

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision makers

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With this week's issue of ALCOHOLISM & DRUG ABUSE WEEKLY, we bring a new design. This is not simply a makeover, however. We want to make our essential information more accessible, faster. We make this change with appreciation of our readers' fast-paced schedules. With that in mind, we will be pulling key components and highlights of longer stories into separate elements, continue to use graphics when appropriate, and, in future issues, use this space to summarize key stories. We hope that you enjoy this new look, and, as usual, we welcome any comments or suggestions as we move forward to meet your information needs. Feel free to email me at bmcalarney@manisses.com.

Brion McAlarney
Senior Managing Editor

Attitudinal barriers pose greatest obstacle to methadone treatment programs in jails

Correctional facilities need to focus on staff attitudes and knowledge about methadone, according to a recent study which found that older and more educated security staff and medical staff can lead the way in helping methadone maintenance therapy (MMT) gain acceptance in correctional clinics.

Establishing prison-based MMT has long been a goal of advocates. In most localities, jail inmates are usually forced to abruptly end MMT. A handful of jurisdictions around the country have some provisions for offering incarcerated individuals methadone treatment.

The study was published in this month's *Addiction Research and Theory*.

Efforts to improve access to

MMT and buprenorphine treatment in jails include pending legislation in New Mexico (see story, page 2) and an American Association for the Treatment of Opioid Dependence (AATOD) project (see story, page 3).

The study, "Staff Perspectives on Methadone Maintenance Therapy (MMT) in a Large Southwestern Jail," found that correctional facilities wanting to provide MMT first need to change staff attitudes about opiate addicts and about methadone as an effective treatment for addiction.

Researchers developed a 45-item "Knowledge, Attitudes and Readiness to Adopt" survey and administered it to 114 jail staff over a two-week period in the spring of 2003. The goal of this research is to help

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SAMHSA brings integrated treatment to provider level with release of TIP 42

The Substance Abuse and Mental Health Services Administration (SAMHSA) took a major step forward last week in bringing integrated treatment for co-occurring mental health and substance use disorders to the ground level with the release of a Treatment Improvement Protocol (TIP) for treating substance abuse in individuals with co-occurring disorders.

Entitled *Substance Abuse Treatment For Persons With Co-Occurring Disorders: A Treatment Improvement Protocol (TIP 42)*, SAMHSA introduced the groundbreaking document at a press briefing last week.

"This new TIP provides state-of-the-art treatment guidelines for counselors and others working in the field

of co-occurring substance use and mental disorders," said SAMHSA Administrator Charles G. Curie.

The core focus of TIP 42 is integrated treatment, the approach now generally accepted in both fields. Curie cited the origins of the two treatment fields — and the separate delivery systems created by separate funding streams — as reasons why people have been historically placed in the mental illness or substance abuse disease category.

But the importance of treating both in individuals with co-occurring disorders — integrated treatment — was succinctly stated by Curie: "If one of the co-occurring disorders remains untreated, both usually get worse. Additional complications often arise,

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policymakers develop effective training strategies for MMT programs in jail, prison, and juvenile detention correctional environments.

Many staff members have strong and often polarized opinions about drug treatment in a correctional setting, according to the study. Younger and non-medical staff generally had low knowledge scores on the survey and had negative attitudes toward methadone as a treatment for opiate addiction.

“Older, better educated staff had better attitudes towards a methadone” treatment program, Garnett P. McMillan, Ph.D., research scientist at the Behavioral Health Research Center of the Southwest, told *ADAW*. “The key here is figuring out how to take a medically accepted treatment program and make it medically acceptable to corrections people and non-clinical staff.”

Citing previous NIDA-sponsored research, the study points to political and philosophical opposition, as well as feasibility concerns (diversion of medication, violence, security breaches) as obstacles to judges and prison and jail administrators embracing MMT in jails and prisons.

Rikers Island

The study cites the Rikers Island methadone program in New York

[Continues on next page](#)

New Mexico legislation addresses methadone treatment in jails

New Mexico lawmakers recently introduced two bills to provide for opiate replacement therapy in correctional facilities.

