ADAMHA Still Seeking to Consolidate Its Identity

Bolstered by a fast-expanding research base and increased public concern with mental and addictive disorders, the agency may be moving in the direction of NIH

FEDERAL SUPPORT for research on mental and behavioral disorders, which has long suffered from relative neglect, is on an upswing. Research budgets for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) have risen rapidly in the past few years as Congress and the general public have become more aware of the terrific costs incurred by mental illness and addictions. They are also getting a boost from AIDS money and the Administration's war on drugs. But most important, ADAMHA is benefiting from what may be the most exciting and fast-expanding frontier in science—the human brain.

ADAMHA is now headed by a world-class scientist, Frederick Goodwin, an expert on bipolar illness (manic depression) who recently took over after Florida pediatrician Donald Ian MacDonald went to the White House to head the antidrug campaign. And all three ADAMHA institutes are now headed by well-known scientists—psychiatrist Lewis L. Judd at the National Institute for Mental Health (NIMH), psychopharmacologist Charles Schuster at the National Institute on Drug Abuse (NIDA), and psychiatrist Enoch Gordis at the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Goodwin, a 23-year veteran of NIMH who for 7 years headed its intramural research division, calls this "the strongest combination of institute directors it's ever had."

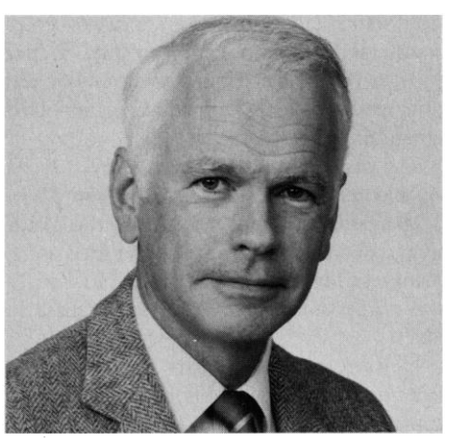
ADAMHA, created in 1973 when the drug and alcohol institutes were separated out from NIMH, has been something of a stepchild in the federal health establishment. Its involvement with substance abuse has made it highly vulnerable to shifting political winds. Its extensive responsibilities in treatment services have made it a different kind of animal from NIH, and its research mission has been underdeveloped because of the stigma attached to behavioral and mental disorders as well as the spotty scientific base from which it operated.

Research budgets for addictive and mental disorders have long been minuscule in relation to treatment costs. For example, in schizophrenia, the federal research dollar per patient has been about one-tenth the corresponding ratio for heart disease.

But all that is gradually changing, particularly now that most of the agency's service functions have been taken over, since 1982, by block grants to the states. And debate has increased over the desirability of ultimately transferring all or part of ADAMHA back to NIH where NIMH began, in 1946, as one of the four original NIH institutes.

Differences over how the agency should be reconstituted are very wide, but some sort of reorganization has more plausibility now than ever before because of the explosion of new knowledge in the neurosciences. "For the first time in our history, those concerned with mental disorders have a legitimate basic biological and molecular biological science," says NIMH director Judd. "This is the beginning of a golden era for brain sciences." According to NIMH, "95% of what we know about brain function" has been discovered within the past decade. Some objective evidence: the number of scientific publications on the brain has doubled within the past 5 years, according to the National Library of Medicine. And the Society for Neurosciences, created in 1971 with 250 members, now has a membership of 11,000.

Assuming Goodwin (a registered Independent) is not promptly replaced in a change of Administration, his leadership is a strong signal that the agency has no intention of turning back to the social concerns that were a large part of its earlier mission. Nonetheless, in a recent interview with *Science*, Goodwin pointed out that ADAMHA's responsibilities are broad—"we're the only act in town for leadership at the federal level for the mental and addictive disorders."



