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BY THE U.S. GENERAL ACCOUNTING OFFICE

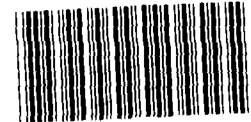
Report To The Honorable Daniel K. Inouye United States Senate

Effectiveness Of Mental Health Clinical Training Programs Cannot Be Evaluated

The National Institute of Mental Health (NIMH) provides support for the clinical training of psychiatrists, psychologists, social workers, and psychiatric nurses. The support is intended to help assure an adequate supply of providers to address certain congressionally directed priorities, including the mental health needs of minorities, children, and the elderly.

While NIMH training program priorities are consistent with the congressional directives, the agency has not developed actual data on program effectiveness, primarily because of cuts in funding for the program--over 70 percent since 1980--and uncertainty about its continuation. GAO is recommending that the agency discuss with cognizant congressional committees the current practices and estimate the costs of developing more reliable data.

In addition, clinical training funds have been used to support individual students through the payment of stipends. Most students receiving stipends are required to provide service to underserved areas or groups following completion of their education. GAO recommends that NIMH develop an adequate system to enforce stipend payback obligations.



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GENERAL ACCOUNTING OFFICE
REPORT TO THE HONORABLE
DANIEL K. INOUYE
UNITED STATES SENATE

EFFECTIVENESS OF MENTAL HEALTH CLINICAL TRAINING PROGRAMS CANNOT BE EVALUATED

DIGEST

Senator Daniel K. Inouye requested GAO to review the extent to which the National Institute of Mental Health (NIMH) has (1) allocated clinical training funds among the traditional mental health disciplines--psychiatry, psychology, social work, and psychiatric nursing--and paraprofessionals during fiscal years 1980-83 and (2) targeted such funds to priority mental health needs.

DATA ON NUMBERS AND LOCATIONS OF MENTAL HEALTH PROVIDERS DO NOT EXIST

When NIMH first began awarding clinical training program grants in 1948, its primary goal was to train an adequate supply of providers in the traditional mental health disciplines. During the 1970's, this goal was broadened to include the training of paraprofessionals, the recruitment of minority mental health providers, and the support of state staff planning and development activities.

Accurate nationwide data on the supply and distribution of the various mental health providers would help NIMH focus its clinical training grants on the disciplines and specialties with identified shortages and in the geographic locations in need of mental health providers. Such comprehensive data, however, have not been developed to date by NIMH or any other organizations, although limited state and regional data have been collected. With this limited data NIMH has a general indication of mental health provider supply and distribution issues, but more precise data would be helpful.

Inherent problems exist in developing nationwide data on the numbers of mental health providers and specialists in the various mental health disciplines. Sizable staff and funding

resources would likely be needed for these efforts. Even with adequate resources, however, except for psychiatrists, identifying mental health providers is a formidable task because:

- --Universal definitions of the various mental health providers do not exist.
- --Licensing/certification requirements for mental health providers vary among the states.
- --Specific information on those who work with or treat the mentally ill is not collected by the states.

Identifying mental health providers, including psychiatrists, who specialize in treating specific patient groups raises additional definition issues.

NIMH CLINICAL TRAINING PROGRAMS EXPERIENCED FUNDING AND STAFF DECREASES DURING FISCAL YEARS 1980-83

The NIMH clinical training programs have experienced significant budget decreases during the 1980's. In fiscal year 1980, $72 million was appropriated for this program. In fiscal year 1983, $20.7 million was appropriated. Staff resources and administrative funding for the NIMH clinical training programs also were decreased, and as a result, the program's management has been affected. Although NIMH has been able to perform its basic duties of processing grant applications, awarding grants, and providing general guidance to grantees, other activities, including data collection, on-site visits, and systematic formal communication, have been curtailed.

ALLOCATION OF FUNDS AMONG TRADITIONAL MENTAL HEALTH DISCIPLINES

NIMH's Division of Human Resources (formerly the Division of Manpower and Training Programs) has principal responsibility for the NIMH clinical training programs. The Division of Prevention and Special Mental Health Programs also funds a few clinical training grants each year. Clinical training funds are allocated annually among the various education branches

and centers within these two divisions. The funds allocated by the education branches to the four traditional mental health disciplines during fiscal years 1980-83 were:

	(millions)
Psychiatry	$ 61.1
Psychology	26.3
Social work	29.5
Psychiatric nursing	22.3
Total	$139.2

NIMH HAS NOT DEVELOPED RELIABLE DATA ON THE EXTENT TO WHICH GRANT FUNDS WERE SPENT ON PRIORITIES

To encourage mental health providers to work in areas of greatest need and to give them the knowledge and skills needed to deal with a wide range of mental health problems, in 1978 the President's Commission on Mental Health recommended that:

--Federal support for students in the traditional mental health professions be either loans or scholarships (stipends) which could be repaid through service in designated geographic areas or facilities where shortages exist.

--Grants and contracts to educational institutions for the training of mental health specialists be awarded to programs specifically aimed at meeting the needs of underserved populations, such as children, adolescents, the elderly, and minorities.

--Mental health training programs be redirected to increase the number of qualified minorities in the mental health disciplines.

As a result of these recommendations and the recognition that certain groups and areas had especially acute mental health needs, the Congress has directed NIMH since fiscal year 1980 to use clinical training grant funds to address the needs of minorities, children, the elderly, the chronically mentally ill, rural areas, and public mental health programs.

For fiscal years 1980-82, NIMH estimated that about (1) $77.4 million in grants were targeted to the mental health needs of children, the elderly, and minorities (see p. 21); (2) $51.1 million in grants were targeted to the needs of underserved rural and urban areas and the chronically mentally ill and encouraging trainees to work in public facilities (see p. 30); and (3) $21.4 million in grants were for projects related to general health care and the education of primary health care providers (see p. 29). These data were based primarily on the plans and estimates included in grant applications. According to NIMH, it has not developed data on, or a system for determining, to what extent project funds were used for priorities because the clinical training program has experienced significant funding and staff decreases during the 1980's.

According to NIMH officials, estimates of typical class enrollments were used to develop data on the numbers of trainees, other than those receiving stipends, who benefited from clinical training projects. NIMH has not determined the actual number of trainees who benefited. Grantees were not requested to provide actual enrollment information concerning these projects. The data developed by NIMH on the number of nonstipended trainees, total individuals trained, and average cost per individual trained for all of the mental health disciplines were all based on estimates. (See p. 13.)

NIMH said that it allocated clinical training grant funds in line with congressional priorities and its own assessments of the mental health field. NIMH policy encourages participants of clinical training projects to work in underserved locations, but NIMH does not routinely follow up with grantees or trainees to determine where the trainees begin their mental health service careers after graduation. Furthermore, except for trainees who receive stipends with a payback obligation, grantees and trainees generally are not required to provide this information. As a result, NIMH cannot determine whether the clinical training grant program is helping to alleviate shortage and maldistribution problems relating to mental

health providers and cannot develop adequate data for the Congress concerning the program's effectiveness.

The continued funding of the NIMH clinical training program has been uncertain. The administration in fiscal year 1983 proposed to terminate the program, but the Congress appropriated funds for the program. During fiscal years 1980-83, the Congress identified 18 specific mental health service priorities. (See p. 15). Because of the uncertainty about the continuation of the program and funding and staffing decreases during the 1980's, NIMH developed little information on the extent to which the program was satisfying congressional priorities.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Recognizing the controversy over the continuation of the program, the funding and staffing decreases that have occurred, and the potential expense of collecting data on program effectiveness, GAO is recommending that the Secretary

--discuss with cognizant congressional committees the acceptability of continuing to use estimates as the bases for measuring program effectiveness and

--instruct the Director, NIMH, to estimate the funds and staff needed to develop reliable data to measure program effectiveness for the Congress to consider.

AGENCY COMMENTS

The Department of Health and Human Services concurred with GAO's recommendations, provided the NIMH clinical training program is continued after September 30, 1984. The Department qualified its agreement to implement the recommendations because the President's budget for fiscal year 1985 again recommended that this program be terminated. (See p. 19.)

NIMH DOES NOT HAVE A SYSTEM TO MONITOR AND ENFORCE STIPEND PAYBACK OBLIGATIONS

NIMH clinical training funds have been awarded both for institutional support (that is, faculty and curriculum development) and for student support through stipends. Since fiscal year 1981, most students receiving stipends have been required to pay them back through service to underserved areas and populations. During fiscal years 1981-82, about $31 million in stipends and other trainee costs was awarded to trainees, most of whom have a payback obligation. (See p. 32.)

NIMH, however, does not have an adequate system to assure that trainees will pay back their stipends. Due to funding and staffing constraints, NIMH's monitoring and enforcement of these payback obligations is handled through a manual system that is maintained by one staff member with part-time administrative support. Because of the volume of stipends awarded annually, delays in obtaining trainee data from grantees and trainees, and the need to review the data submitted, GAO concluded that NIMH will have difficulty carrying out its responsibilities unless improvements are made to the system and the way information is obtained.

