. Isbister, when he was the Administrator of this Agency, tried very hard and succeeded in making contact with various professional groups and I plan to continue to meet with such groups. I have already met with the group in Washington called the Liaison Group on Mental Health which includes representatives of these organizations.

All I can do at this point is identify my past record which I think is a constructive one, and affirm my intention to continue the policies of the institutes and of the administration to be multidisciplinary and multiprofessional. The next years will give you a chance to measure my words against action.

Senator JAVITS. We do have legislative oversight and, of course, that is an important point. I would like to ask when you have open-

ings for professionals will you give adequate representation to psychologists, nurses, and social workers?

Dr. KLERMAN. Yes; wherever possible I intend to let known where there are openings and to invite nominations from various professional groups and various groups that represent specific concerns.

Senator JAVITS. I am glad to hear you say that so that in our legislative oversight we won't have that in mind.

I notice one point, which will be made in Dr. Charles A. Kiesler's presentation, which you may or may not be able to answer, Dr. Kiesler is a Ph.D. and executive officer of the American Psychological Association. I take the liberty of referring to his statement although he hasn't given it yet. He says there is a basic difference between the approach to peer review by psychiatrists and psychologists. He identifies the difference by saying that the peer review of psychiatrists is likely to be retrospective. The peer review of psychologists however, is likely to be either concurrent with the delivery of service or preventive in the sense that the patient's problem, the treatment recommended, and the likely outcome of that treatment represents the attitude of the psychologist, which is prospective.

First, I would like to ask you if that is a valid distinction; and second, how do you feel about it as you consider the peer review question?

Dr. KLERMAN. Peer review refers to a number of different activities. In the review of grants and contracts to be awarded by the different institutes, particularly research and training grants, there is an important mechanism of peer review which is used by NIH, ADAMHA, and by the National Science Foundation. That is one of the cornerstones of public policy, to insure objectivity and lack of bias that administrative staff does not introduce their own special biases and that no one group——

Senator JAVITS. I am talking about clinical review.

Dr. KLERMAN. There is a system of PSROs around the country. I am not aware that those distinctions as indicated would apply with regard to the evaluation of treatments. I believe that Senator Williams and I have just begun to discuss some of the scientific and social principles and my own personal experience as an administrator has been to emphasize concurrent evaluation and prospective long-term studies. I believe that the best scientific principles are those of concurrent and prospective evaluation and I think those apply equally to psychology, psychiatry, social workers, to neurophysiology, and to clinical cardiology. I do not believe they're the exclusive province of any one profession.

Senator JAVITS. I have just two other questions. It may not be fair to you to ask you to answer this here, as you might prefer to give us a letter. I am very interested in what you think would be fruitful areas that can be explored in terms of prevention. I know of few issues of human illness where prevention could be so helpful as they could be in respect to alcohol, drugs, and mental health. I will give you a very simplistic syndrome—invariably I have found when you go to a doctor, he will give you pills, give you treatment, or tell you you need an operation. But it is only very, very recently that a doctor will tell you to go out and get some fresh air, run a couple of miles, and stop eating junk.

It is this concept of prevention, both of physical and mental illness, which I would like to see emphasized in a national health insurance program. I believe that preventive health care is the big benefit we can get out of national health insurance. I just wonder how you feel about that and whether you could outline for us some areas that you think could be well explored in these specific fields from the point of view of prevention.

Dr. KLERMAN. I can only give you a general statement now, Senator. In principle, I would endorse your statements and only reiterate what Dr. Richmond has said, that he puts prevention as part of his high priority, and I would hope that any program of national health insurance of future funding efforts, categorical or otherwise, mandates the development of prevention efforts, but also their evaluation.

Unfortunately, with regard to the disorders which our agency will be concerned, specific skills at this moment are still developing. I could identify one or two specific conditions where it is likely we could be highly effective. One is, say, the fetal alcohol syndrome. Only yesterday Don Kennedy, the Commissioner of FDA mentioned, for example, the possibility of labeling alcohol as indicating that the ingestion of alcohol by women who are pregnant carries with it very, very high risks. There is one example where basic research on this syndrome has identified a population, pregnant women, who are especially at risk for the toxic effects of this widespread substance, and a preventive program could prevent the afflictions of the newborn.

Another preventive area is automobile safety. When it comes to areas of drug abuse, the main areas are education of young people, and that has not been as successful to date with the techniques explored as had been hoped for. This Nation has a great confidence that educating people will lead them to change their behavior. That has worked in some areas, particularly in the relationship between nutrition and heart disease. There is evidence of change and a reduction of the mortality in heart disease. That has not yet worked for some of the areas under consideration by our three Institutes, and particularly the area of concern for me is the increase in teenage drinking, and a continued rise in teenage drug use and a rise in teenage automobile accidents.

I just mention those as two areas that we might work on.

Senator JAVITS. I have to go to the Senate floor, but would you think about this, and if you would like to supplement your answer, please do so no later than the close of business this Friday night.

Dr. KLERMAN. I would be delighted to.

Senator JAVITS. Thank you so much. I appreciate it.

The CHAIRMAN. You mentioned teenage drinking which has been a matter of alarm. Yesterday in this community was another period of alarm with banner headlines in one of the newspapers of the extent of teenage drinking in the Maryland suburban schools. My observation is that if we are going to deal with the hopeful goal of prevention, that the profession that would be most helpful would be sociology rather than some of the other medical areas of psychiatry or others.

What are the handles that you see to get to this alarming and tragic development of teenage drinking?

Dr. KLERMAN. As you indicate, this is an alarming concern. Teenage behavior in general is an area of high concern. As I say, there is an increase in teenage smoking, teenage accidents—automobile accidents,

teenage drug use, and teenage drinking; and there probably is a link between the rise in teenage drinking and teenage accidents. Here is a case where you indicate correctly, and I would agree, that there is important contributions from sociologists. NIAAA has announced its very progressive program of funding clinical research centers, and one of the five or six first such centers that they propose to fund is the group at the School of Public Health at the University of California in Berkeley with Don Cahalan and Robin Room, who are world renowned sociologists who have studied the relationship between family factors and social factors and changes in incidents of such programs. They are specifically proposing to study the social epidemiology and sociology of these conditions.

I think the record would show that NIAAA has been very vigorous in supporting sociologic investigations as well as psychological in addition to medical and biologic. When it comes to the prevention effort, which is an important one, there are different techniques being tried, including educational ones. At this moment, I don't know how successful they are.

Another consideration that needs to be given is a legal one also. A number of States have in past years lowered the age of legal access to alcohol, and there is some evidence that suggests that in those States where the legal age of access to alcohol has been lowered there has been a concommitant rise in automobile accidents and even some antisocial behavior possibly related to the increased use of alcohol, and some legal authorities have suggested that it might be useful to review that trend. Here is a case where legal as well as social techniques might have a valuable role in prevention.

The CHAIRMAN. It seems to be working in the other direction, lowering the age rather than——

Dr. KLERMAN. As I say, many States have gone in that direction, and the results of some recent studies have led people to question whether that is a wise legal trend. And I would suggest that it merits review and perhaps reconsideration.

The CHAIRMAN. I am very encouraged to learn that one of the research grants is directed in this area. The application included the teenage situation as part of its——

Dr. KLERMAN. I don't know that specifically. I know they have looked at drinking patterns across different communities and that they are involved at the University of California in work with the World Health Organization in studies of the impact of alcoholism on communities in a number of different countries and continents; the United States, Canada, Mexico, central Europe, and Asia. Whether there's a specific emphasis on teenage drinking in those studies, I would have to check with Dr. Noble and report back to you.

The CHAIRMAN. That would be helpful if you would. Another group of individuals that seem to get less attention in terms of treatment than others is women, for sociological reasons, I gather. This is an area that I would hope NIAAA would find important to do some research on, too, why it is, all of the reasons why women are less frequently treated than men. Certainly, great progress has been made in the work places in bringing this situation, this condition, this disease to an accepted awareness and eligible for treatment.

But these two areas—it might be a superficial observation—teenagers and women don't seem to be fully into the new stream of discovery, concern, and treatment.

Dr. KLERMAN. If I might just comment on that, Senator, I think you identify an important area, and Mr. Califano at his confirmation hearings did identify teenagers and women as an area of special concern, and the National Council on Alcoholism, which is the leading public nongovernmental group in the field, held a conference in this city just within the past month on the special needs of women in the field of alcohol. I believe that many of the Members of Congress were active participants because as I remember the program, a number of the Senators and Congressmen were joint sponsors of that program with the National Council on Alcoholism. Also, I know that NIAAA was active with that group.

The CHAIRMAN. Excellent.

This concludes our conversations with you, doctor. I will return right after voting, and we will have Mr. Kiesler and Mr. Martin.

Dr. KLERMAN. Thank you.

[A recess was taken.]

The CHAIRMAN. Charles Kiesler, executive officer of the American Psychological Association, accompanied by Clarence J. Martin, executive director and general counsel for the Association for the Advancement of Psychology. We appreciate your being here, gentlemen, and are happy to hear you on the nomination that is before us.

STATEMENT OF CHARLES A. KIESLER, PH. D., EXECUTIVE OFFICER, AMERICAN PSYCHOLOGICAL ASSOCIATION, ACCOMPANIED BY CLARENCE J. MARTIN, EXECUTIVE DIRECTOR AND GENERAL COUNSEL, ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

Dr. KIESLER. Thank you, Mr. Chairman.

I am a psychologist and executive officer of the American Psychological Association. I am representing 45,000 members of the APA, the major national organization of psychologists in the United States. We are pleased to testify at this hearing. We don't specifically object to this candidate nor do we question at length his credentials to serve as Administrator. We are concerned with ADAMHA, which is the major Federal institution for drug abuse, mental health, and alcohol programs in the country. We are very concerned about future policies on these issues. We are concerned about the public nature of the policies involved and public discussions of them.

I want to make a couple of quick points about psychology. I am told I should try to summarize.

The CHAIRMAN. You can see how it is going here. We had to interrupt the hearing twice.

Dr. KIESLER. You have my more extensive statement on the record. I will summarize very briefly.

There are two points that will help you to understand psychology. One is psychology's emphasis on science. We now have over 20,000 researchers in psychology; over 11 percent of the total science doctorates in the country are psychologists. In addition, we have over 25,000 mental health service providers, and that's one-half of the fully trained

doctoral level mental health service providers in the country. We are very concerned about mental health on a variety of fronts in service delivery and in research, and we are here in that context.

We would like to ask some specific questions. Senator Javits has already asked a couple. We would like to go on with some others. We understand that Dr. Klerman, who has seen our statement previously will respond in writing, although not by Friday. We think this is a very productive exchange: To get on the record some of Dr. Klerman's plans for ADAMHA and to make these plans more publicly accountable through public discussion now and through a subsequent evaluation.

The first issue that we have is one that was mentioned, and that is the need for input within ADAMHA from all mental health professions. We feel, as do a variety of our sister organizations, that the process used to obtain Dr. Klerman's nomination was, at best, inadequate. To my knowledge, only psychiatrists were consulted in advance of this nomination. There were no consultations with organizations of psychology, social work, or nursing, the other three core mental health professions. To my knowledge, there was no consultation with the Mental Health Association, the major citizens' group. Indeed, we do not think there was any consultation with Members of Congress who are associated with this area.

This is not, we feel, an issue of parochial interest or territoriality, but rather one in which there should be broad consultation about public goals for mental health. We feel that this is an implicit policy of ADAMHA that must be changed and we ask questions, as Senator Javits suggested, about future personnel changes. We would like to know, as well, if Dr. Klerman plans changes in personnel currently in ADAMHA and in the three institutes.

The second issue concerns research funding. Research funding is taking a terrible beating in the country and particularly in psychology. Over the past several years we have had approximately a 50-percent reduction in dollars, when corrected for inflation, and we are very concerned about the lost research, basic and applied, and the consequent loss to understanding of human behavior.

We feel that in ADAMHA it would be an advantage if we could obtain better public accountability of research funds. That is to say, is Dr. Klerman willing to publish data on the allocation of research funds by research topic, by professional field, by the field of the investigator, and so forth, with sufficient detail for public discussion of trends? Does Dr. Klerman propose an emphasis on, say, drug-oriented research, his own field, or rather on more general research in human behavior, which we feel is the proper long-term tack?

Another issue that concerns us a great deal is manpower data—I know that's a sexist term but it is in the act and we will use it in that context. In response to the Health Professions Educational Assistance Act of 1976, the Bureau of Health Manpower proposed to designate health manpower shortage areas for the field of mental health by the title, "Psychiatric Shortage Areas". This characterization misrepresents the field of mental health by concentrating on only one of the core mental health professions.

The basic problem in manpower statistics is that there is no single good source of data on nonpsychiatric mental health professions; 50

percent of the doctoral level mental health service providers are psychologists. In addition to them, we have thousands more mental health professionals in psychiatric nursing and social work. We have no way of knowing how many there are, what they are doing, what services they're providing and to whom. We do have very good data on psychiatrists, but until we can change the approach to the accumulation of manpower data, I don't think we can plan effectively for national policy about the treatment of mental health problems.

The general question is, will Dr. Klerman work for a valid and comprehensive manpower data system encompassing the entire field of mental health, and more specifically, is he willing to provide funds to accumulate data on all the fields instead of funds for only one?

A fourth issue concerns training and funds for training. We have two problems here: one in training of clinical psychologists and one in training of research psychologists. There has been a continuing discussion with ADAMHA and within NIMH about how these areas should be funded. For example, if the 1979 budget proposal is followed, psychology will be a tremendous loser. Half of our graduate training programs and support for over 1,000 predoctoral psychology graduate students would be lost.

Neither proposal that underlies these recommendations is in line with the specific recommendations of the National Academy of Science's Committee to study National Needs for Biomedical and Behavioral Research Personnel. This training issue is illustrative of the flip-flops in policy that have been coming out of ADAMHA and its institutes. They almost prohibit continuity of training and research in the fields of mental health, and particularly in the social and behavioral sciences.

In addition, we have some problems about the categorization of clinical psychologist under the National Research Services Awards. Clinical psychologists are rather rigorously trained in research. Our researchers and our clinicians take courses together from the first day of graduate school. It's important to us that clinical psychologists have extensive training in research.

On the other hand, the National Research Act of 1974 split apart clinical training and research training and we're having difficulty getting our clinicians trained in that context. We are not able to get them categorized as needing any research training. The funds for clinical training are being cut. We feel that the categories—and this is an administrative problem with ADAMHA—are too sharply defined, and the subfield that gets caught between these sharply defined categories is clinical psychology. We would like to see that changed. We think ADAMHA is going far beyond congressional intent on a variety of points on the National Research Act of 1974, and we would like to see them come closer to the congressional intent and be less restrictive.

So, we ask if Dr. Klerman would actively support change in these ADAMHA regulations—and that's what they are—to recognize and fund further training in the research skills of psychologists.

Another issue on training here refers to who is going to get trained. In each Forward Plan for Health that's been issued in the last 2 years, there has been a proposal to fund the training of generic physicians in the field of mental health. We feel that generic physicians—primary

care givers, as they are called these days—do indeed need further training on mental health issues, but these proposals amount to what could be a massive shift in funds away from the training of doctoral level mental health providers, including psychiatrists and psychologists, toward training of primary care givers and general support for medical schools.

A year ago, funding was proposed to be eliminated for psychology and psychiatry with the funds going to primary medical training. There was a great deal of interaction about that. Funds were ultimately restored. There is no question that the plan to divert substantial amounts of training funds to primary care givers is still alive in ADAMHA. We disagree dramatically with it. We feel that it will produce undertrained people who will then be a primary force in treatment of mental health disorders. It will leave the public with less than fully trained practitioners and, certainly, more costly ones.

Our question there: Does Dr. Klerman support any such shift in training funds? Can he foresee in any way that these primary care givers could be fully competent to treat the full range of psychological and emotional problems?

We're concerned about policy shifts within ADAMHA; both the Assistant Secretary for Health and Dr. Klerman have suggested that they will take a firmer hand in policy in ADAMHA. We think that probably this is needed, but we would like to know what is the policy that we're going to take a firmer hand about? We would like to see a clearly articulated statement on what policy changes are going to take place in ADAMHA. We feel that this deserves public discussion and some congressional oversight, so we would like to know what are Dr. Klerman's plans regarding major goals, directions and priorities for ADAMHA, in which areas does he propose continuity with past efforts and which areas call for major changes or new emphases.

The issue that Senator Javits raised was specific to PSROs but was a question to elicit a statement of approach to the design of mental health systems. The main issue is in terms of third party payment and a question of when do you approve that payment. Do you O.K. it after the fact or do you demand some plan in advance? We feel that the plan in advance is the more appropriate way to fund third party payment within mental health systems and, specifically, national health insurance. We feel it has a major advantage in that it allows you, once you get a treatment plan down on paper, to check whether the plan worked and allows you to begin a system of putting money into those treatments that are cost effective. This is an important ingredient within the design of a system. We mention it only as an example of different approaches by different fields but we, nonetheless, think it is an important aspect and we would like to know how Dr. Klerman feels about these broader-based, more heterogenous, approaches to the design of mental health systems.

Regarding national health insurance, less for our own field than for obtaining specific kinds of feedback, we would like to know the answers to several kinds of questions. First, does Dr. Klerman support cost efficient, or any other, coverage for mental health services under national health insurance? Second, does he support the inclusion of psychologists as independent providers under such a plan? And third, and this is very important to us, what kind of review mechanisms,

evaluation efforts and public accountability controls does he support or propose?

In the interest of time we have only skimmed some of the written testimony and presented only a few of the issues that we care a great deal about and which we think will and should have a strong impact on public policy in the field of mental health. We have met with Dr. Klerman twice. We met with the Assistant Secretary for Health at length once about these issues. We feel that we can work with Dr. Klerman. We look forward to working with him. We do feel that the process and the outcome of obtaining some statements for the record in advance of his tenure as Administrator of ADAMHA is a useful step in public discussion of Federal policy and a useful step for congressional oversight.

I thank you for the opportunity to come.

The CHAIRMAN. Excellent.

I understand Dr. Klerman is going to reply?

Dr. KIESLER. He did agree to do so. We are very pleased to hear that.

The CHAIRMAN. What is the role of the psychologist in the treatment of alcoholism and drug addiction?

Dr. KIESLER. There is a great deal. We don't have a certifiable specialty, nor does psychiatry for that matter. There are varieties of experience to be had. I think you will find psychiatrists and psychologists working in all of the various approaches to the treatment of alcoholism side by side.

The CHAIRMAN. What is the training program? Is there a way to describe the training of a psychologist?

Dr. KIESLER. The training would tend to be standard clinical psychology with internships and postdoctoral experiences in specific treatment centers, such as Lexington or other places. There is no organized specialty in alcoholism in psychology, nor is there in any other areas.

The CHAIRMAN. What are some of the basics to training even though there is no specialty so designated?

Dr. KIESLER. My colleague, Mr. Martin, suggests you are talking about treatment modalities. I think psychologists would be more likely to treat alcoholism as a combination of an emotional and behavioral problem. It has been to a considerable extent psychological in nature. It's a set of therapeutic devices that are very close to learning experiments. There is the underlying suggestion that you have learned to be an alcoholic in essence, and you can unlearn some of those same behaviors. But, if you're inquiring about schools of thought or specific modalities that differ dramatically from psychiatry, I don't think there are easy ways to characterize psychology's approach.

The CHAIRMAN. Do you have any ideas about improvements in treatment modalities for alcoholism and drug addiction?

Dr. KIESLER. No, sir, I don't but I was very much taken with some of your questioning of Dr. Klerman in this regard because what you suggested, at least to my mind, was that it's often very difficult to extrapolate from a closed system—for example the Lexington experience—to a large-scale social system. That's why we support using heterogenous treatment, different treatment methods and modalities

in mental health and in alcohol abuse, and a large-scale assessment program on a national level as very important aspects of program planning and administration.

I don't think we know enough in these areas to say "Here is the specific treatment we're going to use solely at a national level and no other because we know it works." We simply don't know that in large-scale public programs, and we don't have any one specific treatment in mental health or alcohol abuse.

The CHAIRMAN. Is your profession active in drug treatment?

Dr. KIESLER. Very little in drug treatment. There is some active research in drugs, very active research in alcohol. We're less involved in the treatment in alcohol and drug abuse than we are in more general mental health issues. It has not been the major area for psychology in treatment.

The CHAIRMAN. It is a very thoughtful paper you have summarized. We have it and I have been able to read it rapidly. Next time around I will read it more thoughtfully. You have been very, very helpful.

Dr. KIESLER. Thank you very much.

The CHAIRMAN. We will be receiving some written material to complete our record and early next week we will be able to act on Dr. Klerman's nomination, favorably I am sure.

[The prepared statement of Dr. Kiesler and additional material follows:]

TESTIMONY

by

CHARLES A. KIESLER, PH.D.

EXECUTIVE OFFICER OF THE

AMERICAN PSYCHOLOGICAL ASSOCIATION

to the

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

on the subject of

THE NOMINATION OF DR. GERALD KLERMAN

TO THE POSITION OF

ADMINISTRATOR OF THE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

October 26, 1977

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

October 26, 1977

Good morning. I am Charles Kiesler, a psychologist and Executive Officer of the American Psychological Association. I am representing the 45,000 members of APA, the major national organization of psychologists in the United States.

I am pleased to be able to testify at the hearing on consideration of Dr. Gerald Klerman as Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, because the members of our organization are concerned with virtually every aspect of the mental health field. We are vitally interested in the office Dr. Klerman would hold and the complex organization he would head. We believe this committee shares our interest and that Dr. Klerman's responses, either at this hearing or subsequently for the record, will be of value to this committee, the administration, and the public.

ADAMHA has existed for only four years. In that time it has been forced, for political reasons, to make what we consider to be some bad decisions. These decisions have not been beneficial to the public or to the professional constituency ADAMHA must both speak for and utilize. More importantly, some of these decisions will not, in our opinion, benefit the public's mental health and well being.

The three institutes of ADAMHA represent a wealth of expertise which could be used to provide valuable national policy directions. They command significant budgets which could be used to stabilize and energize programs throughout the country. Within ADAMHA is the potential for a far more significant effort than we have seen. We would like to use the forum of this

hearing to suggest some of the past problem issues, and hopefully contribute to a more positive future.

Despite the fact that psychology is one of the core mental health professions and has made very significant contributions both as a research science and as a health service profession, we are most conspicuously absent from the policy-making levels of ADAMHA. The broad-based knowledge of psychologists has largely been a lost resource within the agency thus far. If the reason for this underutilization is a lack of understanding by Congress and the Administration of what psychology is and what it can contribute, then I should preface my remarks with a brief description. This will help you to understand our concerns and our reasons for being here.

As a science, American psychology now has about 20,000 researchers and accounts for over 11 per cent of the total science doctorates in the country. It is a social, biological and health science whose aim is understanding the totality of human behavior. Thus, although it has made countless contributions of both a basic and an applied nature in the area of mental health, its scope is broader than that area alone. Psychological research is finding increasing application in matters of physical health, as well as a wide range of other public policy issues.