One bill, S.B. 426, would establish an opiate replacement treatment program in New Mexico correctional facilities. The Senate legislation would require the state Corrections Department to coordinate with the Department of Health to establish the criteria for assessment and enrollment of an inmate in the opiate replacement treatment program.

According to the legislation, treatment would include methadone and buprenorphine.

“The New Mexico Society of Physicians voted unanimously to ask for legislation to require opiate replacement therapy in the New Mexico prison system,” Barbara J. McGuire, M.D., president of Cielo Azul Medical Services, LLC, a clinical and administrative consulting firm, told *ADAW*.

Another bill (H.B. 267) is a two-year inmate opiate replacement therapy pilot project. The project would provide opiate replacement treatment, utilizing buprenorphine/naloxone, to 30 women with a history of heroin or other opiate addic-

tion who are incarcerated at and later released on parole from the New Mexico Women’s Correctional Facility. The project would include standard therapeutic community and addiction counseling.

McGuire, a former correctional healthcare physician, conducted a presentation before the New Mexico Corrections Oversight Committee in December. She cited a recent study that depicted the overwhelming recidivism rate at New Mexico Women’s Correctional Facility.

Of women incarcerated for the first time, about 75 percent of those with a history of heroin addiction returned to prison within 30 months at an average cost of \$33,000 per year of incarceration, or almost \$100 per day, according to the study. The total recidivism cost was almost \$3 million.


“We are certain that with careful, supervised use of these medical tools, addicted persons will be treated effectively, thus consuming fewer state resources, transmitting less disease such as Hepatitis C and AIDS, engaging in less crime and violence and stepping out of the revolving door of prison recidivism,” McGuire told New Mexico officials.

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City as an example of a successful MMT program in a prison setting. The jail's 3000 opiate-addicted individuals are maintained on stable doses of methadone through the Key Extended Entry Program (KEEP). Almost all (95 percent) of the opiate-addicted individuals eligible for MMT enter, and remain in, the program. About 78 percent of those who participate report to community-based treatment programs upon release.

A recent sample of 1,737 U.S. jails revealed that only 19 percent have any funded drug treatment program other than detoxification, according to the study.

Methadone patients are forced into detoxification upon entering the jail, said McMillan. "This places a burden on the health services staff. If MMT is continued in the jail, then the MMT patients would not have to go through detox."

Lack of knowledge

The study noted that 26 of the 114 survey respondents added written comments to the survey. Several respondents displayed a poor understanding of MMT and how the MMT program would be implemented in jail. Among these respondents, several asked to be educated on opiate addiction and on MMT.

The study also found that many respondents described a tremendous amount of animosity towards drug-addicted individuals and lumped MMT recipients, opiate-addicted individuals, and criminals into one group.

McMillan said he wasn't really surprised by the harsh criticism by jail staff aimed at inmates with heroin addiction. "Illegal drug users are widely viewed as criminals who must be punished rather than given medical treatment for their condition," said McMillan. "This view is not unique to jail personnel."

A positive development

In a recent development in one state in the Southwestern U.S., state public safety and health officials

The study also found that many respondents described a tremendous amount of animosity towards drug-addicted individuals...

have agreed to establish and staff a public health clinic in a newly constructed jail facility. The new clinic will administer MMT to all inmates admitted into the jail who are enrolled in a methadone maintenance program at the time of booking.

The goals of the in-jail MMT program include:

- Educate inmates and staff about the role of MMT.
- Administer MMT or other maintenance therapy to all inmates currently enrolled in MMT programs.

- Reduce the need for medical intervention resulting from methadone withdrawal.

Attitudinal barriers to the program implementation can be overcome through effective staff training, according to the study.

The jail staff must fully understand and appreciate the rationale for implementing MMT. A positive attitude, which is directly influenced by knowledge of MMT, is most strongly associated with the readiness to accept an MMT program, according to the authors. •

AATOD cites progress in project to increase access to methadone treatment

American Association for the Treatment of Opioid Dependence (AATOD) President Mark Parrino cited continued progress involving the organization's work with the Robert Wood Johnson Foundation Innovators Award program to increase access to methadone treatment in jails and prisons. The project is working in five states to evaluate laws and policies and develop guidelines for overcoming impediments and increasing access to methadone treatment (see *ADAW*, Sept. 6, 2004).