RECOMMENDATION TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

GAO is recommending that the Secretary direct the Director, NIMH, to develop a system requiring recipients of stipends with payback obligations to report to NIMH, in a timely fashion, how they are satisfying that obligation and a system for monitoring this process and enforcing the payback obligation.

AGENCY COMMENTS

The Department of Health and Human Services concurred with this recommendation and stated that NIMH will award a contract early in fiscal year 1985 to implement its recently designed monitoring and payback system. (See p. 39.)

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ABBREVIATIONS

GAO	General Accounting Office
HHS	Department of Health and Human Services
NIMH	National Institute of Mental Health

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CHAPTER 1

INTRODUCTION

The National Institute of Mental Health (NIMH) has awarded clinical training grants since 1948. At that time, the grant program's primary goal was to train an adequate supply of mental health professionals--psychiatrists, psychologists, social workers, and psychiatric nurses. During the 1970's this goal was broadened to include the training of paraprofessionals, the recruitment of minority mental health providers, and the support of state staff planning and development activities.

As a result of the 1978 recommendations of the President's Commission on Mental Health (see p. 8) and the recognition that the need for mental health services was especially acute for certain populations and areas, the Congress has directed NIMH since fiscal year 1980 to use clinical training grant funds to address the mental health needs of minorities, children, the elderly, the chronically mentally ill, rural areas, and public mental health programs.

OBJECTIVES, SCOPE, AND METHODOLOGY

Senator Daniel K. Inouye requested that we review the management of the NIMH clinical training program to determine (1) how NIMH allocated clinical training funds among the traditional mental health disciplines--psychiatry, psychology, social work, and psychiatric nursing--and paraprofessionals during fiscal years 1980-83 and (2) to what extent these funds have been targeted for minority providers; child, geriatric, and minority specialists; and various preventive activities. We were also asked to analyze NIMH data on the allocation of funds to the mental health disciplines and the congressional priorities and to determine how accurate the data were and how they were developed. Moreover, we were asked to report on available mental health personnel supply and distribution data.

To explore the issues related to NIMH support for clinical training and the manner in which the program has been administered, we interviewed officials in the Alcohol, Drug Abuse, and Mental Health Administration, representatives of the major mental health professional and advocacy organizations, and experts on specific issues related to clinical training.

We reviewed data on the obligation and expenditure of clinical training funds and summaries of accepted, approved, and funded grant applications. We analyzed data and studies on the supply and distribution of mental health providers. We reviewed

the NIMH clinical training data furnished to congressional committees during the 1980's. We also obtained from NIMH officials the rationale for allocating clinical training funds and establishing funding priorities. Much of the clinical training information in our report was provided to Senator Inouye by NIMH in January 1983. Our review was performed in accordance with generally accepted government auditing standards.

NIMH CLINICAL TRAINING FUNDING HAS DECREASED ANNUALLY SINCE FISCAL YEAR 1980

About $197.5 million was awarded for all NIMH clinical training programs during fiscal years 1980-83. The amounts awarded decreased from $72.1 million in fiscal year 1980 to $20.7 million in fiscal year 1983.

Clinical training grant applications submitted to NIMH are examined by a review group and the NIMH National Advisory Council. Grants may be approved for 1 or more years. Those approved for more than 1 year, referred to as continuation grants, do not have to compete with other grants for funding. When a multiyear grant terminates, a grantee may reapply for grant funds. These and new applications are referred to as competing grant applications or renewals because the applicants are in direct competition for available funds.

During fiscal years 1981-82, the Congress directed NIMH to use most available funds for continuation grants. As a result few new grants or competing renewal grants were funded to address new initiatives or priorities. The administration proposed to terminate the clinical training program in fiscal year 1983; however, the Congress disagreed and funds were appropriated. In fiscal year 1983, NIMH was directed by the Congress to award clinical training grants through competition, with few exceptions. The following table shows the amounts and percentages of competing and noncompeting grants awarded by NIMH in recent years.

NIMH Clinical Training Program
Competing and Noncompeting Grants
Fiscal Years 1980-83

Fiscal year	Type of award: Competing Amount (millions)	Competing Percent	Noncompeting Amount (millions)	Noncompeting Percent	Total amount (millions)
1980	$17.7	25	$ 54.4	75	$ 72.1
1981	6.5	10	55.9	90	62.4
1982	3.4	8	38.9	92	42.3
1983	15.8	76	4.9	24	20.7
Total	$43.4		$154.1		$197.5

ALLOCATIONS OF CLINICAL TRAINING FUNDS BY MENTAL HEALTH DISCIPLINES AND SPECIAL PROGRAMS

The Division of Human Resources (formerly the Division of Manpower and Training Programs) has major responsibility for NIMH's clinical training programs. It administers and supports programs in planning, developing, training, and using mental health personnel to meet mental health service delivery system and research needs. These programs include (1) funding training in the traditional mental health disciplines and related fields; (2) providing technical and financial assistance to states, local governments, service agencies, and training institutions; and (3) supporting research and demonstration projects. The division also collects and analyzes data and conducts studies related to nationwide perspectives and needs regarding mental health staff planning, training, development, and utilization.

Until May 1983 the division consisted of the following eight branches and centers:

--Psychiatry Education Branch.

--Psychology Education Branch.

--Social Work Education Branch.

--Psychiatric Nursing Education Branch.

--Paraprofessional Manpower Development Branch.

--Center for State Mental Health Manpower Development.

--Center for Mental Health Services Manpower Research and Development.

--Mental Health Research Manpower Branch.

The four education branches support programs to develop, educate, and train the four types of mental health professionals. The Paraprofessional Manpower Development Branch funds the development and training of several types and levels of mental health paraprofessionals. The Center for State Mental Health Manpower Development was established in 1978 to stimulate and support state mental health resource development by providing staff resources in state government; encouraging needs assessments, new initiatives, and strategies for training and resource development; providing continuing education; and establishing new alliances among the state agencies and training institutions. The Center for Mental Health Services Manpower Research and Development supports model projects and research studies on mental health training issues and projects to test model approaches on broad staff development issues, including distribution, recruitment, and utilization. The Mental Health Research Manpower Branch does not award clinical training grants.

The following table shows the levels of funding for clinical training within the Division of Human Resources in fiscal years 1980-83.

Division of Human Resources
Clinical Training Program Grant Awards
Fiscal Years 1980-83

Education branch/center	Fiscal year 1980	1981	1982	1983
	(millions)			
Psychiatry	$22.5	$20.3	$12.9	$ 5.4
Psychology	9.8	8.3	5.8	2.4
Social Work	10.6	9.5	6.9	2.7
Psychiatric Nursing	7.8	7.1	5.3	2.1
State Manpower	6.2	6.4	4.6	4.2
Paraprofessionals	2.8	2.1	1.7	0.5
Manpower Research and Development	6.3	4.1	2.5	0.7
Total	$66.0	$57.8	$39.7	$18.0

Each year during fiscal years 1980-82, the Psychiatry Education Branch spent at least 30 percent of the total funds available to the division, the Psychology and Social Work Education Branches each spent from 13 to 16 percent, and the Psychiatric Nursing Education Branch spent about 10 percent. In fiscal year 1983 each of the traditional mental health disciplines was allocated relatively less than in previous years because for the first time NIMH allocated funds for additional purposes--namely, the development of child, geriatric, and minority mental health resources.

The Psychology Education Branch in fiscal years 1980-82 used most of its funds to support doctoral and internship programs. During that time the Social Work and Psychiatric Nursing Education Branches concentrated on supporting programs at the master's degree level. Meanwhile, the Psychiatry Education Branch awarded grants in medical student education, consultation/liaison projects,[1] and basic residency programs.

In 1967 the Division of Special Mental Health Programs was established to deal with social problems of major concern to the nation. At the time of our review, this division (now the Division of Prevention and Special Mental Health Programs) was involved in seven problem areas of direct relevance to mental health. These include meeting the needs of children and families, the elderly, minorities, and disaster victims and dealing with problems related to crime and delinquency, rape, and the work environment. Five of this division's centers awarded clinical training grants during fiscal years 1980-83: the Center for Minority Group Mental Health Programs, the Center for Studies of Mental Health of the Aging, the Center for Studies of Crime and Delinquency, the Center for Work and Mental Health, and the National Center for the Prevention and Control of Rape.

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[1]These are projects aimed at increasing the mental health skills and knowledge of general health care physicians and preparing psychiatrists to work more effectively in the health care field.

The following table shows the distribution of clinical training grants during these fiscal years.

