Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

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Medicare Modernization Brings Big Changes

Easing the Transition

Medicare—the national health care program for Americans age 65 and older and younger people who qualify because of a physical or mental disability—is about to undergo the most dramatic change in its 40-year history.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 makes many improvements to Medicare. Of note, all 42 million Medicare beneficiaries will have prescription drug coverage for the very first time. That new coverage has important implications, especially for those people eligible for both Medicare and Medicaid.

These 6.3 million dually eligible people—almost 40 percent of whom have serious mental illnesses or cognitive impairments—will receive their prescription medication through Medicare rather than Medicaid starting January 1, 2006.

"The prescription drug coverage coming next year is for everyone in Medicare, regardless of their income or how they get

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The Federal Mental Health Action Agenda is now on SAMHSA's Web site at www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx.
Details in September/October 2005 *SAMHSA News.*

Medicare

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their Medicare," said Mark B. McClellan, M.D., Ph.D., Administrator of the Centers for Medicare & Medicaid Services (CMS). "At CMS, we are paying particular attention to making sure that those with Medicaid and Medicare have effective, smooth transitions to what will be very comprehensive coverage for all medically necessary treatments."

Whether you're a state mental health program director, substance abuse program director, treatment provider, advocate, or consumer, you need to know about these changes. And SAMHSA is determined to help.

"Although this is a CMS program, it's a very high priority for us here at SAMHSA as well," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We've made a commitment to the Secretary of Health and Human Services that we'll do whatever we can to ensure this program is a success for the vulnerable populations we jointly serve."

The Basics

To understand the key changes ahead, the following elements are important:

- **Shift to Medicare Prescription Drug Coverage.** Starting in January 2006, every person with Medicare will be eligible for coverage to help pay for prescription drugs. For many people, this means they will have prescription drug coverage for the first time. For people with both Medicare and Medicaid, it means that Medicare—not Medicaid—will pay for their prescription drugs starting January 1. However, Medicaid will continue to pay other mental health and substance abuse treatment costs for dually eligible individuals.
- **New prescription drug plans.** Under the new program, dozens of prescription drug plans, insurance companies, and other private organizations approved by Medicare will negotiate with pharmaceutical manufacturers to offer Medicare prescription drug plans at the most affordable prices. Every beneficiary will have a choice of at least two plans in his or her community. Information about the prescription drug plans will be available in the *Medicare & You 2006* handbook mailed to all people with Medicare this October.
- **Coverage.** The prescription drug plans will cover both generic and brand-name medications. Their formularies—lists of medications available—must include at least two medications within each class of drug. For the six drug classes CMS calls "of special interest," the formularies will include virtually all medications.

Three of these drug categories affect consumers with mental illness: antidepressants, used to treat depression; antipsychotics, used to treat schizophrenia and psychosis; and anticonvulsants, used to treat bipolar disorders. "By far and away, most people will be able to stay on their current medicines," said Anita Everett, M.D., Senior Medical Advisor at SAMHSA.

Timeline: Medicare Prescription Drug Coverage

Note: People eligible for both Medicare and Medicaid should have already received information about Medicare prescription drug coverage. Call 1 (800) MEDICARE for more information. TTY users should call 1 (877) 486-2048.

October 2005:	Detailed information available about Medicare prescription drug plans in the *Medicare & You 2006* handbook and on **www.medicare.gov.** People with both Medicare and Medicaid will be notified which plan they'll be assigned if they don't choose a plan within the next 2 months.
November 15:	First day to join a Medicare prescription drug plan.
November 15 to December 31:	If people with Medicare and Medicaid don't join a plan by December 31, Medicare will enroll them in a plan effective January 1, 2006.
January 1, 2006:	Medicare prescription drug coverage begins.

- **Costs.** Costs are another area of difference between dually eligible people and other beneficiaries. While most beneficiaries will have to pay a premium, dually eligible consumers won't. Beneficiaries whose income and resources are limited, but not low enough to qualify for Medicaid, can apply for extra help, which dually eligible beneficiaries will receive automatically. Dually eligible people will, however, have to make copayments on individual prescriptions. For persons who have both Medicare and Medicaid, the copayments per prescription will be no more than $1 for generic and $3 for brand name. Those with limited income will pay no more than $2 for generic and $5 for brand-name medications.
- **Choice.** Dually eligible people don't have to stick with the plan CMS assigns them. Unlike most beneficiaries who can change drug plans only once a year, people with both Medicare and Medicaid will be allowed to change plans anytime. "If dually eligible consumers don't like the plan they're assigned to or feel it isn't the best fit in terms of their needs or preferences, they can switch," said Dr. Everett.
- **Substance abuse.** Medication is sometimes used in specific situations in substance abuse treatment, and prescription drug plans may cover such medication. Plans must cover at least two medications in the alcohol aversion category, which includes naltrexone (Revia®, Trexan®), acamprosate (Campral®), and disulfuram (Antabuse®). In addition, plans are required to cover smoking cessation medication.

Plans also may cover buprenorphine, a medication used for treating opioid addiction.

- **A seamless transition.** Most beneficiaries will have to research the prescription drug plans in their area and select the one that meets their needs. To ensure continuity of care, CMS will enroll dually eligible people automatically in a Medicare prescription drug plan if they don't join one on their own by December 31, 2005. "Many of the dually eligible consumers

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From the Administrator

Maximizing the Benefit of Medicare

There is a saying: All people are in favor of progress; it's the change that they don't like. We are poised at a time of tremendous change now, as the Federal Government moves forward with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

This landmark act offers new opportunities for the 42 million Americans with Medicare—including people with mental and substance use disorders. In particular, the January 2006 launch of the new Medicare Prescription Drug Coverage will provide many people with prescription drug coverage for the first time. (See *SAMHSA News* cover story.)

We recognize that the changes to the 40-year-old Medicare program also present challenges for people with mental and addictive disorders. In particular, the transition carries special considerations for those who have both Medicare and Medicaid.

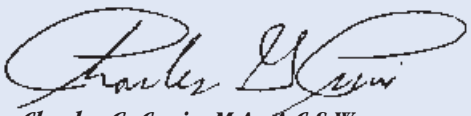
As of January 1, 2006, people with both Medicare and Medicaid will no longer have their medications paid for by Medicaid, but will instead be covered through the new Medicare prescription drug coverage.

The Centers for Medicare & Medicaid Services (CMS), which oversees these programs, is committed to assuring a safe and appropriate transition for people with Medicare and Medicaid, and SAMHSA is committed to assisting with this.

CMS has established certain safeguards for people with mental illnesses and for people with Medicare and Medicaid. For example, Medicare requires prescription drug plans to include at least two medications within each class of drug. However, CMS has designated six classes of drugs "of special interest," and three of these include medications used most frequently by people with mental illnesses: antidepressants, antipsychotics, and anticonvulsants. In these drug categories, plans are required to offer virtually all available medications.