As a health service profession, psychology has nearly 25,000 mental health service providers---one half of the fully trained doctoral level mental health service providers in the nation. Psychology's status as an independent health specialty is well recognized in law and in administrative precedent. Psychologists are licensed or certified in all 50 states and the District of Columbia. A majority of the states now have what we call "freedom of choice" laws to legally recognize the psychologist as an independent provider of mental health services within all health insurance plans. We are included as health service professionals eligible for direct reimbursement through the Federal Employees

Health Benefits Program, the CHAMPUS program, the Veteran's Administration program of health benefits, and many Blue Cross/Blue Shield, Aetna, and similar programs. Psychologists' professional expertise is recognized in a number of other Federal programs including Community Mental Health Centers, Health Maintenance Organizations, the Rehabilitation Act, and the Workman's Compensation Act.

Further, scientific and professional psychology are not divorced from each other, but interact in a vital and productive fashion. Psychology is unique in the degree to which training for both research and service delivery are intertwined in graduate training, In few other fields is there such a productive interchange between research and practice. In psychology, empirical research and theory guide practice, and, in turn, practice sharpens theory and research.

Overall, the activities of psychologists are deeply influenced by two themes: First, a consumer-client orientation, a strong sense of social responsibility, and a concern for advancing the public interest; second, an insistence on high quality research and evaluation in assessing alternatives. When applied to programs that affect the public, this means an emphasis on programs that work and can be demonstrated in a hard-headed, empirical fashion to work. As a science-based profession, we have been in the forefront of support for peer review, formal evaluation of the outcomes of health service programs, interdisciplinary cooperation, strict and public standards for excellence, and accountability to the public for the services we and others provide.

These are more than just idle claims: Psychology has shown on the basis of empirical evidence that it can provide effective and cost-effective mental health services in a way that contributes to the containment of physical health costs. We will say more about this shortly. We are providing this Committee with copies of two APA products which reflect some of these concerns. The

first is a set of guidelines for a Consumer Oriented Health Insurance Act; the second is an outline of recommendations for the role of systematic evaluation and professional accountability in national health insurance.

The nomination before this Committee is an extremely important one for the field of mental health. Both the mental and physical well-being of millions of Americans will be directly affected by the policies and programs of ADAMHA. Thus, psychology is concerned about what ADAMHA's role will be in creating and implementing national mental health policy. The President's Commission on Mental Health is conducting a thorough review of this issue, and the nation is on the threshold of a national health insurance plan. We are approaching the time when mental health concerns can be elevated to their proper level of importance. It is vital that the chief spokesman for mental health within the Administration be kept actively informed on all the facets of science and service within this field. It is one of my obligations as a psychologist and as Executive Office of the APA to push for excellence in this public office.

We are not objecting to this nominee personally, nor is it our purpose to question at length his professional qualifications to be the ADAMHA Administrator. Our purpose, rather, is to raise several issues and to get Dr. Klerman's positions for the record. The Congress and the public need to know what his intentions are for this office, so that there can be greater public review and accountability within ADAMHA than there have been in the past, and so that at a later time there will be a basis for judging ADAMHA's performance and accomplishments.

We want to raise seven issues which are of direct concern to the mental health community and are directly relevant to the mental health needs of the American people.

The first issue is ADAMHA's need for input from all mental health professions. Although there has been undeniable progress in both understanding and treating mental and emotional disorders, it is equally apparent that our knowledge is still

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inadequate to fully meet the nation's needs. As the President's Commission on Mental Health reminded us in its Preliminary Report, we need a broader knowledge base, more effective programs, and delivery systems that are more equitable, effective, and affordable. At such a time, it is especially important that the direction of our national mental health efforts not be guided toward one narrow path.

Consequently, we are concerned that only one of the several core mental health fields is represented among the top leadership of ADAMHA. The directors of all three institutes within ADAMHA are psychiatrists. If this nomination is approved, the top two officials of ADAMHA will also be psychiatrists. Furthermore, only psychiatrists were consulted prior to the appointment. To our knowledge, there were no consultations with the organizations of psychology, social work, or nursing; nor with any of the public interest or advocacy groups in mental health; nor, we understand, with members of Congress associated with this area.

I cannot emphasize too strongly that this issue is not a matter of narrow professional interests or territoriality, but one with the most profound implications for Federal policy in mental health and, consequently, for the American public. We do not object, in principle, to the nomination of a psychiatrist. But we would argue that a system whose entire leadership structure represents only a fraction of its constituent professionals may not be able to avoid a focus that is inappropriately narrow in its approach to mental health. Furthermore, this focus will inevitably be reflected in the kinds of mental health services advanced, the kinds of professional training supported or allowed to wither away, and the kinds of research which are funded. Decisions in each of these areas will inevitably affect the ways in which, and the degree to which, the mental health needs of the American people are met.

We have discussed our objections to psychiatric dominance with Dr. Klerman and with Assistant Secretary Richmond. They have heard our concerns. Our question here is: What personnel changes does Dr. Klerman propose for ADAMHA? Specifically, how will he bring other mental health professionals into leadership positions?

The second issue concerns research funding. Innovation and progress in the delivery of mental health services depend heavily upon maintaining high quality research, both basic and applied. And yet the pattern of funding for mental health research over the past decade has been catastrophic. There has been a 56 per cent reduction in the purchasing power of research grant monies, when budgetary changes and inflation are taken into account. The Director of the National Institute of Mental Health has stated that the nation's mental health research effort is, in his words, "on the brink of collapse."

Does Dr. Klerman plan to restore funding for mental health research? To what levels, and by what date?

The future of the nation's overall mental health program depends upon a coordinated and comprehensive research system, with adequate funding levels of research support. Equally necessary is a long-term pattern of stability and continuity in that support; for only in this way can we insure adequate planning, innovation and high quality research.

What will Dr. Klerman do to achieve continuity and stability in research support?

Earlier I spoke of psychiatric dominance within ADAMHA. Despite the fact that psychiatry has one-fifth or less the number of full-time equivalent researchers as psychology, psychiatrists are awarded nearly 60 percent as much in research funds as psychologists receive from NIMH. At a time when the percentage of approved but unfunded research within NIMH is escalating rapidly, this is particularly troublesome.

Does Dr. Klerman support a pattern of research funding that is more balanced and equitable among the mental health professions?

The third issue is mental health manpower data. In response to the Health Professions Education Assistance Act of 1976, the Bureau of Health Manpower proposed to designate Health Manpower Shortage Areas for the field of mental health by the title "Psychiatric Shortage Areas." This characterization misrepresents the field of mental health by concentrating on only one of the core mental health professions.

A basic problem in this area is that there is no single good source of data on the non-psychiatric mental health professions, and consequently the nation has no good source of manpower data about the general field of mental health. As a result, valid program planning for mental health services delivery is not possible, and the planning that is based on psychiatric data alone is seriously misleading.

Does Dr. Klerman plan to work for a more valid manpower data system encompassing the entire field of mental health?

The fourth issue concerns training. No national mental health system can be considered adequate if it does not provide for the training of both service and research personnel. Yet during the past decade the support for training in both these areas has steadily, and in some cases precipitously, dropped.

Within the past two years, the mental health portion of the ADAMHA Forward Plan for Health proposed plans which would have meant the total elimination of training funds for clinical psychology. Only after the most strenuous activity by psychology and other professions were training funds restored to their previous levels.

The 1976 teaching support funds for both research and clinical training for psychology were only one-third to one-half of their 1972 levels, and support for trainees has undergone considerable erosion as well.

The NIMH Fiscal Year 1978 budget request proposed the elimination of both predoctoral and institutional research training support by the Institute. Neither proposal is in line with the specific recommendations of the National Academy of Science's Committee on Personnel Needs and Training in the Biomedical Behavioral Sciences.

Does Dr. Klerman support the reduction or elimination of training funds? What concrete steps does he plan to take in this area?

The National Research Service Awards, established by the National Research Act of 1974, were created by Congress to counteract attempts at total elimination of research training for the biomedical and behavioral sciences. However, the manner in which this program has been implemented by ADAMHA has undercut the intent of the awards. Several specific aspects are unduly restrictive beyond Congressional intent, but we want to point out in particular the program's impact on clinical psychology. Clinical psychologists, in addition to their service delivery skills, undergo rigorous training in research. They generally have more research training than do psychiatrists. Yet because of ADAMHA's peculiar restrictions on their sharply defined categories of research training and clinical training, clinical psychologists are considered ineligible for research support.

Will Dr. Klerman actively support change in these regulations to recognize and fund further training in the research skills of psychologists?

NIMH has proposed channeling funds previously allocated to training mental health professionals to training so-called "primary care givers;" in other words, physicians. Exactly what kinds of mental health services the physicians so trained would engage in is not clear. Although we support the inclusion of a mental health curriculum within the education of physicians, we seriously question this diversion of funds away from training fully-competent specialists toward minimally adequate mental health training for health generalists.

The complexities of mental and emotional problems cannot be dealt with properly by someone with only marginal knowledge of the field. Yet, the assumption behind this transfer of funds away from mental health practitioners seems to be that the public can be adequately cared for by less-than-fully trained care givers.

Does Dr. Klerman support such a massive shift in training funds? Does he forsee these primary care givers as being fully competent to treat mental and emotional problems?

The fifth issue concerns ADAMHA's management role -- whether it will continue to be primarily an administrative one, or whether greater policy direction over the three institutes will be added to its functions. Assistant Secretary for Health Richmond has been quoted as advocating a larger policy role for ADAMHA, and we must presume that the selection of Dr. Klerman reflects that position.

This would appear to be a desirable direction in which to move. Vesting policy-making authority primarily within the three Institutes, with ADAMHA having essentially only administrative functions, has created problems in the past. Decisions which are critical to a complex constituency have been restricted to a narrow, pre-selected group, with no system of checks and balances and no realistic mechanism for public review or redress of grievances.

Does Dr. Klerman support a greater policy role for ADAMHA? How does he propose to make this public agency more publicly accountable?

The sixth issue concerns the goals and priorities of ADAMHA. If the agency is to play a larger policy role, it is essential to know what its goals and directions will be.

The mental health community is looking for assurances: First, that mental health is seen as an important policy area, to be on a par with other major health issues; Second, assurance that the contributions of the entire

mental health community are valued and have a place in federal programs and planning; Third, assurance that ADAMHA will furnish adequate resources and support to do the job.

What are Dr. Klerman's plans for the major goals, directions, and priorities of ADAMHA? In what areas does he propose continuity with past efforts, and what areas call for major changes of emphasis?

Designing a mental health policy is an extremely complex task. Decisions about mental health services involve not simply questions of what groups get to deliver what kinds of services, but rather the choice of entire systems of delivery, including:

-financing of mental health services;

-delivery of mental health services to all who need treatment;

-training of mental health professionals;

-support of both basic and applied research on mental health related issues;

-ongoing program evaluation and quality assurance in mental health service delivery.

The differences in educational background and professional orientation between the various mental health professions can lead to quite different perspectives on health care systems. The general approach to development of PSRO systems by psychologists and psychiatrists can serve as one example. Psychiatrists have tended to build their review systems on a traditional medical model--based on the assumption that there are accepted and traditional standards and methods of practice. Their orientation is to weed out, through retrospective review, that small percentage of people and/or practices not meeting those standards.

In contrast, psychologists have pushed for peer review that is concurrent with service delivery, or that can be carried out before any substantial portion of the service plan is undertaken. We want the practitioner to state in advance the patient's problem, the treatment recommended, and the predicted outcome of

treatment. In this way we can dwell less on whether the system of treatment is traditionally accepted, and more on whether it works.

Each of these approaches has merit -- neither is perfect. What the illustrate is that there are significant and supportable alternatives fo decision-making about our mental health system.

How will Dr. Klerman work to encompass this broad-based view of mental health systems within ADAMHA policy?

The seventh issue concerns ADAMHA's interface with national health policy. Evidence shows that properly designed mental health services can not only alleviate human suffering directly, but can also lead to such significant reductions in the use of physical health care that the mental health services may virtually pay for themselves. These spin-off benefits also extend to the alleviation of problems such as job absenteeism, alcoholism, and child or spouse abuse.

Psychology has been in the vanguard of research on mental health services and their impact on other aspects of our lives. We have been very strong in our support of program evaluation -- and in the design of programs that explicitly tie evaluation to program change. We have fairly clear ideas about why public systems should be based on publicly-created goals. We are eager to illustrate the ways that psychological practitioners are able to provide effective, cost-efficient mental health services. In all these ways, psychologists have focused their attention on matters of immediate relevance to the top issues in national health policy: cost containment, and national health insurance.

Does Dr. Klerman support cost-efficient coverage for mental health services under national health insurance?

Does he support the inclusion of psychologists as independent providers under such a plan?

What kinds of review mechanisms, evaluation efforts, and public accounta-

bility controls does he support?

In conclusion, we have presented only a few of the issues which are of great concern to the mental health community and which have implications for the health care of the American people. Assuming that Dr. Klerman addresses these issues to the Committee's satisfaction, and is confirmed as Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, we look forward to working with him and his staff in a spirit of mutual cooperation and respect. Be assured that psychology will not fail in its duty to assist Dr. Klerman and the rest of the ADAMHA leadership in attacking the problems we have outlined here and in meeting the mental health needs of the public.

Thank you for the opportunity to appear here today.

D R A F T

Continuing Evaluation and Accountability Controls for a National Health Insurance Program

American Psychological Association Task Force on Continuing Evaluation in National Health Insurance

September 1977

Introduction

Some form of comprehensive health insurance system will almost surely be legislated into existence within the next few years, whether as a National Health Insurance (NHI) system or as an extension and elaboration of the present system. As the legislation is written, the Congress will be under great pressure to broaden the definition of health care provider to include many professional specialties not now receiving direct reimbursement for their services under health insurance policies, and to include many services not now covered. Existing federal programs such as Medicare and Medicaid are thought to be inadequate in coverage for mental health services, and they exclude from participation a number of provider groups that could contribute substantially to the nation's health.

The probable advent of NHI provides psychology and the other health professions with a remarkable opportunity to display professional maturity and leadership in also urging the Congress to build into the NHI provisions for systematic evaluation of covered services and reimbursement only for effective treatments and programs. In the vast majority of cases the only really ethical position lies in providing the public with services of demonstrable effectiveness. It is unlikely that any health profession

would in the long run lose by affirming its confidence in its ability to provide effective services, and the public could only gain.

Evaluation is activity carried out to determine the consequences of implementing a treatment or program.[1] Applied to NHI, evaluation is activity carried out to help determine the worth of programs for improving health or preventing illness and disability. It pertains to a wide range of research activities extending from testing the effectiveness of a specific drug or medical procedure to examining a program of national scope. There are many ways in which evaluation could be accomplished, e.g., reliance on expert opinion, obtaining of consensus judgments of consumers, logical analysis, etc., but within the context of this paper evaluation may be taken to refer to careful and systematic research for determining the extent to which a program is effective. The results of evaluation provide objective evidence of the effectiveness of a program for use by those who will decide what NHI should pay for. Good evaluation research is also directed toward considerations of cost, and cost control must be a powerful restraint within NHI if the system is to be viable. Evaluation research can be useful not only in the determination of whether a program works and in the provision of careful and reasonable measures of its benefits, but evaluation can also provide comparative data on alternative programs so that cost-effectiveness may be judged. If NHI is to be economically sound and reasonably priced, all programs will have to be carefully evaluated to determine that their benefits are being achieved in a cost-effective way.

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1. For the sake of simplicity, the term program will be used henceforth to refer generically to treatments, programs, interventions, and other related concepts.

It is unrealistic to suppose that a National Health Insurance system would begin with coverage limited to those services with well established effectiveness. Many of the health care procedures now considered standard have never been demonstrated in careful experimentation to be effective. Consequently, one realistic suggestion would be the convening of study groups to determine which treatments and other health services have been shown to be effective and then to set priorities for study among those that have not. Reimbursement under NHI might continue for all treatments and services currently judged reasonable, but on a gradual basis currently accepted practices should be examined and dropped if proven ineffective. No new programs should be added without empirical test.

Decision making in most areas of human services is complex, and considerations other than the worth of a service often properly enter into the decisions. Regardless of the existence of evidence for or against a particular decision, political considerations will be especially likely to contribute heavily to decisions about what services are delivered and how. Nevertheless, in decisions about the delivery of health services within the context of NHI the political process should be maximally informed about the effectiveness of the programs in question.

Principles

There are many ways in which the problem of explicating a position about evaluation of and accountability for professional services might be approached. We have here elected to state some general principles which we strongly believe should guide the development of legislation when its time comes.

Principle 1. Legislation should provide for implementing programs in ways that facilitate rigorous evaluation.

The history of social programs in this country is replete with instances of programs brought into being hastily and nationwide before any evidence of effectiveness could be accumulated. In many other instances interventions have been introduced so haphazardly that no persuasive evidence of effectiveness could be gathered. It is of the greatest importance that the various features of NHI be introduced systematically in such a way as to foster rather than retard or frustrate evaluative efforts. The key to linking service delivery to evaluation is the dual recognition that no program or service can actually and effectively be implemented on a national basis instantaneously and that when we do not know precisely what to do about a problem, delay is not disastrous but prudent. What is needed is a set of deliberate strategies for introducing new programs in such ways that data can be collected to assess program effectiveness.

Ideally, evaluation should involve a true experiment with sampling units, whether persons, hospitals, or HSAs, being assigned randomly to various treatment and control conditions. For new interventions especially, such designs are often feasible, and where feasible they should be insisted upon as the most likely to produce high quality and clearcut findings. Many current interventions, however, cannot be evaluated against no-treatment control groups because of ethical considerations. Current programs will in most instances have to be tested against innovations which might replace them. Even so, data occasionally come to light that cast such serious doubts on the efficacy of currently accepted practices that a randomized experiment with an untreated control group is acceptable on

ethical as well as scientific grounds.

Recognizing that the testing and demonstration of effectiveness of many programs is an iterative process, it is probable that the course of evaluating many programs will begin with small scale demonstration projects and laboratory-type experiments, to be followed by larger scale tests. For many of the larger scale tests true experiments may not be feasible. Nonetheless, services and programs can be implemented in ways that will facilitate their evaluation without needlessly depriving any group of services of value.

By phasing in programs systematically at different places or at different times, data of an unusually valuable nature can often be obtained. Programs might, for example, be phased in by geographic regions or by political units so that one could determine whether there were systematic changes within regions or units associated uniquely with the implementation of the program. If a preponderance of the units changed after the intervention, and only after the intervention, and if the intervention began at different times for different units, the case for a causal effect of the program would be strong. Treatments might also be phased in by populations served or by naturally occurring units such as different military units, universities, hospitals, or service clubs.

The possibility of getting useful information from normal variations in current and future practices should not be dismissed as of no value. Although there are limits on the interpretability of many natural variations in health programs because these variations are usually confounded with other variables such as the population served, opportunities to study normal

variations should nevertheless be capitalized upon. Despite the care required to interpret evidence from natural variations, many questions are at least worth asking in this context. An example may help to clarify this point. In the early days of tranquilizing drugs the doses of chlorpromazine given in different institutions varied greatly, and only gradually did evidence become available that the very high doses were not needed and probably were harmful. The same conclusion would have been suggested earlier had easily available information about the practices and experiences of different institutions been used.

Program evaluation is still a new area of endeavor, and the expected development over the coming years of new research designs, better statistical techniques, and other methodological improvements will make the task of evaluating health care interventions easier and in that respect all the more mandatory.

Principle 2. The autonomy of the evaluation components should be guaranteed.

Our definition of evaluation implies that evaluation should be objective--free of political pressures, of the biases of narrow professional interests, of expectancies about what ought to be, and of any other prejudicial factors. In order to achieve that objectivity, it seems essential that any evaluation component established under NHI legislation should be autonomous in virtually every respect. Personnel should be recruited solely on the basis of scientific competence and personal integrity. The guarantee should be absolute that the evaluation component, although subject to oversight and review, control its own budget, plan its own studies, analyze and interpret its own data, and issue its own reports. The

evaluation component should be established and operated in such a way that suspicions of either bias or insufficient courage would not be sustainable. There are unfortunate examples in the federal government of evaluative activities which are rendered suspect because of political and other influence.

There are three important points of contact between an evaluation component and the larger system of which it is a part. First, a variety of interest groups should have a role in the setting of priorities for study and in developing plans to accomplish research. Second, an evaluation component should enter into the decision-making process but only to the extent of providing the best evidence possible. Third, provision should be made for review of the activities of the evaluation component to ensure that they contribute effectively and efficiently to the overall aims of the NHI system.

Principle 3. The national health legislation should provide for adequate funding of evaluation.

Evaluation of health care activities will entail costs of considerable magnitude. We propose that any NHI system have built into it a substantial and continuing capacity to fund research into the effectiveness of all types of health care. In recent decades, enormously costly federal programs have been funded and have proven disappointing in light of the original, perhaps overly idealistic goals. We believe that the lack of provisions for evaluating these programs from the time of their origin contributed to their failure. The consequence of this failure was the unavailability of a rational basis for modifying the programs as evidence for their

ineffectiveness began to appear. The belated addition, often under crisis conditions, of a research and evaluation component proved uniformly unsatisfactory as a way of salvaging programs showing clear signs of incipient failure. Billions of dollars have been wasted, the hope and aspirations of large portions of the populace have been frustrated, and the federal government has suffered losses in public confidence and trust.

The financing of evaluation studies of the kind we are proposing will involve large sums of money and complex decisions. It is our opinion that research needed to support and improve the effectiveness of a National Health Insurance system should come from within the system itself, i.e., should be paid for out of "premium dollars." Only in that way can the research enterprise be protected from the vagaries of funding decisions. Moreover, it seems only just that research meant to improve a system should be funded out of that system, but in a way that preserves autonomy. The level of funding which should be available cannot be specified in other than an arbitrary way, but it probably should be set at some percentage of premiums paid, should be a constant and dependable percentage over a period of years, and should be reviewed periodically to determine whether benefits being achieved from the research are outweighing costs. Annual health expenditures of a fairly direct nature amount to something over $150 billion per year and justify a substantial effort to develop empirical support for the efficacy of those expenditures. Even a small percentage increase in the efficiency of the system would justify a large research budget.

Although good evaluation research can sometimes be done with minimal financial outlay, it is often expensive; sometimes it is very expensive.

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Nevertheless, the justification for these costs is that the costs associated with not doing good evaluation research may be even greater. To begin with, there is a potentially great human cost, both individual and societal, in employing ineffective programs. Scarce resources are wasted when they are invested in ineffective programs. Moreover, there is danger in the belief that some condition is being treated when the treatment is in fact of little or no value. Attention is diverted from the problem, and it will persist and perhaps worsen. In addition, poor research is expensive. It is expensive because in the long run much money is spent on series of weak studies which even in aggregate will rarely be persuasive, especially to those who would prefer to believe something other than the conclusion to which they may point. High quality research is likely to be more persuasive and ultimately to involve a lower final dollar cost. Poor research may also be costly in a human sense because it can be misleading and either support the case for an ineffective treatment or steer decision makers away from a good one.