Division of Prevention and Special Mental Health Programs
Clinical Training Program Grant Awards
Fiscal Years 1980-83

Center	Fiscal year 1980	1981	1982	1983	Total
Minority Groups	$3,861,262	$2,404,475	$1,368,888	$1,200,001	$ 8,834,626
Aging	929,931	766,599	491,521	1,492,339	3,680,390
Crime and Delinquency	714,809	732,839	271,229	-	1,718,877
Work and Mental Health	682,419	649,513	256,987	-	1,588,919
Rape	-	-	164,064	-	164,064
Total	$6,188,421	$4,553,426	$2,552,689	$2,692,340	$15,986,876

Of the $8.8 million expended by the Center for Minority Group Mental Health Programs in fiscal years 1980-83, about $5.8 million was for clinical grants awarded through the Minority Fellowship Program. In this program the center awarded funds to the American Psychiatric Association, the American Psychological Association, the Council on Social Work Education, the American Nursing Association, and the American Sociological Association.

NIMH CLINICAL TRAINING PROGRAMS' ADMINISTRATIVE RESOURCES HAVE DECREASED

The staff resources and administrative funding for NIMH's clinical training programs have decreased during the last few years. The Office of Extramural Project Review arranges and coordinates Initial Review Group meetings and also summarizes each application reviewed by the National Advisory Council. In fiscal year 1980, this office was allocated 14.5 full-time equivalent employees and about $1 million to carry out its clinical training review responsibilities. In fiscal year 1981, the office was allocated 14 full-time equivalent employees and about $700,000 for this purpose. In fiscal years 1982 and 1983, no staff were provided for clinical training review activities, and $74,500 and $200,000 were allocated, respectively, to cover the expenses related to the Initial Review Group meetings.

No funds were budgeted for site visits by reviewers in fiscal year 1983. To carry out its grant review activities, the Office of Extramural Project Review borrowed staff from other

NIMH units. In that year, 27 professional and 39 clerical staff members were temporarily reassigned to staff review panels and to otherwise help process NIMH clinical training grants. In addition, 15 consultants assisted in the review process. Staff members from outside the office devoted about 18,000 hours to reviewing clinical training program grants.

In fiscal year 1980 the Division of Human Resources had 39 full-time staff and about $1.8 million to administer the clinical training program. In fiscal year 1983, the division was authorized 23 full-time staff and about $1.5 million for that purpose. The Division of Prevention and Special Mental Health Programs, which funds relatively few clinical training grants, also experienced slight staffing and administrative funding decreases.

Despite the staffing and administrative funding decreases in the clinical training program, NIMH has performed its basic duties of processing grant applications, awarding grants, and providing general guidance to grantees. According to NIMH, however, other activities necessary for effectively managing the program have been curtailed because of these decreases. For example, (1) on-site evaluations to monitor ongoing clinical training projects are seldom arranged unless serious problems occur and (2) communication with grantees is irregular after the grants are awarded and varies among the mental health disciplines. Furthermore, although formal reports on program accomplishments or benefits that occurred as a result of the grants are required at the end of the grant periods, a standard format to obtain these data from grantees and trainees has not been designed by NIMH.

In the absence of these activities, NIMH has not gathered data from grantees to measure the effectiveness of the clinical training programs and adequately monitor various aspects of its programs, including stipend payback obligations. Details concerning these issues are discussed in the following chapters.

CHAPTER 2

LIMITED DATA AVAILABLE TO MEASURE EFFECTIVENESS OF NIMH CLINICAL TRAINING PROGRAMS

During the 1970's, the supply and distribution of mental health providers surfaced as important issues needing to be addressed. However, NIMH and other organizations in the mental health field have developed only limited data on the effectiveness of efforts to increase the numbers of mental health providers and influence where they practice. The Congress has directed NIMH to focus the funding of clinical training grants on specific priorities, and NIMH, through its annual clinical training grant announcements, has provided guidance to applicants on implementing these priority directives. Yet NIMH has not developed data on the amounts grant recipients spent to meet established priorities or the numbers of trainees benefiting from the grants. According to NIMH the data have not been developed largely because of funding and staff decreases that the clinical training program experienced annually in the 1980's.

NIMH CLINICAL TRAINING PROGRAMS' PRIORITIES ARE CONSISTENT WITH RECOMMENDATIONS OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH

In 1978, the President's Commission on Mental Health concluded that (1) geographic maldistribution of providers was the major mental health personnel problem facing the country; (2) public mental health facilities, particularly state mental hospitals and community mental health centers, were often unable to recruit and retain personnel; (3) not enough mental health specialists were being trained to treat children and the elderly; (4) more minorities needed to be trained as mental health providers; and (5) more effort was needed regarding the prevention of mental illness.

To encourage mental health practitioners to work in areas of greatest need and to give them the knowledge and skills to deal with a wide range of mental health problems, the President's Commission recommended that:

- --Federal support for students in the traditional mental health professions be either loans or scholarships (stipends) which could be repaid by a period of service in designated geographic areas or facilities where shortages exist.

--Grants and contracts to educational institutions for the training of mental health specialists be awarded to programs specifically aimed at meeting major service delivery priorities or the needs of underserved populations, such as children, adolescents, and the elderly.

--Mental health training programs be redirected to increase the number of qualified minorities in the mental health disciplines.

Beginning in 1979, NIMH announcements of the availability of clinical training grants paraphrased the Commission's report and emphasized the need to redirect federal mental health personnel policy along the lines of those recommendations. With priorities being specified came the need to develop additional data to measure the effectiveness of the clinical training programs. According to NIMH, however, it has been unable to collect these data because of staffing and funding limitations.

ACCURATE DATA ON NUMBERS AND LOCATIONS OF MENTAL HEALTH PROVIDERS DO NOT EXIST

Although some attempts have been made, no comprehensive information has been compiled on the numbers of practicing mental health providers or specialists in the various mental health disciplines. Some data on the numbers of mental health providers and where they practice are compiled by the professional associations that represent them, but this information is limited. Accurate information does not exist on mental health providers who specialize.

The President's Commission on Mental Health identified mental health specialists in all disciplines as being in short supply and recommended that psychiatry be considered a medical shortage specialty. In 1980 the Graduate Medical Education National Advisory Committee[1] also indicated that psychiatry should be considered a shortage specialty and suggested that more information be developed regarding the numbers of other mental health providers, where they practice, and the potential for substituting nonmedical for medical mental health providers whenever possible. The Congress also recognized the need for accurate mental health provider data to identify mental health personnel shortage areas.

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[1]The Committee was established in 1976 to advise the Secretary of Health and Human Services (HHS) on the numbers of physicians required in each specialty and develop methods to improve the geographic distribution of physicians and mechanisms to finance graduate medical education.

Inherent problems exist in developing nationwide data on the numbers of mental health providers and specialists in the various mental health disciplines. Sizable staff and funding resources would likely be needed for these efforts. Even with adequate resources, however, except for psychiatrists, identifying mental health providers is a formidable task because

--universal definitions of the various mental health providers do not exist,

--licensing/certification requirements for mental health providers vary among the states, and

--specific information on those who work with or treat the mentally ill is not collected by the states.

Identifying mental health providers, including psychiatrists, who specialize in treating specific patient groups raises additional definition issues. Nevertheless, NIMH, through its clinical training program, and several professional associations have attempted to collect information on supply, distribution, and specialists.

NIMH awarded a contract in 1977 to the American Psychiatric Association to develop information on the number and location of practicing psychiatrists, but a final report was never issued because the contractor found that certain survey data were inaccurate. In 1982, NIMH awarded a contract to develop information on the number and location of practicing psychiatrists, but no results have been reported. The Health Resources and Services Administration, in collaboration with NIMH, awarded a contract in 1982 to obtain information on the number and location of practicing psychologists. The preliminary results of this study are expected in 1984. NIMH officials were not aware of any attempts to obtain comparable comprehensive information regarding the numbers and locations of social workers, psychiatric nurses, or mental health paraprofessionals.

Professional associations have undertaken surveys of their members to determine their locations and specialties. These efforts, however, have not collected uniform data because (1) certain providers have not been included, (2) information on certain specialties has not been obtained, and/or (3) the surveys' scope and purposes have varied.

Nevertheless, the best estimates of the numbers of practicing mental health providers nationwide come from the providers' professional associations--the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, and the American Nursing Association. According to these associations, nationwide, there are about

--34,000 psychiatrists,

--34,000 health service provider psychologists,

--30,000 clinical social workers (that is, mental health service providers), and

--6,000 psychiatric nurses with at least a master's degree.

NIMH estimated that in 1980 there were about 150,000 paraprofessionals employed in mental health settings. This group generally includes mental health workers, licensed practical nurses, certain counselors, and activity therapists.

None of the associations had developed firm data on the numbers of mental health providers who specialized in treating certain types of patients. However, the Academy of Child Psychiatry told us that there are about 3,200 child psychiatrists. The American Psychological Association estimated that 5,000 doctoral-level psychologists provided some service to children as part of their practice. The NIMH Center for Mental Health of the Aging estimated there were 500 geriatric psychiatrists. A national study of psychologists in the late 1970's showed that about 400 psychologists concentrated on working with the elderly, but that few had been trained in gerontology. Data on the total number of minority mental health providers or those who specialize have not been developed for any discipline.