This and other safeguards are part of an overall CMS strategy to provide comprehensive coverage, ensure continuity of coverage, work with states, protect special populations, and offer outreach and education to help people sort through the various choices they will need to make. SAMHSA will be especially active in educational efforts.

Modernizing Medicare is an enormous task, but SAMHSA is committed to helping consumers and providers of services as well as other stakeholders overcome any potential challenges and make the most of this new opportunity.



Charles G. Curie, M.A., A.C.S.W.
Administrator, SAMHSA

YOUTH VOICES: Speaking Out About Recovery

"When I was 15, I attempted suicide," said Lorrin McGinnis. "My mom was devastated, and a lot of my friends felt hurt. As a result, I decided about a week later that, okay, I can't live for myself right now because I'm not happy, but I'm going to try to live for other people. I was trying to make the biggest impact I could in other people's lives because I felt like I couldn't do that in my own life. The ironic part is that, by doing that, it really helped me. I found purpose in my own life."

Now age 20 and studying for a degree in social work, Ms. McGinnis is a youth coordinator at Utah Allies for Families in Ogden, UT.

"I was about 11 or 12 and I was using alcohol," said Gerald Slaughter. "At 15 I was arrested, and I went to an outpatient treatment center. But I continued to relapse," he said. "I would show up and try to figure out how to pass the urine test. It was a 1992 pilot program, an outpatient service for adolescents."

Mr. Slaughter, now 24, is a team leader at Thunder Road, a Medical Center subsidiary, Chemical Dependency Recovery Hospital, and residential group home for adolescents in Oakland, CA. He is also in college.

Both programs are funded in part by SAMHSA. Utah Allies for Families, a participant in the Statewide Family Network program, is funded by SAMHSA's Center for Mental Health Services. The program provides information, referral, and support to families of children and youth with or at risk of experiencing serious emotional disturbances. Thunder Road is a grantee of the Strengthening Communities for Youth Program funded by SAMHSA's Center for Substance Abuse Treatment.

These programs are an important part of SAMHSA's guiding matrix area for children and families. One of the most fundamental tenets is that services for children, adolescents, and their families should be family-driven and youth-guided.

At a recent SAMHSA staff training, Ms. McGinnis and Mr. Slaughter both offered their personal insights on the importance of involving youth in their own treatment.

"Youth voices need to be heard," said Ms. McGinnis. "The biggest thing is to have youth involved at all levels," she said. "Youth should be at the center of their treatment plan, and when there's a team, then everybody's at the table and the youth is driving that team."

"In order to help anyone, you have to *listen* to them—especially young people," said Mr. Slaughter. "They are in the best place to tell you where they are at. Traditionally, in our society, youth are supposed to 'be seen but not heard,' but now, we have youth that make a lot of noise—and not always positive."

Ms. McGinnis agreed. "So many times, youth have problems with authority figures, Because they find themselves in situations where everything is dictated to them. But if programs have buy-in from young people, then those programs are going to work. It's not enough that you have family and professional partnerships."

Common sense is also a consideration, however. "I wouldn't have someone come in off the street for treatment and dictate how to handle their long-term program," Mr. Slaughter said. "I'm not going to give them a blank check when they are coming from their chaos and every moment is about their emotions instead of thinking strategically."

Logically, there needs to be a balance with adolescents having significant input into their treatment plan. "As far as mental health and substance abuse treatment is concerned, said Mr. Slaughter, "let's have family participation and buy-in, have clinicians sit in, have a roundtable for youth to discuss in a very adult manner what they are going to do about their treatment. Then, support their goals, and when they meet a goal, move on."

What if adolescents don't meet their treatment goals? "Then programs need to see what's going on, make adjustments, tailor it, and maybe see if they need to go on a different course," he said. "Life is like that—everything changes. For a young person to say, 'Okay, I've had equal say in this and I've done the work and now it's time for me to move in another direction,' or 'it's time for me to get out of here.' That's fair."

Schools need to partner more with the mental health system, according to Ms. McGinnis. "When I was released from the hospital when I was 12, I went back to school and they wanted to expel me. I had a counselor take me out of the school and tell me flat out that the principal wanted me removed from that school. I was a straight-A student, never got in trouble, but I had been hospitalized for a couple of months, and they had found out that I had been cutting myself and that scared them."

"To have someone who understood what I was going through—someone my age, not someone older dictating to me—that's important."

—Gerald Slaughter

"Youth voices need to be heard. . . . The biggest thing is to have youth involved at all levels."

—Lorrin McGinnis

"Why are dropout rates so high? Because the needs of young people with mental illnesses are not being met in schools," she said. "The stigma surrounding mental health affects so many young people I work with because there is no mental health education in schools. I'd like to see mental health care systems partner with the school boards to do more training, do more outreach, educate teachers, be a resource for the schools, and provide technical assistance."

Peer support is another vital element in adolescent treatment. "To have someone who understood what I was going through—someone my age, not someone older dictating to me—that's important," Mr. Slaughter said. "When people my age call me on my stuff and say, 'Hey, what you're doing is unacceptable.' Initially, I might not have heard it, but I respected it later because I understood that there were people who were in it with me, calling me on my behaviors. It really shined a light on areas I needed to change."

"When I was in treatment," Mr. Slaughter said, "there were one or two young counselors, 21 or 22, who had been through that program. They were a little bit older than me then, but not old enough for me to consider them 'adults,' so I really listened to them a lot because they came from a place of compassion."

"When I joined a youth advocacy group in Seattle, I was 15," said Ms. McGinnis. "The youth coordinator there was in her thirties, more than twice my age. But she was bipolar also, and she had been through some of the same things as me. I went to her graduation when she got her master's degree in social work. I was crying as she walked across the stage. Seeing her graduate made me think, 'I can do that!' She gave me so much hope for my own life. She'd been where I'd been, and now she was successful. She was somebody I could go to, talk to, and I knew she understood—because she'd been there. She had conquered some of the same things."

Being a mentor himself keeps Mr. Slaughter on his toes. "There's a term—keeping your ear to the streets," he explains. "Youth entering treatment—it's important to listen to them so you can help the next young person. It's easy to get lost with all the new lingo, the new drugs, the trends. To make it '3D,' you really have to understand where they are coming from. That takes a lot of patience and respect on the part of the clinician. Kids pick up early on whether you respect them. And if you don't respect them, they're not going to respect you."

Faith in the process seems to be the key. "I believe in the 12-step concept," said Mr. Slaughter. "And for me, the 12th step is giving back and helping people."

