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NAATP Visions is the official newsletter of the National Association of Addiction Treatment Providers (NAATP), the American College of Addiction Treatment Administrators (ACATA), the National Adolescent Treatment Consortium (NATC) and the National Treatment Consortium (NTC).

4 ISSUE

naatp
national association of addiction treatment providers

119 IS FINAL COUNT!

The final count is **119**! Launched in 1998, the National Association of Addiction Treatment Providers has been collecting and providing benchmarking information to participating members. 2002 marked the 5th year of this

effort and the participating members for 2002 numbered nearly 4x the number that first responded in 11998. With almost 100 participants competing the benchmark survey on-line the 2002 participation rate was a significant success using any measurement.

The collected data has now been tabulated and converted into color graphs.The information is currently at the printer and the 2002 benchmark survey reports will be on your desk (if you participated and provided information) by the middle of May. Along with your benchmark report, you will also receive information on how you can obtain a custom report and also have a presentation for your organization on this benchmark activity.

This is extremely useful management and planning data and should be incorporated into your review and planning process each year. The 2003 benchmark data collection form will again be mailed out in January of 2003. Mark your calendars and plan to participate and move the 119 participation number to 130!

We are anticipating 200 attendees at the 2002 NAATP annual conference in Scottsdale,Arizona. **Will you be one of those 200?** All of the preparation has now been completed and all that remains is for you to make your final arrangements and to remember to register for this conference.

This year we will feature a golf outing on May 18, 2002 at the Talking Stick Golf Course followed

by a luncheon in the club house and the patio adjacent to the club house. Using a best ball format, this outing will be an opportunity for everyone to enjoy the Arizona early morning weather and to get to know other NAATP members. If you have not signed up for this event, it is not too late as long as you call the NAATP office today. Bring a friend and make this a super beginning to a fabulous conference.

The NAATP conference begins on Sunday May 19 and continues through Tuesday noon on May 21. This year there will be nearly 30 organizations with exhibits at the conference so be sure to visit the exhibit area and support the exhibitors and sponsors.

The conference is a pleasant mix of plenary sessions, outdoor receptions, award presentations, workshops, outdoor luncheon and ample time to network and relax and enjoy the facilities of the Marriott Mountain Shadow Resort.

Plan to be present with the other members of the National Association of Addiction Treatment Providers at this annual gathering and celebration!

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AS RJH SEES IT

Recently I completed a search on a popular internet search engine for the term "disease management". Not surprising, I found well over a thousand listed references to this term. Though my review was somewhat cursory, I did not find a single reference to an article or web location that focused on addition! Nearly every other imaginable disease was mentioned and there was ample documentation to efforts that have been undertaken to "manage" the disease, particularly in the areas of disease that are chronic in nature. Instead of only responding to a disease when it presents itself in some crisis form or when it evolves into an acute outbreak, the emphasis is to mange (through professional healthcare involvement) the disease throughout the lifetime of the individual.

After reviewing this material, a more novel idea came to me, "why not search for references to ***Recovery Management***". Again the search engine roared and came back with over 700 references to what it thought were sites related to recovery management. The returns on this search were even more startling than the former one. There at the very top of the list was a site: www.bhrm.org – Behavioral Health Recovery Management. This project and this website are committed to "Applying the principles of disease management to assist in the treatment of chemical dependency and/or serious mental illness." So while there was no serious reference to addiction under "disease management" here at the top of the list on "recovery management" was a Web site reporting on a project that is making the translation from disease management to the issues of recovery related to addiction treatment.

But even more import is the fact that www.bhrm.org reports on the efforts being carried out by two organizations in Illinois: Chestnut Health Systems and the Fayette Companies, both of which are members of the National Association of Addiction Treatment Providers. The two lead project directors of this effort are William White, the opening plenary speaker for the NAATP 2002 annual conference and Mike Boyle who will join Mr. White on Sunday afternoon for a presentation on Recovery Management. It could be hardly more appropriate that that NAATP will feature the two lead researchers and project directors who are working to move us in the direction of this paradigm shift in our thinking and then in our practice.