While more accurate information is needed on where mental health providers are located, individual states and regional groups have developed some information which indicates that maldistribution of such providers is a problem. For example, the state of Ohio and the Western Interstate Commission on Higher Education reported that some rural counties and catchment areas have no full-time psychologists or psychiatrists. Surveys show that a high proportion of psychiatrists and psychologists are clustered in several states and in large metropolitan areas. NIMH has documented that many psychiatrists employed in state hospitals and other public settings have resigned to work for private organizations or to establish private practices.

Where they obtain their training and related experience appears to influence where mental health professionals ultimately practice. Several studies show that the mental health providers most likely to practice in shortage areas and public settings are those who received their training in these underserved areas. Similarly, trainees with geographical or cultural ties to an underserved area are most likely to practice there.

NIMH believes that clinical training grants can help to alleviate maldistribution problems when given (1) to recipients with cultural and geographic ties to underserved areas, (2) in support of training experiences at facilities within underserved areas, and (3) to outstanding faculty to teach in these areas. Information developed through various studies suggested that several nontraining initiatives can also help resolve maldistribution problems. Some of these initiatives included:

--Establishing affiliations involving universities and underserved service areas, not only for basic education and training, but also for continuing education and consultation.

--Expanding private insurance and Medicare/Medicaid programs' reimbursement for mental health services.

--Encouraging a multidisciplinary approach among mental health providers and primary health care providers to solve mental health problems.

--Developing incentives for mental health professionals to practice in underserved locations.

--Considering the possibilities for substituting mental health personnel.

NIMH HAS LITTLE DATA ON THE SUBSTITUTABILITY OF MENTAL HEALTH PROVIDERS

"Substitutability" concerns the degree to which the roles and functions performed by mental health providers from various disciplines overlap and the extent to which a provider from one discipline may assume the responsibilities and tasks usually carried out by a provider from another discipline. This concept appears to have considerable relevance to the issues of staff resource supply and distribution. The Graduate Medical Education National Advisory Committee recommended in 1980 that data be gathered on the substitutability of mental health providers. To date, however, NIMH has not studied this issue in depth.

A few studies have been undertaken with NIMH funds on the tasks and functions commonly performed by professional and paraprofessional mental health providers. NIMH analyses have documented a movement over the years to substitute other mental health professionals for psychiatrists in public settings. Some training experts have commented on the trend to identify mental health positions in general terms--for example, case manager and emergency service director--rather than by specific disciplines.

In September 1983 the Health Resources and Services Administration awarded a contract to develop revised criteria for designating mental health resources shortage areas. One of the contract's objectives will be to develop measures for evaluating the relative contributions of various providers.

NIMH HAS NOT DEVELOPED RELIABLE DATA ON PERSONS BENEFITING FROM ITS CLINICAL TRAINING GRANTS

According to NIMH officials, estimates of typical class enrollments were used to develop data on the numbers of trainees, other than those receiving stipends, who benefited from clinical training projects. NIMH did not determine the actual number of trainees. Grantees were not requested to provide actual enrollment information concerning these projects.

NIMH told us that it has not developed data on persons benefiting from its clinical training grants because (1) before fiscal year 1980, the data were not necessary since mental health priorities were not identified and (2) since fiscal year 1980, significant budget and staff decreases have prevented NIMH from allocating resources to develop such data. Because actual data are not developed, NIMH is not certain of the extent to which the mental health priorities identified by the Congress are being addressed by grantees.

The data provided to Senator Inouye in January 1983 on the number of nonstipended trainees, total physicians/individuals trained, and average cost per physician/individual trained for all of the mental health disciplines were based on NIMH estimates. To illustrate, for consultation/liaison grants to train psychiatrists, NIMH estimated that each grant would benefit 86 trainees. That figure was based on NIMH's estimate of the typical class size in medical schools. Accordingly, in fiscal year 1982, NIMH multiplied the 64 consultation/liaison grants by 86 trainees and estimated that 5,504 physicians would benefit from these projects. Since 17 stipends were included in these 64 grants, NIMH subtracted 17 from 5,504 and arrived at 5,487 as the "estimated number of nonstipended trainees" who benefited.

To develop the "cost per physician trained," NIMH divided the total funding of the 64 grants--$2,807,894--by the 5,504 trainees and came up with an average cost per physician trained of $510. For psychology, social work, and psychiatric nursing, different average enrollment numbers and funding figures were used to develop this information, but the same methodology, based on average class size, was used to develop the estimates.

For medical student education grants in psychiatry, NIMH said a different method was used to develop an estimate of the number of trainees who benefited from the clinical training grants. In fiscal year 1980, 100 of the 126 medical schools (79.37 percent) received medical student education clinical training grants. NIMH estimated that about 65,497 medical students were enrolled at these universities. It multiplied 65,497 by 79.37 percent and estimated that 51,982 medical students were trained through these 100 grants. The grants totaled $5,403,125. To derive the average cost per physician trained, NIMH divided that amount by 51,982 medical students to arrive at an average of $104 for each physician trained.

NIMH DOES NOT GATHER DATA ON WHERE PARTICIPANTS IN CLINICAL TRAINING PROJECTS PRACTICE

NIMH told us that it allocated clinical training grant funds in line with congressional priorities and its own assessments of the mental health field. But because of funding and staff constraints, it has not gathered data on where participants in its clinical training projects begin their careers.

NIMH policy encourages participants in clinical training projects to work in underserved locations, but except for trainees with a stipend payback obligation, NIMH does not follow up with grantees or trainees to determine where the trainees work after graduation. Furthermore, except for trainees who receive stipends with a payback obligation, grantees and trainees generally are not required to provide this information. As a result, NIMH cannot determine whether the clinical training grant program is helping to alleviate shortage and maldistribution problems relating to mental health providers. A trainee with a payback obligation is expected to keep NIMH apprised annually of the location and setting where mental health services are provided to ensure that the payback requirement is satisfied. (See p. 37.)

NIMH clinical training grants could help alleviate the recognized shortage and maldistribution problems of mental health providers. But until NIMH develops data on where mental health providers practice, it has no way of knowing whether its grant program is effective.

ACCURATE DATA ARE NOT AVAILABLE TO SHOW EXTENT TO WHICH CLINICAL TRAINING GRANTS SATISFY CONGRESSIONAL DIRECTIVES

During fiscal years 1980-83, the Congress identified specific funding priorities for the NIMH clinical training program. These priorities generally paralleled the recommendations of the President's Commission on Mental Health. Some priorities were specified in all 4 fiscal years, while others were added or deleted each fiscal year. For fiscal years 1980-82, NIMH estimated the number of grants and funding amounts that addressed the various priorities. These data were based primarily on estimates in grant applications. NIMH did not develop data on the extent to which project funds were actually used for priorities.

While funding for NIMH's clinical training program decreased each year, the number of priorities to be addressed increased annually. The Congress' directives do not specify precise dollar amounts to be spent on each priority. The table below shows the congressional priorities established for each fiscal year.

Priority	Fiscal year			
	1980	1981	1982	1983
State manpower development	X	X	X	X
Primary care providers	X			
Shortages in all disciplines	X			
Minority providers	X	X	X	X
Minority Fellowship Program	X	X	X	X
Innovative training	X		X	X
Paraprofessionals		X	X	X
Geriatric training		X	X	X
Short supply/underserved specialties		X	X	X
Stipend payback		X		X
Criteria for designating personnel shortage areas		X	X	
Underserved areas--state hospitals, community mental health centers, rural areas		X	X	X
Child-oriented training			X	X
Disadvantaged students			X	X
Psychiatric nurses			X	
Targeted grants for specific development activities				X
Prevention				X
Equitable support of four traditional branches				X

NIMH has responded to the priority directives in several ways. First, it continued to emphasize special programs for some priorities, such as the Minority Fellowship Program and the State Manpower Development Program. Second, it gave preference to clinical training applications that concentrated on addressing specific priorities. For instance, in fiscal year 1982, NIMH officials told us that no competing applications were accepted for review which did not plan to focus on one or more of the designated priorities in the clinical training grant announcements. Third, NIMH organized special interdisciplinary groups to review fiscal year 1983 grant applications for projects that focused on children, minorities, and geriatrics.

NIMH fiscal years' 1980-82 clinical training grant announcements, which publicized the availability of funds for potential applicants, contained information stressing the types of priorities that grant projects should address. Upon receiving the grant applications, NIMH analyzed the planned objectives for each grant and estimated the percentage of each project that proposed to address each priority. According to NIMH, grant applications that did not address any of the designated priorities were usually returned to the applicants and were not further considered. The grant applications accepted for further review were approved or disapproved by the Initial Review Groups on the basis of their perceived scientific merit and were given a priority rating on the basis of their quality. Decisions on the total funding for each mental health discipline and on the funding for each grant were made by the NIMH Office of the Director and/or Division of Human Resources program staff.