As with any other activity involving expenditure of public monies, evaluation research itself should be evaluated. The potential benefits should, however, be calculated from the proper base. It may well be a bargain to spend more on a good evaluation of an intervention than the intervention itself costs, if the intervention is likely to be regarded as a prototype for a national program. Account should also be taken of the likelihood that the benefits from many proven interventions will extend for years into the future, although the costs of the evaluation are incurred immediately. Determining whether an evaluation study is worth doing at the proposed cost will not always be simple, but the effort should

be made.

Very often the best bargain in research is sound basic research on human processes and problems. Although the emphasis of research within NHI should, we believe, be on evaluating the effectiveness of programs, a strong case can be made for allocating at least some portion of the research dollar to more basic studies, particularly if areas can be identified which are ignored by other funding agencies.

Principle 4. The system should have articulated procedures for encouraging new and innovative programs with rigorous evaluation designs.

The requirement that the effectiveness of a new program be demonstrated prior to its reimbursement under NHI might seem unduly to retard innovation or to make change almost tortuously slow. That need not be the case. Much of the slow pace of development that now exists comes from artificial barriers, professional jealousies, and lack of funds for research. None of these problems is inherent to an empirically based system. Some portion of premium funds should be invested, perhaps through the National Institutes, in demonstration projects, large scale clinical trials, and other research activities. Undoubtedly, a large number of important health questions could be resolved within a very few years. Nevertheless, nothing should become routine in the system until tested and proven efficacious and safe. We have more than enough experience of the rapid acceptance of ineffective and even dangerous treatments to justify an insistence on the slightly more deliberate pace that an outcome based system would follow.

The needs of the NHI for information will require a type and level of research not now characteristic of most National Health Institutes

although other federal agencies such as the National Center for Health Services Research and the National Institute of Mental Health do support some research of the sort envisioned here. With a fully operating NHI system, wide participation in health research will be required.

Nothing here should be taken as implying that development of new programs should be slighted. Special procedures should be established so that individual practitioners, clinics, or other provider units could be reimbursed for nonstandard services of an innovative nature. Those procedures would probably involve prospective peer review focused on the prior research support for the innovation, the logic of the innovation, and the plan by which the innovation would be evaluated. The initial evaluation might be clinical and relatively informal, but with subsequent extension of the innovation, more rigorous evaluation designs could be demanded.

Principle 5. The system should provide for the evaluation of the relationship of program characteristics to outcomes, with primary focus on how programs affect recipients.

Desired outcomes should be specified for every health service delivered or for every program to be implemented. Outcomes should be specified in ways that are conceptually clear and in forms that are measurable. It is also necessary to specify the time span during which outcomes should be detectable, for not every program will produce either immediate or permanent effects. Ideally, the set of outcomes expected from an intervention or a program should form a coherent body of related effects with clear linkages to the treatments employed. The outcomes to

be assessed should be evident in the characteristics or behavior of the units to which services are delivered so that when families are served, then effects on families should be detectable, and when communities are served, community effects should be observable.

The focus of all programs under NHI and thus of all evaluations of them too, should be on the recipient rather than on the provider or the system itself. Every effort should be expended to determine the actual health needs of persons insured by the system and how those health needs might best be met. The NHI and health care systems should then be structured so as to meet those needs. What providers might prefer to do, what might be easy or convenient, what would be pleasant should not be considered at all except when such factors pose obstacles to delivery of effective service. Nor should efficiency become such a preeminent criterion that it results in the impersonal or demeaning management of people.

At some point the effectiveness of the entire health care delivery system must be examined. It will not suffice to evaluate health care treatment by treatment and service by service. The effectiveness of the system will be evident only in terms of system goals. Those goals will have to be stated objectively and relevant data will have to be collected. The system will be judged deficient and will have to be corrected if system goals are not met. For example, one goal of the health care system might be that no more than .5% of pregnant women would go without prenatal care beyond the fourth month of pregnancy, the small allowance being for exceptional cases of women hiding their pregnancies or refusing care. If 10% of pregnant women are not receiving prenatal care, then the system

is failing, no matter how good the care when it is given. Obviously, any single index or even any set of absolute goals must be applied with caution, and progress toward them must be viewed in context.

Principle 6. Guidelines on which accountability is based should be made explicit and generally understood in advance.

The interests of the health care system, of providers of services, and of recipients of services coincide with respect to the need for mechanisms to control the delivery of services in such a way that quality and appropriateness are assured and that costs are minimized. Without doubt, a variety of control mechanisms will be required because the problem is multifaceted and involves a number of different levels of analysis. At one level, provision must be made for determining what services will be covered under NHI, and that determination will involve complex issues having to do with costs to the system, needs of recipients, equity across social class lines, and national priorities. At another level, specifications for quality services will have to be devised and permissible variations stated. At still another level, some sort of review for compliance with specifications of quality will have to take place. It is important to all concerned that the process involved in control of health services delivery be open and comprehensible. Almost surely, mechanisms of control will have to include a system of peer review for providers of services.

Both providers and recipients of services will want the guidelines by which

appropriateness, quality, and cost of services will be evaluated to be explicit and understood in advance of any interventions undertaken. Both providers and recipients should know at every step whether a specific treatment plan or procedure would be regarded as appropriate, of good quality, and as a covered service for which reimbursement would be forthcoming from NHI. In general, guidelines should be as simple as is consonant with the assurance of quality of care. In particular, the guidelines for controlling costs should be straightforward with as few special provisions as possible concerning such matters as proportion of costs covered, deductibles, co-payments, and the like.

Principle 7. Criteria examined via evaluation programs should be explicit and should represent the concerns of diverse constituencies.

If the goals of accountability and quality of care are to be met, it will be necessary to specify treatment and case management criteria by which judgments can be made. The criteria must be stated in an explicit form; reliance on implicit judgments even if made by peers, will not be sufficient. As with general guidelines, criteria should be available to all parties involved in the process. Patients and clients no less than peers should be aware of what is considered standard or quality treatment. Explicit criteria do not unnaturally limit decision making by provider and consumer, individually or jointly. Mechanisms for exception should be a part of the system. All that is required in most cases is that the reason for the exception be as explicit and reasonable as the criterion itself.

Consumer satisfaction with health services should be studied as

carefully and routinely as with the most successful commercial products. If consumers are dissatisfied with the health services they receive, they may not continue to use those they need and may dissuade others from using them. Problems with consumer satisfaction are especially troublesome when health deficits are chronic and when consumer freedom to choose among services is limited. When health problems are chronic, dissatisfaction may lead to poor compliance with a treatment regimen that requires patient cooperation. A case in point is the poor compliance of some males with a hypotensive drug treatment that as a side effect produces impotence. When patients have little freedom of choice in selecting health services, dissatisfaction may lead to a failure to get treatment at all. Humane considerations demand that services be provided in ways that are satisfactory to clients if that is at all possible.

Ours is a large country with a diverse and pluralistic society. Consequently, any satisfactory health care system will have to be both complex and flexible. People of diverse backgrounds will require different types of services. Similarly people living under some conditions will often require special services, although they will also have to recognize that they may incur some unusual risks by their choice of residence or way of life. Even within a given group or geographic area, people will have different needs or will respond differently to the same services. Neither the complexity of the task of providing diverse services nor the necessity of responding to complex needs should be underestimated. Flexibility and complexity in an adequate health care system will, of course, add to the problems involved in evaluating the system and its components because a service may be differentially

effective across geographic locations, ethnic or socioeconomic groups, and the like. Although demonstrating differential effectiveness and building provisions for different services into a national health program with effective quality assurance mechanisms will be difficult, this effort will be required in an adequate overall health system.

Even though the focus of health program development and evaluation should be on the recipient, the needs of providers and of society more generally should not be ignored. Providers need a health care system within which they can work effectively and which will reward them financially and in other ways commensurate with their contributions to individual and societal welfare. To work effectively, providers need a health care system which not only sets forth clear expectations for behavior, but which also permits the exercise of individual judgment in the particular case. Providers need a system which is reasonably stable and predictable, and one which yields ample feedback about adequacy of performance. They also need a system which is not capricious, but which is forgiving of errors which will inevitably be made without being at all tolerant of errors in the long run nor of professional incompetence. In addition, providers need to have some sense of participation in the planning and development of the health care system, while at the same time sharing this responsibility with other interests so that they are not burdened with complete and final responsibility for everything that happens--or does not happen.

Other interests also have a legitimate stake in the way criteria are developed for accountability and assessing quality. Legislators need to be assured that their intentions in approving and funding a

a health insurance system are represented in the working of the system and in what it achieves. Administrators of the system need mechanisms which are workable and efficient so that they can do the tasks with which they are entrusted and know that the system is functioning properly. Taxpayers need to be confident that they are getting good value for their money and that the system is realistic and fair. All of these interests will benefit from an open, explicit system.

Principle 8. Evaluation and accountability mechanisms should make it possible to assess the degree to which the objectives of individualized treatment plans are achieved.

Virtually every case seen within a health care system is in some respects unique and represents a fresh challenge to those involved in planning care. Because there are few health conditions which are not influenced by a wide variety of patient characteristics, specifications of treatment and outcomes by general prescriptions can serve only as general guidelines. In the individual case, it will often be necessary to tailor treatments or to modify expectations in light of the characteristics of that case. Since goals have to be set for the individual, some provision must be made for determining whether those individual goals are met.

A review system will have to be devised which will permit review of individual cases and determine the degree to which individual goals are met. The review process might well need the flexibility which would make possible a review of no more than a small percentage of some types of cases and a review of every single case of other types. It will be necessary for clinicians and case managers to be explicit about

individualized treatment plans, how they will be evaluated, and procedures for reconciling any persistent differences between providers and those doing the review. It is to be expected that the assessment of the individual being treated will be an important part of the evaluation. Evaluation at the system level would then include aggregating data on outcomes across individual cases. A system might be judged effective if most treatment goals were being met in most cases, however diverse those goals.

Principle 9. Claims of special competency to perform services by any professional group should be evaluated.

It is common for various professional groups to claim a special competency in service delivery achieved by special training or selection of members of those groups. Along with the claim of special competence very often goes pressure for licensure of the professional group as a certified, and often the only, provider of a type of service to the public. When any individual, profession, or institution claims special competence to perform some service on behalf of the public, the actuality of that competence should be demonstrated. In that demonstration lies much of what is meant by accountability. In some instances, a virtual monopoly may exist so that not only does a potential client have no basis for judging quality of service provided, but may neither have any choice where to seek it. Under those conditions a firm and dependable procedure for demonstrating competence is mandatory.

The existing system of certification and licensure of health service providers does not in any absolute way ensure either categorical or

individual competence of a special nature, but it is a point from which systematic study of the various health professions can begin. Just as it seems reasonable to initiate health insurance coverage for currently accepted treatments and services, initial recognition should be accorded to present systems of licensure as entry levels for health service providers. The legal definition of practice under licensure laws will determine the professional's scope of practice. However, any claims made by professional groups that would result in an exclusive position in the health care system should be examined empirically, and status as provider of a service should be based on evidence of the same nature as would be required for program effectiveness. As provider groups not now commonly recognized make claims on the health insurance system, evidence for effectiveness should be the basis for their inclusion as covered professions.

Principle 10. The evaluation system should utilize the judgment and leadership of service providers to help promote the functioning of service delivery and the cooperation of service providers throughout the evaluation process.

Bringing about changes in our health care system will not be easy. Despite current efforts to require that the services offered be of demonstrated value, that idea is still considered radical by many. There are no ready and simple answers to questions about how changes of large magnitude might be brought about. Strong leadership exercised by the large and prestigious groups involved in the provision of health care service could be a powerful force for change if those groups

displayed a unity of determination and commitment. Each of the individual health professions may have to take some degree of risk in order to demonstrate a persuasive level of unselfish interest. In the long run, none of the health professions stands to lose by insisting on empirical tests of its claims and services.

Every effort must be made to enlist the support of providers of services if evaluation efforts are to succeed. Providers should be prominently represented in those groups established to fix guidelines and define criteria for quality and appropriateness of services. The counsel of providers should be sought in developing review systems so that review will have a maximum effect on quality of care but will produce minimal administrative burden and disruption. Quality assurance systems should not and need not be onerous and limiting, but the help of providers in designing them will be required if their potentially undesirable features are to be avoided.

Principle 11. Provision should be made for the systematic collection of information compatible with the needs of program evaluation. Confidentiality must be protected while at the same time providing access to the information required for evaluation.

No adequate and systematic program evaluation effort can succeed without an appropriate information system, and the existing health information system is not suited to the task. The need for evaluation of health services is so great that it justifies the development of an information system devised specifically to meet the requirements of evaluation of NHI programs. Such an information system would provide

systematic, relevant, accurate, and timely information in a form that could be analyzed efficiently. It would be especially desirable if an information system could be established which would provide for collection of comparable information across political units and geographical and time boundaries.

The problem of maintaining confidentiality of information cannot be ignored. To begin with, absolute confidentiality of health records cannot exist under any feasible insurance system because some records must be reviewed by the payer. Currently, medical claims are reviewed in insurance companies by clerks at the very first level. A systematic evaluation plan would not represent a greater threat to confidentiality than the current forms of review. For many evaluation purposes, however, individually identifying information would be unnecessary because the research questions would require only data aggregated by categories, types of treatments, etc. For these research purposes, then, confidentiality concerning individual records would be preserved. Confidentiality might be more difficult to promise for individual providers since there are often very few of them involved in any one study, particularly in the case of specialists. To a certain degree, those who exact the special and favorable position afforded by licensure probably forfeit any rights to absolute confidentiality involving their own behavior. Nonetheless, confidentiality is an important issue, and an evaluation system should not abuse it.

Principle 12. Special attention should be paid to changes in the functioning or effects of programs as they evolve. Both long- and short-term effects should be examined and consideration should be

given to the unintended as well as intended program consequences.

Programs always change over time. Some of the changes may represent improvements, other may represent degradations. As programs come into being and reach operational stages, staff members may become more skillful, but they may also become blase. Clients may become more faithful, but they may also come to take more for granted. Particularly when programs devised in one setting are copied elsewhere, some of the essential features that made the original program successful may be distorted or lost. It is essential that evaluation be regarded as a continuing process rather than as a discrete, point-in-time event.

Attending to the possibility of long-term program effects that are discrepant with more immediate effects is also important. It is possible that a program appearing to have little in the way of immediate effects might have long-term effects that would make the program worthwhile, or that a program appearing immediately effective might have long-term effects of an undesirable nature. Naturally, health program decisions cannot be postponed until all the evidence is in, but provisions should be made for insuring that necessary evidence eventually becomes available.

Efforts should be expended to consider all the possible consequences of a program in order to narrow the range of potentially surprising outcomes. During early planning stages for an evaluation, potential clients and experts from various fields relevant to the program might be asked to think about possible side effects. Once a program is in operation it should be monitored carefully to determine the unanticipated side effects. A time lag between the trial of a program and widespread program implementation may be necessary to detect delayed effects.

Principle 13. Procedures for controls on and reviews of the scientific quality of evaluation should be established.

How is an evaluation to be evaluated? Some procedures and criteria will have to be established to review evaluations to determine whether they have been properly conducted and whether the conclusions are properly drawn. If the results of evaluation studies are really going to be the basis for policy setting within NHI, then it is essential that the evaluations be of the highest quality. The most efficient way to accomplish this review of evaluations will probably be to convene panels of experts. These panels would use such criteria as adequacy of problem definition, fidelity of adherence to program or treatment standards, appropriateness of the sample studies, soundness of the original research design and effects of any deviations from it, adequacy of data quality control procedures, adequacy of statistical analysis, and overall legitimacy of the conclusions. Evaluation researchers within NHI must be held to exceptionally high standards.

Principle 14. Procedures for disseminating the results of evaluation should be established.

An overall strategy for disseminating the results of evaluation studies should be developed and implemented. Because of the diverse constituencies represented among those interested in health services and their delivery, no one mechanism for dissemination will be adequate. One tactic which might make research findings easier to disseminate would be, whenever possible, to make the existence of studies known

from the beginning and to keep various interested groups informed of progress during the course of the work. The final report on the work would then be anticipated with interest. The important thing, however, is that there be designated responsibility for disseminating the results of every study by all the channels appropriate. Those channels should be well established and provided for within the health insurance system and its evaluation component.

Principle 15. The National Health Insurance program should contain a formal mechanism for change incorporating the results of evaluation.

Problems in achieving appropriate utilization of evaluation results can be anticipated. Findings may not be used and have the desired effect on policy even when they are available. One very important factor having to do with the utilization of research findings is centralized decision making; centralization facilitates the adoption of programs of demonstrated value. That NHI would be characterized by centralized decision making seems beyond question, and many interventions can be implemented by the fairly simple expedient of announcing that reimbursement for them will begin at a certain time and that reimbursement for alternatives will have to be justified. Still, because the possibilities of non-utilization and mis-utilization will not be negligible, a panel will be needed to sift through research findings and evaluation studies in order to facilitate the appropriate utilization of results. One additional activity which could have considerable impact would be to conduct regular, carefully planned workshops and other training activities to help administrators

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understand and use research findings. Scientists may also want to know more about how to conduct research that is persuasive and usable so that where decisions involving trade-offs must be made, they will be made in the direction of enhancing the impact of the research.

An effective plan for dissemination of information and support for its utilization would probably do much to promote the acceptance of evaluation efforts in the entire health field, including acceptance by providers, consumers, and legislators. One of the persistent criticisms of federally funded research is that so many of its results are never translated into practical programs.

Principle 16. A program should be developed to inform the public about the process of evaluation and its results.

Acceptance of evaluation findings by the public, including those with direct or vested interests in health programs, will require general public understanding of evaluation as a process and of the links between evaluation and program decision making. If evaluation as an enterprise is not understood by any segment of the public, then there will probably continue to be resistance within that segment to the idea of evaluation and to conclusions stemming from it, particularly when those conclusions contravene popular beliefs or what many people would prefer to believe. The controversies about Laetrile and saccharin, for example, may be exacerbated by a general lack of understanding about the processes by which they have been evaluated and the reasoning that has gone into the conclusions about them. Some efforts have been made in newspaper articles to explain the research

on both substances, but a better course of action in the long run would be to devise longer-term, systematic ways of increasing the general sophistication of the public about research on drugs and other substances. A continuing effort to inform the public about health program evaluation and the way it operates in the public interest is needed.

American Psychological Association
Committee on Health Insurance

Feb. 25, 1977

Criteria for National Health Insurance

CONSUMER ORIENTED HEALTH INSURANCE (COHI) ACT

PREAMBLE

The intent of this Act is to assure primacy of the consumer: consumer choice of practitioner, of plan, representation at policy and governance levels, while guaranteeing personal and human rights. To enhance quality assurance, competitive models of health care in the private and public sectors are to be strengthened with the federal role focused to determination of minimum standards, and state roles to the licensing of facilities and health professionals, again with consumer representation. Standards of accreditation, licensure, and statutory certification are to be established for all health professions and types of health facilities, subject to systematic implementation and regular review.

The entitlement of the consumer to health care shall assure access to necessary care and continuity, with regional planning to assure adequacy in the distribution of health resources and efficiency in their delivery. The federal role is limited to standard setting and revenue collection through shared tax and to setting conditions and incentives for the rational allocation and most effective use of the full range of qualifying health facilities and professional resources. Coverage is seen as mandatory with all residents entitled to the full range of services as they are phased in sequentially. All civilian health care would be subsumed by this Act and the predominant focus in health delivery would be to independent practice

PREAMBLE (cont.)

and effective utilization of the health insurance industry and health service plans, including individual practice associations and health maintenance organizations. This orientation is based on the conviction that such care will be more accessible, more cost effective, more flexible, innovative and responsive to changing knowledge in the health field and consumer needs, and of better quality.

GENERAL PRINCIPLES

1. All residents of the United States shall be entitled to the provision of available quality comprehensive health services under the Consumer Oriented Health Insurance Act.

2. There shall be no limitation of coverage and no discrimination in quality of health care by the practitioner or health facility based upon age, sex, race, creed, or economic circumstances.

3. The consumer shall be assured a choice of health practitioner and health service plan. Consumer choice and access to service shall be guaranteed by the availability of pluralistic and competitive health care systems in the private and public sectors.

4. All health plans shall provide a comprehensive range of services for all health disability, whether physical and/or psychological, for preventive services and for services designed to promote effective and individualized growth and development.

5. To assure that health needs of the public are adequately served, distinct provisions shall be made for the funding, staffing, and resources necessary to the psychological, environmental and physical components of health.

6. Quality assurance, utilization, and cost controls shall be directed primarily to the provider (practitioner and/or facility) with all services and benefits subject to organized peer review and regional planning.

7. Consumers shall participate in the implementation and development of health services at all levels. Citizens who are accountable to the public shall be in the majority of Boards and Committees involving decisions, planning priorities, and rate setting. Consumers shall have representation in setting policies regarding quality assurance,

GENERAL PRINCIPLES (cont.)

professional standards review organizations, accreditation, certification and licensure of facilities and practitioners. Public accountability for each service delivery organization shall be assured through consumer representation in governance either in an advisory or management capacity.

8. There shall be assurance for the plan member of privileged communication and confidentiality within the health care system as well as respect for the dignity of each individual.

9. All health plans shall provide coverage for health education, preventive services, and out-of-hospital services with the intent to maximize consumer responsibility for personal health and the promotion of a healthful life style and to maximize health maintenance and minimize the utilization of direct services, particularly in-patient services.

10. This Act shall include funding at stipulated amounts, both nationally and regionally, for research, education, and program evaluation with a priority to reduce or control disability producing environments and behaviors.

HEALTH BENEFITS

1. Health services funded under the Consumer Oriented Health Insurance Act shall be responsive to the needs of the population to be served and, therefore, patterns of service may vary between geographical areas. Given our current knowledge, any designation of specific health service patterns or limits of utilization are arbitrary, therefore, co-insurance or deductibles will not be used as utilization controls or financing mechanisms.

2. It is intended that a comprehensive range of health benefits will be provided within not more than five years of enactment, with benefits for both the psychological and physical components of health to be mutually phased in sequentially over this period.

3. The basic sequential order will first concentrate on health planning and the introduction of health education and disability prevention, and health enhancement services. Second in sequence will be the development of comprehensive ambulatory health care. Coverage for acute hospital care would follow and later, the services of extended hospitalization and nursing and convalescent care. The intent is to re-order priorities of importance in methods of health care and to assure the broadest impact toward improving the general health of the consumer and of families.

4. An individualized service plan must be authorized by a health practitioner for each patient. These plans shall stipulate service objectives within designated time intervals, indicate procedures to be used to attain these objectives, and identify the health personnel who will be involved. Progress related to the service plan must be documented with periodic review and modifications noted. The plan will be developed with patient involvement.