The year 2003 marks the 25th anniversary of the National Association of Addiction Treatment Providers. During the first 25 years we have been the acknowledged leader in numerous issues related to addiction treatment, funding and financing of treatment, accessibility of treatment and the establishment of standards for addiction treatment. Over the course of the next 18 months you will be introduced and in some cases reminded of the 25 year history, our leaders and the issues that have engaged us over those years.

But you will also be urged to not live in the past and perhaps no issues will be more important to launch us into our second 25 years than that of recovery management. Addiction treatment providers, NAATP members and non NAATP members, need to relinquish their reliance on looking at "treatment" as an isolated incident in the life of an individual. The diagnosis of alcoholism or other chemical dependency must automatically carry with it the understanding that the diagnosed person has and will have this disease for the rest of her or his life. Because of that ***given*** the following questions, it seems to me, need to be asked:

- Who (what organization) is going to take responsibility for managing the **life-long recovery process** for this individual?
- What is the optimal monitoring needed by this individual to ensure that the recovery process can be managed as effectively and efficiently as possible?
- If "I" do not provide life-long recovery management services, what would it take for my organization to **transfer** the patient to an organization that does?
- What would I have to change about my organization if I stopped thinking about addiction treatment episodes and began thinking about identifying persons with the disease of addiction and then managing their recovery for the rest of their lives?
- Who could I talk to that has given some thought to these questions?

I am certainly not sure about the first four questions, but I know the answer to the fifth (last one). Those persons are William White and Mike Boyle. If you quickly sign up now and attend the NAATP 2002 annual conference, you will have a chance to interact with both Bill and Mike and then raise your own questions.

So, 2003 will be the 25th anniversary of NAATP and already there are issues for us to move to the front and assume leadership roles. I wonder how many more issues will emerge over the next 25 years? Whatever the number, NAATP will be there to respond!

That's the Perspective of RJH

Washington Roundup

House Leadership Introduces Legislation Supporting Bush Administration TANF (Welfare) Reauthorization Proposal: House Committees Hold Hearings, Take Testimony from Health and Human Services Secretary Tommy Thompson

In the third week of April, House Republican leadership, including Speaker Dennis Hastert (R-IL), Majority Whip Tom DeLay (R-Texas), Republican Conference Chairman J.C. Watts (R-OK), Education and Workforce Committee Chairman John Boehner (R-OH), and Ways and Means Subcommittee Chairman Wally Herger (R-CA) introduced,"The Personal Responsibility, Work, and Family Promotion Act of 2002," that would reauthorize the Temporary Assistance for Needy Families (TANF) program which by law is due for reauthorization this year. The bill reflects President Bush's welfare reauthorization proposal with certain modifications.

Like the Administration's proposal, the House Republican bill would require 40 hours of work per week for most TANF recipients and would count as work up to three consecutive months of drug and alcohol treatment during any 24 months of TANF benefits. It also would permit individuals to spend as much as 16 of their 40 hours of work per week engaged in other types of activities, with the specific eligible activities determined by each state. A state would be able to include drug and alcohol treatment in this category of "other" activities.

The House Education and Workforce Committee and Ways and Means Subcommittee on Human Resources held hearings on TANF reauthorization this week. Both Committees heard testimony from Health and Human Services Secretary Tommy Thompson on the Administration's TANF reauthorization proposal. Concerns raised during these hearings included issues around the proposal's significant work requirements that would require States to eventually have 70% of TANF recipients engaged in 40 hours of work per week. The desire to provide drug and alcohol treatment services to TANF recipients was expressed by both members of the Committees and Secretary Thompson in his remarks.

The House Ways and Means Subcommittee on Human Resources could hold a vote on TANF reauthorization legislation as early as next week. Other bills up for consideration by the Subcommittee include Congresswoman Patsy Mink's (D-HI) bill, H.R. 3113, "The TANF Reauthorization Act of 2001." This legislation was developed in cooperation with grassroots and national organizations across the country representing individuals affected by welfare reform and providers of welfare, health care, and social services. It includes several provisions that would help individuals gain access to drug and alcohol treatment services, including:

- Permitting States to count drug and alcohol treatment as a work activity.
- Repealing the ban on receipt of TANF benefits and food stamps by individuals convicted of a drug felony.
- Requiring States to assess and address barriers that prevent individuals from moving from welfare to work, including drug and alcohol abuse and dependence, before imposing sanctions.