The states are Arizona, Florida, Maryland, New York and Vermont. AATOD has already met with officials in most of the states, said Parrino. AATOD is also a just a few months away from developing a survey instrument to help gauge the attitudes and concerns regarding methadone treatment among representatives of the American Probation and Parole Association, the American Jail Association, and the National Drug Court Institute, said Parrino.

"We realize there's increasing awareness about opiate dependence," Parrino told *ADAW*. "Inmates need access to some form of treatment."

Parrino said he is encouraged by pending federal legislation, the Second Chance Act of 2004, which specifically authorizes the use of pharmacotherapies for incarcerated individuals. The legislation is designed to reduce recidivism, increase public safety and help states and communities better address the growing population of ex-offenders returning to communities (see *ADAW*, Jan. 31).

Parrino said he is encouraged by New Mexico's efforts and other jurisdictions around the country in their attempts to increase buprenorphine and methadone treatment to inmates who are opiate dependent. "We are definitely making inroads," said Parrino. "Yes, it's slow going, it's a huge focus and it's time consuming [but] I'm sensing a shift; it's an increasing shift in how policy-makers are thinking about this."

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including the risk for medical problems, suicide, unemployment, homelessness, incarceration and separation from families and friends.”

The prevalence numbers surrounding co-occurring disorders are daunting. SAMHSA estimates that 50-75 percent of patients in substance abuse treatment programs have co-occurring mental illness, while 20-50 percent of those treated in mental health settings have co-occurring substance abuse.

Though the prevalence of integrated treatment at treatment centers is increasing, SAMHSA estimates that most people with co-occurring disorders do not receive treatment for both maladies and many receive no treatment of any kind.

TIP 42 is designed for substance abuse treatment counselors and mental health treatment providers who usually treat one or the other of the two ailments, but it is also geared toward administrators, primary care providers, criminal justice

staff and other health care and social service personnel.

“Since people with co-occurring disorders cannot separate their addiction from their mental disorder, they should not have to negotiate separate service delivery systems,” said Curie. “We know that with appropriate treatment and supportive services, people with co-occurring disorders can and do recover. This is the premise of TIP 42.”

Screening and assessment

“Co-occurring disorders are the expectation — they should be screened for and evaluated for when people come in the door [for treatment],” Curie told attendees at last week’s press briefing.

TIP 42 leads practitioners through the screening and assessment process — gathering information that will provide evidence of co-occurring disorders; assessing problem areas, disabilities and strengths; assessing readiness for change; and gathering data to

decide the necessary level of care.

It is important for practitioners to identify past periods of mental health stability, determine past successful treatment for mental disorders and discover the nature of substance use disorder issues arising during stable periods.

Practitioners should also conduct integrated assessments — identifying the interactions among the symptoms of mental disorders and substance use — and how the interactions relate to treatment experiences, periods of stability and periods of crisis.

TIP 42 discusses diagnosis of mental disorders while acknowledging that substance abuse counselors are not expected to diagnose mental disorders. The limited aim of TIP 42 in this area is to increase substance abuse treatment counselors’ familiarity with mental disorder terminology and criteria and to provide advice on how to proceed with clients who demonstrate symptoms of mental disorders.

TIP 42 also outlines a substance abuse counselor’s role in helping individuals follow and adhere to prescription instructions. The counselor can also play a role in providing physicians with accurate description of client behavior and symptoms, helping to ensure that proper medication is chosen.

TIP 42 also provides guidance on enhanced staffing that incorporates professional mental health specialists, psychiatric consultation, or an onsite psychiatrist. There is also guidance on psychoeducational classes and community-based dual recovery groups that can increase a substance abuse counselor’s understanding of mental disorders and symptoms and interrelated issues.