HEALTH BENEFITS (cont)

5. The plan shall allow the practitioner/professional latitude during the initial phases of service and resource utilization, with monitoring by audit procedures; a moderate latitude for more extended utilization, with provider profile analysis and exception reporting; and close control over extended services and costs, through a proscriptive and concurrent review process.

6. Health services shall be reimbursed, regardless of the site where provided, as long as they are provided by or under the supervision of a qualified health practitioner and in accordance with requirements relative to quality and cost control.

7. The plan shall provide all reasonable health services, generic prescription medications, prosthetic and corrective devices considered appropriate and essential to health maintenance.

8. To assure an equitable delivery of health care, each consumer will be issued an entitlement voucher which will enable development of a service profile for each plan member, subject to utilization controls.

9. The consumer entitlement to benefits by identification voucher, according to plan limits, shall enable emergency out of area services nationwide and transferability upon change in residence.

HEALTH PROFESSIONALS

1. Only qualified health practitioners will be eligible for direct reimbursement. Health practitioners shall include: physicians and surgeons, osteopathic physicians and surgeons, dentists, psychologists, podiatrists, optometrists, and other health professions as designated by the Secretary of the Department of Health. The disciplines designated in this Act shall meet the following qualifications:

   a. Have a graduate degree in a recognized health profession from a regionally accredited educational institution or professional school.

   b. Have not less than twelve months of full-time, approved, supervised clinical experience.

   c. Be licensed/statutorily certified in the state.

   d. Have license or statutory certificate renewed at least biennially. Such renewal must be contingent upon demonstrated, competent practice and continuing education according to established standards developed with the participation of a national professional organization.

   e. Additionally, each profession shall develop and maintain a national register of its health providers, based upon explicit standards. Listing shall be based on proficiency (credential) review by peers with areas of specialty competence designated.

2. The relationship among the health professions shall be collegial.

HEALTH PROFESSIONALS (cont.)

3. All practitioners and practitioner groups in each geographic area, as a condition of maintaining recognized provider status, shall accept an equitable proportion of plan members whose membership is paid through general funds.

4. Incentives shall be provided to acquire an adequate supply of health professionals according to the needs of each geographic area of the country.

5. To qualify for reimbursement, health facilities must:

   a. Be licensed by the state. State licensure shall be directed towards safety, sanitation, and living arrangements.

   b. Be accredited by a single nationally recognized body which has representation of the major health professions, institutional associations and consumers. The major emphasis of the accreditation process should be the quality of services and program with focus on the outcome of services rendered.

   c. Have all health services delivered under the supervision of qualified health practitioners.

   d. Be relicensed and recertified biennially.

FINANCING

Federal

1. Health care will be financed on a prepaid basis with regional allocation of funds through the states on a per capita basis.

2. A finite limit for the funding of the Consumer Oriented Health Insurance Act will be established biennially by the Congress. Financing will be derived from three sources: support for the cost of those services presently financed through government funds will be derived from general revenue transfer; the balance of the revenue will be collected equally by the Internal Revenue Service from a proportionate tax on personal income, earned and unearned, and a corporate/employer tax based on payroll and assets. The personal tax will be determined according to income limits and family size, by revenue classes. These health funds will be allocated to the states on a per capita basis, but with consideration given to varying circumstances among the states.

3. The funding sources proposed assume that the majority of health care will be self-supporting and not require general revenue expenditures. Thus the health tax for the employed, the self-employed, and those with unearned income is a deductible health expenditure, while the temporarily unemployed will be covered by unemployment insurance. General revenue would be required to assure health care for the unemployable and indigent and those entitled to Armed Services health care.

4. The revenue generated is allocable only to the national health plan, and annual income shall approximate annual expenditure.

5. Just as the majority of funding for this national health plan will not be dependent upon or derived from general tax revenue, so will the majority of the resources be

FINANCING (cont.)

Federal (cont.)

allocated to enhance the quality of health care in the private sector; its scope, more equitable distribution and more effective coordination and continuity.

6. There shall be financial and training incentives, including continuing education, for practitioners; and financial incentives for health organizations and consumers to assure quality of services and to control utilization and costs.

7. Philanthropic support of health services shall be protected and encouraged.

State and Local

1. There shall be public accountability for the health funds with explicit financial requirements and a uniform independent annual audit and an annual report to the plan member of the benefits, costs, and projected needs. There shall also be an individual report to each plan member of his/her services received and their cost.

2. Provider fees and hospital charges shall be regularly reviewed and limited by prospective rate setting.

3. Annual expenditures shall approximate annual allocations to the State Health Service Fund.

4. Philanthropic support of health services shall be protected and encouraged.

5. The continuity of any particular service or facility is fiscally dependent upon its ability to become an effective part of the health services under this Act.

ADMINISTRATION

Federal

1. A Cabinet-level Department of Health shall be established with full responsibility for development and coordination of national health insurance with implementation through the states.

2. The federal role should be directed toward determining the basic level of health benefits and establishing standards of quality, with control mechanisms that are implemented at the state level.

3. With the objective of a coordinated and comprehensive national health insurance program, this Act will subsume, with the exception of the active Armed Forces, all recognized health services.

State and Local

1. Each state shall establish a Health Service Fund, administered in trust and used to pay for consumer health care.

2. The governor of each state shall establish a State Health Service Fund Board of Trustees, consisting of at least eleven and not more than twenty-one members with staggered terms of office. All participating health professions shall be eligible for Board membership, however, the Board shall have a majority of consumer representation.

3. The planning and policy determination for implementation of health service delivery, including the psychological and physical components of health, shall be by the Board's regional health planning staff.

ADMINISTRATION (cont.)

State and Local (cont.)

4. The State Health Service Fund shall be used to purchase competitive insurance plans which meet federal minimum requirements and provide the consumer a choice of service models. All insurers, HMO's, and other health plans shall offer optional additional coverage.

5. The regulatory role of states should extend to review of quality assurance, benefits provided, certification of service need and planning activities, utilization review and controls, carried out under appropriate federal guidelines.

6. No organized health setting or institution may exclude from its staff or governance any of the health professions recognized under this Act.

7. Organized health facilities shall be entitled to subcontract with health practitioners and/or facilities for specified health services.

8. The role of government in the provision of direct health care should be limited to those services which are cost and quality effective or for which no private sector competitive alternative can be generated.

TRAINING

1. Trainee support shall be dependent upon a contractual agreement to serve in areas of need upon completion of training, with individual choice in selection among the designated underserved areas.

2. Support for the training of health professionals and allied personnel shall be in accord with national priorities; shall be related to anticipated staffing needs for psychological and physical health care and shall provide capitation support to accredited schools that provide professional training for all designated health professions; and shall be funded at a stipulated amount in the national health plan budget.

RESEARCH

1. Support for basic and clinical health research shall be in accord with national priorities and related to the incidence of unresolved health disability and identified high risk populations, and shall be funded at a stipulated amount in the national health plan budget.

2. Basic health research shall be separate in administration and implementation from the health insurance program, and shall embrance both the physical and the psychological bases of health.

3. Support for program research and evaluation, within a research and development model under regional allocation, shall be funded at a stipulated amount of each state's health services budget. Cooperative research and development projects across administrative units shall be encouraged.

4. The health plan budget shall provide for the development of a standardized, unified, management information system, with access to utilization data as an aid to quality, coordinated service and cost control and audit procedures, while assuring proper confidentiality and consumer safeguard.

Report prepared by,

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RESPONSE TO QUESTIONS SUBMITTED BY SENATOR WILLIAMS

Senator Williams: In view of your written and other more recent public utterances, Dr. Klerman, it appears that your primary interests and activities heretofore have been in the field of therapeutic and recreational drug use, as teacher and researcher, and also in teaching in the field of mental health. If these truly have been your predominant interests, will you be comfortable, content, and satisfied with a purely administrative job, one which will effectively remove you from direct involvement with or responsibility for research and for programmatic or policy-making functions except in the broadest administrative sense? Then you are fully aware of the autonomous nature of NIAAA, NIDA, and NIMH, in the sense that each is responsible for its own policies and programs, subject only to the administrative or supervisory oversight of ADAMHA acting for the Secretary of HEW?

Dr. Klerman: When I accepted Secretary Califano's offer to serve as Administrator of the ADAMHA I was well aware of the nature and history of the position. Part of the legislative mandate for the Office of the Administrator is a requirement to ensure appropriate and equitable support for each Institute and to promote cooperation among the three Institutes. As part of this effort I would expect discussions and decisions on policy issues to strengthen the programs of the Institutes. Moreover, since many of our grantees, constituents, and clients are directly or indirectly affected by more than one Institute, it is important that policies are consistent or at least compatible. Another of the roles of the Administrator is to serve as a channel of communication and an advocate for the individual Institute and for the Agency, both within the Department and to outside groups and institutions. There are some program and policy areas in which I have a particular experience and professional interest and to which I will devote my energies; however, I can assure you and the Committee that my involvement in these areas will have as its major purpose the strengthening of the legally mandated programs of the three Institutes.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Williams: Will you detail for us your actual administrative experience, including specific types of activities and of personnel over which and whom you have exercised supervision? What were the budgetary amounts within which you have been required to operate?

Dr. Klerman: During the past 20 years, I have had experience administering programs involving areas of research, training, and service activities and employing diverse personnel.

In research activities, I have been project director or principal investigator of several grants with budgets of up to $2 million. I am currently the Director of the Stanley Cobb Psychiatric Research Laboratories, Massachusetts General Hospital, which has a budget of $1 million and a staff of 25. The focus of these activities, and thus the personnel whom I have supervised, have included some laboratory scientists but have involved primarily applied researchers and clinical investigators from the fields of psychiatry, psychology, sociology, neurology, pharmacology, physiology and related biomedical, behavioral, and psychosocial disciplines.

My experience in the administration of training programs included two years as Acting Head, Department of Psychiatry of Harvard Medical School at Massachusetts General Hospital. This program had a budget of $1.2 million, and a staff comprised of 150 personnel, particularly psychiatrists, psychologists, social workers, psychiatric nurses, psychopharmacologists, neurochemists, and physiologists.

In the area of services activities, I have had administrative experience including the directorship of two mental health centers, the Connecticut Mental Health Center, where I was Director of Clinical Services and then the Center Director from 1967-1969, and the Erich Lindemann Mental Health Center, where I served for six years as the Superintendent from 1970-1976. These Centers had budgets of $4 million and $3 million, respectively, and their clinical staffs included professional and paraprofessional personnel from various fields (including psychiatrists, psychologists, social workers, psychiatric nurses, counselors, non-psychiatric physicians, and occupational and art therapists).

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Williams: During your appearance before the Coalition you acknowledged that "medicine in general and psychiatry in particular have had a somewhat ambivalent position with respect to the concept of alcoholism as a disease" and that the evidence of this is to be seen in the curricula of medical schools, in admission policies of general hospitals, mental health centers, etc. Do you, Dr. Klerman, consider alcoholism a disease? What would you do as Administrator of ADAMHA to foster better understanding of alcoholism among the medical and other health professions?

Dr. Klerman: Yes, I consider alcoholism a disease and a major public health concern. I believe our policy and programs should foster better professional and public understanding, so that this disease is seen as a result of many factors for which the ill person should not be blamed, demeaned, or "stigmatized." Presently, NIAAA has underway program efforts which we expect to continue and expand whose goal is to eliminate the ambivalent and negative views of alcoholism held by many medical and other health professionals. For example, the Career Teacher Program in medical schools, a collaborative effort with NIDA, is being expanded by NIAAA to iclude other health professionals (nurses, social workers, psychologist, counselors, clergy, and similar groups). This new program will incorporate into the "mainstream" of health professional training the knowledge and attitudinal background necessary to treat alcoholism in compassionate but objective ways. This training should be integrated within the regular curriculum of course work and clinical practicum. NIAAA is presently working with a number of health professional groups in these enterprises.

Also, I personally intend to work closely with the Health Care Financing Administration, and with the concerned professional associations in particular, to review diagnostic codes, professional examinations, and criteria for quality treatment to further the inclusion of alcoholism as an appropriate health responsibility. I expect to make public appearances to medical and health professional groups in which my speeches and talks will reinforce and support present NIAAA efforts to bring alcoholism services into the mainstream of health care in the Country.

Senator Williams: In this connection, I understand that the Navy, recognizing this problem, requires all Navy Doctors, all Commanding Officers of Naval Hospitals, all medical flag officer selectees, etc., to attend a two-week training course at the Long Beach Rehabilitation Center for Alcoholics where they participate in treatment with the patients and counsellors. The theory is that since these men set priorities and control resources, it is important that they understand the treatment of alcoholism. Are you familiar with the Navy's program and would you consider such a program for ADAMHA employees?

Dr. Klerman: I am not presently familiar with the program conducted by the Navy. However, I shall look into it and give consideration to whether instituting such a program would be beneficial to this Agency.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Williams: I understand that your wife has been a member of the research review committee of NIAAA. Does she still serve in that capacity and will she continue to do so should you be confirmed as Administrator of ADAMHA?

Dr. Klerman: My wife, Lorraine V. Klerman, Ph.D. is Associate Professor of the Heller School for Social Welfare, Brandeis University, Waltham, Massachusetts and had served on the NIAAA Research Review Committee from November 1973 until June 1976. Since that time, she has not been a member of any review committee in ADAMHA and will not do so during the time I serve as its Administrator.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Williams: You mentioned in your address to the Coalition that the scope of the alcoholism problem goes beyond health, that "it spills over into law enforcement, family stability, traffic violations, air safety," and that national policies about alcoholism will involve many agencies. The Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism was created "to evaluate and coordinate efforts undertaken to deal with alcohol abuse and alcoholism in carrying out Federal health, welfare, rehabilitation, highway safety, law enforcement, and economic opportunity laws."

This Committee has not received the support and attention from the various agencies it needs to coordinate these activities. What would you do as Administrator of ADAMHA to strengthen these coordinating efforts?

Dr. Klerman: It is my understanding that the Interagency Committee is now fully operational and has begun to fulfill its mission of improving coordination and communication among Federal agencies in the alcoholism field. However, it is also my understanding that some agencies have not accorded the high priority to this Committee that its function deserves. Regular attendance by the appropriate senior officials of the Agencies would provide evidence of their commitment to the Committee's task. I believe the best way to encourage this is to seek top-level management support within HEW for the Interagency Committee.

Coordination of alcoholism programs across Federal agencies requires strengthening. I am recommending to Dr. Richmond and Secretary Califano that this matter be reviewed and the Interagency Committee be strengthened or a new coordinating mechanism be established.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Williams: What improvements would you suggest to improve prevention efforts across the three Institutes? Would you recommend a combined agency including the prevention units of the three Institutes, the programs in the Office of Education, etc.?

Dr. Klerman: I would work with the three Institutes to place greater emphasis on the development of primary prevention strategies. Prevention offers promise of containing the cost of medical care and for significantly improving the health status of the American people. I suggest the following:

(1) Major priorities should be given on research and development to provide the knowledge base for prevention policies and programs to be carried out at the Federal and especially the State and local levels.

(2) The systematic dissemination and utilization of knowledge about successful prevention programs need to be improved.

(3) Greater emphasis would be placed on the evaluation of primary prevention models to determine what works, with which target populations, and under what conditions.

(4) I would establish coordinating mechanisms to encourage the Institutes to identify common areas for policy and program development among themselves and with other Federal agencies whose responsibilities could link them with ADAMHA Prevention activities.

I have found it useful to consider prevention under two broad categories:

(1) those activities which promote general well being and
(2) those which provide protection against specific diseases or prevent dysfunctional behaviors.

The Institutes will be looking at their prevention activities in these areas so that we more clearly develop interventions for target populations known to be at risk, and more precisely indicate which strategies are the responsibility of ADAMHA, which are the responsibility of other Federal or State or nongovernmental organizations, and which are joint responsibilities.

I would not recommend a combined prevention agency which would include units of the three Institutes and other Federal agencies. Rather, I favor an ADAMHA prevention approach which encourages coordinated policy and program development and ongoing sharing of information among the Institutes and with other Federal, State, and local agencies. Each of the Institutes serves distinct but overlapping communities which provide the stimulation and opportunities for preventive activities. This includes not only mental health, drugs and alcohol, but other health concerns, and the educational, criminal justice, and social service systems. Each should vigorously pursue a variety of preventive activities and the development and evaluation of new models. There may be some common areas in theory, in approaches, in methods, and in evaluation. The sharing of this information should be one basis for coordinating the further development of policy and program development.

RESPONSE TO QUESTIONS SUBMITTED BY SENATOR KENNEDY

Senator Kennedy: The Community Mental Health Program is within NIMH. Do you think this is an ideal location from an organizational point of view? Should it be so closely allied to the research arm of the mental health field?

Dr. Klerman: The current organization is in a setting which provides close linkages to manpower development and to research and evaluation programs. This arrangement has been vitally useful in the development of the community mental health services program. The Institute has extensive research and evaluation programming efforts aimed at assessing service program needs for knowledge, development and evaluation of solutions to service problems, and dissemination and utilization of new knowledge at the service program planning and delivery levels.

Over recent years, the States and local communities have developed their planning, and they are implementing more sophisticated service delivery systems; effective development of mental health services has increasingly depended on more effective manpower planning and research evaluation of program effectiveness and efficiency. Estimates of future service development needs are basic to ADAMHA and NIMH planning for the Nation's training and manpower programs. These efforts are closely reflected in technical assistance to States and to NIMH support of community mental health centers and other mental health service endeavors. This close organizational alliance between research training and services programming is similarly vital to all NIMH programs although the full potential of this organizational linkage has not yet been realized.

One example of the advantages of close organizational linkage between research (knowledge development) and service programming is the recently initiated Clinical Infant Development Program whose goal is innovative approaches to identification, prevention, and treatment of mental health problems in infants and their families who otherwise would be at high risk for a variety of severe disorders. Plans include research, training, and service components for a national network of collaborating centers.

Other examples of efforts to enhance dissemination and utilization are two publications, INNOVATIONS and EVALUATION, one summarizing current research and demonstration findings pertinent to service program problems and the other aimed at upgrading capacity of service programs staff to evaluate their program's relevance and effectiveness. Both are distributed widely across the Nation to community mental health and other service providers.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Kennedy: The CMHCs have fought to be independent of the rest of the health care system seeing themselves as very different from the "medical" model of health care. Do you believe that this is appropriate? How might services be better coordinated between CMHCs and the Neighborhood Health Centers?

Dr. Klerman: In my opinion, ideally, mental health, alcoholism and drug abuse services should be part of integrated comprehensive health care. Effective planning and administration of mental health services require intimate linkages with the broad array of comprehensive health, social welfare, rehabilitative and educational programs. At the same time, effective mental health services require a range of treatment methods and techniques much broader than those provided by the existing traditional health facilities. However, although independent conceptual scope and programming efforts have been required for mental health, the CMHC Program was never intended to be separated from health planning and from the total health system.

That CMHCs are and must remain a part of the national health care system has been firmly expressed throughout the history of the program, as seen in Congressional actions and in NIMH development and implementation of the CMHC program. For example, 92 percent of the CMHCs represent joint endeavors of mental health and other health and human service programs; 74 percent of all CMHCs are either sponsored by or formally affiliated with public and private general hospitals.

Moreover, coordination at the planning and service delivery levels is essential. CMHC staff have initiated collaboration in emergency health and rural health endeavors, HMO and PSRO developments, and health planning at neighborhood, local, regional, and State levels. In the future, we anticipate even greater coordination, collaboration and integration at State, municipal, community and neighborhood levels.

At the national level, NIMH staff are collaborating with representatives of a wide range of Federal and private health agencies. One example is a recent joint programming agreement developed with the PHS Bureau of Community Health Services, the Health Services Administration, to promote collaborations between Community Health Centers, including Neighborhood Health Centers, and Community Mental Health Centers serving the same communities. The Neighborhood Health Centers program initiated in the 1960's represented one important innovation in which comprehensive services were planned; including mental health, alcoholism and drug abuse services. The Institute of Medicine is now reviewing some of the potential lessons of this program for future planning.

Other examples are participation in the Secretary's Rural Health Initiative backed up by an NIMH work group on rural mental health, and collaboration in assessing needs for and manpower planning for health and mental health services.

A more detailed report on the relationship of the CMHC Program to national, State and local health programming is attached.

NIMH/DMHSP Status Report #1 10-7-77
Revised: 10/21/77

CMHCs, RELATIONSHIPS WITH OTHER HEALTH PROGRAMS

Background and Major Issues

CMHCs are a solid link in a national health care system. This concept has been firmly expressed throughout the twelve year history of the CMHC Program, both in congressional actions, and in the NIMH development and implementation of the program. From the outset, emphasis has been placed on making high quality mental health care available and accessible to citizens within their communities (catchment areas) regardless of ability to pay. Equally emphasized has been the coordination at planning and services delivery levels of such care with that of other public and private health and social service agencies within the community.

CMHCs are a solid link in the national health care system as it exists today, despite handicaps in that system. Most centers, 92 percent, are joint endeavors of mental health and other health and human service programs. Seventy-four percent of all centers are either sponsored by or formally affiliated with public and private general hospitals for the delivery of services. Forty-seven percent of all referrals to CMHCs from other human services are from health resources; health professionals and related personnel are extensively involved in CMHC activities; and CMHC staff have initiated collaboration in emergency health and rural health endeavors, HMO and PSRO developments, and health planning at local, regional and State levels. Further in FY 76 approximately 1.8 million persons were seen in CMHCs, representing over 30 percent of all patient-care episodes of the mentally ill in the U.S.

The solidarity of the CMHC link in the future national health care

system will depend heavily on the specific nature of any national health insurance program, and its potentials for participation. Depending on its terms, it can act as a powerful stimulant to the development of more effective linkage of all health care with community mental health centers, or it can result in their exclusion, deter coordination and lead to economic starvation. The philosophy of the existing declining Federal participation in financing of CMHCs is based on a projection of favorable reimbursement for mental health services in CMHC settings, in a future NHI program.

The statutory provisions applicable to the potential for CMHC/HMO relationships are found in P.L. 94-63 (CMHC Amendments of 1975) and P.L. 93-222 (Health Maintenance Act of 1973).

Of the two, P.L. 94-63 gives the better picture of Congressional intent stating in sec. 206 (c)(1)(C), "To the extent practicable, such CMHC will enter into cooperative arrangements with Health Maintenance Organizations serving residents of the center's catchment area for the provision through the center of mental health services for the members of such organizations under which arrangements the charges to the HMO's for such service shall be not less than the actual costs to the center of providing such services;"

In the context of grant application requirements, this means that a CMHC must make assurances to the Secretary's satisfaction that arrangements with HMOs will be made for the provision of mental health care to HMO members on the basis of actual costs.

P.L. 93-222 on the other hand simply states in sec. 1302 (1)(D) that

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1. Links to general health care.
2. True accessibility for all in need of health/mental health care.
3. Quality care by professionals with consultation and education from arenas - health and mental health.
4. Cost effectiveness by concentration efforts upon primary prevention programs to reduce mental health problems and mental illness.