For more information about SAMHSA's matrix program for children and families, visit **www.samhsa.gov/matrix/matrix_families.aspx.**

—By Meredith Hogan Pond

National Alcohol & Drug Addiction Recovery Month

SAMHSA recently released television and radio public service announcements (PSAs) to be used as part of the 16th annual National Alcohol and Drug Addiction Recovery Month observance in September. *Recovery Month* spotlights the need for alcohol and drug abuse treatment and recovery, and honors both those in recovery and treatment providers.

In 2004, over 400 events were held in local communities.

The TV and radio PSAs, produced in both English and Spanish, aim to dispel negative characterizations about individuals who have achieved sobriety and are now in recovery, as well as emphasize the reconnection to society that is associated with recovery from substance abuse disorders.

The materials for this year's *Recovery Month,* "Join the Voices for Recovery: Healing Lives, Families, and Communities," include SAMHSA's *Recovery Month* planning kit, the new PSAs, and other Web-based and print materials. These materials were developed by more than 75 organizations and coalitions within and outside the alcohol and drug addiction treatment field.

The *Recovery Month* toolkit (see *SAMHSA News,* May/June 2005) has been distributed to 75,000 individuals and organizations across the Nation.

For more information about this year's *Recovery Month* events, visit **www.recoverymonth.gov.**

New Report Spotlights Substance Use Among Pregnant Women

A new report from SAMHSA shows that, despite many warnings, over 4 percent of pregnant women age 15 to 44 reported illicit drug use during the past month, 4 percent engaged in binge drinking, and 18 percent smoked cigarettes. The report also shows a distinct age discrepancy in this substance use: Pregnant women age 15 to 25 were more likely to use illicit drugs than pregnant women age 26 to 44.

"We know that substance use by pregnant women is a leading cause of mental, physical, and psychological problems in infants and children," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

The report, based on combined 2002 and 2003 data from SAMHSA's National Survey on Drug Use and Health (NSDUH), shows that 4.3 percent of pregnant women age 15 to 44 reported using an illicit drug during the past month, compared with 10.4 percent of nonpregnant women in that age group (see chart below). NSDUH defines illicit drug use as the use of marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically.

"We know that substance use by pregnant women is a leading cause of mental, physical, and psychological problems in infants and children."

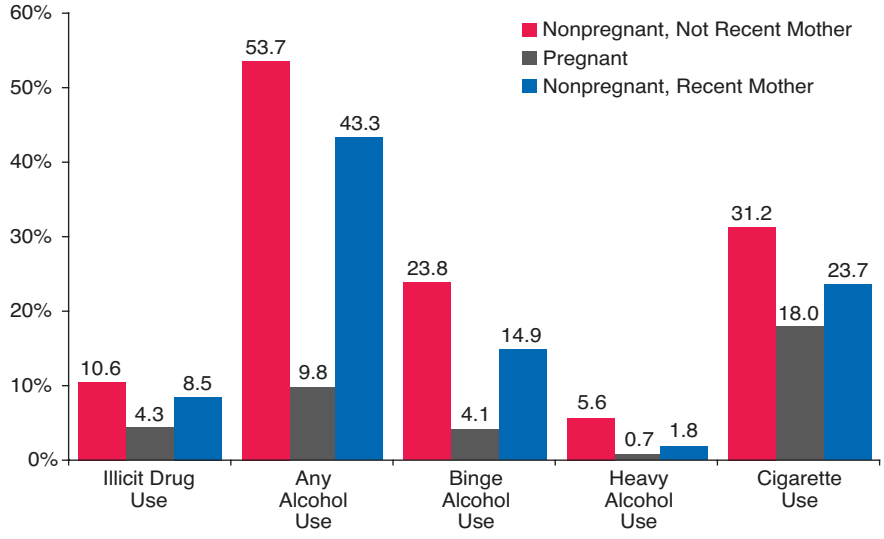
—Charles G. Curie, M.A., A.C.S.W.
SAMHSA Administrator

Among pregnant women in the 15-to-44 age group, 9.8 percent reported drinking alcohol during the past month, 4.1 percent reported binge alcohol use, and less than 1 percent reported heavy alcohol use. NSDUH defines binge alcohol use as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days. Heavy alcohol use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days.

In the 15-to-44 age group, the rates of past-month illicit drug, alcohol, and cigarette use were lower among pregnant women than among nonpregnant women who were recent mothers and nonpregnant women who were not recent mothers. Among nonpregnant women, substance use rates were lower for recent mothers than for women who were not recent mothers. This suggests that women in this age group increased their substance use during the year after giving birth, although not to the level of nonpregnant women who were not recent mothers.

For a copy of this report, *Substance Use During Pregnancy: 2002 and 2003 Update,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). The report is also available on the SAMHSA Web site at **www.oas.samhsa.gov.**

Percentages of Women Age 15 to 44 Who Reported Past-Month Substance Use, by Pregnancy and Recent Motherhood Status: 2002 and 2003**



Source: SAMHSA *National Survey on Drug Use and Health,* Office of Applied Studies, 2002 and 2003.

** "Pregnant women" were those women age 15 to 44 who were currently pregnant at the time of the survey. "Nonpregnant, recent mothers" were defined as women age 15 to 44 who were not currently pregnant and who gave birth during the prior year. "Nonpregnant, not recent mothers" were defined as women age 15 to 44 who were not currently pregnant and who did not have a biological child under age 1 in the household.

SAMHSA Raises Awareness About Fetal Alcohol Spectrum Disorders

SAMHSA's Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence will participate in National FASD Awareness Day on September 9, 2005, to focus attention on the complications of drinking during pregnancy. The annual event has been observed since 1999.

SAMHSA's FASD Center, launched in 2001, provides national leadership in the fight against FASD and fosters collaboration among service providers in the field.

The Center is working to improve quality of life for individuals and families affected by FASD. In particular, the Center's new American Indian/Alaska Native initiative will focus on FASD in Indian Country.

In 2004, SAMHSA expanded the FASD Center's work to include coordinating planning and program development by states, community-based organizations, and criminal justice organizations.

The Center's Web site, an online information resource, provides science-based information on FASD and local and national resources. The Center also publishes an online newsletter—*FASD: Knot Alone.*

The Web site's "Grab and Go" section offers downloadable fact sheets, brochures, and posters.

A wide variety of materials are available from the FASD Center, including the Center's new educational program, *FASD—The Basics,* which can be obtained in several formats, including CD-ROM.

A video for women in recovery is also available, and an educational slide show on FASD service needs, *Many Doors, No Master Key,* can be either viewed online or downloaded for presentations. The video kit, *Recovering Hope: Mothers Speak Out About FASD,* includes a discussion guide. A nominal fee of $12 covers video production costs.

In addition to educational materials on FASD, the Center conducts trainings and meetings across the Nation. So far, more than 10,000 participants in 36 states, the District of Columbia, Canada, England, and Japan have attended.