TIP 42 also presents strategies for effective treatment of co-occurring disorders, including motivational interviewing; contingency management; cognitive-behavioral therapy; relapse prevention; assertive community treatment (ACT); intensive case management; and modified therapeutic community. •

SAMHSA making strides in treatment of co-occurring disorders

While the release of TIP 42 is a critical development by the Substance Abuse and Mental Health Services Administration (SAMHSA) for the integrated treatment of co-occurring disorders, it is not the agency’s first. Other ways SAMHSA has been active in this area include:

- **State Incentive Grants for Co-Occurring Disorders (COSIG).** Eleven states have received COSIG grants that help them enhance their infrastructure and treatment systems.
- The establishment of the **Co-Occurring Center for Excellence**, a national co-occurring disorders prevention and treatment technical assistance and cross-training center.

- Enhanced efforts to identify and disseminate effective programs, including the evaluation of a best practice tool kit.
- Expansion of the agency’s **National Registry of Effective Programs and Practices (NREPP)** to include effective programs serving co-occurring disorders.
- Working with the **Centers for Medicare and Medicaid Services (CMS)** to explore using existing reimbursement mechanisms to serve people with co-occurring disorders.
- Convened two **National Policy Academies on Co-Occurring Disorders** to help states and communities enhance service capacity.

Security of health information — the latest HIPAA deadline

by Paul Litwak

Editor's Note: This column is the first in a series by Paul Litwak on how providers and other health organizations can prepare for the HIPAA Security Rule that goes into effect in April.

April 21, 2005 is the deadline for compliance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Security Rule. You're probably sick of HIPAA, and I don't blame you. But this isn't a job that can be assigned to your computer network administrator and forgotten about. Security management decisions should be made on the "enterprise" level and be based on a solid understanding of business needs, regulatory requirements, security risks, and risk management.

The purpose of these articles is to identify some practical issues your organization may face in developing and implementing an information security program and to present a few technical requirements for information security in the context of business operations, which will (hopefully) facilitate communication between compliance officers and information technology professionals. This isn't a comprehensive review of all security standards, although it does cover a number of requirements of the HIPAA Security Rule.

Real stories

Here are a few publicly reported events in which the security of confidential information was compromised and individual privacy rights were compromised. In each case, the organization that held the information meant to keep it confidential.

- The Miami Herald reported on Sept. 30, 2004 that confidential child-abuse and foster-care records for nearly 4,000 Central Florida children were made available to anyone with Internet access through a gaping security breach in a child welfare agency's computer system.
- On April 2, 2004, a hacker gained access to a server at the University of Kansas that contained records of prescriptions filled at an on-campus pharmacy since 1994. Files on the server included prescription information for students, faculty and staff, Social Security numbers, student identification numbers, names, addresses and birth dates.
- In February 2003, a jury awarded \$2.3 million to three women whose mental health treat-

ment records were not kept private by West Virginia University Medical Corp., also called University Health Associates. A records clerk had removed the records, taken them home and to local bars and discussed them with people. The clerk was clearly acting outside the scope of his employment and was fired. Nonetheless, the jury found that the hospital had breached its duty of confidentiality. The verdicts did not include punitive damages.

- For eight days, beginning on Oct. 29, 2001, detailed psychological records of at least 62 children and teenagers were accidentally posted on the University of Montana website.
- Eli Lilly and Company, maker of the antidepressant Prozac, inadvertently divulged the names and e-mail addresses of 600 psychiatric patients in a mass e-mail. The company was investigated by the Federal Trade Commission, and reached a settlement in which it agreed to bolster the security of its Internet site.
- A Nevada woman bought a used computer, and discovered the prescription records of thousands of people on the machine's hard drive. The previous owner was a pharmacy.
- On Dec. 14, 2002, burglars stole computer equipment and data files from TriWest Healthcare Alliance, a Phoenix-based management service organization. The equipment included health records of over 500,000 people covered by the Department of Defense TRICARE program in 16 states.

Standards relating to information security

The U.S. Department of Health and Human Services (HHS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) each require healthcare organizations to adhere to standards for securing the confidentiality, integrity and availability of "electronic protected health information."

