Review of National Institute of Mental Health, National Cancer Institute and National Institute on Drug Abuse

Assignment 1
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In the following pages I will review the history and mission of the National Institute of Mental Health, National Cancer Institute and National Institute on Drug Abuse which are all funded by the National Institute of Health. I have selected to review the above agencies based on the idea that they relate to my current studies in the field of marriage and family therapy. I selected the National Cancer Institute because I currently work as a research assistant for a study that is funded by this institute. Overall, I found that my anticipations of the priorities of the three institutes were basically wrong. As a person studying to become a therapist I am very attentive to the behavioral choices or factors that impact a person's health. Prior to fully evaluating each of the institutes I had thought there might be more of an emphasis on behaviorial interventions for various health issues.

NATIONAL INSTITUTE OF MENTAL HEALTH

The mission of the National Institute of Mental Health is to help alleviate the burden of mental health and behavioral disorders. They attempt to do this by funding research on the mind, brain and behavior. The national institute of mental health was established in 1949 by congressional legislation (http://www.nimh.nih.gov/About/history.cfm). This institute seemed to truly gain power in 1955 when it was authorized to study and make recommendations on mental health issues. NIMI expanded greatly in 1963 with the funding allocation for building Community Mental Health Centers and Mental Retardation Facilities nationwide. Historically funding seems to be contingent upon the popularity of mental health issues. As issues such as alcoholism and autism come into greater public awareness funding seems to quickly follow from congressional allocation. While this seems to generate additional funding, I question how the funding for less popular disorders has continued through the years. The website does not really contain information on funding that is not longer around for certain disorders, rather there is an expectantly positive bias that includes he newest funding.

The priority of the research funds is going to major depression, schizophrenia, bipolar disorder and autism, with the remainder going to all other NIMH research. Like the other institutes in NIH, this institute balances funding between medical and behavioral research. I was surprised to see amidst the many funding decisions that there are grants available to small business research programs. The small business research grants are an interesting way to support the private sector in helping to advance issues that are largely of interest to the public sector. I found the sections on the various types of research grants to be very helpful. Knowing the types

of research grants available, both in the past and future takes a bit of the guess work out of know what is possible.

It seems a little more difficult to navigate the NIMH's web site than other National Institute of Health websites. This could be because many of the research opportunities seem to be medically based, thus involving terminology or links that I am not especially familiar with. In the available jobs section of the website there were clearly more jobs available on the medical end of the research. In reviewing the research topics of the various branches of NIMH there were very few non-medical issues.

One of the things that discouraged me when reading the Setting Priorities section of the Strategic Plans and Priorities was the omission or soliciting advice from psychologists at any level. Advice was solicited from physicians and scientists as well as patients and their advocates but, there was not a mention of seeking information from clinicians who work with the population they are attempting to help on a daily basis. It would seem that working therapists who are not necessarily scientists or researchers would have a considerable amount of information to contribute to the dialogue of helping those plagued by mental disorders. This information points to the very clinical priorities of the NIMH. While it is understandable that one must seek quantifiable results to justify research spending, it seems like evaluating different perspectives when setting research priorities would not be a waste of time. This seems very interesting considering the agency is attempting to translate it's basic funding into intervention development. Not using practicing psychologists to develop research or set priorities seems like it will make it more difficult to then have such practitioners implement the suggestions of the NIMH findings. This concern clearly comes from my own bias belief that the everyday experiences of mental health practitioners are relevant to the dialogue about developing solutions.

I found it discouraging that the NIMH plans to reduce its training budget strategically to support fewer developing researchers. This seems to indicate that the vision of the agency is becoming narrower as it supports only specific goals. Given that a majority of the goals seem to be targeting medical interventions, the left over resources for therapeutic research seems like it will be very minimal.

I was overall disappointed with this institute because I thought it would really be a place for research on interventions that were not entirely medical. From what I have been able to research this was an inaccurate assumption. Out of the 13 principal researchers in the mood and anxiety disorder section of intramural research I was only able to find one staff researcher whose background was not entirely medical in nature

(http://intramural.nimh.nih.gov/research/res_areas.html). A majority of the staff has training in psychiatry. I expected to find at least a few token psychologists who specialized in behavioral research but this was not the case. I had again mistakenly expected that the section on anxiety and mood disorders would contain a non-medical emphasis to some extent. While psychiatrists clearly have an understanding of psychology, their training and emphasis generally follows the medical model. The training of the psychiatrist does not really address the entire mental health field which clearly includes many different schools of thought and successful treatment approaches.