The Center also sponsors town hall meetings, which garner support for states' efforts to build systems for FASD prevention and intervention. To help local efforts build awareness, the Center offers a brochure on *Planning a Town Hall Meeting on FASD.*

Last year, the Center organized a network of birth mothers of children affected by FASD. The Center also convenes summits for women in recovery.

For professionals, several curricula for diverse audiences are in development, including an online "FASD 101" course and materials specifically for juvenile justice and addiction professionals.

Additional resources include print public service announcements, educational rack cards, posters, and a fact sheet series, *What You Need to Know.*

For more information, visit **www.fasdcenter.samhsa.gov.**

SAMHSA
Fetal Alcohol Spectrum Disorders
Center for Excellence
www.fasdcenter.samhsa.gov

What Is FASD?

Fetal alcohol spectrum disorders (FASD) is an umbrella term that describes the range of effects that can occur in an individual whose mother drank alcohol during pregnancy.

These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

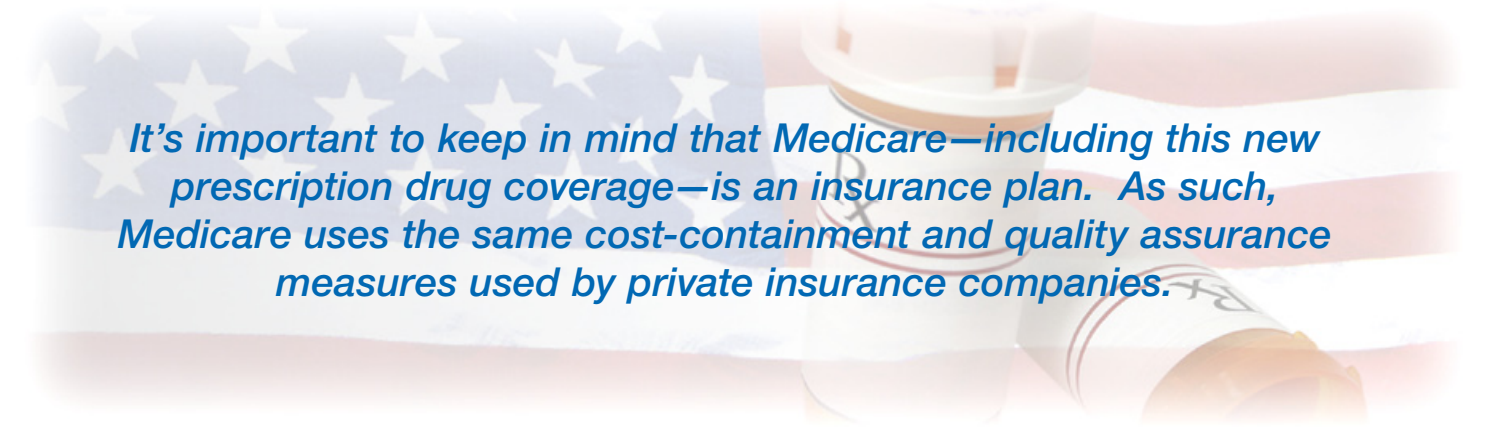
FASD is not a clinical diagnosis.

FASD refers to conditions such as fetal alcohol syndrome (FAS), alcohol-related neurodevelopment disorder (ARND), and alcohol-related birth defects (ARBD).

What causes FASD? The sole cause of FASD is drinking alcohol while pregnant.

For persons with FASD, daily activities, such as working, managing money, and maintaining a home, present huge challenges. A supportive community is essential for people with FASD. They need a strong circle of support made up of family members, mentors, social workers, and others who understand the limitations of FASD.

For more information, you can download fact sheets on FASD available at **www.fasdcenter.samhsa.gov.** The fact sheets include "Independent Living for People with Fetal Alcohol Spectrum Disorders" and "Understanding Fetal Alcohol Spectrum Disorders: Getting a Diagnosis."



It's important to keep in mind that Medicare—including this new prescription drug coverage—is an insurance plan. As such, Medicare uses the same cost-containment and quality assurance measures used by private insurance companies.

Medicare

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have serious mental illnesses or cognitive impairments," explained Dr. Everett. "There was a concern that they would fall through the cracks if they weren't automatically enrolled." This automatic enrollment helps to ensure that individuals with both Medicare and Medicaid don't miss a day of coverage.

Addressing Concerns

Some observers are worried about the impact of the new Medicare prescription drug coverage.

"We're concerned about the implementation of the Medicare Modernization Act and its impact on providers and the consumers they serve," said Linda Rosenberg, M.S.W., President and Chief Executive Officer of the National Council for Community Behavioral Healthcare. "We have been working closely with CMS and SAMHSA and have appreciated their leadership in efforts to make this a smooth transition for everyone."

Major concerns include the following:

- **Cost-containment measures.** "It's important to keep in mind that Medicare—including this new prescription drug coverage—is an insurance plan. As such, Medicare uses the same cost-containment and quality assurance measures used by private insurance companies," said Dr. Everett.

Some observers are concerned that those measures could make it harder for beneficiaries to obtain specific medications. "We're concerned about individuals who are clinically stabilized who might have to switch medications," said Sam Muszynski, J.D., Director of the Office of Healthcare Systems and Financing at the American Psychiatric Association.

CMS, working closely with SAMHSA as well as stakeholder groups, has developed a set of checks and balances to protect patients with mental illnesses. For example, Medicare will use "risk adjustment"—whereby prescription drug plans are compensated differentially for certain high-risk users—to reduce incentives for plans to deny specific medications or benefits to certain beneficiaries as a way to reduce costs. Comparative analyses will be conducted between plans to assure that drug use patterns do not represent discrimination against high-cost categories of illnesses.

Among other protections, CMS will require every Medicare prescription drug plan to establish a transition procedure for accommodating individual medical needs. This procedure must ensure that consumers have access to medications that work for them, even if those medications are not on the formulary.

CMS also created an appeals process. Prescription drug plans are required to respond to an enrollee's request for

The State Perspective

Consumers aren't the only ones the Medicare Modernization Act will affect. "There's a lot of anxiety in the states about how this will affect them," said Charles Ingoglia, M.S.W., Special Expert in the Office of Program Analysis and Coordination in SAMHSA's Center for Mental Health Services.

Costs are a major concern. Currently, states match the Federal Government's contribution toward Medicaid beneficiaries' prescription drug costs. Shifting those costs from Medicaid to Medicare doesn't eliminate those costs, however. A provision called the "clawback" requires states to use the savings gained by no longer offering prescription drugs through Medicaid to reimburse the Federal Government in part for the new benefit.