The final HIPAA Security Rule, codified at 45 CFR Parts 160–164, is the most comprehensive statement of standards for the security of health information. JCAHO standards for Confidentiality and Security (IM.2.10–40) are far less specific. Compliance with the Security Rule ensures compliance with the JCAHO information security standards, but the opposite is not true. For that reason, the focus here is on the Security Rule.

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The HIPAA statute required the HHS Secretary to enact national standards for the security of health information systems. Those standards, published in February 2003, supersede inconsistent requirements of state law (unlike the Privacy Rule, which defers to “more stringent” provisions of state law). The deadline for compliance with the Security Rule is April 21, 2005 for covered providers and most health plans. It is April 21, 2006 for small health plans.

Both the HIPAA statute and the final Security Rule require covered entities to:

- Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.
- Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Rule.
- Ensure compliance by its workforce.

The HHS Secretary is empowered to impose civil penalties for non-compliance with these requirements. The law also creates criminal penalties for willful or malicious violations of privacy rights (although criminal prosecution is extremely unlikely for anything short of selling celebrity medical records).

While there is no “private right of action” to directly enforce the HIPAA Security Rule, it is reasonable to expect that the standards adopted in the rule will become the “standard of care” applied to determine liability in private lawsuits.

A few important principles Flexibility

The final Security Rule is based on three concepts derived from the HIPAA statute. It is designed to be:

- *Comprehensive and coordinated* to address all aspects of security.
- *Scalable*, so that it can be effectively implemented by covered entities of all types and sizes.

- *Technology-Neutral*, allowing covered entities to make use of future technology advancements.

The rule allows covered entities a great deal of *flexibility* in selecting security measures to meet its standards and implementation specifications. Covered entities are permitted to apply any security measure that is *reasonable and appropriate* to meet the underlying standards. The measure of “*reasonable and appropriate*” is based on a number of factors, including the nature of the security risk, the size, complexity and resources of the covered entity, and cost.

Standards and implementation specifications

The Security Rule includes standards and implementation specifications that provide instructions for implementing standards. Covered entities are required to meet each standard. Implementation specifications fall into two categories — “*required*” and “*addressable*.” There are only 13 required implementation specifications, and covered entities must implement all of them. HHS introduced the concept of “addressable implementation specifications” to provide covered entities additional flexibility with respect to compliance with the security standards. Covered entities are free to evaluate each addressable implementation specification to determine if it is “reasonable and appropriate” to apply that specification to meet the underlying standard, or whether alternative security measures are sufficient, given the risks involved.

Next week: Ideas for consideration

Paul Litwak is an attorney and consultant to organizations with interests in information technology. He is the author of A Path to Compliance with the HIPAA Security Rule and A Path to HIPAA Compliance, an online guide to compliance. Both are available at www.hipaacomplianceguide.com. He is an expert in regulatory compliance, privacy, information security and software development and licensing transactions. He also has a background in mental health and disability law and works with government agencies, providers and consumers interested in reform of mental health systems.

NAMES IN THE NEWS

Harvard-affiliated **McLean Hospital** in Belmont, Mass. has named **Esther Dechant, M.D.** as medical director of the Klarman Eating Disorders Center, established in 2003 to provide state-of-the-art treatment for eating disorders in girls and young

women ages 13 to 23. Dechant is experienced in child, adolescent and adult psychopharmacology and psychotherapy. She completed her fellowship in child and adolescent psychiatry at Massachusetts General Hospital and McLean Hospital.

The Providence Center, a community-based outpatient behavioral

health organization, announces the following appointments:

Deborah O'Brien, R.N. has been named chief program officer. In this role, O'Brien will oversee all of the center's clinical programs for adults and children. Since 1995, she has been director of quality improvement at the center.

Lynn Mulvey has been named

director of Adult Behavioral Services, where she will be responsible for administrative and clinical operations. Since 1999, Mulvey has been coordinator of the Behavioral Health Outpatient Program.