After the grants were awarded, NIMH tallied the estimated funds which were to address each priority area, as spelled out in the grant applications, and developed the information included in the table on the following page. As discussed on page 18, these are judgmental estimates. According to NIMH, it did not systematically obtain information from grantees on how the grant funds were used in addressing the priorities because of funding and staff constraints.

Distribution of Clinical Training Funds Among Priorities
As Estimated by NIMH
Fiscal Years 1980-82

Priority	Fiscal year 1980[a]	1981	1982	Total
	(millions)			
Underserved rural areas	$10.8[b]	$5.6	$4.3	$28.0
Underserved urban areas		4.4	2.9	
Children and youth	8.7	7.3	5.1	21.1
Aged	2.7	3.2	2.2	8.1
Services to minorities	12.4[b]	5.8	3.7	35.9
Increase supply of minority providers		8.1	5.9	
Chronically mentally ill	5.3	4.4	3.1	12.8
Staffing public facilities	4.3	3.5	2.4	10.2
Crime and delinquency	0.4	0.7	0.3	1.4
Prevention	2.5	2.4	1.4	6.3
General health-primary care	9.3	8.4	5.3	23.0
Staff development systems	4.9	4.6	3.5	13.0
Information, data, innovative models	1.3	1.4	0.9	3.6
Nontargeted general education[c]	2.5	1.5	0.8	4.8

[a]Only Division of Human Resources' priorities were compiled for fiscal year 1980, according to NIMH.

[b]In fiscal year 1980, these priorities were combined.

[c]These were all noncompeting, continuation grants.

According to NIMH officials, in fiscal years 1980-82 most funded grant projects addressed one or more of the above priorities. When only one priority was addressed in a grant application, NIMH assumed that all of the grant funds were devoted to that priority. When more than one priority was addressed, NIMH judgmentally divided the total amount of funding requested among the priorities. In some cases, the funds were divided proportionately. For example, in a grant to train individuals to work with minority children in rural areas, one-third of the funds requested would be attributed to children, one-third to minorities, and one-third to rural areas. NIMH officials pointed out that in this overlapping priorities example, the amount of the grant funds attributed to each priority may have been understated.

The total funding of other grants addressing more than one priority was divided among the priorities disproportionately. For example, the funding of a grant to train individuals to serve minority elderly persons in a poor, underserved section of an inner city may have been divided as follows: 50 percent to minorities, 30 percent to the elderly, and 20 percent to underserved inner cities. NIMH officials told us that for grants that did not have overlapping priorities, the estimated proportions attributable to each priority were more obvious.

After a grant was funded, because NIMH did not obtain data from grantees and trainees, it had no systematic way to determine whether the grantee addressed priority areas as planned. NIMH seldom evaluated projects during or after the grant periods, so it had no formal way to determine to what extent the targeted populations or geographic areas mentioned in the grant applications benefited from the grant and whether the planned purposes were achieved. While NIMH requires grantees to submit annual progress reports when they apply for funds to continue their projects in later fiscal years, the reports vary in scope and content because NIMH has not designed a standard reporting format. NIMH officials acknowledged that an adequate reporting system to enable them to know whether grantees addressed the priority areas as planned does not exist.

CONCLUSION

According to NIMH, funding and staffing uncertainties and decreases during the 1980's have adversely affected the management of its clinical training programs and the collection of data. In particular, NIMH has developed limited information on the effectiveness of its clinical training programs to increase the numbers of mental health providers and influence where they practice. Also, NIMH has developed limited data on the amounts grant recipients have spent to meet congressional priorities or

the numbers of trainees benefiting from the grants. Rather, the information developed was based primarily on estimates derived from grant applications.

To collect data from grantees and trainees would likely be expensive, and the NIMH clinical training program as it is now funded and staffed is not in a position to take on these tasks. On the other hand, unless NIMH develops actual data from grantees and trainees, it will have no assurance that its clinical training programs are addressing congressional priorities and/or helping to alleviate mental health supply and distribution problems.

RECOMMENDATIONS TO THE SECRETARY OF HHS

Recognizing the controversy over the continuation of the program, the funding and staffing decreases that have occurred, and the potential expense of collecting data on program effectiveness, we recommend that the Secretary

--discuss with cognizant congressional committees the acceptability of continuing to use estimates as the bases for measuring program effectiveness and

--instruct the Director, NIMH, to estimate the funds and staff needed to develop reliable data to measure program effectiveness for the Congress to consider.

AGENCY COMMENTS

HHS concurred with our recommendations, provided the NIMH clinical training program is continued after September 30, 1984. The Department qualified its agreement to implement the recommendations because the President's budget for fiscal year 1985 again recommended that this program be terminated. (See app. I.)

CHAPTER 3

NIMH EFFORTS TO TRAIN PROVIDERS TO MEET NEEDS OF CERTAIN TARGET GROUPS, AREAS, AND ACTIVITIES

NIMH estimated that during fiscal years 1980-83 most of the clinical training grants were targeted to meet the needs of underserved groups and areas or focused on specific priority activities. NIMH, however, has not developed data on how grant funds were used. Information concerning NIMH estimates of the extent to which clinical training grants addressed congressional priorities and examples of related clinical training grant projects follow.

NIMH EFFORTS TO TRAIN PROVIDERS TO CARE FOR CHILDREN, THE ELDERLY, AND MINORITIES

NIMH estimated that during fiscal years 1980-83, grants totaling about $77.4 million were awarded for projects intended to address the training of mental health providers to care for children, the elderly, and minorities. Although the exact mental health needs of these groups have not been determined, mental health experts generally agree that more mental health providers are needed to treat these underserved groups. In fiscal year 1983, NIMH specifically allocated funds for projects that planned to address the needs of minorities, the elderly, or children. The following information represents NIMH's estimates of the extent to which funds were used to address these priorities.

NIMH Estimates of Clinical Training Funds Awarded to Address the Needs of Minorities, the Elderly, and Children and Percentage of Total Funding for Fiscal Years 1980-83

Priority	Fiscal year 1980		Fiscal year 1981		Fiscal year 1982		Fiscal year 1983		Total	
	Amount (millions)	Percent	Amount (millions)	Percent	Amount (millions)	Percent	Amount (millions)	Percent	Amount (millions)	Percent
Minorities	$16.3	22.6	$13.9	22.3	$ 9.6	22.7	$2.5	12.1	$42.3	21.4
Elderly	3.7	5.1	3.2	5.1	2.2	5.2	2.3	11.1	11.4	5.8
Children	8.7	12.1	7.3	11.7	5.1	12.1	2.6	12.6	23.7	12.0
Total	$28.7	39.9[a]	$24.4	39.1	$16.9	40.0	$7.4	35.8	$77.4	39.2

[a]Does not total due to rounding.

NIMH officials told us that in fiscal year 1983, other grants awarded through the traditional discipline education branches also addressed these priorities. NIMH, however, did not develop estimates of the amounts used to address the priorities.

MENTAL HEALTH SERVICE NEEDS OF CHILDREN

Various studies suggest that 4 to 19 million of the 64 million children under 18 years of age in the nation may experience psychological maladjustment. The Children's Defense Fund estimates that about 3 million children are seriously disturbed.

Developing information on the number of children treated for emotional problems is difficult because many are not clients in the mental health system. Rather, some are treated through the educational, welfare, or juvenile justice systems. Others are treated as part of family mental health services and may be counted as adults or not counted at all. NIMH established a new unit on the epidemiology of child mental health, but this unit may not start developing comprehensive data on the extent of child mental health problems for several years.

The Academy of Child Psychiatry told us that about 3,200 child psychiatrists practice in the United States. The American Psychological Association estimated that in 1978 about 1 percent of the 19,000 doctorate level clinical psychologists spent over 75 percent of their time providing services to children and only about 5,000 of them provided some services to children as part of their clinical practice. Many of the mental health providers from these two groups do not work with children full time. In addition, they tend to cluster in metropolitan areas, creating a maldistribution problem. Data on the number of clinical social workers and psychiatric nurses who are specifically trained to treat children with emotional problems have not been developed.

In 1982, more than 100 medical schools had divisions of child/adolescent psychiatry, and they were training about 500 child psychiatrists. The Society of Pediatric Psychology directory reported that in 1980 there were 40 training programs in pediatric psychology, 38 in clinical child psychology, and 16 with combined programs in pediatric and clinical child psychology. A total of 379 child training positions are offered at internship and postdoctoral levels each year. Firm data on the numbers of psychiatric nursing programs specializing in children are not available.