Much of the funding that NIMH is participating in seems to be connected to other departments of NIH. Of the funding that is actually available much of it seems to be going to the small business innovation. In reviewing the program announcements I was surprised to see how few seemed to be directly related to mental health. Funding for basic biological health seems to be a priority over research aimed at behavioral interventions. In the research program announcements section of the website (http://www.nimh.nih.gov/grants/pamenu.cfm) a clear majority of the new programs are with other institutes and are primarily medical in nature. The mission of NIMH and other NIH agencies clearly overlap. One of the few recently funded grants that were exclusively funded by NIMH was on functional assessment of people with mental disorders. While this is related to behavioral interventions this is still fairly abstract. My perception of the limited intervention research is clearly related to my current training to become a marriage and family therapist. I have the expectation that an agency designed to serve mental health would have research funding allocations that would be oriented towards directly helping people.

This agency seems to have the goal of providing research to the end consumer, the mental health population. In order to do so, publications are available with easy to navigate information on many disorders. The actual projects funded are much more abstract and biologically based. As far as I can understand the connection between the more abstract research and the practical knowledge offered on the website is likely the staff that NIMH employs. Considering little practical (consumer oriented) research seems to be conducted by NIMH and their goal is to work to elevate the burden of mental illness this is the most likely explanation I can come up with. I think NIMH funds foundational research that is used by other researchers to formulate and test interventions. Outside research then seems to be used by NIMH staff to produce the plethora of information on disorders available on their website. Clearly NIH employed staff play a key part in mixing NIMH research with

other available research. The job of the research committee, groups, and consortia is to specialize in specific problems of interest to NIMH. The consortia are primarily NIMH staff that works to find and disseminate information to the general public. The consortia that are identified on the NIMH website include the human brain project, aging research, child and adolescent research, suicide research, women's mental health and the pain consortia.

NATIONAL CANCER INSTITUTE

Developed in 1937 under the National Cancer Act the National Cancer Institute (NCI) is the federal government's principal agency for cancer research funding and training. (http://www.nci.nih.gov/aboutnci/overview/mission). The national cancer institute has only been around since 1937 and since its beginning an Oncologist has always been the director. As part of the funding, mandates have been set for information dissemination. One of the things that impressed me about this institute was the goal to educate the public. The website has several easy to read sections about various forms of cancer. The NIC website also has an easily accessible dictionary of terms related to cancer.

The National Cancer Institute (NCI) is responsible for the coordination for the National Cancer Program which has extensive responsibilities including conducting research, training, and health information dissemination. The National Cancer Program also deals with programs relate to the cause, diagnoses, prevention and treatment of cancer, rehabilitation from cancer and the ongoing care of cancer patients and their families.

One of the very positive things about the national cancer institute is that it supports a national network of cancer centers. As a potential researcher, I find this exciting because it offers an automatic forum for research to be utilized. It would seem that if NCI was willing to fund one's research then they would be willing to then use their investment in the network of cancer centers.

I found the section of the NCI website that included program announcements to be very interesting. The program announcements indicate that NCI is interested in addressing a set of specific research questions. This section is a good way to determine the trends of the agency. By looking at the diversity of the research requests I was given a better understanding of what the agency is actually funding. It seems like there is a nice mix between behavioral and biological research. From talking with other researchers I have learned that the funding of the behavioral aspect of cancer research is relatively new. As many of the decision makers, such as

congressional leaders and organization heads, experience cancer on an intimate or familial level they begin to understand the more emotional side to this disease. Though I have not found research to verify or quantify this, there seems to be a trend of increased non-medical funding when cancer occurs in the lives of decision makers.