RESOURCES

Johnson Institute launches faith-based journal

The Rush Center at the Johnson Institute announces the launch of its new quarterly publication, *Faith Partners Journal*. Johnny Allem, president of the Johnson Institute, calls the journal “another resource for the faith community to respond and support the Faith Partners model” and says its launch is “an important milestone in (the institute’s) 40-year history for innovation in the addiction recovery field.” The journal aims to serve as an inspirational and instructional guide for congregations of all faiths in addressing treatment of addiction. More information is available at www.johnsoninstitute.org.

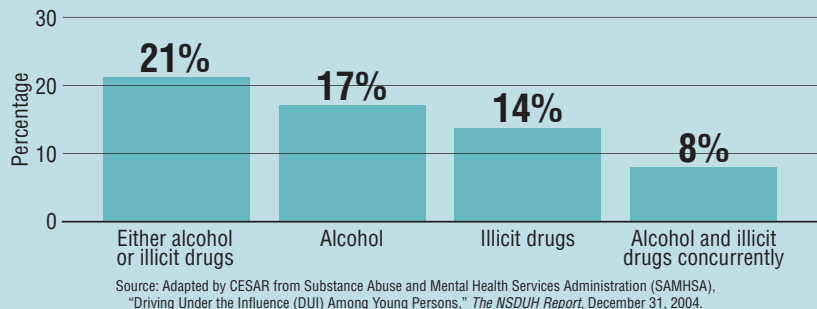
Kit targets youth drug prevention

A new resource from the Substance Abuse and Mental Health Services Administration (SAMHSA) entitled, *Essential Prevention Partners: Community and Faith-Based Organizations*, is a kit created to help organizations incorporate drug prevention strategies into youth programs. A comprehensive list of resources will accompany detailed instructions on integrating drug prevention efforts. Visit www.cadca.org for more information.

Resource guide supports mental health practitioners

The National Center for Mental Health and Juvenile Justice (NCMHJJ) has developed a comprehensive resource guide entitled, *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System*.

Percentage of U.S. persons aged 16 to 20 who reported driving a vehicle under the influence of alcohol and/or illicit drugs in the past year, 2002 and 2003 data combined



A Resource Guide for Practitioners. The guide was created with grant support from the Office of Juvenile Justice and Delinquency Prevention. Best practice information is provided to assist practitioners in identifying cases of mental health and substance abuse disorders. The publication is accessible online at www.ncmhjj.com/publications.

BRIEFLY NOTED

S.D. legislators reject medical marijuana bill

South Dakota lawmakers rejected Bill HB1109, sponsored by Rep. Gerald Lange (D.-Madison), that would have legalized the use of marijuana for medicinal purposes in South Dakota, the Associated Press reported. “There are certain debilitating medical conditions that are rather untreatable by contemporary medical practices,” said Lange. Such diseases include cancer, glaucoma and AIDS, and the drug has shown benefits for patients suffering from chronic pain, nausea or seizures. However, the House Health Committee has voted 11-1 against the bill.

Under the bill, doctors could have prescribed up to 5 ounces of marijuana, but only after certifying that their patients had qualifying conditions. In addition, both doctor and patient would have been required to register with the state

health department. A state lawyer, who suggested the law would lead to increased drug trafficking, urged legislators to reject the bill.

States consider restricting cold medicines

Citing an “overwhelming linkage” between drugs and crime, Iowa’s Attorney General Tom Miller has requested an additional \$14 million for drug treatment and prevention programs, the Associated Press reported. He has also asked the state legislature to tighten restrictions on the sale of pseudoephedrine-containing cold medicines, which have been key in the manufacture of methamphetamine. Miller’s plan would include pharmacist-control and monitoring of cold medicine sales.

Such a cold-medicine restriction was enacted in Oklahoma about 10 months ago, and authorities there say meth production is down by 80 percent. Arkansas, Kansas, Missouri and Texas are also considering this approach. And responding to several deaths last year, Vermont is at work on a prevention strategy in hopes of heading off a methamphetamine crisis.

In Indiana, the number of methamphetamine labs dismantled by authorities in 2004 was up 25 percent from the year before, the majority spread across the southwestern and south-central counties.