The Senate Finance Committee also held a hearing this week on TANF reauthorization that focused on the issue of work requirements. While the Senate Finance Committee still is in the process of developing TANF reauthorization legislation, it would like to hold a vote on reauthorization legislation by Memorial Day recess.

National Institute on Alcohol Abuse and Alcoholism Releases Findings From Major Study on College Drinking: Key Prevention Strategies Outlined

In the middle of April, the National Institute on Alcohol Abuse and Alcoholism's Task Force on College Drinking announced the publication of findings from a three-year review of research on college drinking and the relative effectiveness of various prevention strategies. The announcement coincided with the celebration of National Alcohol Screening Day which was sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other national and local partners. Held on April 11th this year, the event provided professional screening and treatment referral at more than 2,600 sites around the country, including more than 500 universities and colleges.

As part of its review, the NIAAA Task Force on College Drinking commissioned two dozen studies, many of which have been published during the last month. One study highlighted by the Task Force found that drinking by college students 18-24 years old contributes to an estimated 1,400 deaths, 500,000 injuries, and 70,000 cases of sexual assault or date rape each year. The study, conducted by Ralph W. Hingson, Sc.D., of the Boston School of Public Health in collaboration with researchers at Harvard and SAMHSA, analyzed data about drinking and its consequences from a number of national databases.

NIAAA's review both assesses the extent of the college drinking problem and identifies the best research-supported strategies for addressing it. The NIAAA Task Force has released its review findings in a number of different formats designed for a wide range of users: two panel reports, *High-Risk Drinking in College: What We Know and What We Need to Learn* and *How to Reduce High-Risk College Drinking: Use Proven Strategies, Fill Research Gaps*; a handbook for college planners on implementing and evaluating alcohol prevention programs; and brochures and pamphlets for college and university presidents, student peer educators, and parents. With these documents, the Task Force aims to help colleges and universities design prevention programs that simultaneously address the entire student population, the college and surrounding environment, and at-risk or alcohol-dependent individuals. The Task Force also describes the research gaps that must be filled to develop better prevention programs. The Task Force's publications can be accessed on the world wide web at www.collegedrinkingprevention.gov.

Once again, Your Association Speaks Out!

In the April 8, 2002 issue of ***Modern Healthcare*** an Op-Ed piece was published calling for the passage of meaningful mental health parity legislation at the federal level. Citing the discrimination issues and also pointing out the relatively insignificant cost increase, the widely read magazine within the "hospital" management ranks, lent their weight to this issue.

However, the most glaring omission from this Op-Ed piece was any mention of the need to include substance abuse or the raising of questions as to why substance abuse has not been included in the proposed legislation.

In response to this publication, the National Association of Addiction Treatment Providers sent a letter to Mr. William A. Morrow, Executive Vice President/Operations of Modern Healthcare raising our objections to the omission and calling attention to how this omission perpetuates the discrimination experienced by providers of addiction treatment and those seeking addiction treatment. The text of that letter follows:

April 18, 2002

William A. Morrow, Executive Vice President/Operations
Modern Healthcare
360 N. Michigan Avenue
Chicago, IL 60601-3806

Dear Mr. Morrow:

In the April 8, 2002 issue of *Modern Healthcare*, Mr. Todd Sloane, you assistant managing editor wrote a OP-Ed piece "*For mental health parity*" which was carried on page 26. In this OP-Ed piece, Mr. Sloane has lent the support of your prestigious magazine to have meaningful parity legislation passed at the federal level. On the surface this piece is laudable and Mr. Sloane is to be commended. However, just below the surface resides the stigmatization that is so prevalent in our culture and apparently at your magazine as well. Where in the piece is the call for the inclusion of *substance abuse* in meaningful federal legislation or more importantly, where are the questions concerning why Substance Abuse is not included in the referenced legislation and what are the forces that have kept it from being included?