Some of the NIMH activities which are being directed in this area are:

1. In the area of linkage joint activities between NIMH and other agencies are focusing upon health problems and the emotional concommitants of physical illness.

   Staff psychiatrists at NIMH serve as the ADAMHA representative to the following national health groups: Interagency Technical Committee on Health, Blood Vessel, Lung and Blood; National Commission on Diabetes; and Commission for the Control of Epilepsy and Its Consequences; and the Commission for Control of Huntington's Chorea. Because of the interest manifested by NIMH in the mental aspects of the above several activities have generated:

   1a. Professional Services Contract (No. PLD 09306-77RC; for $1200) is currently being funded which will prepare an annotated bibliography on Psychosocial Impact of Major Physical Illness. This effort is being directed toward strengthening the understanding of the interrelationships of physiological diseases and the mental health field (Period of service: Sept. 27, 1977 through Oct. 27, 1977).

1b. Information was forwarded to the Commission for the Control of Epilepsy and its consequences on NIMH publication entitled, "Information Sources and How to Use Them" (R & D Branch/DMHSP).

2. Efforts are being directed by NIMH in the development of linkages between CMHCs and CHCs. In order to encourage the development of linkages with other health services, BCHS, through its Community Health Centers (CHC) Program, is making available CHC funds to be used to assure provision of mental health services to project patients by forming linkages with an established CMHC located in or near the area served by BCHS ambulatory health care projects.

The Bureau of Community Health Services (BCHS) has set aside $1,500,000 of Community Health Centers (CHC) funds in fiscal year 1978 to be awarded to those ambulatory health care projects which have yet to develop adequate mental health service linkages with Community Mental Health Centers (CMHCs). For the purpose of developing linkages with CMHCs ambulatory health care projects will consist of all CHCs, including projects that are a part of the Bureau's Rural and Urban Health Initiatives, and all Migrant Health Projects. These funds will be awarded to those ambulatory health care projects which submit approvable plans for the development of linkages with CMHCs which either serve the same area or are located close enough as to benefit BCHS project patients. The

NIMH remains active in this area by maintaining contacts with the BCHS Rural Health Initiatives Program and the Rural Mental Health Work Panel and Migrant Sub-panel of the President's Commission on Mental Health. Also, the NIMH fostered the establishment of its own workgroup in Rural Mental Health to seek ways in which to plan for, stimulate and promote interest in CMHC/RHI relationships. Visits to RHI sites in Maine and California will hopefully generate such relationships in those States.

The basic element in these linkages is the services of a mental health professional to be obtained from the local CMHC through a negotiated agreement which will be initiated by the project. The mental health professional will be located within the BCHS project and will perform the liaison functions of triage, referral and consultation. The direct mental health services are to be performed either at the CMHC or CHC. These funds are to be used to assure that mental health services are made available to BCHS project patients. Support services should be provided by the BCHS project to the extent its present resources are available, thereby utilizing the funds primarily for the salary and benefits of the mental health professional. (See addendum for a brief description of the CMHC/CHC linkage project application and other NIMH linkage activities.)

3. Review of the policies and procedures related to PSRO activities with joint meetings held between NIMH and the Health Standards and Quality Bureau around procedures for the review of ambulatory care, as well as its application to CMHCs.

4. Proposed Medicare regulations have been written for inpatient psychiatric units of general hospitals. As yet, they have not been approved by the Secretary, nor have they been submitted in terms of Intent to Publish.

Major Implementation Problems

1. The solidarity of the CMHC link in a national health care system will depend heavily on the prospect of enactment of National Health Insurance which presents both an opportunity and a threat. Depending on its terms, it can act as a powerful stimulant to the development of an effective linkage with community mental health centers, or it can result in their economic starvation. Stimulation of growth would result if reimbursement for mental health services in CMHC settings is given favorable terms. Starvation would occur if a national health care system is adopted with little or no mental health coverage followed by a withdrawal of existing Federal financing of community mental health centers.

2. While there are bases and rationales for attesting to the CMHCs positive role and linkage in a national health care system, there exists a degree of uncertainty, pursuant to the foregoing conclusions, as to whether the enactment of a National Health Insurance will actually facilitate the continued growth and development of CMHCs to the point of its goal attainments of 1500 centers by the year 2000. Considering the precepts of the present NHI proposals which are based on historic roots, persistence is necessary to encourage appropriate coverage for mental health care. Mental health coverage has been added to many of the private

health insurance programs; however, there are limitations as to the scope and duration of coverage. This pattern has carried over into the Medicare and Medicaid provisions of the Social Security Act resulting in continuing discrimination against the mentally ill. Several legislative reforms have been introduced to address these disparities. The community mental health centers should be a solid link in a national health care system; however, the positiveness of "will" in terms of implementation and collaboration, is determined by the initiatives and leverage within the medical care market and by the trade-off of various economic interests involving the mental health professionals (provider), insurance carriers (sellers), and the consumers (buyers).

3. PSROs, as enacted by legislation in 1972, have been oriented toward users of health services, rather than people who do not use services. PSROs have not considered access to care or underutilization of services. There exists considerable variation among the PSRO programs in the depth, timing and frequency of review. Most of the PSRO activities have been focused upon inpatients in general hospitals. These activities have been based on a review of claim forms submitted by physicians to fiscal intermediaries and/or State fiscal agents (for Medicaid) for reimbursement services.

4. The HMO is a personal health care delivery system for voluntarily enrolled members. Consequently, consultation and liaison in mental health is predominantly an inhouse function between mental health and other parts of the health delivery system.

Other than the twenty visit requirement (interpreted as 20 one hour visits), P.L. 93-222 places HMOs under no obligation with respect to the provision of mental health care, i.e., supplemental services are entirely optional and there is no directive requiring HMOs to link with CMHCs.

Despite this, HMOs have chosen to provide mental health services such as hospitalization, partial hospitalization and emergency services for their respective memberships in addition to the required 20 outpatient visits (albeit, an average of less than .2 mental health encounters per member per year has been reported). And, we have already seen in actual practice that some attempts have been made to form cooperative arrangements between HMOs and CMHCs for the delivery of mental health care to HMO members. But, generally speaking, the P.L. 94-63 requirement regarding "actual cost" is too restrictive a reimbursement formula for the profit oriented HMOs to make long-term cooperative arrangements with CMHCs "practicable." In fact, where arrangements have been made, reimbursement is either on a capitation basis or a fee-for-service basis rather than actual cost as required by law. Instead, HMOs tend to develop their own mental health faculties as part of the cost-effective total care concept they provide for the membership.

Direct benefits can accrue as a result of CMHC linkage with other health providers. NIMH interest in this is evidenced by its funding several studies which have attempted to assess the degree of cost-savings in the delivery of non-mental health care within HMOs and health insurance plans when mental health coverage is included in the overall benefit

structure. With regard to the HMO setting, Goldberg, et al. demonstrated that GHA of Washington, D. C. could reduce non-psychiatric physician usage by almost one-third in the year following the establishment of a mental health care referral mechanism. With a concommitant decline in the use of ancillary services (x-ray and lab) it was determined that the decrease in utilization of non-psychiatric physicians and ancillaries saved GHA more than the cost of the actual delivery of mental health services. Jameson, et al. studying the Blue Cross Plan subscribers using psychotherapy outpatient benefits in CMHCs used medical/surgical services significantly less than a control group of subscribers without the psychiatric benefit. Medical/surgical inpatient days per month and outpatient visits per month dropped more than 54 percent. This reduced utilization resulted in a decrease of $9.41 in the monthly cost of premium per patient. These and other favorable research findings should have a positive implication for the inclusion of mental health benefits under an NHI program as well as for a concerted effort to interface mental health with general health care through a variety of linkage mechanisms.

Despite the potential attractiveness of this cost-savings via program linkage, HMOs generally choose to provide mental health care within their own plan, except, perhaps, for specialized mental health services such as alcoholism treatment. At the present time, there are only a few examples of HMOs opting to contract with CMHCs for mental health services. The Rocky Mountain HMO in Grand Junction, Colorado, provides 30 days of inpatient services through the Colorado West Regional Mental Health Center of Glenwood Springs, Colorado, and 20 outpatient visits to the Medicaid eligibles only on a prepaid capitation payment basis.

In the final analysis, while Congress seems to promote the concept of CMHC/HMO interface, the burden is entirely on the CMHC to initiate cooperative arrangements, but any affiliation is entirely at the discretion of the HMO. The law as presently written is a mandate without substance because HMOs could always find a linkage with CMHCs to be non-practicable if they so desired.

To rectify this situation, conforming amendments are required that will overcome the lack of reciprocal language regarding HMO and CMHC responsiblities to each other, and also to allow more reimbursement leverage as a mutual incentive for cooperative arrangements between CMHCs and HMOs.

5. To help engender linkages between CMHCs and RHI programs, several problems should be mitigated. This may entail a strengthening of the current advocacy and dissemination activities to educate and enlighten appropriate agencies of the need for program coordination. The placement of mental health staff in rural and migrant health projects should be a principal activity to ensure proper utilization, quality and continuity of care. Transportation in rural areas will be an additional problem to overcome in fostering program accessibility and linkage.

MHSF/Burton/Brands/Seidenberg (Revised)

NIMH/DMHSP ADDENDUM 10-21-77

Status Report #1

CMHCS, RELATIONSHIPS WITH OTHER HEALTH PROGRAMS

A. Further discussion of CMHC linkage with BCHS ambulatory health care projects.

1. Eligibility

BCHS ambulatory health care projects, which are not currently providing adequate mental health services either directly or through linkages with CMHCs in the same catchment area, and BCHS projects with an established CMHC in or adjacent to their service area, are eligible to make application to the Regional Health Administrator for supplemental funding to establish linkages with CMHCs. Upon submission of an acceptable application for the provision of mental health services and a full-time mental health liaison professional by the CMHC, the Regional Health Administrator and staff will review the applications and will forward summaries of those found acceptable to the Associate Bureau Director, Office for Community Health Centers. The Director, BCHS, will recommend to the Regional Health Administrators those BCHS projects to be funded from the funds which will be made available.

2. Funding

Funds will be available to those eligible BCHS projects to provide mental health services for their patients by developing agreements with the appropriate CMHC. These funds are to be used to purchase the services of a full-time mental health professional to be provided in the community health center setting.

3. Mental Health Professional Liaison

There must be a job description for the mental health professional whose functions will require differing degrees of sophistication and familiarity with medical and allied skills depending upon the clinical model chosen for each linkage arrangement. The mental health professional will function primarily in a liaison role providing triage, and consultation and will be responsible for patient referral between the centers. Although most of this professional's activity will be in the ambulatory health care project, the BCHS project must describe the means for insuring a continuing relationship with the mental health center. The job description must describe professional requirements, the availability of adequate clinical supervision and other related personnel information.

The staff requirements will be the responsibility of the BCHS project to negotiate with the participating CMHC based upon the type of manpower available, availability of National Health Service Corps psychiatrists or psychiatric nurses, the needs of the population and other factors existing in each project setting. It will also be necessary for the BCHS project to identify barriers to the integration of services and suggest ways by which this plan can be corrected.

4. Program Aspects

The application must indicate what services will be provided, where and by whom. Examples of services to be provided are as follows:

a. Direct Clinical Services

Diagnostic Evaluation

Psychological Testing
Group Therapy
Individual Therapy
Treatment for Alcoholism
Treatment for Drug Addiction

b. Indirect Services and Education

Outreach
Other Therapy
Case Conferences
Community Consultation and Education
Inservice Training
Other Education Programs

c. Services to Targeted or Problem Populations

(Special problems i.e., the pregnant adolescent and the elderly).

The mental health professional may be directly responsible for the services or for making the necessary arrangements to see that they are provided. A clear commitment must be obtained from the CMHC to provide the necessary back-up services and assurance that services will be available when required.

5. Evaluation

It will be necessary to evaluate the effectiveness of this aspect of the program. Therefore, it will be required that each BCHS project that is approved for supplemental funding maintain appropriate patient records in order to provide data and to participate in the evaluation. This evaluation will be designed and performed jointly by BCHS and Alcohol, Drug Abuse and Mental Health Administration (ADAMHA).

6. Application and Review

The eligible BCHS Project should submit an amended application requesting supplemental funds to formulate an agreement with the

appropriate CMHC for mental health services. This should be accompanied by a narrative which will describe the delivery of mental health services to BCHS project patients. These should be submitted to the Regional Health Administrator who serves as the awarding authority. The Regional Office Program staffs in consultation with Regional ADAMHA staffs will conduct the review, make recommendations and provide summaries of the supplemental applications to the Associate Bureau Director for Community Health Centers BCHS.

Applicants are urged to consult with their Regional Program Consultant for Community Health Centers in developing their applications for these supplemental funds. Agreements should be submitted to the Regional Health Administrator at the time of supplemental application. Before finalizing the agreements, the Regional Office staffs should also be afforded an opportunity to review each agreement before negotiations with the CMHC are finalized.

CMHC - CHC Linkage Activity

Final Guidance Developed and Transmitted to Regions and Projects.	August 31, 1977
Regional Office Staff Provide Technical Assistance in Proposal Development.	September 1 - October 15, 1977
Regional Office Review of Proposals.	November 1, 1977
Regional Approved Projects Submitted to Central Office for review and final allocation purposes.	November 21, 1977
Allocation to Regional Office.	December 15, 1977
Regional Office Supplemental Awards.	January, 1978

B. Additional CMHC linkage activities with other health programs

1. Project: Stress Management Project

Project Number: 1R01 MH29010-01; Level of Award: $78,945 (1976 - 1977)

Sponsoring Agency - Arizona Health Plan, Phoenix, Arizona

This project is in its first year of three years with NIMH. Its focus is upon the evaluation of three treatment modalities for effective intervention with stress vulnerable persons. Relaxation training, self-help group therapy and cognitive effectiveness will be utilized. A further goal will be to evaluate case effectiveness of each treatment method for the health maintenance organization.

2. Project: Systems Approach to Mental Health Care in a HMO Model

Project Number: 2R01 MH24109-04; Level of Award: $183,644 (1976 - 1977)

Sponsoring Agency - Kaiser Foundation Research Institute, Oakland, California

This project is in its third year of NIMH support to integrate mental health skills and understandings into the delivery of prepaid health services. Patient interactions with the health system to identify inappropriate utilization and to develop more appropriate means of improving health status.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Kennedy: PL 93-641, The National Health Planning and Resources Development Act of 1974, mandates health planning at the local level. Have the mental health programs been working closely with the HSA's and if not how might this working relationship be strengthened.

Dr. Klerman: Neither the PL 93-641 Act nor implementing regulations require any formal mechanisms to link specifically the alcohol, drug abuse or mental health systems with the health planning process. Therefore, the nature of working relationships is determined by local conditions. It is strongest where the HSA has determined that alcohol, drug abuse or mental health are priority concerns, or where alcohol, drug abuse or mental health interests have organized to assert a role in the process. In other parts of the country, alcohol, drug abuse, and mental health providers and consumers have no significant input to the HSA's and many of the HSA's admit that they have no expertise to deal with the assessment of alcohol, drug abuse or mental health needs and resources. Admittedly, some of the difficulties can be attributed to the transition period while the HSA's are organizing, but they may continue where HSA's do not have the experience with alcohol, drug abuse, or mental health problems to realize their importance to the health and socioeconomic conditions of the community.

Adequate representation of alcohol, drug abuse, and mental health concerns is especially necessary in the PL 93-641 governance structures.

This is currently not required. Closer working relationships would also be promoted if there were a requirement to linkages with existing alcohol, drug abuse, and mental health planning groups. ADAMHA and HRA have been working closely in this area to resolve this problem.

ADAMHA is also providing assistance to the Bureau of Health Planning and Resources Development through a variety of program-oriented activities. These include a feasibility study of criteria and standards for use by HSA's, development of review criteria and preparation of guidelines for use by HSA's and SHCC's which will address potential roles in relation to the mental health system.

Furthermore, NIMH has taken the initiative in providing contracts to groups such as the Southern Regional Education Board to help HSA and Community Mental Health Center governing bodies develop a better understanding of the interrelationships between health and mental health planning and program development. Information is being provided to various national groups through such activities as the ADAMHA participation in the National Council of Community Mental Health Centers next February, which will provide an opportunity to encourage the active involvement of CMHC's.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Kennedy: The mental health catchment areas and the health service areas are often different, and mental health plans are different from the health system plans of the HSAs. Is keeping the two distinct useful?

Dr. Klerman: Ideally, the service areas for health and social service programs should have identical boundaries. Unfortunately, the current reality involves multiple overlapping boundaries as is reflected in HSA and CMHC area boundaries. Health service areas have been designated as the basis of sub-State planning on the general assumption that they represent a full health care planning capacity. They have a population base averaging about a million people. The typical catchment area has a population of 150,000. The assumption that treatment near place of residence is facilitated by community support linkages which in turn reduce the need for extensive inpatient care is basic to the CMHC program.

Most CMHC catchment areas are within health service areas because of the prior influence of the OMB A-95 sub-State planning process. Fewer than ten percent of the catchment areas cross health service area boundaries. To facilitate coordination of planning, NIMH is urging all new CMHCs to adopt catchment area boundaries within health service boundaries, unless there is compelling health utilization data which indicate that the provision of services would be impaired.

Health plans are developed by HSAs, by CMHCs, and also, in many instances, by other sub-State mental health planning bodies organized

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at the city, county, district or regional level. At present, the vast majority of HSAs do not have the capacity in either staff or experience to adequately plan for mental health services. ADAMHA is working towards strengthening the capacity of the HSAs by providing basic mental health, alcoholism and drug abuse information kits, by developing and making available more detailed planning information for alcohol, drug abuse, and mental health planning, by arranging for technical assistance, etc. Even with the development of this capacity, HSA would not develop specific operational plans for a facility like a CMHC, but rather general goals and objectives for the development of health resources in the health service areas.

At the State level, the State Comprehensive Health plans are the aggregate of the local HSAs. The State alcohol, drug abuse, and mental health agencies also develop plans. ADAMHA is working with the State agencies to insure the development of relationships between State Comprehensive Health Planning agencies and alcohol, drug and mental health agencies so that the categorical plans can become a part of comprehensive health plans. In addition, we are reviewing our planning requirements to insure compatibility (same submission dates, same definitions) with those of comprehensive health.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Kennedy: In ADAMHA there are three research Institutes -- NIMH, NIDA, NIAAA -- do you believe these might better be combined into a single unit? How should these Institutes relate to the NIH?

Dr. Klerman: I do not believe advantage is to be gained by combining the three current ADAMHA Institutes into a single unit. The laws establishing the Institutes took cognizance of special health and social objectives that each is to address. In particular the NIDA and the NIAAA are organizational "off-shoots" of the NIMH, and they were provided Institute status by the Congress in recognition that the problems they address were of sufficient national importance to dedicate independent Institutes to their solutions. Thus, the three Institutes are able to concentrate on defined objectives in a way that may not be possible were they to be consolidated.

Currently the working relationships among these three Institutes; the Office of the Administrator; the Office of the Director, NIH; and the NIH Institutes are close with frequent interaction and close collaboration occurring at many levels. For example, a major portion of the NIMH Intramural Program is located on the NIH Reservation, is closely collaborative administratively and scientifically with the NIH Institutes, and has been cited for its excellence within that environment.

I believe that we need to develop increased opportunities for intramural research collaboration among NIDA, NIAAA, and the NIH, preferably on or near the NIH reservation. Explorations toward accomplishing this objective have already begun.

Among the Institutes individual program levels have multiple interactions with NIH -- for example:

(1) between NIMH, with its concern for the mental health of the elderly, and the National Institute on Aging;

(2) cooperative research efforts in the behavioral sciences with the National Heart, Lung, and Blood Institute;

(3) cooperation between NIDA and the National Cancer Institute on the health consequences of smoking;

(4) active collaboration between the National Institute of Mental Health and the National Institute of Child Health and Human Development in areas relating to behavioral science research problems of youth, the mentally retarded, children with learning disabilities, teenage pregnancy needs, and minimal brain damage (MBD).

ADAMHA collaborates with NIH in :

(1) the development of regulations; policies; procedures, under their jointly-shared authorities in areas as research training;

(2) On policies and procedures common to the Agency's interests such as (a) peer review, and (b) the protection of human subjects.

(3) The ADAMHA Administrator's senior staff serve on a number of high-level NIH standing committees, as well as provide daily liaison with the Office of the Director, NIH.

(4) In addition, the NIH provides for ADAMHA a number of services such as the receipt of grant applications and data capture and analyses.

In summary, at the policy level and in the day-to-day working functions, there is the closest of collaboration between all elements of ADAMHA and NIH. It is my intent and desire to strengthen this collaboration.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Kennedy: Over the next year, I plan to continue to study the decision-making processes within the research community, and plan to look at how research dollars are allocated. Are you satisfied that ADAMHA is performing satisfactorily in this area? If not, how might this be improved? Is there an adequate balance between biological and behavioral research? Do consumers have an adequate input into the decisionmaking process?

Dr. Klerman: While I have not had the opportunity to study in depth whether the allocation of research dollars in the ADAMHA Institutes is reasonable and justifiable or whether an adequate balance exists between biological and behavioral research, it is a matter of great personal interest to me and will be a high priority for ADAMHA.

As part of implementing this priority, one of my first efforts will be the appointment of an Associate Administrator for Research who will be charged with:

(1) the development of criteria by which questions of allocation and balance may be addressed,

(2) the development of long-term plans for the allocation of research resources,

(3) definitions of adequate balance between basic and applied research and

(4) the assessment of ADAMHA performance in the area of technology transfer and recommendations for any improvements that may be made in that effort.

I believe that this effort must be given adequate attention despite the limitations of our knowledge of how best to undertake research planning. It must be undertaken with the recognition that the fundamental scientific knowledge about the nature and causes of mental illness, alcoholism and drug abuse is presently inadequate for ideal planning for major preventive and

therapeutic and rehabilitative advances we all desire.

While there is consumer input currently in the decisionmaking process, I will study ways in which this input may be increased. I believe consumer input into the decisionmaking process is an important element of national policy formulation in general and for science and health in particular. Currently, consumer input is both sought and volunteered by a very active constituency addressing the Congress and all levels of the Administration. In addition, the Agency has formal advisory mechanisms, such as the National Advisory Councils, which in part represent the interests of consumers. We have in the Office of the Administrator and in the Institutes formal and informal advisory mechanisms to provide input from the minority community, and the Institutes are very active in calling together and collaborating with consumers, especially those likely to be affected by policies and programs sponsored by the Institutes. These include, not only organized constituency groups, but State and local-level individuals, particularly those involved in the organization and delivery of health services.

A major policy task will be to assess the manner in which these consumer inputs can be expanded and better utilized in research policy formulation.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Kennedy: This Committee has been concerned with technology transfer at the NIH. What mechanisms exist at ADAMHA for the purpose of transferring new knowledge into practice at appropriate rates? And what mechanisms exist to insure that new clinical practices are tested and evaluated for efficacy before they are widely adopted?