NIMH supports training of mental health providers to treat children

NIMH estimated that in fiscal years 1980-82, about $23.7 million in basic discipline training grants were aimed at serving children with emotional problems. In fiscal year 1983, grants totaling about $2.6 million were awarded to address the needs of children. The table below summarizes the grant estimates for each of the traditional mental health disciplines.

Estimated NIMH Clinical Training Grants
Aimed at Treating Children
Fiscal Years 1980-83

Education branch	Fiscal year 1980	1981	1982	1983	Total
Psychiatry	$4,745,000	$3,758,656	$2,471,190	$1,237,043	$12,211,889
Psychology	2,511,000	2,294,454	1,566,222	811,377	7,183,053
Social Work	255,126	249,312	228,918	409,010	1,142,366
Psychiatric Nursing	465,496	401,320	350,830	116,306	1,333,952
Other branches and centers	704,378	638,332	508,866	26,290	1,877,866
Total	$8,681,000	$7,342,074	$5,126,026	$2,600,026	$23,749,126

MENTAL HEALTH SERVICE NEEDS OF THE ELDERLY

NIMH estimated that between 4 and 6 million of the 25 million persons in the nation aged 65 and older in 1980 had mental problems. Of these, according to NIMH, about 750,000 elderly persons resided in nursing homes, and 38,000 resided in state and county mental hospitals.

Recent surveys by mental health professional associations showed that a small percentage of patients treated by private mental health professionals are elderly, few mental health providers specialize in treating the elderly, and many mental health providers never treat elderly patients. Specifically:

--The American Psychiatric Association found that 2 percent of psychiatric private practice patients were elderly. An NIMH representative stated that about 65 percent of psychiatrists in private practice do not

treat elderly patients. NIMH estimated that between 500 and 600 psychiatrists specialized in treating the elderly.

--The American Psychological Association reported that 3 percent of the psychological services of health service provider psychologists were received by the elderly, about 400 psychologists specialize in treating the elderly, and about 69 percent of health service provider psychologists do not work clinically with the elderly.

Comprehensive information on the numbers of clinical social workers and psychiatric nurses who treat or specialize in working with the elderly has not been developed. Likewise, information on the proportion of mental health care provided to the elderly by clinical social workers and psychiatric nurses has not been gathered.

NIMH clinical training grants train mental health providers to treat the elderly

During fiscal years 1981-83 the Congress identified the elderly as a priority of NIMH's clinical training program. During fiscal years 1980-82 about $9.1 million in grants were awarded by NIMH to train providers in the mental health needs of the elderly. In fiscal year 1983, about $2.3 million was allocated for the geriatric program in NIMH. Of this amount about $763,000 was awarded by the Division of Human Resources for the development of model programs focused on the elderly within the professional disciplinary training programs. Funds were used for faculty salaries, trainee stipends, and the development of specialized courses.

The Center for Studies of the Mental Health of the Aging in the Division of Prevention and Special Mental Health Programs awarded $1.4 million for geriatric clinical mental health training in fiscal year 1983. The Center funded grants in two categories: (1) faculty development awards to support specialized preparation in geriatrics for faculty members of graduate departments/schools of the four traditional mental health disciplines and (2) postgraduate specialty training programs in these disciplines to prepare mental health professionals to serve as clinical teachers and resource persons for their departments in geriatric mental health.

MENTAL HEALTH SERVICE NEEDS OF MINORITIES

NIMH estimated that of the 46 million minorities counted in the 1980 census, about 4.6 million were mentally ill. Experts in mental health recognize that minorities need more and improved mental health services.

According to the Western Interstate Commission on Higher Education, in addition to access to services, other factors affect the level of mental health services available to minorities. For example, (1) nonminority providers may not be well prepared for cross-cultural service delivery and their services may not be appropriate, (2) relatively few nonminority mental health providers are bilingual and in some cases language may be a barrier to effective treatment, and (3) there is a recognized shortage of minority mental health providers.

Determining the numbers of practicing minority mental health providers is a problem. Some estimates of minority providers have been made for all the mental health disciplines. For example, the American Psychiatric Association reported in 1980 that about 3,000 of 32,000 members were minorities. Of these 3,000, the Association estimated that there were about 480 Blacks, 650 Hispanics, 110 American Indians, and 1,760 Asians.

An American Psychological Association survey of doctoral members in 1978 estimated that of 19,824 specialists in clinical and counseling psychology, there were 205 Blacks, 191 Hispanics, 211 Asians, and 19 American Indians and Aleuts. In 1983, an American Psychological Association official estimated that there were 1,000 members in the Black Psychologists Association and 100 members in the Hispanic Psychologists Association.

In 1977-78 the American Nursing Association Inventory of Registered Nurses reported that 59 percent of the members provided information on race. Of these about 91 percent were White, 4 percent were Black, 3.1 percent were Asian, 1.1 percent were Hispanic, and 0.8 percent were Native American or "other." The Association did not analyze data on the 59,569 nurses working in psychiatric settings to determine race.

The National Association of Social Work reported that of the 73,179 members responding to a data inquiry in 1983, 8,387 (11.5 percent) indicated they were minorities.

In regard to trainees in the basic mental health disciplines, the American Psychiatric Association reported that in 1981, 18 percent of 4,545 psychiatric residents were minorities.

The American Psychological Association reported that 7.7 percent of the 792 recipients of doctoral degrees in clinical psychology in 1980 were minorities. In all of the psychology specialties, there were 17,114 students enrolled in doctoral programs in academic year 1980-81, of which about 10.6 percent were minorities.

In fiscal year 1979, the NIMH psychiatric nursing education branch surveyed 23 undergraduate and master's levels programs, including over 11,000 nursing students, and found 10.8 percent of the students were minorities.

The Council on Social Work Education reported that 1,600 (or 16 percent) of the 9,976 master's students who graduated in all social work specialties in 1981 were minorities.

NIMH does not develop data on minorities

NIMH reported that it funded about $42.3 million of grants which focused on minorities during fiscal years 1980-83. Of this amount the Center for Minority Group Mental Health Programs, through the Minority Fellowship Grant Program, funded about $5.8 million in clinical training grants. As shown in the table below, all of the traditional mental health disciplines participate in this stipend program.

Minority Fellowship Program Awards for Clinical Training by Mental Health Discipline Fiscal Years 1980-83

	Fiscal year				
Discipline	1980	1981	1982	1983	Total
Psychiatry	$ 373,055	$ 467,958	$ 238,384	$ 258,699	$1,338,096
Psychology	570,932	501,768	378,360	385,109	1,836,169
Social Work	212,715	252,774	139,135	141,326	745,950
Nursing	419,285	319,410	207,804	212,735	1,159,234
Sociology	67,361	257,519	198,290	202,132	725,302
Total	$1,643,348	$1,799,429	$1,161,973	$1,200,001	$5,804,751

NIMH collects some data on the minority trainees who benefit from the Minority Fellowship Grant Program; however, grantees receiving other clinical training funds are not asked to provide this information.

NIMH officials told us that since the mid-1970's attempts have been made to require clinical training grantees to submit data on minorities. Office of Management and Budget regulations and the provisions of the Paperwork Reduction Act have prevented NIMH from developing the survey instruments needed for this purpose.

The education branches for the various mental health disciplines have collected data on minorities from the grantees--primarily those that awarded stipends to trainees--but this has not been done systematically. For example, the Social Work Education Branch placed special emphasis on minorities in the 1980's. The branch reported that, regarding fiscal year 1981 grants, of 726 stipends, 380 were known to have been awarded to minorities and another 86 may have been. For fiscal year 1982 grants, 303 of 583 social work stipends were awarded to minorities and another 70 may have been. The Psychiatry Education Branch estimated that about 14 percent of its stipends in general medical education clerkships were awarded to minorities in 1982. The branch assumed that somewhat fewer minorities in the psychiatric residency programs were awarded stipends, but no data were available.

The Psychology Education Branch surveyed 97 NIMH-supported psychology doctoral training programs and reported as of May 1980 that of 5,395 students, 1,001 were minorities.

The Psychiatric Nursing Education Branch has not developed minority data on its overall program, but a follow-up study of a 1980 special initiative to train nurses to serve the chronically mentally ill found that 3 of 55 trainees were minorities. The Paraprofessional Manpower Development Branch in fiscal year 1982 awarded three grants that focused on training minorities; however, NIMH did not know how many minorities were trained.

NIMH CLINICAL TRAINING GRANTS SUPPORT SOME PREVENTION ACTIVITIES

The President's Commission on Mental Health stated that efforts to prevent mental health problems are necessary to a systematic approach of promoting mental health. In its working definition of prevention, the Commission included a broad range of activities aimed at helping individuals to avoid becoming

mental patients. The Commission identified three levels of prevention: primary, to eliminate the causes of mental disorders or disabilities; secondary, to detect minor problems quickly and treat them promptly before they become serious; and tertiary, to rehabilitate individuals during or after mental illnesses so that they may live independently and/or with minimal permanent disability. The Commission report considered efforts to (1) strengthen the family and aid healthy child development, (2) reduce stigmas and discrimination, and (3) manage developmental life crises and stress management.