Simply initiating the new program will also take money, said Andrew D. Hyman, J.D., Director of Government Relations and Legislative Counsel at the National Association of State Mental Health Directors. And at least some of the burden of helping consumers choose the Medicare prescription drug plan that's best for them will fall on state mental health agencies and their providers. "State mental health agencies have a huge responsibility when it comes to the issue of education and outreach," he said.

a decision within 24 hours under an expedited coverage determination and within 72 hours for a standard coverage determination. CMS established a Medicare Beneficiary Ombudsman Office to provide a troubleshooting mechanism for beneficiaries.

"Overall, NAMI is pleased with the collaboration and cooperation of SAMHSA and CMS to make this transition as smooth as possible," said Andrew Sperling, Director of Legislative Advocacy at the National Association for the Mentally Ill (NAMI).

- **Benzodiazapines.** Currently, Medicare Part A covers benzodiazepines for detox purposes in an inpatient setting. However, by law the new Medicare prescription drug coverage (Medicare Part D) must exclude coverage of benzodiazepines, often used for treating anxiety and panic disorders.

"That was in the actual legislation, so there's nothing CMS can do about that," explained Dr. Everett. Legislation was introduced in Congress in July to remove the exclusion of benzodiazepines from Medicare prescription drug coverage. As *SAMHSA News* was going to press, no conclusive action had been taken yet.

- **Possible confusion.** "Navigating benefit programs is not an easy thing, especially with a brand-new program," said Andrew D. Hyman, J.D., Director of Government Relations and Legislative Counsel at the National Association of State Mental Health Directors. In addition, he noted that many individuals with mental illness are "poor and ill," increasing their vulnerability.

Recognizing the need for clear and accessible explanations, SAMHSA has been working with a number of advocacy groups, such as the National Association of State Mental Health Program Directors, to provide specific information to people with mental illness and substance use disorders.

Getting Help

"The Federal Government will work hard to ensure that Medicare beneficiaries understand their options," said President Bush in a recent address on Medicare.

By now, people with both Medicare and Medicaid should have received a letter from CMS explaining that they automatically qualify for extra help. And in the fall, CMS will also send *Medicare & You 2006* to all Medicare beneficiaries. The handbook explains Medicare prescription drug coverage and contains a list of plans available in the area.

CMS will also partner with more than 90 patient, consumer, advocacy, and support organizations—the Access to Benefits Coalition—to provide personalized assistance.

SAMHSA is working with advocacy groups, provider groups, and other stakeholders to educate their members about the changes ahead. SAMHSA is also working with CMS to develop fact sheets and other materials.

SAMHSA News will report on continuing developments as they unfold.

—By Rebecca A. Clay

Resources

The Federal Government, provider groups, and advocacy organizations are all creating resources to ease the transition as the Medicare Modernization Act goes into effect. As you review these materials, keep in mind that many of the Act's provisions are different for people with both Medicare and Medicaid than for people with Medicare only. Also, specific details of what each prescription drug plan offers will not be available until October 2005.

Centers for Medicare & Medicaid Services (CMS)

There are many publications, fact sheets, and tip sheets on these CMS Web sites, including a fact sheet called "Quick Facts About Medicare's New Coverage for Prescription Drugs for People with Medicare and Medicaid, and Medicaid Now Pays for Their Prescription Drugs." Visit **www.medicare.gov** and **www.cms.hhs.gov/medicarereform** or **www.cms.hhs.gov/partnerships.**

"A Strategy for Transitioning Dual Eligibles from Medicaid to Medicare Prescription Drug Coverage," which provides guidance to states, is available at **www.cms.hhs.gov/medicarereform/strategyforduals.pdf.** Questions? Call 1 (800) MEDICARE. TTY users should call 1 (877) 486-2048.

Other Organizations

- Access to Benefits Coalition: Visit **www.accesstobenefits.org.**
- American Psychiatric Association: Visit **www.psych.org.**
- Kaiser Family Foundation: Visit **www.kff.org.**
- National Alliance for the Mentally Ill: Visit **www.nami.org.**
- National Association of State Mental Health Program Directors: Visit **www.nasmhpd.org.**
- National Council for Community Behavioral Healthcare: Visit **www.nccbh.org.**
- National Mental Health Association: Visit **www.nmha.org.**

More Information

- The March 2005 issue of this newsletter, *Prescriptions for Progress,* focuses specifically on the Act's impact on dually eligible consumers. Visit **www.postgradmed.com/pfp/pfp_index.htm.**

SAMHSA Honors Film, TV, Radio Portrayals of Mental Illness

Writers and producers of "The Aviator," "ER," "Monk," and "Scrubs" were honored recently by SAMHSA with the Agency's first Voice Awards for their positive portrayals of people with mental health problems.

Sponsored by SAMHSA, the Voice Awards recognized film, TV, and radio writers and producers who have created positive, accurate, and dignified portrayals of people with mental health problems.

The gala awards ceremony, hosted by Mariette Hartley and Kathleen Sullivan, was held at the Skirball Cultural Center's Ahmanson Ballroom in Los Angeles, CA, on July 20.

Actors Brooke Shields and Maurice Benard, and Spanish-language television network Univision, were honored for their activities on behalf of mental health awareness. In addition, Neal Baer received a special Career Achievement Award for his work in bringing mental health issues into the mainstream. Mr. Baer is executive producer of "Law & Order: Special Victims Unit" and former executive producer of "ER."

"The entertainment industry is a powerful vehicle for helping shape public opinion," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Positive portrayals show the Nation that people with mental health problems do live, learn, work, and fully participate in the American community."

In addition to the entertainment awards, the Voice Awards recognize mental health advocates across the country for their efforts to expand public understanding that mental health problems exist in every community—and affect almost every family—in the United States.

Mr. Baer co-created the character of Maggie Lockhart (portrayed by Sally Field), a woman who is struggling with her bipolar disorder, on NBC's "ER." As executive producer of "Law and Order: SVU," he created several characters with mental health problems.

Ms. Shields recently wrote a book about her experiences with postpartum depression.

Univision devoted extensive coverage to mental health awareness through its intiative, "Salud es Vida . . . ¡Entérate!" (Health Is Life . . . Inform Yourself!).

Program partners of the Voice Awards include the American Psychiatric Foundation, the American Psychological Association, the National Association of State Mental Health Program Directors, and the Mental Health Media Partnership.

The Voice Awards are part of SAMHSA's Elimination of Barriers Initiative (EBI), a collaborative pilot effort between SAMHSA and eight state mental health authorities in California, Florida, Massachusetts, North Carolina, Ohio, Pennsylvania, Texas, and Wisconsin.

For more information about the Voice Awards or the EBI visit **www.allmentalhealth.samhsa.gov/voiceawards.**

Mariette Hartley (left) and Kathleen Sullivan (right) hosted the Voice Awards gala in Los Angeles, CA. Both diagnosed with bipolar disorder, they are outspoken advocates for mental health awareness. Ms. Sullivan is also a member of SAMHSA's National Advisory Council.