Dr. Klerman: I believe that greater initiative in technology transfer is an obligation of every Federal health agency engaged in the development of science and technology. Uncertainties arise in definitions of that role, including the resources to be committed to it and in the expectations or advantages to be derived from that effort.

I strongly believe it is the responsibility of the ADAMHA to be vigilant to new research results, not only from its own programs, but from the entire scientific world, that imply or demonstrate possible preventive therapeutic or rehabilitative application. The Agency then needs to seek the best advice it can command as to studies that (1) need to be conducted to verify the observation and (2) to develop a particular health intervention for possible large-scale testing and/or the entry into general health practice. ADAMHA has a corollary obligation to transfer technology to administrators and practitioners and the public, complete with the best available evidence and judgments as to its efficacy, imperfections, and the

trade-offs that are always involved. Any technology is imperfect, all entail fiscal and other costs, and involve trade-offs. It is the obligation of all Federal agencies to make those considerations clear to the legislators, to practitioners and to the consumers in the technology transfer process.

The role of a Federal agency is limited by the fact that, while the Federal agency can resist or delay taking the initiative in the transfer of technology at a premature stage, it cannot prevent directly the utilization of unproven technologies by institutions or practitioners in the delivery of health care. Furthermore, the provision for equal access by the public to the highest-quality health care and the latest technology hinges on social forces and fiscal resources far beyond the control of any individual Federal agency engaged in the development of technology.

It is my observation that the leadership and the staff of the ADAMHA Institutes now maintain an active interest and awareness of new technology. Indeed, they direct their energies toward being alert to and facilitating the orderly development of new research knowledge into the health care system. The NIMH and the NIDA in particular have a history of active leadership in this regard. Also I have the impression that the Institutes have performed a commendable Federal role in the evaluation of psychoactive drugs and of narcotic antagonists and substitutes. Much of the current knowledge was developed via the evaluation of psychopharmacologic

treatments and was carried out at the initiative of the Institutes, in collaboration with many scientists and universities in the United States and elsewhere. I have had personal involvement in this development.

With reference to psychosocial technology, until recently the record of achievement has been less impressive, at least in part due to the deficiency of fundamental knowledge that underlies some of these measures and also the methodological difficulties in testing and evaluating such psychosocial interventions in an acceptable and convincing scientific fashion. However, I am confident we can and will develop systematic evaluation and trials of psychosocial treatments.

The ADAMHA Institutes have carried out their dissemination efforts through the national clearinghouses of all three Institutes and through the publication of books, periodicals, and special research reports. They have made continued use of conferences, both formal and informal, by the utilization of ad hoc groups on specific topics. The Institutes and the OA have developed a structured monitoring capacity of research activity to identify potential "ripe" areas, and they have allocated funds for the study of the subject of technology transfer.

It is my strong conviction that ADAMHA's high level of interest and accomplishment in technology transfer is facilitated by the current structure of its three Institutes which include research, service and

training programs. This provides the opportunity within demonstration and service programs funded by the Institute to keep abreast of technology needs; to evaluate technology; and, in some instances, to provide a direct entrypoint into the service system for new technologies. An example of this relationship is the periodic survey carried out by NIMH of problems experienced by the community mental health center personnel, both currently and anticipated; the retrieval of available knowledge related to the primary needs as reported by the community mental health centers through the employment of traditional methods for knowledge retrieval; plus a system for on-site access. At NIMH and within the participating community mental health centers, a small and inexpensive "typewriter terminal" is connected to a center at UCLA in which recent research reports in brief form are stored. In addition, these participating centers are provided a continuous update of information on the particular needs that they cite, may be provided with consultant assistance and may through the citing of their needs stimulate NIMH to conduct research on needed technology. Thus, the direct availability of service programs funded by an Institute is instrumental in identifying appropriate technology needs, evaluation of technology, and the recognition of the need for research on specific technologies.

In conclusion, it is my intent to intensify the active participation by ADAMHA in technology transfer and to determine various means by which the implementation of this very important role may be further improved and expanded in mental health, alcoholism and drug abuse.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Kennedy: S. 1728, the Domestic Violence and Prevention Treatment Act of 1977 is presently pending before the Child and Human Development Sub-Committee. Do you support this bill and in what directions do you see ADAMHA moving in this area? What work is ADAMHA now doing in this important area?

Dr. Klerman: The matter of domestic violence is of great concern to the Alcohol, Drug Abuse, and Mental Health Administration. With additional research funding and staff resources our efforts would be directed at the issues of prevalence, type of abuse, what services are available, what type of innovative demonstration services might be developed, an evaluation of their efficacy, and what is or can be the role of prevention services.

The National Institute of Mental Health has funded some research in the area of violence in the home. It supported the research at the University of New Hampshire which indicated that the incidence of violence between parent and child and spouses is much greater than expected. The Institute is also supporting programs in the area of child abuse; of particular note is a research grant identifying cases of sexual abuse of children and understanding the potential consequences. Research programs like these have led to the development of training programs which emphasize the development of counseling techniques for the professional and paraprofessional.

Criticisms of the federal, state, and local response to family violence has been directed at the fragmentation of services. One of our present concerns is whether mounting a large effort without knowing more about the problems, what types of services could or should be provided and whether these services if linked to the Social Service or Health/Mental Health Systems might not increase that fragmentation. Any effort must also address the long range funding

implications. While these concerns are not unsolvable they should be addressed before new legislation is initiated and can be addressed through additional resources for a directed research demonstration effort, which is currently within the authority of the National Institute of Mental Health.

There remains the question, however, of whether or not NIMH is the proper agency for the services aspect of the Act. Representatives from the Women's Movement indicate that some women feel that services for the battered woman or wife through a mental health mode would have the liability of the added stigma of mental illness. This is an issue which needs further consideration.

ADAMHA is supportive of the concept of greater resources for research, training and services as embodied in the "Domestic Violence Prevention and Treatment Act of 1977." However, we believe that there needs to be further attention to some of the policy issues mentioned above in order to strengthen the Act and to clarify the specific responsibilities of individual Federal agencies.

Senator Kennedy: When Congress passed P.L. 94-63 to renew the Community Mental Health Center's Program, it established in the National Institute of Mental Health a National Center for the Prevention and Control of Rape. As I am sure you would agree, we need to increase our efforts to deal with the problems of sexual assault in our society. Members of the Congress and of this Committee are being urged by people working in this field to make available additional Federal funding and authority, so that these programs can go beyond the research and demonstration stage and to begin to provide services. What advice would you have for this Committee about the appropriate Federal role in this area? Will you support funding for services beginning in fiscal year 1979?

Dr. Klerman: As you and other members of the Committee may be aware, the National Institute of Mental Health established a National Center for the Prevention and Control of Rape in April 1976 to implement P.L. 94-63, Title III, Part D. Since that time, the Center has been implementing a program consistent with the legislative mandate to conduct research on the problem of sexual assault, develop and evaluate models to improve prevention and treatment services, establish a clearinghouse, and develop educational and training materials. While the problem of sexual assault has been with us for a long time, the strategies of how best to address the problem, prevent its occurrence, and treat those who are victimized, have only recently received the concentrated attention this problem deserves. The number of persons working in the field, the establishment of new community programs, and the availability of services from other helping agencies are only beginning to be adequate to meet increasing demand for services.

Everyone, including myself, would agree on the urgent need for additional service programs in the problem area of sexual assault and the need for adequate financing of these services. However, a major policy question that needs to be addressed is how should such services be organized and financed. It is also unclear as to what should be the Federal role in general and that of NIMH in particular. There is limited collective experience of Federal, State and local programs in this field.

Also, there are important issues which need further attention about the types of services which should be provided, who should provide what services, and the effectiveness of these services. As a consequence, it may be premature to move at this time to expanding the Rape Center's authority to include Federal financing of direct services. Rather, we should continue our effort through the Rape Center to develop and evaluate service demonstrations which can be useful in local communities, and stimulate States and localities to address local needs and coordinate existing health and mental health services or develop new programs if needed.

Moreover, we will continue to provide selected services for those affected by this problem through the Community Mental Health Center programs. We plan to continue funding for these services and service demonstration programs in FY 1979. In addition, subject to the availability of resources, we will in FY 78 and FY 79 convene several working conferences on the delivery of services to rape victims.

At such conferences, the findings from completed and ongoing research projects and service demonstration models dealing with the organization, delivery and financing of such services will be reviewed and analyzed. Resource materials on these issues will also be developed. Based on the outcomes of such activities, we will be making legislative recommendations regarding appropriate Federal, State, and local roles.

The issues raised are complex and have important implications not only for service providers but also for the services to be delivered. We will continue to assess how we, as part of the Federal Government, can best respond to these and other health and mental health needs. We hope that through the results of the Rape Center's initial research activities and those of others that we can provide better information and informed advice about how best services can be provided. It is important that decisions be made in the best interest of citizens who may have been victimized by this criminal activity and to prevent others from becoming new victims. We look forward to continued dialogue with members of Congress on resolving these important policy issues.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Kennedy: You have been critical in the past of the criminal penalties associated with the use of certain drugs such as marihuana. What is your position and what legislative changes would you suggest?

Dr. Klerman: My position on criminal penalties associated with drug use and possession for personal use is that the criminal penalties should be structured to reflect society's disapproval of such behavior, based on its detriment to society, considered in the context of the risk to the individual user. The criminal penalties surrounding the possession of marihuana for personal use have, in many instances, been more severe than the risk the individual has experienced from the use of the drug.

I heartily endorse the proposal made by the President in his recent drug message to the Congress:

> "Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself; and where they are, they should be changed. Nowhere is this more clear than in the laws against possession of marihuana in private for personal use. We can, and should, continue to discourage the use of marihuana, but this can be done without defining the smoker as a criminal. States which have already removed criminal penalties for marihuana

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use, like Oregon and California, have not noted any significant increase in marihuana smoking. The National Commission on Marihuana and Drug Abuse concluded five years ago that marihuana use should be decriminalized, and I believe it is time to implement those basic recommendations.

"Therefore, I support legislation amending Federal law to eliminate all Federal criminal penalties for the possession of up to one ounce of marihuana. This decriminalization is not legalization. It means only that the Federal penalty for possession would be reduced and a person would receive a fine rather than a criminal penalty. Federal penalties for trafficking would remain in force and the States would remain free to adopt whatever laws they wish concerning the marihuana smoker."

RESPONSE TO QUESTIONS SUBMITTED BY SENATOR HATHAWAY

Senator Hathaway: What do you see as ADAMHA's overall priorities over the next few years? The five-year Foward Plan for ADAMHA issued last fall stated that it would be a policy goal of ADAMHA working through HEW to assure that Medicare and Medicaid fully covered treatment of drug abuse and alcoholism. Would this continue to be a high priority under your administration? What sorts of mechanisms or policies do you envision ADAMHA proposing in order to better promote the dissemination of available research to those engaged in treatment?

Dr. Klerman: I see ADAMHA's overall priorities during the next few years as falling into four major areas -- research, services, training, and prevention. I see the major priorities in these four areas as follows:

In research: The development and support of research is the top priority of the ADAMHA. A strong program of basic and applied research is absolutely essential to the accomplishment of ADAMHA objectives in prevention and treatment. The immediate goal is to strengthen financial support for research in order to recoup the dollars lost to inflation.

In services: The agency's overall priority in this area is to seek the inclusion of ADM services on an equal basis with general health services. Currently a wide range of alcohol, drug abuse, and mental health services do not now qualify for private insurance or title XVIII (Medicare),

XIX (Medicaid), or XX (Social Services) reimbursement. Prior to the development of National Health Insurance, this can be achieved through such things as:

a. Outpatient care coverage for mental health, drug abuse, and alcoholism under Medicare comparable to coverage for outpatient physical health care.

b. Coverage for inpatient care in a psychiatric hospital comparable to physical health care in a general hospital under Medicare.

c. Provider status under Medicare for organized alcoholism, drug abuse, and mental health programs.

d. Clinic services included as a mandated service in State Medicaid plans, including CMHC's, and other mental health, drug abuse, and alcohol programs.

In training: The impending action on National Health Insurance underscores the importance of anticipating the needs for appropriately trained additional professional and paraprofessional manpower. The agency will undertake this objective by sponsoring programs to encourage manpower planning by the States, the training of primary

care physicians in the needs of the mentally ill and alcohol and drug abusers, as well as research and development efforts directed toward improving the effectiveness of training efforts to meet service delivery requirements.

In prevention: The rising costs of medical care and our desire to improve the health status of the American people make prevention one of the major priorities of ADAMHA. More resources are needed to develop, demonstrate, and evaluate effective techniques in both primary and secondary prevention. Improved evaluation methods as well as more evaluation research are necessary to provide the knowledge base for new and improved prevention methods. ADAMHA will need to assume a stronger leadership role in coordinating its prevention activities with those of other Federal agencies, among the Institutes, and with State and local governmental and non-governmental agencies.

As previously indicated in identifying services as a high priority, I feel that alcoholism and drug abuse as well as mental illness services should receive coverage on an equal basis with general health services. Consistent with this, I would continue to place a high priority on obtaining Medicare and Medicaid coverage for treatment of drug abuse and alcoholism as well as mental illness.

As I have stated on previous occasions, ADAMHA presents a unique model in public administration in that it combines research, services, and training in one agency. Because of this network of agencies and institutions with ties to the Agency, and through which information can thus be channeled, I believe that ADAMHA is better equipped to disseminate research findings to treatment professionals. This dissemination of research findings can be achieved through workshops, publications, technical assistance, and guidance manuals.

Senator Hathaway: Part of the statutory mandate of ADAMHA is to assure that the programs of the three Institutes under its jurisdiction -- NIAAA, NIDA, and NIMH, receive "appropriate and equitable support". Given the extraordinary economic cost of alcoholism and alcohol abuse to our society of well over $40.0 billion, and the tragic impact this illness has directly upon over 10 million individuals and indirectly upon countless others, do you believe that NIAAA has in the past received appropriate and equitable support, and if not, have you formulated any proposals to alter this prior emphasis?

Do you feel that the Federal drug abuse policy has favored hard drugs at the expense of licit drugs? If so, what suggestions do you have for future policy to remedy the situation?

In short, what do you feel the relative Federal priorities should be with respect to alcohol, illicit drugs, and licit drugs? How would you propose to correct any current imbalances?

How much responsibility do you believe the Federal Government should assume in the areas of alcohol abuse, drug abuse, and mental health? Where should Federal responsibility, including funding, end, and the State, local government, and private sectors' responsibilities begin?

Dr. Klerman: In answer to the first part of your question, I feel strongly that NIAAA has not received support commensurate with the magnitude and importance of the problems it addresses. As you have noted, alcoholism directly affects approximately 10 million individuals in this country, and exacts an economic cost of approximately $40 billion each year. In view of this, I would work closely with Dr. Noble and NIAAA to help further refine and implement their 5-year plan so that NIAAA programs may continue

to grow in a manner that will permit them more adequately to address the problem of alcoholism.

NIDA is currently coordinating a review of its treatment programs to assure that there is an appropriate balance among all program components as regards the hard drugs, especially heroin, on the one hand, and the licit drugs, particularly the amphetamines and barbiturates, on the other. A recently completed NIDA study on barbiturates is now being reviewed by the Office of Drug Abuse Policy in the White House, the Secretary's Office of DHEW, and NIDA. The policy proposals contained in this report, together with additional reviews on other categories of drugs, will enable NIDA to achieve an appropriate programmatic balance.

In general, with respect to your question about funding levels for programs directed at alcohol, illicit drugs, and licit drugs, I feel that the funding for alcoholism research and prevention programs should be increased.

The responsibility of different levels of Government in the areas of alcohol, drug abuse, and mental health must vary, I believe, with the different program areas. I am particularly concerned that appropriate roles be maintained

and fostered as regards research, training, services, and prevention programs.

With respect to research, the lead clearly belongs to the Federal Government. The results of research have relevance for and impact on practices in the nation as a whole. The Federal Government should continue to maintain adequate levels of funding for high quality behavioral and biomedical research related to the problems of alcoholism, drug abuse, and mental illness.

With respect to training, I think we must continue to support the development of new training methods, as well as the training of some practitioners. Training emphasis will appropriately vary as between professionals and paraprofessionals. Professionals, for example, are a national resource who participate in a national labor market, and as a result I believe the Federal Government should continue to provide some support for the training of professionals. Paraprofessionals, on the other hand, are more often a local resource, and the States and localities, as a result, must continue to provide the bulk of the support for the training of paraprofessionals.

With respect to services, the Federal Government should provide a major, but not exclusive, level of support for

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alcoholism, drug abuse, and mental health services, especially to help them get started. We must work, however, to develop a more balanced set of funding mechanisms in the future. I would hope that we could increase insurance coverage for alcoholism, drug abuse, and mental health services in Medicare, Medicaid, and private insurance programs, as well as assuring adequate coverage in any future National Health Insurance Program. State and local funds will continue to be important, though, for the support of various components of these programs, as well as project or formula grant funds for those services not covered under a National Health Insurance Plan. In the long run, once a truly diversified set of funding mechanisms is in place, including insurance coverage, project grant support, and formula grant support, among others, the role of the Federal Government should move more in the direction of setting standards, supporting the development of new treatment techniques, supporting appropriately coordinated data systems, providing technical assistance, and the like.

With respect to prevention programs, Federal support will continue to be needed to develop and demonstrate effective prevention techniques, but State, local, and private support will be needed for much of the on-going funding of such techniques and programs.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Hathaway: In his August 2 Drug Message the President pointed out the need for greater public education efforts on the health hazards posed by drugs, including alcohol and tobacco, as well as increased emphasis on the need to identify reasons why individuals turn to drugs. Could you elaborate on the shape these policies might take and on the role which ADAMHA would likely play in the implementation of these policies?

Dr. Klerman: It has been and will continue to be an ADAMHA priority to understand those factors which cause people to become involved in alcoholism and drug abuse. It is my opinion that an informed and educated public will develop values, attitudes, and behaviors which will inhibit the abuse of drugs, alcohol and tobacco.

ADAMHA's responsibility in implementing these policies and program areas is to assure that the public education efforts are approached in a planned and coordinated manner by the three ADAMHA Institutes. In some efforts, programs of education involve features common to drug abuse and to alcohol problems; while in other programs, there are features unique to each problem. I also see the need to assure that our efforts are compatible with the larger prevention and health promotion activities of the PHS and the Department. These activities would include, for example, the development and demonstration of new techniques, the identification of special high-risk groups, and the evaluation of program effectiveness. In this regard the new NIDA program to educate physicians and patients about the potential hazards of barbiturate use and alternative effective and safe treatments for insomnia is a useful model. This vital, new project grew out of, and continues to rely heavily on, our ADAMHA research scientists. It is also a prevention project in the best public health tradition.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Hathaway: Last spring the Subcommittee on Alcoholism and Drug Abuse held hearings on the Alcohol and Drug Abuse Education Act, as well as on the primary prevention activities of NIAAA and NIDA, among other Federal agencies. That Act is currently administered by the Office of Education. In the course of the two days of those hearings, it became increasingly clear to me that our current education and primary prevention activities are overly fragmented and duplicative. In particular, there were inadequate or nonexistent evaluative studies on what works and what does not work in this area. Since alcohol and drug usage and abuse among youth apparently continue to grow, this would appear to be an area of primary concern for ADAMHA to "assure that...there is cooperation among the institutes in implementation of such programs". Under your leadership, would ADAMHA be prepared to move aggressively in this area and if so, do you have any specific proposals to share with the Committee at this time?

Do you believe that alcohol and drug abuse education programs should be transferred from the Office of Education to ADAMHA? Please elaborate.

Dr. Klerman: There are presently two policy reviews relevant to this issue ongoing in the area of drug abuse program coordination. The first of these is being conducted by the White House Office of Drug Abuse Policy. A second is the Secretary of HEW's examination of the relationship of activities within the Department relating to drug abuse. It is my intention to participate actively in these deliberations and to await their outcome before formulating a final opinion.

Confirmation Hearings - Gerald L. Klerman, M.D.

Senator Hathaway: Are you aware of any reorganization plans formulated or in the process of being formulated which would directly affect ADAMHA or its component Institutes?

Dr. Klerman: I am not aware of any specific reorganization plans which would directly affect ADAMHA. However, I am aware the President has requested the OMB to conduct a review of all Government programs. Based on requests for data received by the Agency from the President's Reorganization Project Human Resources Staff, I am aware that the organization and delivery of human services, which includes ADAMHA's service delivery (treatment) programs, currently are being reviewed with possible reorganization recommendations to be derived from that review.

Senator Hathaway: If so, could you indicate to the Committee the content or present likely direction of such plans, as well as your present views on such reorganization?

Dr. Klerman: My personal views regarding any reorganization of the ADAMHA, are that I am opposed to any major reorganization of the Agency. I feel ADAMHA represents a unique experiment in public administration by combining research, training, prevention, and service programs in one organizational unit. Each program complements the others and augments alcoholism, drug abuse and mental health efforts. For example, new research findings are disseminated to improve the service delivery system. The goals of training programs are modified to ensure that the changing needs for research manpower and treatment personnel will be met in the future.

Senator Hathaway: Do you have any intentions of proposing any reorganization within ADAMHA? If so, please elaborate.

Dr. Klerman: With respect to my intentions to propose any reorganization within ADAMHA, as I stated above and in the hearings, I am opposed to efforts to merge any of the Institutes, either within the agency or with any other agency.

Senator Hathaway: Regarding any of the above, it would seem that since ADAMHA and its constituent agencies are created by statute, any proposal to change or modify this structure ought to be proposed by way of legislation. Would you be willing to agree with this proposition?

Dr. Klerman: Yes, I agree that any proposal to change the structure set forth by statute would require legislative change.

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16 August 1977

The Honorable Harrison A. Williams
United States Senate
Washington, D.C. 20510

Dear Mr. Williams:

I appreciated the recent opportunity to meet with you and Miss Nancy Olson of your staff to discuss the programs and policies relating to the Alcoholism, Drug Abuse, and Mental Health Administration (ADAMHA).

Since that meeting, I have been reviewing various issues, and I believe it would be useful for me to set forth more specifically my views on the policy question of the resumption of "responsible drinking" by alcoholic persons. Least there be any misunderstanding, let me state clearly that it is my professional recommendation that alcoholic persons should abstain indefinitely from the consumption of alcoholic beverages.

This policy issue has arisen, in part, since the publication of a report by the RAND Corporation of a research effort which reached public attention in 1976. At that time, Dr. Ernest Noble, Director of NIAAA, requested my evaluation of the research aspects of the RAND report. My comments at that time were directed to the research methodology and related scientific aspects. Miss Olson of your staff has a copy of my report, and it is available for further discussion.

However, I wish to emphasize that that document, prepared in 1976, was primarily addressed to the research and evaluation aspects. Now, as I consider the overall policy issues of clinical treatment and national concerns, it is important that I distinguish between possible research issues and treatment recommendations.