The NIMH clinical training announcements for fiscal years 1980-81 included provisions for grants to develop strategies for primary prevention activities for all mental health disciplines when relevant. In fiscal year 1983, the traditional disciplines were expected to include prevention components in their training projects.

No surveys or evaluations have been made to identify the amount of clinical training grant funds devoted to prevention. The NIMH estimates of funds awarded for this priority in fiscal years 1980-82 are shown below. According to NIMH officials, the extent to which prevention is addressed in a given grant may be understated because such major priorities as children, minorities, and the elderly are more likely to be identified as being addressed.

Clinical Training Grant Funds
That Address Prevention
Fiscal Years 1980-82

Fiscal year	Grant funds awarded
1980[a]	$2,465,000
1981	2,408,354
1982	1,372,007
	$6,245,361

[a]Only includes grant awards by the Division of Human Resources.

In addition to the initiatives funded through the clinical training programs, during fiscal years 1980-83, NIMH's Office of Prevention conducted workshops, commissioned a number of publications, and funded several other research grants and studies on the state of the art of specific prevention intervention. Also, the Mental Health Education Branch in the Division of Communications and Education has developed public education materials on prevention.

NIMH EFFORTS TO TRAIN PRIMARY CARE PROVIDERS IN MENTAL HEALTH

NIMH estimated that during fiscal years 1980-82, grants totaling about $21.4 million were awarded through the traditional mental health discipline education branches for projects related to general health care and the education of primary health care providers.

During those years, both the Psychiatry and Psychiatric Nursing Education Branches provided funds to enrich the psychiatric components and experiences in general medical and nursing education. Psychiatry Education Branch grants were awarded to medical schools to increase the psychiatric knowledge and skills of medical students who were in general medicine and to foster an appreciation of psychosocial phenomena for all medical students. Several psychiatry consultation/liaison projects were also funded; they were aimed at increasing the mental health skills and knowledge of general health care physicians and preparing psychiatrists to work more effectively in the health care field.

The Psychiatric Nursing Branch supported curricula development and provided stipend support in the junior and senior years for nurses agreeing to work in public mental health settings.

In 1983, the Psychiatry Branch placed major emphasis on efforts to increase recruitment in psychiatric residencies and improve the mental health training of nonpsychiatric physicians. The Psychiatric Nursing Branch increased the percentage of funds for undergraduate support and provided support for 6-week psychiatric experiences for nursing students.

The Psychiatry and Psychology Education Branches have supported training related to improving working relationships between health and mental health personnel in psychiatry and psychology. In fiscal year 1983 the Social Work Education Branch funded projects that placed clinical social work students in primary health care units in hospitals and in physicians' offices in rural areas. The State Manpower Development Branch awarded 2-year, $20,000 grants to 13 states to improve mental health treatment in primary care. The Psychology Education Branch also funded programs to train clinical psychologists to treat and prevent the psychological aspects of general health problems.

As shown below, the NIMH clinical training funds awarded by the basic discipline branches to support general health and primary care training in fiscal years 1980-82 totaled about $21.4 million. Complete funding data on this priority for fiscal year 1983 were not developed by NIMH.

NIMH Clinical Training Grant Funds in the Traditional Disciplines Awarded for General Health and Primary Care Fiscal Years 1980-82

Fiscal year	Psychiatry	Psychology	Social work	Psychiatric nursing	Total
1980	$ 6,571,000	$ 749,000	$ 575,344	$ 683,309	$ 8,578,653
1981	6,092,203	743,441	499,925	421,166	7,756,735
1982	3,885,187	494,874	535,199	144,576	5,059,836
Total	$16,548,390	$1,987,315	$1,610,468	$1,249,051	$21,395,224

NIMH CLINICAL TRAINING GRANTS ADDRESS OTHER PRIORITIES

NIMH has requested clinical training grant applicants to develop projects that address the placement of more providers in underserved rural and urban areas, public mental health settings, and programs aimed at the chronically mentally ill. NIMH estimated that grants totaling about $51.1 million were awarded in fiscal years 1980-82 to address these three priorities. NIMH officials told us that data on the distribution of funds among these priorities in fiscal year 1983 had not been compiled. The grant details by priority for fiscal years 1980-82 are shown in the table below.

	Fiscal year			
	1980[a]	1981	1982	Total
	(millions)			
Rural and urban underserved areas	$10.8	$10.0	$7.3	$28.1
Chronically mentally ill	5.3	4.4	3.1	12.8
Public facilities	4.3	3.5	2.4	10.2

[a]In fiscal year 1980 only Department of Human Resources priority data were developed.

Most of the grant funds for these priorities were awarded through the four traditional mental health education branches. In addition, the State Manpower Development Program encouraged states to create affiliations between psychiatric and psychological training programs and state institutions. According to NIMH, in some states this arrangement increased the recruitment of psychiatrists to work in state mental hospitals and was endorsed by the National Association of State Mental Health Administrators. The research and development branch has supported the development and dissemination of vocational rehabilitation models for the chronically mentally ill. The Paraprofessional Manpower Development Branch has analyzed the roles for paraprofessionals in the care and treatment of the mentally ill and found that paraprofessionals who work in mental health programs in rural areas are more likely to work with chronically ill patients than with the acutely ill.

CHAPTER 4

NIMH DOES NOT HAVE ADEQUATE

SYSTEMS TO MONITOR AND ENFORCE

STIPEND PAYBACK OBLIGATIONS

NIMH clinical training funds have been awarded both for institutional support (that is, faculty and curriculum development) and for student support through stipends. Since fiscal year 1981, most students receiving stipends have been required to pay them back through service to underserved areas and populations. During fiscal years 1981-82, about $31 million in stipends was awarded to trainees. Inadequate reporting and monitoring systems, however, will make it difficult for NIMH to obtain accurate and timely information to enforce the stipend payback obligations. Unless NIMH devotes more resources to these systems, it will not be able to adequately monitor and enforce the payback obligations.

A HIGH PROPORTION OF NIMH CLINICAL TRAINING GRANTS SUPPORT STIPENDS

A significant proportion of NIMH clinical training grant funds during fiscal years 1980-82 were used to fund stipends. The extent to which stipends were awarded to trainees varied among the traditional mental health disciplines. Details on the extent to which stipends were awarded and the education levels of those who received the stipends are shown in the tables as follows.

Psychology Education Branch
Numbers of Stipends Awarded and Amounts of Trainee Costs
by Education Level-Fiscal Years 1980-82

Fiscal year	Education level: Undergraduate Number	Undergraduate Amount	Master's Number	Master's Amount	Doctoral Number	Doctoral Amount	Field training Number	Field training Amount	Total Number	Total Amount	Total grant funds awarded	Percent of trainee funds to total grant funds
1980	79	$297,649	72	$ 411,953	729	$ 5,237,824	240	$1,435,763	1,120	$ 7,383,189	$ 9,813,887	75.2
1981	53	271,624	67	402,667	628	4,362,117	198	1,270,120	946	6,306,528	8,302,040	76.0
1982	46	231,448	50	288,926	446	3,164,611	164	1,041,677	706	4,726,662	5,780,864	81.8
Total	178	$800,721	189	$1,103,546	1,803	$12,764,552	602	3,747,560	2,772	$18,416,379	$23,896,791	77.1

Psychiatry Education Branch
Numbers of Stipends Awarded and Amounts of Trainee Costs by Education Level
Fiscal Years 1980-82

Fiscal year	Education level: Medical student education		Consultation/liaison		Residency		Total		Total grant funds awarded	Percent of trainee funds to total grant funds
	Number	Amount	Number	Amount	Number	Amount	Number	Amount		
1980	739	$ 620,760	44	$ 710,016	108	$1,662,641	891	$2,993,417	$22,521,370	13.3
1981	674	566,160	42	698,208	64	1,013,985	780	2,278,353	19,773,913	11.5
1982	530	445,200	17	276,960	19	302,796	566	1,024,956	12,883,702	8.0
Total	1,943	$1,632,120	103	$1,685,184	191	$2,979,422	2,237	$6,296,726	$55,178,985	11.4

Psychiatric Nursing Education Branch
Numbers of Stipends Awarded and Amounts of Trainee Costs by Education Level
Fiscal Years 1980-82

Fiscal year	Education level: Undergraduate Number	Undergraduate Amount	Graduate Number	Graduate Amount	Continuing education Number	Continuing education Amount	Total Number	Total Amount	Total grant funds awarded	Percent of trainee funds to total grant funds
1980	22	$ 99,747	771	$ 4,804,679	16	$ 82,396	809	$ 4,986,822	$ 7,813,000	63.8
1981	21	112,021	788	4,486,081	8	38,890	817	4,636,992	7,070,333	65.6
1982	17	78,264	593	3,303,068	-	-	610	3,381,332	5,275,900	64.1
Total	60	$290,032	2,152	$12,593,828	24	$121,286	2,236	$13,005,146	$20,159,233	64.5