Frederick Goodwin. *Research is "the fundamental, defining mission of ADAMHA."*

Goodwin repeatedly stressed the preeminence of research—"the fundamental, orienting, defining mission of ADAMHA"—and the need for it not to be compromised by pressures for quick results. He believes research is the key to bringing public legitimacy to research on addictions and mental illness, which still retain the kind of stigma that used to be accorded cancer when it was regarded as a hopeless illness. He remembers the newspaper obituaries in the 1960s that covered up cancer deaths by saying the individual died "after a long illness." Today, similarly, deaths from alcoholism are attributed to such things as "a liver ailment." Legitimatization, he points out, generates hope and optimism. "If all you're doing is asking people to pay attention to how awful" an illness like schizophrenia is, "we want to avert our eyes." But "the optimism itself already begins to destigmatize."

NIMH is hoping to demonstrate this with its campaign on depression—or D/ART, for Depression Awareness Recognition and Treatment—launched in May. Judd calls this the institute's "first-ever science-based prevention program," analogous to past NIH campaigns on hypertension and diabetes. The campaign seeks to get the news out that severe depression is an illness that is relatively common, well understood scientifically, and highly treatable.

Goodwin sees the depression campaign as a model for public education about the combined psychological and biological nature of psychiatric illness, and, indeed, of any illness. In psychiatry, he says, we are still "fighting the general bias against anything that smacks of biological determinism," in part because in the past, when the only treatments available were behavioral, the tendency was to ascribe all mental illnesses to psychosocial causes. On the other hand, "biological predispositions rarely become totally deterministic."

Thus, says Goodwin, "we need to break down the artificial dichotomy between behavioral disorders and mental disorders." It is still difficult to get across the notion that all medical disorders have behavioral components, and psychological disorders have biological components. Diabetes and hypertension, for example, notes Goodwin, arise from genetic predispositions but are also aggravated or controlled by behavior. The same can be said of many forms of alcohol-

ism, which, despite arguments to the contrary, Goodwin says is clearly a "disease" with definable symptoms, course, and treatment, and where genetic vulnerability has been demonstrated.

NIMH has been gaining in visibility lately not only with the D/ART crusade but with its new "national plan for research on schizophrenia" engineered by former director Shervert Frazier, which will involve a substantial expansion in grants as well as new centers for schizophrenia research. The NIMH budget for schizophrenia, long the most underfunded area in mental illness relative to its costs, has grown from $18.5 million in 1985 to over $40 million for 1989. The schizophrenia plan, which includes new research on diagnosis and treatment, overlaps with what is being called the "Decade of the Brain," a wide-ranging plan of research in the neurosciences that involves NIMH, the National Institute for Child Health and Human Development, and the National Institute on Neurological and Communicative Disorders and Stroke (these two institutes are both spin-offs of the original NIMH). There are plans for a new $90-million center for neurosciences research, to be shared by the three institutes on the NIH campus.

With the brain sciences booming, the question has arisen with renewed frequency as to whether it is time for "mainstreaming" ADAMHA by reintegrating it with NIH. As Goodwin points out, mental illness and addictions are like minority groups—they had to engage in separatism for a while to gain visibility, but "in the long run separate implies something less than equal." Goodwin says the "long-term, orienting goal" should be mainstreaming not only in research but in reimbursement strategies, treatment, and prevention.

Last year the Department of Health and Human Services, in response to congressional concerns, made a stab at addressing ADAMHA's future by asking the firm of Lewin and Associates to examine the desirability of restructuring the agency. Sixty-two leaders in the field were interviewed about their reactions to five possible options, including transferring NIMH to NIH; transferring ADAMHA to NIH but putting service functions elsewhere; and combining the drug and alcoholism institutes into one institute for addictions. The upshot was that the majority (37) favored retaining the status quo.

Nonetheless the question is still very much alive. The National Advisory Mental Health Council (the advisory group for NIMH) complained to HHS secretary Otis R. Bowen that the Lewin report failed to provide a meaningful analysis of issues, and said that it was "strongly opposed" to maintaining the status quo. The Council recommended instead that the agency be structured in a manner identical and parallel to NIH. It also proposed renaming ADAMHA "the national institutes of brain and behavior" or "the national institutes of mental and addictive disorders."