One of the things that I found most exiting about this institute was the desire to be, in a sense, consumer friendly. One of the most innovative sections on the website was the *NCI Listens and Learns* portion. This section is a forum for both advocacy groups and the public at large to comment on various discussions that NCI posts. Each specific forum is posted by NCI, comments are gathered and then a summary of comments is complied with a final official response later published by NCI. This seems revolutionary to me because it shows an attempt to be responsive to the needs of those that are not a part of NCI. I appreciate this acknowledgment of the value of the opinions or thoughts from the community at large. I did not find anything like this on the other NIH websites.

NATIONAL INSTITURE OF DRUG ABUSE (NIDA)

The mission of the national instate on drug abuse is to use science to bear on drug abuse and addiction (http://www.nida.nih.gov/about/welcome/mission/NIDA_Movie1.html). NIDA supports 85 percent of the world's research on the health aspects of drug abuse and addiction. The agency supports research on a foundational molecular level and on a community intervention level. NIDA works to use the newest scientific technology to understand how drugs impact both the brain and behavior. The NIDA website is a major component of it's mechanism to disseminate information to policy makers, drug abuse practitioners, and the general public. Similar to the other websites sponsored by the national institute of health the NIDA website has information available to meet every facet of it's constituency. Scientifically based information is available for practitioners while jargon free information is available to partners and teachers.

The national institute on drug abuse was developed in 1974 as the federal government's center for research on prevention, treatment and training services on the nature of drug abuse. The mission of this agency was temporarily changed in 1981 as congress gave more power to states to deal with drug abuse. The agency gained more funding when it joined the National Institutes of Health in 1992. The current director of the NISA is a psychiatrist; she is the first women director. Little information is available about the history of who has been a director.

In reviewing the legislative chronology of the National Institute on Drug Abuse it seems very clear that funding is contingent upon the way the political wind is blowing. Congress has put several stipulations on funding such as limiting the funding of clean needle exchange programs.

One of the things that interested me about NIDA is the perspective that drug abuse is a disease that can occur during any time of life even early childhood. NIDA has noted an interest in research that evaluates the co-morbidity of drug abuse and mental illness (NIDA Strategic Plan) I found it interesting that NIDA is interested in evaluating risk taking behaviors to determine what induces drug usage. NIDA studies the biological, psychological, genetic, environmental, social and neurobiological antecedents to drug abuse. The study of the co-morbidity of mental illness and drug addiction shows one of the many practical applications of the institute's research.

NIDA has a very broad mission in attempting to evaluate drug abuse across the human lifespan. Though very interested in the impact of drug abuse on the adolescent brain, NIDA is conducting research on the impact of drugs on the neonatal and elderly brain. This broad research spectrum indicates a desire to really understand the brain throughout the entire human life experience. Understanding of this impact is used for intervention development.

Children seem to be the focus of NIDA. This is interesting because it shows the allocation of funds is geared towards those the research has identified as possible for intervention. This was especially shown with the call for research to develop behavioral interventions for pregnant women in drug treatment centers at risk for contracting HIV. The basis for soliciting this research is based more on the unborn children than the mothers.

Understandably much of the drug abuse research is very medical in nature. I found the institutes' mission to understand genetic factors of drug abuse very interesting. As part of it's goals NADA works to bring both medical and behavioral interventions to practitioners helping though with drug abuse problems. Current research funds are now being allocated to integrating the biological sciences with the behavioral and social sciences. Overall, I was fairly impressed with the agency's mix of more technical biological research and the attempts to make advance the research on the behavioral or psychological aspects of drug abuse. Perhaps having a director that is a psychiatrist has contributed to the achievement of this balance.

In the five year mission plan NADA shows a broad vision by continuing to evaluate the impact that drug abuse has on racial and ethnic minorities (http://www.nida.nih.gov/StrategicPlan/StrategicPlan.html#FiveYear). Once concern that I have with the five year plan, as outlined on the website, is the apparent understanding that disseminating information about drug abuse can solve the addictions many people face.. Thought he goal is to provide information in plain English presenting scientific information to the general public I remain skeptical that simply providing such information will act as a drug abuse deterrent. It is my understanding that often individuals who abuse chemicals do not do so when everything is going especially well. Often people use chemical abuse to hide or cover up emotions they are not willing to experience. I am not sure that giving people information on just how much they are harming themselves or their brain structure will act as a deterrent, especially in the case of addiction. While I do not expect the agency to have a magical solution I wonder if it is overly optimistic to expect that information given out about the negative effects of drug abuse will impact drug abusing individuals.