Some preliminary research data, such as was developed by the RAND Corp. did make the suggestion that some alcoholic persons did report that they were able to return to "moderate drinking" with "limited risk". However, this report was based primarily on material obtained from alcoholic persons' self-reports. There was no objective information as to their personal and family relations, their employment, and their societal adjustment by observers other than the alcoholic persons themselves.

Further research is needed to substantiate whether or not these self-report assertions are, in fact, corroborated by objective behavior. Moreover, even if their self-reports were to be substantiated, we have no adequate basis for predicting which alcoholic persons, indeed, if any, can resume use of alcohol at any level.

Therefore, the present state of our research knowledge, the accumulated experience of the alcoholism field, and clinical judgment require that any goal other than abstinence in the treatment of alcoholism acknowledges a potential for serious abuse with adverse impact on the lives of an unfortunate large number of our citizens. This is my professional judgment and concurs with the current policy of NIAAA.

I trust the foregoing comments make clear my views on this important subject.

Again, I want to thank you for the opportunity to meet with you and with Miss Olson.

Sincerely yours,

Gerald L. Klerman, M.D.

GLK/hjg

HARVARD MEDICAL SCHOOL ◇ MASSACHUSETTS GENERAL HOSPITAL

GERALD L. KLERMAN, M.D.
Professor of Psychiatry

Director
Stanley Cobb Psychiatric Research Laboratories
Massachusetts General Hospital
Boston, Massachusetts 02114

13 October 1976

MEMORANDUM

TO: Ernest Noble, M.D., Director, National Institute of Alcoholism and Alcohol Abuse (NIAAA)

FROM: Gerald L. Klerman, M.D., Director, Stanley Cobb Psychiatric Research Laboratories, Massachusetts General Hospital, and Professor of Psychiatry, Harvard Medical School, Boston, Massachusetts

SUBJECT: Evaluation of Report[1] on "Alcoholism and Treatment", by D.J. Armor, J.M. Polich, and H.B. Stambul, Rand Corporation, Santa Monica, California

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OVERVIEW

This report describes the secondary statistical analysis of three sets of data generated by the NIAAA evaluation program in 1970-74. These three sets of data derive from -

1) NIAAA Alcoholism Treatment Centers (ATC) Monitoring System which contains data on 30,000 clients in 44 comprehensive centers throughout the country,

2) the ATC 18-Month Followup Study, based on a sample of ATC data base, and

3) four Public Education Campaign Surveys commissioned by NIAAA and conducted by L. Harris & Associates on 6,000 respondents.

Using advanced multivariate statistics, particularly multiple regression and other correlational techniques, Armor and associates attempt to evaluate the outcomes of current treatments and assess their relative efficacy. Based on these analyses, they find relatively good rates of overall remission (over 70%) over an 18-month follow-up. Various indices of remission are calculated including drinking behavior, socio-economic status, and treatment status.

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[1]This report was prepared under a grant from NIAAA, grant no. R-1739, June, 1976.

Integrating these results with review of other studies and data from public surveys, the authors interpret their findings optimistically, but conclude that no single treatment appears to offer greater remission rates overall, or for unique types of alcoholics, and recommend re-assessment of complete abstinence as the goal of treatment.

These conclusions, particularly those relating to the traditional emphases on total abstinence, have generated moderate controversy, more so among clinical and public groups than among researchers and public policy circles.

My comments will be divided into two aspects:

1) scientific issues, and

2) implications for policy

SCIENTIFIC ISSUES

Full discussion of the policy implications depends upon the reliability and validity of the scientific procedures. These issues need to be addressed as forthrightly as the public policy issues.

The report is based on secondary statistical analyses of data collected by groups other than Armor and associates at Rand. To a certain extent, but not completely, the validity of the statistical findings are limited by the sampling procedures and accuracy and reliability of the data gathering and recording. These considerations apply particularly to the two ATC studies which attempts to assess treatment effectiveness. (I will not discuss the data from the Public Education Surveys, since this area is outside my major competence. Moreover, these data are not being challenged and do not enter into the controversy about abstinence and treatment effectiveness.)

There are two possible sources of limitations in the two ATC studies: design limitations and data limitations.

1) As regards design - These findings do not derive from a controlled treatment trial in which the clients were randomly assigned to the different treatment groups or matched prior to treatment. Rather, the treatment assignments were made in the different ATC's by clinical decisions, and statistical analyses were used post hoc by Armor et al to evaluate the comparative efficacy of the different treatments and to control for background characteristics of the subjects. The authors of the report acknowledge that this is not necessarily the most powerful design; controlled clinical trial design is far more powerful, since it approximates experimental control. However, the type of statistical control of naturalistic clinical treatment decisions is very acceptable. Moreover, given the large sample size, there are ample opportunities for post hoc matching and statistical comparisons which can approximate some aspects of matching of samples.

2) Data limitations - The information collected on the clients, both at intake and at follow-up, was not designed by the research group, but was designed as part of the NIAAA program. In retrospect, it would have been desirable to have included more information about the clinical characteristics of the clients, particularly whether or not they had had episodes of DT's, tremor, or withdrawal. In the follow-up phase, it would also have been desirable to have more information about occupational performance and clinical status as regards symptoms such as anxiety and depression.

These additions, however, are only possible to request after the completion of the study. The findings do not indicate any differential effects of the various treatments on subtypes of alcoholic clients. The clinicians still believe that different treatments such as AA, hospitalization, and group psychotherapy may be specifically indicated for certain clients, but the available data do not allow that conclusion.

The main strength of the scientific aspects of the report derive from highly sophisticated statistical analysis and the interpretive skill used by Armor et al. They are very cautious in acknowledging the limitations of the data and go to great lengths to discuss the possible sources of unreliability. Other statistical techniques, such as life table method, could have been applied to this data, but the statistical techniques used here are perfectly appropriate and very powerful.

IMPLICATIONS FOR POLICY

Given these considerations, I conclude that the methods employed to analyze the data are reliable and valid and within the limitations of the design and information collected, the conclusions drawn are appropriate and justified. The question now arises as to what are the implications for policy.

1) Value of NIAAA evaluation effort - This report confirms the basic policy value of the NIAAA evaluation research efforts undertaken in 1970. The use of a standard intake form for the assessment of clients and treatment services at ATC's has provided a very comprehensive data base for secondary analysis and comparison of treatment. The leadership of NIAAA should be congratulated and feel proud of this basic policy decision. No such equivalent decision, for example, was made by NIMH for aspects of its community mental health centers' program, and that program cannot be evaluated in the same way as the NIAAA program. This procedure should be continued with a large sample of ATC's continuing to report to a central, independent data center using standarized forms. The forms should be re-evaluated and their content gradually expanded.

2) Continued support for multiple treatment approaches - The findings here indicate that no one treatment is superior, and NIAAA should continue to support multiple treatment approaches including AA, hospitalization, outpatient treatment, group psychotherapy, and medication.

3) Search for new treatments - Systematic efforts are needed to develop new treatments such as new forms of medication or re-evaluation of medications used in other fields, new forms of behavioral psychotherapy based on learning theory, various forms of family therapy, and other self-help groups such as AA.

4) Continued support for policy of multiple outcomes - NIAAA should continue to support the principle that there is no one criteria for improvement. Clients with alcoholism should be assessed flexibly with regard not only to their drinking status, but also to their occupational and vocational activities, marital and family stability, self-report of mood, anxiety, depression, medical status, and other relevant areas of performance.

5) Policy regarding complete abstinence - The most controversial aspect of this report has been to challenge the traditional emphasis on complete abstinence as the only legitimate goal for treatment of alcoholism. I believe that the data presented and the review of the literature provide very, very strong support for the need to re-evaluate this traditional view and to have a more flexible definition of the goals. The report should not be interpreted as supporting drinking return for all alcoholics. The report merely advocates the abandonment of abstinence for all alcoholics. The treatment goals need to be evaluated for individual clients, and more research is needed as to which types of clients are capable of controlled drinking, normal drinking, and which clients require complete abstinence. In this respect, it is of note that almost simultaneous with the publication of the Armor/Rand report, E.M. Pattison published a paper, "Nonabstinent Drinking Goals in the Treatment of Alcoholism", in the Archives of General Psychiatry, Volume 33: 923-930 (August, 1976). Pattison reviewed the available literature as well as his own clinical experience and concluded that abstinence was not the appropriate goal for rehabilitation programs and that other treatment goals were equally appropriate. Moreover, he indicated that in some or even many alcoholics, the achievement of abstinence was gained at the expense of other legitimate goals of rehabilitation. The Pattison review confirms independently the conclusions of the Armor/Rand report.

6) Needed research - I recommend that NIAAA provide more focused and targeted clinical research in the following three areas:

a) Methodological - More research is needed as to the reliability and validity of various methods of assessment, particularly the self-report technique by clients and the various techniques for measuring drinking status, vocational status, etc.. Some of the indices developed by Armor need to be tested using advanced psychometric methods.

b) Field studies of subsamples - The selected subsamples of patients from either the ATC studies or new samples should be evaluated by trained observers so as to ascertain the quality of their life in the community. Specific areas of evaluation should include vocational functioning, marital performance, financial independence, possible antisocial behavior, community adjustment, self-report, mood, psychological tests of intelligence, and perhaps even medical evaluation for liver and neurological damage, etc..

c) Controlled trials of various treatments - The naturalistic design, using statistical methods for post hoc analysis as employed by Armor, has definite limitations. More powerful conclusions could be drawn from systematic trials in which clients were either randomly assigned to selected treatment (AA, group psychotherapy, medication, etc.) or matched in advance. These techniques have been used in psychopharmacology of schizophrenia and depression and in fields of medicine such as heart disease.

CONCLUSIONS

This report represents a major policy advance. Traditionally held views, as to the possible superiority of one treatment over another or the nature of abstinence as a goal of treatment, have been challenged by a careful analysis of data from a large sample of clients seen at a variety of ATC's. The findings have been carefully analyzed using advanced statistical techniques, and the policy implications for NIAAA need to be reviewed carefully.

Even with the limitations fo the research design and data base and the possible unreliability of the reports, the conclusions are internally consistent and are also consistent with other reports from the clinical and research literature. The net conclusion of this evaluator is that the report stands as a landmark in evaluation research in alcoholism, and credit is due to the NIAAA leadership and to Armor and his associates.

NCAAP

NATIONAL COALITION FOR
ADEQUATE ALCOHOLISM PROGRAMS

RIVERVIEW BUILDING • 1925 N. LYNN STREET, ARLINGTON, VIRGINIA 22209
(703) 527-5083

October 13, 1977

Honorable Harrison A. Williams, Jr.
Chairman
Committee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The National Coalition for Adequate Alcoholism Programs, at its meeting on September 16, resolved to support the President's nomination of Dr. Gerald L. Klerman as Administrator of the Alcohol, Drug Abuse and Mental Health Administration. The Coalition represents 23 national, non-profit organizations dedicated wholly or partly to the prevention and control of alcoholism.

We are pleased that Dr. Klerman is committed to support 1) the maintaining of the present administrative structure of the Alcohol, Drug Abuse and Mental Health Administration as three distinct institutes, 2) federal initiatives in the alcoholism field, and 3) the minimization or eradication of the use of the term "substance abuse."

We hope Dr. Klerman's nomination to this most important post will be confirmed. We also hope that you will look to our Coalition as a resource on alcoholism programs.

Sincerely,

Leo Perlis
Chairman

Enclosure

cc: Senate Human Resources Committee Members

NCAAP

NATIONAL COALITION FOR
ADEQUATE ALCOHOLISM PROGRAMS

RIVERVIEW BUILDING • 1925 N. LYNN STREET, ARLINGTON, VIRGINIA 22209
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ORGANIZATION MEMBERSHIP

Alcohol and Drug Problems Association of North America

American Bar Association

American Federation of Labor-Congress of Industrial Organizations

American Medical Society on Alcoholism

Association of Halfway House Alcoholism Programs of North America

Association of Labor-Management Administrators and Consultants on Alcoholism

Christopher D. Smithers Foundation

Distilled Spirits Council of the United States

National Association of Alcoholism Counselors

National Association of Anti-Poverty Alcoholism Programs

National Committee Against Mental Illness

National Council of Community Mental Health Centers

National Council on Alcoholism

National Indian Board

National Nurses Society on Alcoholism

National Spanish Speaking Commission on Alcoholism

North American Indian Women's Council on Chemical Dependency

North Conway Institute

Rutgers University Center for Alcohol Studies

Salvation Army

United States Brewers Association

Volunteers of America

Wine Institute

American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900

October 13, 1977

The Honorable
Harrison A. Williams, Jr.
Chairman
Senate Human Resources Committee
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Williams:

On behalf of the American Psychiatric Association and its more than 23,000 members, I am writing to express our strong support for the Senate Human Resources Committee's prompt and favorable consideration of the President's nomination of Dr. Gerald L. Klerman as Administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).

Dr. Klerman has an excellent national and international reputation as a leader in the formulation and implementation of mental health policy matters.

We believe Dr. Klerman's outstanding record of attainment in the science of human behavior will foster national leadership for ADAMHA in exploring and encouraging innovative concepts of mental health research, treatment, prevention and services.

Dr. Klerman understands mental health is much more than just the absence of mental illness and that America's mental health problem is not limited to individuals with disabling mental illness and identified psychiatric disorders. He knows that in achieving a complete understanding of the dimensions of mental health problems it is based upon an understanding of the variety of social conditions and circumstances, as well as the biological and sociological factors, that affect the mental health of the American people.

Dr. Klerman is most aware for example that another mental health related problem which pervades society is the misuse of alcohol. Similarly, he is acutely aware that the non-therapeutic use of psychoactive drugs other than alcohol

can have profound mental health implications for individuals, their families and communities of Americans who experiment with and use a wide variety of mind and mood altering drugs on a frequent basis, often with harmful results to themselves and society.

We would be grateful for your leadership as Chairman of the Human Resources Committee in providing prompt consideration of Dr. Klerman's nomination and your support for his confirmation.

With best wishes,

Sincerely,

Melvin Sabshin

Melvin Sabshin, M.D.
Medical Director

MS:JBC:mag

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
ROCKVILLE, MARYLAND 20857

OFFICE OF THE ADMINISTRATOR

The Honorable Jacob K. Javits
United States Senate
Washington, D. C. 20510

Dear Senator Javits:

I greatly appreciate the opportunity to respond to your question concerning my interest in prevention to detail types of prevention activity the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) might pursue.

As you know, there has been a growing interest in prevention at many levels of Government.

At the Federal level: The National Health Planning and Resources Development Act (P.L. 93-641) requires that the Health Systems Agencies extend their planning efforts to personal health and environmental concerns when it can be shown that planned changes in these areas are necessary to improving the health of people. The recent enactment of the National Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317) provides an important new organizational focus for the coordination of Federal prevention policies.

At the State level: Interest in prevention has been reflected in recommendations made at the 1976 ADAMHA Conference of the State and Territorial Alcohol, Drug Abuse, and Mental Health Authorities. These recommendations urged a stronger ADAMHA role in coordinating prevention efforts among the three Institutes and with other Federal agencies and State agencies, in developing a national strategy and in accelerating the development of primary prevention efforts at the Federal and State levels.

There is a growing body of authoritative opinion and scientific knowledge proposing that a greater investment of Federal resources in primary prevention should be made. Dr. Julius B. Richmond, the Assistant Secretary for Health, has stated that development of a Federal prevention strategy is among his highest priorities. I support this proposal.

It is clear that the cost of health care will continue to rise with only marginal improvements in the health status of the American people unless some new approaches and alternatives to the present system are developed. Direct medical intervention to treat the casualties cannot solve the problem as efficiently as preventive efforts. We have seen success in reduction of heart disease mortality possibly due to change in diet, exercise, and alteration of personal habits or lifestyles.

Given a growing public support, a developing professional interest, an expanding knowledge basis and increased Congressional understanding of the need for primary prevention, it is timely for ADAMHA to develop a knowledgeable and sound basis for the formulation of policy and program initiatives and possibly the reallocation of resources.

I have found it useful to consider two general approaches to primary prevention:

(1) the promotion of general well being through improving the quality of life and raising the level of the general health of the population; and

(2) the provision of specific protection to avoid the onset of a specific disease, illness, or dysfunctional behavior.

Promoting general health of the population requires that we have a better understanding of the social and economic factors which affect rates of alcoholism, drug abuse, and mental and emotional dysfunction. Among these factors are employment levels, poverty, adequate housing, nutrition, family stability, fertility, and discrimination. While ADAMHA cannot change employment levels, improve housing, eliminate poverty or reduce racial discrimination, ADAMHA can support research which measures the impact of these social and environmental conditions in increasing the incidence of alcoholism, drug abuse, and mental and emotional dysfunctions.

Moreover, policy-makers need to have a better understanding of how these general forces (unemployment, the conditions of work, disposable income, the price of alcoholic beverages, limiting the availability of drugs, substandard housing, and racial discrimination) affect the incidence and prevalence of alcoholism, drug abuse, and mental and emotional disorders. There must be more specific research which will help other Government agencies evolve policies which promote and improve the quality of life and raise the general level of health in the population.

Some of the specific research initiatives which have been suggested and might be undertaken by ADAMHA and other governmental agencies are:

(1) obtain more health and social indicators of mental illness, drug and alcohol use and their antecedents and consequences;

(2) develop simulations or other forecasting models to anticipate impact of changes in unemployment, level of poverty, or alternative retirement requirements on drug or alcohol use, or rates of selected mental disorders;

(3) analyze alternative policies for the aged (housing, supplemental income) to forecast impact on health; and

(4) commission econometric studies of the impact of increased taxation on alcohol consumption (per capita).

Another possible approach to primary prevention is to focus on the conditions of known etiology which is possible to prevent by specific protection. Specific protection in the medical-psychiatric sphere would include the prevention of sequela of german measles by vaccination of mothers prior to pregnancy, the prevention of paresis by cure of syphilis, the prevention of birth defects by adequate and timely prenatal care, and the prevention of pellagra by improved nutrition.

The fetal alcohol syndrome is caused by the abuse of alcohol by mothers during their pregnancy. This is a preventable condition which requires further research. With the information we have, we should mount and sustain a public information campaign directed toward women ages 15-44 to make them aware of the dangers of drinking during pregnancy.

ADAMHA is currently engaged in analyzing some of the major issues, problems, and activities in primary prevention which will lead to a more rational approach in the development of an ADAMHA prevention strategy. The analysis will include a review of the manner in which the agency's three Institutes approach and support prevention programs, will attempt to formulate a conceptual framework for policy and program analysis, and will set forth guiding principles and strategies for coherent prevention strategy. Although prevention has been traditionally defined to include early treatment and intervention, ADAMHA will emphasize primary prevention.

Some of the major organizational, planning and programmatic issues which confront ADAMHA in developing its prevention strategy are:

(1) the development of policy which encompass the similarities and differences among the three fields;

(2) the delineation of specific roles to be carried out by ADAMHA, other Federal agencies, the States and local communities and the private sector;

(3) the identification of specific research issues which could be pursued to provide a knowledge base for ADAMHA's policy and program development initiatives;

(4) the dissemination and utilization of knowledge about existing effective prevention programs;

(5) the identification of other Federal agencies with responsibilities for prevention which should be linked with ADAMHA's prevention efforts;

(6) the identification of common areas for program development among the Institutes in which collaborative efforts would reinforce each other, e.g., prevention programs directed toward children ages 8 to 14;

(7) the identification of training programs and incentives to improve the quality of staff necessary to provide leadership in the prevention field;

(8) the development of evaluation methodologies and their utilization to determine what works, with what target groups and under what conditions; and

(9) the identification of alternative financing methods to provide more stability for the ongoing funding of prevention programs.

I see ADAMHA's role as essentially to provide national leadership and to act as a catalyst in stimulating the development of primary prevention programs at the State and local levels. To function effectively, ADAMHA must work collaboratively with other Federal agencies, State and local agencies to assure that resources currently available in the educational, social service, criminal justice, and other areas are appropriately utilized in primary prevention. Many of the problems as well as the resources to prevent alcohol abuse, drug abuse, and mental and emotional dysfunction will be found outside the health and mental health systems.

Because of the limited state of knowledge on how to prevent dysfunctional behavior, ADAMHA's priority should be on research and development to establish a base for policies and programs to be carried out at the Federal, State and local levels. Because of limited resources, ADAMHA should concentrate its efforts on identifying high-risk target populations which are particularly vulnerable to alcohol abuse, drug abuse, and mental and emotional disorders. Some of the groups which have been identified within the population are the poor, minorities, children, teenagers and women.

Although I have indicated that ADAMHA's priority should be on research and development, I do not want to neglect the importance of using a broad array of strategies which include public information and education and the appropriate utilization of Government policy and regulatory authority, particularly as these relate to alcohol abuse and drug abuse. We need to develop a policy analysis model which would assist Federal, State, and local agencies to evaluate the impact of proposed policy and regulations on the incidence of alcohol, drug abuse, and mental and emotional dysfunctioning (similar to an environmental impact statement).

In the meantime, ADAMHA will be identifying joint program initiatives which might be undertaken collaboratively. These might include the development of an approach to assist teachers to help children develop social and functional competency; expanding existing model programs targeted to prevent teenage drinking, substance abuse, and other dysfunctional behavior; working with one or more States to develop a model State prevention program. ADAMHA will also be establishing mechanisms to initiate a pattern for cross-Institute communication and to improve the coordination of policy and program development activities among the Institutes and with other Federal agencies.

There are a number of other possibilities for developing, evaluating, and replicating new primary prevention models directed toward specific, vulnerable high risk populations. Some of the areas which have been identified for special consideration are:

(1) family planning and preparation for parenthood;

(2) changing mothers' negative perceptions of their newborn children which could lead to later emotional disturbances; and

(3) preventing needless anxiety or emotional disturbances among young children hospitalized for acute or chronic physical conditions and providing emotional support to children who "lose" a parent by divorce.

These comments are not as well organized or elaborated as I would hope but the press of time prevented the preparation of as full a response to your question as I would desire. I hope we can work together to develop policy for preventive efforts.

May I again express my appreciation for the opportunity to set forth some of my views on ADAMHA's role in primary prevention and to assure you of my commitment to move forward as rapidly as our knowledge and resources will permit.

Sincerely yours,

Gerald L. Klerman

Gerald L. Klerman, M.D.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
ROCKVILLE, MARYLAND 20852

OFFICE OF THE ADMINISTRATOR

DEC 5 1977

The Honorable Harrison A. Williams, Jr.
Chairman
Committee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

During the Confirmation Hearings on October 26, you raised questions regarding the extent of ADAMHA effort currently being expended on dealing with the problems of alcohol among our youth. The National Institute on Alcohol Abuse and Alcoholism is actively engaged in the development of youth alcoholism programs in the areas of research, prevention and services.