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Authorities suspect that the roughly 1,500 labs discovered is only a fraction of the total. As in other states, legislation has focused on restricting the sales of materials used in the manufacture of the drug.

DWI history linked to plane crashes

The results of a study published in the journal *Accident Analysis and Prevention* suggest that general aviation pilots with a history of driving while intoxicated (DWI) are more prone to crash their planes than pilots with no such history. A team of researchers from Johns Hopkins University studied the medical records of over 300,000 pilots who held a Class III medical certificate in the United States in 1994, and subsequently tracked their flying records until 2000. They estimated that after adjusting for age, gender and flight experience, pilots with a DWI history had a 43 percent higher crash risk than their counterparts.

Since 1990, pilots applying for a license must undergo a DWI background check. All major airlines conduct regular, random testing of pilots and safety personnel.

NIH employees subject to stricter ethics rules

The National Institutes of Health (NIH) has announced new ethics regulations that focus on the outside activities, financial holdings and awards for all of its employees. In particular, NIH is addressing concerns regarding outside consulting with the pharmaceutical and biotechnology industries. In a recent press release, NIH Director Elias A. Zerhouni, M.D. wrote, "I am confident that these new rules will prevent the recurrence of past abuses and will go a long way in preserving the historic role of NIH as the primary source of unbiased scientific health information for the country."

Under the new regulations, NIH employees are prohibited from engaging in certain kinds of outside

Coming up...

The World Research Group sponsors the Performance Measurement for Behavioral Healthcare conference, "Improving Data Collection Methods, Benchmarking Quality Standards, and Measuring Behavioral Health Outcomes," **Feb. 23-25 in Scottsdale, Ariz.** For more information visit www.worldrg.com.

The **Institute for Integral Development** will sponsor the 19th Annual Conference on The Family in Stress and Crisis, **March 21-24 in Santa Fe, N.M.** For more information visit www.institutefortraining.com.

The American Society of Addiction Medicine's 36th annual conference will take place **April 14-17 in Dallas.** For more information visit www.asam.org.

The second **UK/European Symposium on Addictive Disorders**, "To Match or not to Match: Enhancing Client Outcomes," will take place **May 19-21 in Central London, England.** For more information visit www.ukesad.org.

The **Texas Association of Addiction Professionals** will hold its 31st Annual State Conference on **July 7-9 in Corpus Christi, Texas.** For more information visit www.taap.org.

The North River Foundation Inc. will sponsor the 18th Cape Cod Symposium on Addictive Disorders, **Sept. 29-Oct. 2, in Hyannis, Mass.** For more information call 781-585-3536.

employment, though they may maintain their academic pursuits and practice medicine as appropriate. Employees would be prohibited from outside employment with substantially affected organizations, including pharmaceutical and biotechnology companies; supported research institutions; health care providers and insurers; and related trade, professional or similar organizations. Investments in organizations substantially affected by NIH would also be disallowed.

NIH intends to evaluate certain provisions of the regulations and will accept public comment for up to 60 days after the interim final rule is published in the Federal Register, which is expected in a few days.

Student drinkers report boredom in school

According to the results of a recent Gallup survey reported in the New York Times, 63 percent of student drinkers claimed they were bored in school, compared to 45 percent of non-drinkers. Only 19 percent of the drinkers said they were happy in school, versus 36 percent of non-drinkers. In addition, half of the 785 student drinkers polled said they were consistently tired at school. The students surveyed ranged in age from 13 to 17 years. Asked how they expected their parents to punish their drinking, 46 percent said they would be grounded or lose their privileges.

In case you haven't heard...

Adolescence is more dangerous than we once believed, the Press Association Limited reports. According to the pediatric scientist who led recently publicized research, the region of the brain that inhibits risky behavior is not fully developed until the age of 25, not 18, as previously believed. Magnetic resonance imaging of the brains of over 2,000 young people suggests that their brains are "still under construction," raising questions about learning patterns and conditions. Wide ranging implications could include driving regulations; road accidents are the leading cause of accidental death to individuals aged 16-24.