Photos by Albert Postel

SAMHSA Administrator Charles G. Curie presents the Special Recognition Award to Emmy-Award winner Maurice Benard, who has bipolar disorder. Mr. Benard is best known for his portrayal of Sonny Corinthos on "General Hospital."

Measuring Outcomes To Improve Services

SAMHSA and the states are collaborating on an effort to measure the outcomes for clients in all SAMHSA-funded programs with the goal of using the information to improve services for people with mental and addictive disorders.

"Increasingly, policymakers and budget planners at all levels—Federal, state, local, and private—are basing funding decisions on outcome data," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Eventually, this Web-based tool—SAMHSA's National Outcome Measures (NOMs)—will provide the public and policymakers with the information to improve the management and performance of our programs and make the most of the limited dollars available to help people attain and sustain recovery."

SAMHSA is realigning all of the Agency's grant and contract data collection programs—both internal and external—with NOMs. And SAMHSA is expanding and focusing its technical assistance resources to help states and providers develop NOMs reporting capacity.

Mr. Curie observed that "streamlining SAMHSA reporting requirements will reduce the reporting burden on the states in the long run."

The NOMs information available online at **www.nationaloutcomemeasures.samhsa.gov** uses maps and charts to describe states' substance abuse and mental health prevalence, treatment, and funding data. This Web site also provides substance abuse prevention data. As new data are collected, the Web site will present cross-year data to help users examine program changes over time.

NOMs Covers 10 Domains

- The first domain is abstinence from drug use and alcohol abuse. Also in this area is the goal of decreasing symptoms of mental illness and improving functioning.
- Four domains focus on resilience and sustaining recovery. These areas include getting and keeping a job or enrolling and staying in school, decreasing involvement with the criminal justice system, finding safe and stable housing, and improving social connectedness to others in the community.
- One domain deals with increased access to services for both mental health and substance abuse.
- Another domain looks at retention in substance abuse treatment or decreased inpatient hospitalizations for mental health treatment.
- The final three domains examine the quality of services provided. These include client perception of care, cost-effectiveness, and use of evidence-based treatment practices.

SAMHSA and the states have agreed to the goal of bringing all states to full NOMs reporting by the end of Fiscal Year 2007. Although each state is at a different stage of readiness and some of the measures are still being developed, NOMs will enable states to report consistent, cross-year data. Providers should contact their respective states for information on NOMs and on developing requests for technical assistance.

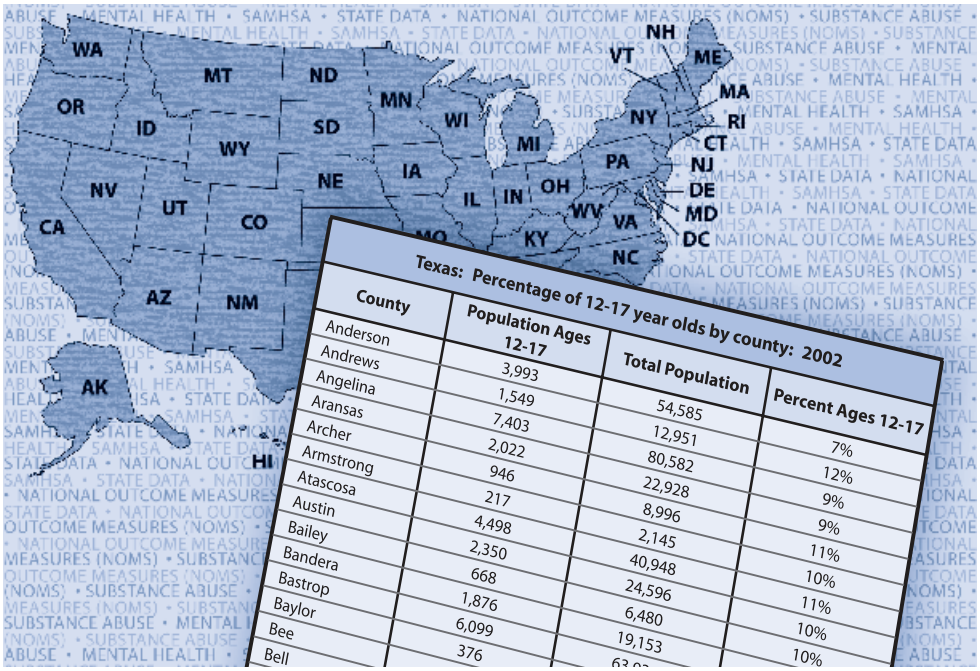
As part of this effort, SAMHSA is launching the new State Outcomes Measurement and Management System (SOMMS) Central Services Center, which will serve as a central data repository and support further technical work on standardized operational definitions and outcome measures for states.

The Center also will offer technical assistance to states to support their development of the capacity to link records so that states and service providers can make pre-service and post-service comparisons to evaluate outcomes.

In addition, SAMHSA and the states will work together to develop management reports that will guide technical assistance needs and promote the use of evidence-based interventions for improved client outcomes.

"Our goal is to achieve a performance environment with true accountability," said Mr. Curie. "Our emphasis on a limited number of national outcomes and related national outcome measures is built on a history of extensive dialogue with our colleagues in state mental health and substance abuse service agencies—and most importantly, the people we serve."

Visit the SAMHSA Web site at **www.nationaloutcomemeasures.samhsa.gov.**



Texas: Percentage of 12-17 year olds by county: 2002

County	Population Ages 12-17	Total Population	Percent Ages 12-17
Anderson	3,993	54,585	7%
Andrews	1,549	12,951	12%
Angelina	7,403	80,582	9%
Aransas	2,022	22,928	9%
Archer	946	8,996	11%
Armstrong	217	2,145	10%
Atascosa	4,498	40,948	11%
Austin	2,350	24,596	10%
Bailey	668	6,480	10%
Bandera	1,876	19,153	10%
Bastrop	6,099	63,...	...
Baylor	376	...	...
Bee	...	...	...
Bell	...	...	...

SAMHSA Awards First 2005 Grants

SAMHSA has announced the Agency's first grant awards for Fiscal Year 2005.

The awards include 30 grants totaling $59.5 million over 5 years to provide substance abuse and mental health services to homeless individuals, and 12 grants totaling $15.5 million in funding over 3 years to colleges and universities for campus screening and brief interventions to combat underage drinking.

Other grant award announcements will be made in the coming weeks.

Treatment for Homelessness Grants

These grants will support treatment programs and other services for people who are homeless, as well as people who are at imminent risk for becoming homeless because they are sharing another person's residence on a temporary basis.

"There are 2 to 3 million Americans homeless at some point each year," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Of these, an estimated 20 percent have a serious mental illness, and up to half of those with a serious mental illness also have an alcohol or drug use problem."