In fiscal year 1977, these research projects totaled $224,000. The specific projects are:

1. Logos Research Institute
   Van Nuys, California
   "Self-Regulation of Adolescent Drinking"

2. University of California
   Berkeley, California
   "Black Adolescent Alcohol Consumption"

3. Washington State University
   Pullman, Washington
   "Problem Drinking, Delinquency and Maturational Reform"

4. Harvard University
   Cambridge, Massachusetts
   "Natural History of Alcohol Abuse"

5. University of Denver
   Denver, Colorado
   "Adolescent Alcohol Use: A Cross National Typology"

In light of awareness of growing adolescent and youth drinking as a problem, these projects represent modest efforts in studying youthful drinking.

NIAAA is also sponsoring contract research. (1) The project I mentioned at the hearings which is located at the University of California, Berkeley, includes a small sample of youth-related alcohol problems in a series of interrelated epidemiological studies. It was funded in fiscal year 1976 for $344,000 and received an additional $99,000 in fiscal year 1977. (2) Additionally, NIAAA launched a study in fiscal year 1977 of cultural influences upon drinking practices among expatriated U.S. youth ($25,000). (3) The Institute has also engaged in followup studies of the sample of students in the 1974 national survey of high school students which examined youthful drinking behavior over time and studied influences of peer group pressures. The followup study was funded in fiscal year 1976 for $300,000 and was supplemented in fiscal year 1977 for $25,000. (4) A two-year project is presently underway for collecting data on youth at risk for alcohol problems to give insight into the problems and to estimate their prevalence. The first phase of the study was funded in fiscal year 1977 for $70,000. During fiscal year 1978, studies on the relationships between the legal drinking age and automobile accidents are being considered.

Prevention efforts include demonstration projects, outreach and training efforts, and limited technical assistance activities. In fiscal year 1977, 12 prevention projects were funded for $1,929,000. In fiscal year 1978 NIAAA will continue to support the four ongoing projects for an estimated $489,000.

With respect to treatment services NIAAA currently is sponsoring six youth and young adult alcohol abuse services programs throughout the country totaling $1,073,000 in fiscal year 1977. These projects will be continued in fiscal year 1978. Specifically, the youth and young adult services programs direct attention to the varied, often unique, and frequently unmet needs of young people and their families whose social functioning is (or may become) impaired by their abuse of alcohol. The intent of the youth and young adult services programs is to support projects which provide for integrated and nonstigmatized treatment and rehabilitation services that stress outpatient or short-term residential treatment while viewing the family as the client, where possible. It is estimated that approximately 13,000 clients 18 years of age and under received treatment during calendar year 1976 in NIAAA funded treatment and rehabilitation programs.

Reports from those treatment and rehabilitation programs monitored during calendar year 1976 indicate that approximately five percent of the total client population being served are 19 years of age and under.

As you will note from the above, NIAAA has been active in research, prevention, and treatment related to youth and alcoholism. Even greater effort is needed to meet this major health and social problem. I look forward to working together with you and the Committee as we move to meet this challenge.

Sincerely yours,

/s/

Gerald L. Klerman, M.D.
Administrator

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
ROCKVILLE, MARYLAND 20852

OFFICE OF THE ADMINISTRATOR

DEC 7 1977

Honorable Harrison Williams
United States Senate
Washington, D.C. 20510

Dear Senator Williams:

At the time of my Confirmation Hearing before the Committee on Human Resources, Charles Kiesler, Ph.D., of the American Psychological Association presented testimony which posed several questions as to my views and goals in selected areas. As you requested, I have responded in writing to his questions, and am enclosing a copy for your information.

I very much enjoyed our discussion during the Confirmation Hearings, and look forward to working with you and the other members of your Committee as we move to further strengthen the programs in the alcohol, drug abuse, and mental health fields.

Sincerely,

Gerald L. Klerman

Gerald L. Klerman, M.D.
Administrator

Enclosures

Question: What personnel changes does Dr. Klerman propose for ADAMHA? Specifically, how will he bring other mental health professionals into leadership positions?

Dr. Klerman: As I discussed in my earlier meeting with you and at my confirmation hearings, I have had the opportunity to work with members of the various mental health fields including psychology in my experience as a researcher, clinician, and teacher. As a result, I have acquired the greatest respect for the abilities and competence of individual workers as well as for the perspectives and conceptual orientation offered by the various disciplines.

It is my intention to utilize fully the contributions to be made to the mental health field by the various professional and paraprofessional groups. In this effort, as opportunities for personnel appointments become available, I plan to consult with the core professional groups to solicit their views as to whom they consider to be the most highly qualified individuals for the job. A case in point is the Associate Administrator for Science, a position which I consider to be extremely important and which I plan to review for possible creation and filling after my confirmation.

Question: Does Dr. Klerman plan to restore funding for mental health research? To what levels and by what date?

Dr. Klerman: The power to restore funding for mental health research lies with Congress and is expressed through the appropriation process.

I am in full agreement with your conclusion that there has been a drastic erosion, by way of inflation. I am committed fully to working by every means possible within this Administration and, especially through the budget formulation process, to rectify this condition. As Administrator of ADAMHA, my highest commitment will be to the objective of redressing what I believe are the past deficiencies in the funding of ADAMHA research programs.

I have not had the opportunity to conduct a thorough study of the research funding levels, and it would be premature for me to state recommended levels at this time. However, it is clear that major increases to the budgets will be necessary even to counteract the forces of inflation over the last ten years. In the meantime, I am in agreement with the preliminary report of the President's Commission on Mental Health.

The achievement of increased research funding will require, among other things, the full demonstration of and communication by professionals and consumers and the conviction that major improvements in preventive, therapeutic, and rehabilitative efforts will come about only through a national research effort based on excellence and supported by the disciplines, the policymakers, and the public.

Question: What will Dr. Klerman do to achieve continuity and stability in research support?

Dr. Klerman: We are aware of the concerns and recommendation on this issue expressed by the President's Biomedical Research Panel which expressly identified ADAMHA needs for increased and stable research funding. As a research investigator, I share those concerns. I am personally aware of the apprehensions, delays, and inefficiencies from a lack of stability and continuity in research support. The lack of stability results from two features of the appropriation process:

1. A Federal appropriation system involving an annual justification and appropriation which must be expended in the fiscal year for which it is appropriated, and

2. The decreasing level of support for ADAMHA research (based on constant dollars).

Consequently, the programs result in fewer awards for shorter periods of committed support. Admittedly, there is an alternative way of dealing with these features of the appropriation process that involves trade-offs and constitutes an issue on which the Association may care to give advice. Specifically, with a near-stable appropriation--if projects are to be funded for four, five, or six years thereby increasing continuity and stability--then by necessity less new projects will be supported each year. In other words, are public policy goals best attained by the support of fewer projects for longer terms or more projects for shorter terms?

Realistically, I am not optimistic that the Federal system resulting in an annual budget justification and appropriation will be significantly revised. I am more optimistic that increases in research funding can be secured, and this in turn will permit significant improvement in terms of continuity and stability. It is in this direction that I intend to invest my energy.

Question: Does Dr. Klerman support a pattern of research funding that is more balanced and equitable among the mental health professions?

Dr. Klerman: I believe that the first obligation of a research administrator is to support the highest-quality research that is likely to contribute to basic or applied knowledge in those areas for which he is responsible. I would oppose strongly allocating research funds by discipline. This philosophy has served well the mental health professions. Concentration on the quality of the research will best result in what you refer to as the "balance among professions."

Indeed, it has been implemented by the mental health research professions through their services on peer review groups which are concerned with the quality of research and as the recipients of research funds as principal investigators.

In actuality, psychologists, more than the members of any other discipline, have participated in and contributed to this system through their efforts in assisting in the quality determination and as recipients of research funds in conducting research.

For example:

1. On ADAMHA research review groups on which 20 or so disciplines and specialties are represented, psychologists provide 99 of the 226 members, or about 44%, and

2. In 1976 psychologists received 48% of the NIMH research awards, representing 40% of the total research funds, and this percentage has been fairly constant over the past 20 years.

I believe that all of the mental health professions have made, and will continue to make, important contributions in ADAMHA research programs and that excellence should be the principal criterion by which research funds are allocated.

Question: Does Dr. Klerman plan to work for a more valid manpower data system encompassing the entire field of mental health?

Dr. Klerman: It is my intention to develop a comprehensive manpower data system which will ensure the availability of information on the supply, need for, and deployment of each of the major types of mental health manpower nationally. NIMH has had a long standing need for a more adequate manpower data base to guide the development of its training and services support programs. Recent demands for greater accountability in manpower programs, together with increasing requests for statistics and reports on mental health manpower from the Congress, special task forces, and commissions (e.g., the President's Commission on Mental Health), make it mandatory that existing manpower data resources be strengthened. Of particular concern at this time is the need to monitor and evaluate the initiatives in training and manpower development now being implemented by the Institute. The following steps have been taken:

1. A Committee on Manpower Information Needs and Resources has recently been appointed to assess NIMH manpower data needs, identify resources required to meet those needs, and recommend alternatives for developing the required resources.

2. Several studies have been initiated or are under consideration to augment the data presently available. These include:

   a. A contract with the American Psychiatric Association that will produce information on the approximately 30,000 psychiatrists in the United States -- both APA and non-APA members. Data will include education/training, work setting, professional activities and interests, credentials, geographic distribution by State, county, Standard Metropolitan Statistical Area, and, where possible, mental health service catchment area.

   b. A contract with the National Association of Social Workers, to design a study of the academic preparation, duties, functions, work settings, and other characteristics and qualifications of social workers who provide mental health services, both in mental health facilities and elsewhere. Data will include information related to the training needs and geographic distribution of social workers who perform mental health services.

   c. Similar contracts will be explored in the next fiscal year with the American Psychological Association and the American Nurses' Association.

Other efforts toward strengthening the manpower data system will focus on the need for and patterns of utilization of mental health manpower in community mental health centers, and the supply and utilization of minority mental health specialists in providing services to underserved minority populations.

Additional areas of need for augmented manpower information will undoubtedly be identified in the course of further analysis. It is important to recognize, however, that the ability to implement a comprehensive manpower data system will be largely determined by the resources available for this effort. Among the alternatives to be examined by the Ad Hoc Committee on Manpower Information Needs is the possibility of reallocating resources within our currently constrained budget. But it appears unlikely that resources commensurate with the need can be made available in this way, since our most critical constraint will probably be in the area of staffing.

Question: Does Dr. Klerman support the reduction or elimination of training funds? What concrete steps does he plan to take in this area?

Dr. Klerman: I have conducted research training and I believe in its importance to the national research effort. This need is the basis on which Congress justified the Federal role in the provision of funds for research training. The National Research Service Award Act of 1974 confirms the Federal role in research training. It authorized individual and institutional awards for the support of the training of scientists for careers in biomedical and behavioral research in order to increase the capability of NIH and ADAMHA to maintain a superior national program of research. The law requires "payback" by individuals for Federal support and provides alternative "payback" methods.

As you know, the Administration, wishing the opportunity for further study of the issues around research training, restricted the FY/78 budget request to a limited number of postdoctoral fellowships. The questions posed include:

1. The extent of the Federal role in terms of dollars,

2. The mechanisms by which the Federal role will be implemented, and

3. How many and what kind of people will be trained.

It was in recognition of these continuing questions that the Congress provided for their study by the National Academy of Sciences.

I believe that:

1. There is a Federal role to be maintained in research training, and

2. In pursuing that role, the justification--namely the strengthening of the national research effort--must be kept paramount.

We must avoid in fact and in appearance any suggestion that these activities are carried out for reasons other than their contributions to the national health research effort. Similarly, in terms of the potential hazards in human and financial cost, we must on the one hand be sensitive to the special manpower needs of the future and on the other hand avoid contributing to an oversupply of manpower in any area. I believe that the efforts of the NAS provide one source of guidance in accomplishing these goals.

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I believe we need to study the research training programs carefully in order to form judgment on:

1. The manner in and extent to which the programs contribute to the national health research effort,

2. Ways in which that level of contribution may be enhanced, including the provision of additional funds, and

3. The best mechanisms and policies under which such training can be supported.

Based on these reviews, I will be in a better position to address the level of funding.

Question: Will Dr. Klerman actively support changes in these regulations to recognize and fund further training in the research skills of psychologists?

Dr. Klerman: I do not agree that the manner in which this program (NRSA) has been implemented by ADAMHA has undercut the intent of the awards. The National Research Act provides the only authority available to ADAMHA for research training. To implement this Act, ADAMHA has provided support at the pre- and postdoctoral level by both institutional and individual awards for individuals training to engage in research careers as authorized and required by the National Research Act.

ADAMHA has other authorities under which it provides support for the training of professionals and paraprofessionals who will be service providers. Because the research and clinical training authorities have distinct requirements, ADAMHA has found it necessary to make some administrative distinctions between those training projects which have as their purpose or have demonstrated performance toward one or the other of the above objectives--training for research or clinical/service careers. In many instances, this has not caused a significant problem because many programs are geared predominantly toward one or the other and are accordingly assigned to programs under the appropriate authority. Some projects are not easily distinguishable in this regard and, for that reason, where support for both efforts is required, it has been necessary for the applicants to submit separate applications. In any event, any project which proposes to provide training for clinical specialists to engage in careers in clinical research is eligible for and would be assigned to the NRSA program.

While we recognize that the requirement for some applicants to submit two applications is an additional administrative burden, this requirement is seen ultimately as a distinct advantage to the applicants and especially to the trainees. The utilization of NRSA funds to support programs or individuals who have not stated or shown evidence of preparing for research careers would clearly violate the intent of the law. In addition, the utilization of such funds for this purpose would by necessity impose the payback requirements of NRSA on trainees and, in conformance with DHEW policy for NRSA institutional awards, limit the grantees' awards for institutional costs to 25% of the total cost. Thus, there are distinct disadvantages for programs that are predominantly clinical in nature to compete under the NRSA authority. Conversely, if we were to use clinical/service training (defined in law as all training which is not research training) authority and funds to support programs that are dedicated to training individuals for research careers, it would be in direct violation of the law.

While it is unfortunate that in a few instances separate applications may be necessary, the alternative--which has been resisted by ADAMHA--would be to impose administratively the requirements of NRSA on the clinical/service training programs and thus, for most practical purposes, make the two authorities indistinguishable.

In any event, there is ample evidence that the mental health professions are making full use of and competing successfully under the programs of both authorities. For example, approximately 64% of all research trainees (individual and institutional awards) which were supported by NIMH in FY/76 were psychologists or individuals training to become psychologists. In the clinical training programs, the record indicates that over the past three years NIMH has obligated on the average 14% or $10.7 million of its clinical training funds for psychology programs. There has been no appreciable decrease in this figure over these years.

I am aware that significant time in the training of clinical psychologists is devoted to the acquisition of research knowledge and skills, more so than in the education of other mental health professionals. The NRA mandates career intent as a criterion for eligibility, not curriculum content. Clinical psychologists who intend research careers and pledge "payback" are in fact eligible and have received awards.

Question: Does Dr. Klerman support such a massive shift in training funds? Does NIMH foresee these primary care givers as being fully competent to treat mental and emotional problems?

Dr. Klerman: It is my understanding that no massive shift in training funds from mental health specialists training to primary care generalist training is expected in the clinical training policy of the NIMH. They have maintained a modest level of support for the training of generalist primary care providers. A modest level of increase is proposed for primary care providers, primarily in the area of Research and Development for evolving experimental training models as they relate to the training of primary care providers. However, this minimal increase will not be at the expense of a major undercutting of funds for training mental health specialists.

In the past, training in the primary care area has been focused on training physicians and nurses. Physicians and nurses who are primary care providers are not expected to manage serious social, psychological, and emotional problems of patients and clients. In their practice, they do encounter serious, complex mental disorders. They should have the ability to assess and triage their clients, and promptly and expeditiously refer them to appropriate mental health specialists. The role of the primary care provider should be to assist individuals and families in the community, to help them cope with the problems and stresses of daily living, to intervene in crises situations and to take action for immediate appropriate referral and followup care.

If the generalist primary care provider is to fulfill these roles and functions, then there must be mental health specialists available to accept referrals, to collaborate in designing care plans and to serve in liaison and consultation functions. This mental health manpower model conceptualizes the generalist primary care provider and the mental health specialist as interacting in an interdependent relationship. It would be unfortunate indeed if generalist and specialist training become juxtaposed in opposition to each other. The primary care provider, with more effective educational training, can provide a limited type and quality of mental health care and services. Because of their insufficient numbers and the maldistribution problem, the mental health specialist can be better utilized in more selective roles and functions which focus on the more serious and complex mental and emotional problems of their clients and patients.

Question: Does Dr. Klerman support a greater policy role for ADAMHA? How does he propose to make this public agency more publicly accountable?

Dr. Klerman: As I have stated publicly on several occasions, I believe there is a strong need for the Institutes to retain their autonomy and visibility. I do not believe, however, that that precludes the possibility of inter-institute cooperation and collaboration or of a meaningful role for the Office of the Adminstrator. One of my long-term goals will be to work with the Institutes to clarify where the differences and the commonalities are in the fields of alcohol, drug abuse, and mental health, and how the Institutes might separately and collectively best approach these areas. In this process, it will be important to maintain open communication channels with the constituent associations and to maintain public confidence in our processes and conclusions.

Question: What are Dr. Klerman's plans for the major goals, directions, and priorities of ADAMHA? In what areas does he propose continuity with past efforts, and what areas call for major changes of emphasis?

Dr. Klerman: With regard to the directions in which I would like to see the Agency and the mental health field moving, I am in full agreement with the "assurances" that the American Psychological Association is seeking: that mental health is seen as an important policy area on a par with other major health issues; that the contributions of the entire mental health community are valued and have a place in Federal programs and planning; and that the Agency will be able to furnish adequate resources and support to do the job. In this context, I see one of my major roles to be as an advocate to promote and support these goals within HEW and other Federal agencies as well as to outside institutions and groups. Within each of the functional areas of the Agency, my priority goals are as follows:

With regard to research, I consider this to be the top priority of the Agency. The restoration of dollars lost to inflation and the development and support of a program commensurate with the public need and the scientific state of knowledge is one of my highest objectives.

With regard to services, I think it is extremely important for our short- and long-term objectives that services for alcohol, drug abuse, and mental and emotional illness be covered under National Health Insurance, on an equal basis to the coverage for physical health problems. Even so, there will still be certain services not covered by NHI which are important to alcohol, drug abuse, and mental health problems; and for these we must delineate other sources of funds (e.g., Title XX Social Services, State and local, formula grant, project grant).

With regard to training, it is important that the Agency anticipate the needs that will be generated by NHI for appropriately trained additional professional and paraprofessional manpower, the respective roles of the Federal and State agencies in their support of training programs, and the relationship to services and providers in the general health sector.

With regard to prevention, I believe this is an important area in which new research efforts in particular are needed to enhance our knowledge base for policy and programmatic decisions. Focused efforts are needed to identify specific goals and target populations, and to develop, demonstrate, and evaluate methods and techniques for dealing with the high incidence and prevalence of alcohol, drug abuse, and mental problems and their consequences.

Question: How will Dr. Klerman work to encompass this broad-based view of mental health systems within ADAMHA policy?

Dr. Klerman: The agency is committed to the concept of multi-disciplinary peer review, which draws on the strengths of both models. We are also interested in exploring the possible participation of citizens/consumers in some aspects of the peer review process. It is true, as the American Psychological Association points out, that an adequate peer review system will require concurrent reviews as well as prior review (approval) for certain types of mental health services as well as for elective general health services.

Both of the peer review related activities in which the National Institute of Mental Health has had a major involvement (i.e., CHAMPUS and FEHB), have been conducted on a fully interdisciplinary basis and both have served as models for future efforts.

As I have communicated recently to the Assistant Secretary for Health and to Secretary Califano, it is my strong belief that treatment services for alcohol, drug abuse, and mental health problems should be covered under NHI on a basis equal to that for any other health problem. These services must be both effective and cost-efficient. In this respect, I view a major objective of this agency to be the development of a strong, coordinated program of treatment assessment research, to develop the methodology for and to support the evaluation of specific treatment techniques for specific disorders, an evaluation of the organization and structure of treatment programs, and the roles and relationships of the various types of service providers. This must ultimately include clinical data as well as information on the cost efficiency per unit of service and the longer-term cost-benefit ratios.

Question: Does Dr. Klerman support cost-efficient coverage for mental health services under national health insurance?

Dr. Klerman: As I have discussed recently with the Secretary and the Assistant Secretary for Health, I strongly believe that the coverage under the National Health Insurance for alcohol, drug abuse, and mental health treatment services should be equal to that for treatment of any other health problem. These services, of course, must be both effective and cost-efficient. In this respect, I view a major task of this Agency to be the development of a strong and coordinated program in treatment assessment research, for the evaluation of specific treatments for specified disorders, as well as types of delivery systems and the roles and relationships of various service providers. Such assessments must include data on the cost per unit of service and cost-efficiency as well as longer-term clinical data and cost-benefit ratios.

Question: Does Dr. Klerman support the inclusion of psychologists as independent providers under such a plan?

Dr. Klerman: As a mental health profession, psychology is having a great impact on health care. Some 19,000 clinical psychologists practice in a health setting, and of these 13,000 are providing service in group, institutional, hospital or hospital-type care settings on a full or part-time basis.

Under the Medicaid program, psychologists are reimbursed for care as independent providers without requiring physician referral in 16 or 17 States. In so doing, States have acknowledged the positive role that comprehensive and balanced mental health services can play in improving and maintaining the health of individuals affected by Title XIX of the Social Security Act.

However, it is my understanding that under the current Medicare provisions, licensed or certified psychologists are eligible to be reimbursed directly for services as independent health service providers if a physician referral is involved.

Other Federal programs such as the Federal Employee Health Benefits Acts and CHAMPUS recognize psychologists as autonomous health service providers.

Current JCAH standards do not include psychologists as members of the medical staff nor do they provide for psychologists to have admitting privileges. This latter situation is pending court action.

Federal quality assurance activities aimed primarily at Medicare and Medicaid have the greatest opportunity for success if a productive relationship between psychologists and such programs as PSRO is developed and expanded under a national health insurance plan. Additional research and demonstrations in the area of psychologists as independent providers under Medicare (for example in Colorado) should shed further data as to the future prospects for creating such a productive relationship.

Question: What kinds of review mechanisms, evaluation efforts, and public accountability controls does he support (under National Health Insurance)?

Dr. Klerman: Proven approaches directed at assessing and improving mental health patient care and practitioner and provider performance are highly supported under any national health insurance program. Vigorous efforts in the areas of regulations and standards monitoring by Federal and State authorities and non-Government organizations, and facility-based internal quality assurance programs which include utilization and peer review components as well as any other evaluative approaches found to be effective in an adaptable to the mental health field, should be integrated into a nationwide accountability effort for ensuring that National Health Insurance monies purchase the best possible quality of care delivered most efficiently and appropriately.

The CHAIRMAN. We have no further requests for appearances on this nomination so the hearing is closed.

[Whereupon, at 1:05 p.m. the committee adjourned.]

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