Research Questions

Research Question 1

The research question that I think would be very interesting is actually from National Cancer Institute's extramural funding opportunities section of the website. PA -05-016 titled *decision making in behavioral health* asks for researchers to submit requests for funding to address why patients make medical decisions that are against their doctor's advice. An example of this would be to continue smoking after the patient has been advised that to do so will likely lead to difficulty in cancer treatment and a shortened lifespan. Such decisions seem to be made with an interaction of several factors.

It would be my hypothesis that a lack trust in the heath care system or specifically their doctor could lead the patient to not implement medical advice into their lives. Another factor could be the patient's lack of hope or level of depression. If a patient believes there is little hope for their recovery from cancer then they may not consider making lifestyle or behavioral changes. A way of studding this would be to solicit oncology practitioners at various locations in the country. Nurse recruiters could be used to solicit patients who have just received a cancer diagnosis to become part of the study. Nurses would recruit patients who have been asked to change a behavior in order to increase their chance of successful cancer treatment. Consenting patients would agree to a series of interviews that would be conducted at specified intervals. The first interview would

be conducted as soon as possible with another two interviews scheduled a month apart. The interviews would ask about intentions to make changes, if changes have been made, depression levels, hope, trust in care providers and cancer treatment symptom levels. With consent, the cancer patient's medical record could then be evaluate to determine if they had followed doctors advice or even heard their recommendation. The data would then show which variables are correlated with non-compliance. This research would be conducted using National Cancer Institute funding. The National Institute on Drug abuse could potentially be interested in a similar study if the research was limited to cancer patients and smoking or other drug abuse.

Research Question 2

Another research question that I have been thinking about for some time is what factors impact a cancer patient's ability to seek help from their doctor. Clearly there is a large spectrum of comfort with the medical system. Those who feel comfortable with their cancer care providers will be willing to initiate contact when they have a question or problem. The other end of the spectrum includes individuals who, for a series of reasons, do not feel comfortable seeking medical help to address their symptoms other than scheduled visits. This is a problem because if symptoms are ignored during early stages they can escalate and require emergency attention. Not addressing problematic symptoms can be a medical setback because if a patient experiences a symptom that does have a solution that they do not use, it could add to the overall high symptom levels that make recuperation from cancer difficult. I would like to evaluate the factors that preclude an individual from being an advocate in their cancer care. Identification of individuals who are unlikely to be an advocate for themselves would be helpful for treatment because the provider then could augment treatment with a way of checking in with the patient. Data on age, socio-economic status and previous experience or exposure to the medical system would be collected to determine which factors could impact a person's comfort with the medical system. It is my hypothesis that a lack of exposure to or a negative experience with the medical system could prevent a patient from seeking medical help.

This research question can advance the mission of NCI as it could help meet the goal of supporting projects for cancer control. Information from this research could help to identify the patients that doctors need to target for interventions.

Research Question 3

The third question would be addressed by NIMH. Autism is clearly a disorder that has caught a lot of national attention and NIMH funding. Many states pay for in home service providers to work on behavioral modification techniques with autistic children. The outside service providers are generally independent of the classroom that children are in. It would be interesting to see how much coordination of care is taking place and specifically, if the parents of young autistic children are working with the same behavioral plan. With autism it is important to have consistency in reinforcements. If the parents of young autistic children are not willing to work within the same intervention plan, then the funding is in many respects not utilized to it's full extent.

This would work within the goals of the National Institute of Mental Health has they seek to reduce the burden of treatment non-adherence. Since so much money is being allocated to autism and autism research a key part of responsible spending would be to ensure that, for the most parts, the caregivers of autistic children are comply with the determined treatment protocol. While such caregivers do not have a legal obligation to do so compliance and uniformity would benefit this at risk population.

One of the ways to address this research question would be to call parents or caregivers and interview them over the phone to see how much they agree with and seem themselves working within the treatment plan. In addition to the self reported compliance the independent providers could also be asked to rate the caregiver's participation in the treatment plans. The next step in research, after identifying if this was actually a problem, would be to develop interventions that engage the caregivers in participating.