These 30 awards in 20 states build on the 34 grants funded in 2004. The awards for 2005 are up to $400,000 per year in total costs. Continuation of these awards is subject to availability of funds, as well as the progress achieved by the grantees.

This year's grantees for Treatment for the Homeless Projects and their award amounts are as follows:

- **Cook Inlet Tribal Council, Inc.,** Anchorage, AK. $400,000 per year for 5 years.
- **Rural Alaska Community Action Program,** Anchorage, AK. $399,630 per year for 5 years.
- **Decisions Point, Inc.,** Springdale, AR. $400,000 per year for 5 years.
- **Homeless Health Care,** Los Angeles, CA. $400,000 per year for 5 years.
- **Monterey County Health Department, Behavioral Health Division,** Salinas, CA. $399,951 per year for 5 years.
- **Phoenix Programs, Inc.,** Concord, CA. $399,695 per year for 5 years.
- **Columbus House, Inc.,** New Haven, CT. $400,000 per year for 5 years.
- **Mental Health Care, Inc.,** Tampa, FL. $400,000 per year for 5 years.
- **Hope Center, Inc.,** Lexington, KY. $400,000 per year for 5 years.
- **People Encouraging People,** Baltimore, MD. $400,000 per year for 5 years.
- **Institute for Health and Recovery,** Cambridge, MA. $400,000 per year for 5 years.
- **Kent County CMH Authority of CMHSA Network,** Grand Rapids, MI. $359,761 per year for 5 years.
- **Burrell Behavioral Health,** Springfield, MO. $363,398 per year for 5 years.
- **Swope Health Services and Model Cities Health Corp. of Kansas,** Kansas City, MO. $399,892 per year for 5 years.
- **West Care Nevada, Inc.,** Las Vegas, NV. $400,000 per year for 5 years.
- **Newark Department of Health and Human Services, Newark Homeless Health Care Project,** Newark, NJ. $400,000 per year for 5 years.
- **Presbyterian Medical Services,** Santa Fe, NM. $399,956 per year for 5 years.
- **Clear View Center,** Albany, NY. $399,998 per year for 5 years.
- **E.A.C., Inc.,** Bronx, NY. $400,000 per year for 5 years.
- **Institute for Community Living, Inc.,** New York, NY. $400,000 per year for 5 years.
- **Odyssey House, Inc.,** New York, NY. $391,868 per year for 5 years.
- **St. Vincent Catholic Medical Centers of New York Department of Community Medicine,** New York, NY. $400,000 per year for 5 years.
- **Westchester County Office of Alcohol and Substance Abuse Services,** White Plains, NY. $399,999 per year for 5 years.
- **Southeast, Inc.,** Columbus, OH. $399,978 per year for 5 years.
- **DePaul Treatment Centers, Inc.,** Portland, OR. $400,000 per year for 5 years.
- **Josephine County Human Services Department,** Grants Pass, OR. $400,000 per year for 5 years.
- **Mental Illness Recovery Center, Inc.,** Columbia, SC. $399,892 per year for 5 years.
- **Tarrant Council on Alcoholism and Drug Abuse,** Fort Worth, TX. $400,000 per year for 5 years.
- **Spokane County Community Services,** Spokane, WA. $400,000 per year for 5 years.
- **Health Care for the Homeless of Milwaukee, Inc.,** Milwaukee, WI. $400,000 per year for 5 years.

Campus Screening and Brief Intervention Grants

These 12 grants for Targeted Capacity Expansion Campus Screening and Brief Intervention (SBI) are designed to expand existing campus-based medical services by integrating into student health programs both screening for substance abuse and brief interventions to motivate students to take actions needed to end alcohol or drug abuse.

Substance abuse is a well-documented problem on college and university campuses. The new grants will assist colleges and universities with their efforts to reduce the health and social consequences of substance abuse.

"A person's life is shaped in late adolescence and early adulthood. Drug and alcohol abuse can seriously derail an individual's emotional and social growth," Mr. Curie said. "College and university health service centers provide an ideal setting to identify and intervene early with students

who are abusing drugs or alcohol. Brief and early intervention can help keep students on track towards healthy and productive lives."

The colleges and universities are expected to screen and refer students in need to appropriate treatment, using either university or community-based providers.

This year's Targeted Capacity Expansion Campus SBI grantees and award amounts are as follows:

- **Arizona Board of Regents, University of Arizona,** Tucson, AZ. $493,224 per year for 3 years.
- **UCLA Integrated Substance Abuse Program,** Los Angeles, CA. $500,000 per year for 3 years.
- **University of Hartford,** West Hartford, CT. $364,064 per year for 3 years.
- **University of Delaware Center for Counseling,** Newark, DE. $403,297 per year for 3 years.
- **University of Hawaii at Manoa, University Health Services,** Honolulu, HI. $433,225 over 3 years.
- **University Health Services, University of Massachusetts,** Amherst, MA. $473,789 per year for 3 years.
- **Northeastern University,** Boston, MA. $500,000 per year for 3 years.
- **Bristol Community College,** Fall River, MA. $500,000 per year for 3 years.
- **New Mexico Highlands University,** Las Vegas, NV. $500,000 per year for 3 years.
- **Research Foundation of SUNY,** State University of New York at Albany, NY. $465,403 per year for 3 years.
- **University of Texas at El Paso, Department of Health Promotion,** El Paso, TX. $451,500 per year for 3 years.
- **University of Tennessee,** Knoxville, TN. $381,310 per year for 3 years.

In the coming weeks, SAMHSA will announce other new grants including the Agency's Young Offender Reentry Program (TI-04-002), the Strategic Prevention Framework grants (SP-04-002), Adolescent Substance Abuse Treatment Coordination (TI-00-006), and Co-occurring State Incentive grants (SM-04-020).

For more information, visit **www.samhsa.gov** or **www.grants.gov.**

Recent Statistics

SAMHSA's Office of Applied Studies (OAS) recently released two short reports. SAMHSA extracted the data from the 2002 and 2003 National Survey on Drug Use and Health.

Adult Drivers Drinking, Using Drugs

About one in three adult drivers age 21 to 25 drove under the influence of alcohol or drugs during the past year, according to a report recently released by SAMHSA. These data also show that 16.6 percent of adult drivers age 21 or older (30.7 million persons) reported driving while under the influence of alcohol or illicit drugs during the past year.

The report, *Driving Under the Influence Among Adult Drivers,* estimates that among adult drivers age 21 or older, 15.7 percent drove under the influence of alcohol, 4.3 percent drove under the influence of illicit drugs, and 3.0 percent drove under the combined influence of alcohol and drugs during the past year.

Marijuana Use: Boston, Boulder Substate Areas

A new report from SAMHSA estimates that Boston, MA, and Boulder, CO, are among the areas with the highest rates of past-month marijuana use in the Nation.