Meanwhile, there is considerable pressure from other quarters to move NIMH (whose intramural program never left the NIH campus) back to NIH. Senator Daniel K. Inouye (D–HI) has repeatedly introduced bills to that effect, and the National Alliance for the Mentally Ill has been aggressively lobbying for such a transfer. The main problem with that is that most other observers think it would be a disaster to separate mental health from the drug and alcohol institutes. "We all drink from the same pond of knowledge," says Goodwin, who also points out the high degree of co-morbidity among mental illness and the addictions.

The idea of transferring all of ADAMHA to NIH has some appeal for, as the Lewin report points out, this could be expected to add to prestige of mental and behavioral research, stabilize funding, and, in particular, enhance research on major mental illness. On the other hand, as the report also observes, "NIH leadership has traditionally been disdainful of mental health research, including research on the interaction between biological and behavioral processes. . . ." Nonbiological behavioral research thus could get short shrift, and the focus on major mental illness "could retard research into disorders not now understood to be the result of biological/genetic problems."

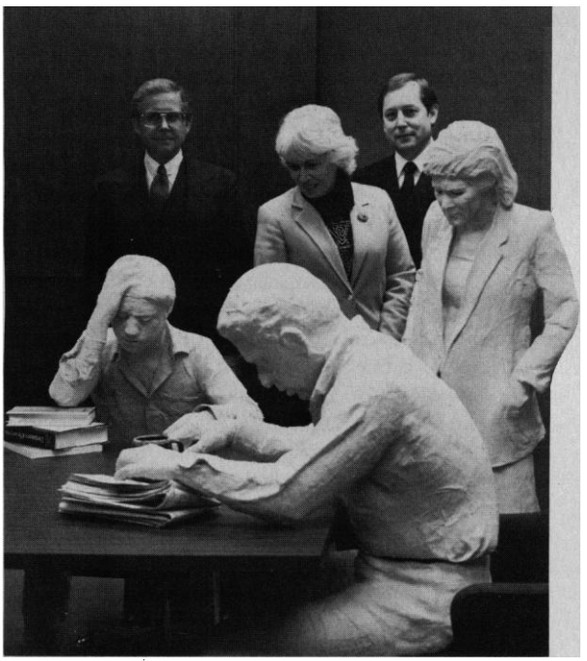
There are other drawbacks to moving ADAMHA into NIH. Although its major service programs have been transferred to the states, there are other service-related activities that would not sit well at NIH but could suffer if put in a separate administrative agency from research. Furthermore, while NIMH might well be ripe to return to NIH, the alcohol and drug people are opposed to any move that might submerge their identity or jeopardize their competitive position, and they do not want to be separated from the much larger and more prestigious NIMH.

As for fusing the alcohol and drug institutes into a single institute for addictive disorders, there is much to be said for this from a basic science point of view, but as Goodwin says "it may not make symbolic sense." Neither the drug nor the alcohol people want to obscure their hard-won visibility and they perceive themselves—despite growing evidence of polydrug abuse and cross-tolerance between alcohol and other drugs—as catering to different clienteles.

Given all the cross-currents in the field of mental and behavioral disorders, the time does not seem to be ripe for any major reorganization. More probably, ADAMHA will be trying as hard as it can to look like another NIH. That would mean, for one thing, the depoliticization of ADAMHA appointments—the Lewin report points out that "continuity of leadership has been a problem at ADAMHA" with tenure of administrators and institute directors being about half of that of comparable NIH officials. It would mean thinning out the ADAMHA bureaucracy, which is already happening, to maximize the autonomy of the individual institutes. And it means continuing to emphasize the generation of new knowledge as the best way to erase the stigma attached to mental and behavioral disorders and to gain legitimacy in the eyes of the holders of the purse.

Regardless of organizational outcome, ADAMHA still has a lot of catching up to do. The NIMH budget lost much momentum after it was separated from NIH in 1967. The proposed research budget for fiscal 1989 is $613.3 million, including $71 million for AIDS research. Goodwin says that if ADAMHA had been growing at NIMH's pre-1967 rate, its research budget would now be $1 billion.

■ CONSTANCE HOLDEN



Depression awareness. *NIMH director Lewis Judd (left) launches the D/ART campaign, the institute's "first-ever science-based prevention program." Statues were created for television public service announcements.*