Social Work Education Branch
Numbers of Stipends Awarded and Amounts of Trainee Costs by Education Level
Fiscal Years 1980-82

Fiscal year	Education level: Undergraduate Number	Undergraduate Amount	Graduate Number	Graduate Amount	Continuing education Number	Continuing education Amount	Total Number	Total Amount	Total grant funds awarded	Percent of trainee funds to total grant funds
1980	10	$ 28,751	754	$ 4,608,933	-	-	764	$ 4,637,684	$10,664,735	43.5
1981	12	50,073	707	4,561,801	-	-	719	4,611,874	9,499,556	48.5
1982	13	56,645	568	3,694,866	-	-	581	3,751,511	6,945,210	54.0
Total	35	$135,469	2,029	$12,865,600	-	-	2,064	$13,001,069	$27,109,501	48.0

Section 303 of the Public Health Service Act authorizes NIMH to award grants to institutions for training instruction and traineeships in mental health and related disciplines. This provision was amended by section 803 of the Mental Health Systems Act (Public Law 96-398, Oct. 7, 1980) to obligate each individual who receives a clinical traineeship in graduate psychology, psychiatry, psychiatric nursing, or social work to repay each year of support through a year of service. The service obligation applies to each stipend awarded to trainees beginning in the first full academic year after October 7, 1980.

NIMH regulations excluded students receiving stipend support for less than 180 days from the payback obligation. Students who decide not to pay back their stipends in service may "buy out" of their obligation by reimbursing NIMH for three times the amount of the stipends they received and other trainee costs, plus interest.

NIMH initially decided to impose the payback obligation on those receiving stipends on or after July 1, 1981. The interim regulations to formally implement this requirement, however, were not published in the Federal Register until August 5, 1981. On the advice of counsel, the effective date of the payback obligation was revised to September 1, 1981. As a result of this change, 627 of the 2,306 trainees receiving stipends in fiscal year 1981 (those appointed from July 1 through August 31, 1981) were later released from the payback obligation for that year.

NIMH SYSTEMS TO ENFORCE STUDENT PAYBACK OBLIGATIONS ARE INADEQUATE

NIMH does not have an adequate system to assure that trainees will satisfy the payback requirement by providing mental health services in an acceptable facility and/or location after completing training. NIMH monitors and enforces payback obligations through a manual system that is maintained by one staff member with part-time administrative support. Because of the volume of stipends awarded annually and delays in obtaining needed trainee data from grantees and trainees, NIMH will have difficulty carrying out its responsibilities unless improvements are made to the system and the way information is obtained.

Students are required to agree in writing to satisfy the payback requirements before they receive stipends. Grantees are required to submit to NIMH at the beginning of each academic year information on the students receiving NIMH stipends. As of June 1983, NIMH had received most initial information on trainees receiving stipends in the 1981-82 academic year. For academic year 1982-83, grantees were not punctual in reporting

trainee information, even though most institutions select the trainees to receive stipends before the academic year begins. Of the 2,000 appointments reported by the grantees as of July 15, 1983, only about 300 had been incorporated into the NIMH monitoring system.

At the end of each academic year, grantees are to report to NIMH information on the termination of the stipend period and specify which students will not be receiving NIMH stipends in the next academic year. As of June 1983, almost all termination notices for academic year 1981-82 had been received, but they had not been verified for accuracy. Consequently NIMH does not consider them to have been fully processed. For academic year 1982-83, NIMH expected 1,658 termination notices from grantees.

Trainees receiving stipends do not have to begin the payback until 24 months after the termination of the last training period for which they received a stipend. All trainees who received stipends are expected to provide detailed information annually on where and how they are satisfying the payback obligation. Office of Management and Budget authorization to use the Annual Payback Activity Certification form to monitor payback obligations expired in July 1983, and approval for an extension had not been granted as of August 15, 1983. Since the form was not approved, most of the communication between NIMH and trainees with payback obligations has been initiated by the trainees over the telephone; therefore, NIMH had no assurance that those with a payback obligation were satisfying it.

The payback obligation is significant considering that in fiscal year 1982 more than 2,000 students received stipends and funds for other costs totaling about $12.9 million, and most of them were subject to the payback obligation. In fiscal year 1983, about 900 students received stipends and most have payback obligations. Also, in fiscal year 1981, 1,652 recipients had payback obligations. Because trainees do not have to begin the payback until 24 months after their training, only a few have started the payback service.

CONCLUSION

During fiscal years 1981-82, about $31 million in stipends and other trainee costs was awarded through NIMH clinical training programs, and a high proportion of the recipients have a payback obligation. Without improved monitoring by NIMH and better reporting by grantees and trainees, NIMH cannot be assured that graduates of its clinical training programs are satisfying their payback obligations by serving underserved areas and priority groups.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Director, NIMH, to develop a system requiring recipients of stipends with pay-back obligations to report to NIMH, in a timely fashion, how they are satisfying that obligation and a system for monitoring this process and enforcing the payback obligation.

AGENCY COMMENTS

HHS concurred with this recommendation and stated that NIMH will award a contract early in fiscal year 1985 to implement its recently designed monitoring and payback system. (See app. I.)

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

MAY -7 1984

Mr. Richard L. Fogel
Director, Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report "Effectiveness of Mental Health Clinical Training Programs Cannot Be Evaluated." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "EFFECTIVENESS OF MENTAL HEALTH CLINICAL TRAINING PROGRAMS CANNOT BE EVALUATED," DATED MARCH 27, 1984

General Comments

We believe that the General Accounting Office (GAO) draft report presents a fair summary of the clinical training program of the National Institute of Mental Health (NIMH) in recent years. The report notes the problems of reconciling a declining budget, staff reductions, and the Department's position favoring phase-out, with congressional directives to continue the program. It recognizes that congressional priorities were followed in the redirection of the program and the award of grants.

GAO Recommendation

Recognizing the controversy over the continuation of the program, the funding and staffing decreases which have occurred and that collecting data on program effectiveness may be expensive, we recommend that the Secretary, Health and Human Services:

--discuss with the Congress the acceptability of continuing to use estimates as the bases for measuring program effectiveness, and

--instruct the Director, NIMH, to estimate the funds and staff needed to develop reliable data to measure program effectiveness for the Congress to consider.

Department Comment

We concur contingently with these recommendations. If the program is discontinued at the end of Fiscal Year 1984 as recommended by the President's budget for Fiscal Year 1985, it would not be beneficial to carry out these recommendations. However, in the event the program is continued, we will discuss with the Congress the use of estimates for measuring program effectiveness and provide the Congress with an estimate of the resources that would be needed to develop reliable data to measure program effectiveness.

The Department has for several years recommended, and continues to recommend, to the Congress that the NIMH clinical training program be abolished. The clinical training staff has been reduced in line with this position. Also, the Congress has considerably reduced the size of the appropriation for clinical training programs. Accordingly, it may not be feasible to conduct the extremely complex and costly manpower data studies needed to pinpoint the degree and location of different types of personnel shortages.

GAO Recommendation

We recommend that the Secretary, Health and Human Services, direct the Director, NIMH, to develop a system requiring the recipients of stipends with payback obligations to report to NIMH, in a timely fashion, how they are satisfying that obligation, and a system for monitoring this process and enforcing the payback obligation.

Department Comment

We concur with this recommendation. NIMH has designed a monitoring and payback system. The Office of Management and Budget's approval for the necessary forms has been received. Complete implementation of this system will be achieved by the beginning of Fiscal Year 1985 with the award of a contract for the operation of the ongoing system.

GAO note: The Department's technical comments have not been included here; however, we considered them in preparing our final report.

(102558)

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES DIVISION

B-215302

The Honorable Daniel K. Inouye
United States Senate

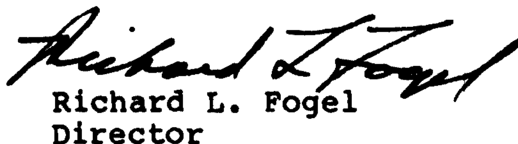
Dear Senator Inouye:

This report is in response to your request that we review the extent to which the National Institute of Mental Health (NIMH) clinical training programs addressed congressional priorities during fiscal years 1980-83.

In addition to providing information relating to your questions, the report also discusses the effect that funding and staffing reductions during the 1980's had on NIMH's ability to (1) manage its clinical training programs, (2) develop data concerning the use of clinical training grant funds, and (3) implement a system to monitor and enforce payback obligations of students who received stipends under these programs.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 2 days after its issue date. At that time we will send copies to interested parties and make copies available to others on request.

Sincerely yours,



Richard L. Fogel
Director

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