In Boston, an estimated 12.2 percent of the population age 12 and older used marijuana; the rate in Boulder was 10.3 percent. Northwestern Iowa and southernmost Texas were among the areas with the lowest estimated rates at 2.3 percent and 2.6 percent, respectively.

Data in the short report *Marijuana Use in Substate Areas* are derived from a new online report, "Substate Estimates from the 1999-2001 National Surveys on Drug Use and Health." The complete substate report is available on the Web only, at **http://oas.samhsa.gov/substate2k5/toc.htm.**

This report combines 3 years of data to estimate—for the first time—drug use in 331 substate areas.

Areas were designated by the states. For example, New York has two areas (New York City and the rest of the state), while Pennsylvania has 23 areas.

For a copy of these reports, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the reports are available on the SAMHSA Web site at **www.oas.samhsa.gov.**

We'd Like To Hear From You!

SAMHSA News strives to keep you informed about the latest advances in treatment and prevention practices, the most recent national statistics on mental health and addictive disorders, relevant Federal policies, new publications, Web sites, and other available resources.

Are we succeeding? We'd like to know what you think.

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In the current issue, I found these articles particularly interesting or useful:

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- ❑ From the Administrator: Maximizing the Benefit of Medicare
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- ❑ New Report Spotlights Substance Use Among Pregnant Women
- ❑ SAMHSA Raises Awareness About Fetal Alcohol Spectrum Disorders
- ❑ National Alcohol and Drug Addiction Recovery Month
- ❑ Voice Awards: SAMHSA Honors Film, TV, Radio Portrayals of Mental Illness
- ❑ Measuring Outcomes To Improve Services
- ❑ SAMHSA Awards First 2005 Grants
- ❑ Recent Statistics
- ❑ Drug Abuse Warning Network Data Released on Drug Deaths
- ❑ ***SAMHSA News*** online—the current issue and archives—at **www.samhsa.gov/SAMHSA_News**

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Thank you for your comments!

Drug Abuse Warning Network Data Released on Drug Deaths

SAMHSA recently released findings on drug-related mortality from the 2003 Drug Abuse Warning Network (DAWN) that provide a picture of deaths involving recent drug use in 6 states and 32 metropolitan areas.

This is the first time there has been any state information from DAWN.

Six states provided mortality data to DAWN—Maine, Maryland, New Hampshire, New Mexico, Utah, and Vermont. Fatality rates for drug misuse in these states ranged from 88 to 162 deaths per 1 million population.

"These findings from the new DAWN provide a clearer picture of drug-related mortality than we have had before," said Judy K. Ball, Ph.D., M.P.A., DAWN Team Leader in SAMHSA's Office of Applied Studies.

She explained that this information is important for a number of reasons. First, knowing what drugs and drug combinations are lethal can be a potent tool for prevention and treatment efforts. Second, the addition of the 6 states provides the first view of drug-related mortality in rural areas where even a few deaths may indicate an important problem. Third, better information is essential to guide action, and this will be the only available information on drug use for some areas.

Among the metropolitan areas, Baltimore and Albuquerque had the highest rates of drug misuse deaths, exceeding 200 deaths per 1 million population. Another 14 areas had drug misuse death rates that exceeded 100 deaths per 1 million population.

These data show substantial variations in drug-related deaths across jurisdictions within the states, with the highest rates not always found in urban centers.

Participation in DAWN is voluntary, so not all jurisdictions provide data. DAWN counts of drug-related deaths cannot be projected to the Nation as a whole.

The study, *Drug Abuse Warning Network, 2003: Area Profiles of Drug-Related Mortality,* is a new version of DAWN—the result of a major redesign—so these data cannot be compared with data from prior years. In one key change, DAWN now captures any death related to recent drug use. Findings are presented for deaths involving drug misuse and abuse, as well as drug-related suicides.

"We must encourage those in need to enter and remain in treatment before they become a mortality statistic," said Charles G. Curie, M.A., A.C.S.W., SAMHSA Administrator.

DAWN mortality data indicate that the typical drug misuse death involves multiple drugs, an average of 2.7 drugs per case. Opiates, which include prescription pain relievers and heroin, were found more often than any other type of drug in 29 of the 32 metropolitan areas and all of the 6 states. Cocaine was the most frequently reported drug in 3 metropolitan areas and was in the top five drugs in 28 metropolitan areas and all 6 states. Alcohol was one of the five most common drugs in 30 of the 32 metropolitan areas and 5 of 6 states.

The report indicates that stimulants—reported as either methamphetamine or amphetamines—appeared in the top five drugs in 5 metropolitan areas: Minneapolis-St. Paul; Ogden-Clearfield, Utah; Phoenix; San Diego; and San Francisco.

Other common drugs in drug misuse deaths were prescription antidepressants and benzodiazepines, which are anti-anxiety medications.

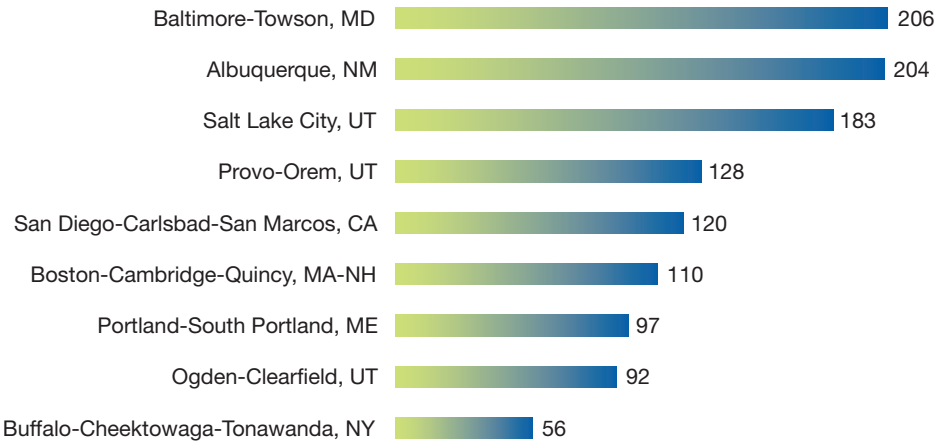
Drug-related suicide deaths were much less frequent than deaths involving drug misuse. On average, less than 20 percent of drug-related suicides involved an illicit drug. Alcohol was among the five most common drugs in drug-related suicides in all but 1 of the 32 metropolitan areas and 5 of the 6 states.

For more information, visit SAMHSA's DAWN Web site at **www.dawninfo.samhsa.gov.**

New DAWN

Drug Misuse Deaths

In the 9 metropolitan areas with full participation, fatality rates ranged from 56 to 206 drug misuse deaths per million population.



Source: SAMHSA's Office of Applied Studies. *Drug Abuse Warning Network, 2003: Area Profiles of Drug-Related Mortality,* DAWN Series D-27. Rockville, MD, 2005.

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