The very same arguments regarding annual and life-time dollar caps and day limits that were made regarding the need for mental health parity apply to substance abuse parity. The only exception is that substance abuse is not mention in the legislation and was not mentioned by your magazine. If you believe discrimination has been at work in not having meaningful mental health parity legislation, then what do you propose to call what is happening by not including substance abuse?

From a strategic point of view, doesn't it make sense to combine the issues and call for an end to discrimination in health plans toward both substance abuse and mental health treatment? We believe that substance abuse and mental health issues are tied together diagnostically and therapeutically. Would not the health care field be better served by collaborative efforts to fix a combined injustice?

The National Association of Addiction Treatment Providers, represents the premier providers of addiction treatment organizations across the country has had a consistent voice in support of parity legislation that addressees, in a real way, the current discriminatory annual and lifetime dollar caps and day limits for both substance abuse treatment and mental health services. At the federal level this effort has been championed by the leadership and courage of Rep. Jim Ramstad (R-MN) and Senator Paul Wellstone (D-MN) We would have hoped that a prestigious publication such as *Modern Healthcare* would have used its Op-Ed opportunity to go above discrimination and call for comprehensive federal parity legislation. To do less, as you have done, only deepens the discrimination toward substance abuse which is already present.

Sincerely,
Ronald J. Hunsicker, D.Min., FACATA
President/CEO

Employers See Problems with Managed Treatment, But Not Convinced About Solutions

The following is a summary of a larger article from Join Together Online and can be found at http://www.jointogether.org/sa/news/features/reader/0,1854,550163,00.html

Many large employers are as dissatisfied with managed behavioral healthcare as their employees are, but that doesn't mean they support parity or even lifting lifetime or episode-of-care limits on addiction treatment.

Employers like American Airlines, Eastman Kodak, IBM, General Motors, Delta Air Lines, Pepsico, and AT&T provide relatively generous benefits packages for addiction treatment. Most utilize managed-care firms to control costs, and they see the current system as being cost-effective.

At the same time, however, large employers recognize that treatment quality can suffer under managed care, said Kristen Apgar Reasoner, a behavioral-health researcher and director at the Washington Business Group on Health (WBGH).

For example, while most employers have chosen to use carve-outs to manage care and costs, they recognize the trade-offs in service quality and lack of integration with related health services.

"The employers' experience with lack of accountability under unmanaged care, as well as with the lack of access to care for employees in HMOs, makes them doubt the arguments being made in favor of a return to integrated health care," according to a 2001 report prepared by WBGH for the federal government detailing the behavioral-health benefits offered by large employers and the implications of current benefit design on parity. "Yet, at the same time they recognize that the opting for a carve-out is often at the expense of care coordination. They also know that their employees continue to receive a significant share of their treatment for mental illnesses and substance abuse through primary care. And, they have increasing concern about the lack of access of available providers within networks, particularly for an increasingly diverse workforce."

"Both employers and employees are very dissatisfied with what they've got, but they don't want to negotiate with providers directly," said Apgar, who authored the report. "There's the feeling that they need to improve, but they're not sure of the direction."

A Striking Lack of Employee Outcry

By and large, employers still see managed care as preferable both to tough limits on benefits — which drive up utilization of other health-care services — and the unlimited benefits

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Brown & Associates, Ltd. And Rx2000 Institute Announce Strategic Alliance

Dan Brown, President, Brown & Associates, Ltd., Behavioral Services Consultants, announced his company's strategic alliance with Rx2000 Institute of Minneapolis, Minnesota. The alignment of the two organizations combines the behavioral health care expertise of Brown & Associates, Ltd.With the demonstrated skills of Rx2000 Institute, a non profit organization dedicated to helping health care organizations address the challenges of HIPAA.

By combining resources, Brown & Associates, Ltd. Believes the alliance will ensure their clients the required expertise in both HIPAA and behavioral services. Services comprise all aspects of HIPAA compliance including analysis and risk assessment, staff education, and implementation of policies and procedures, forms, contracts, authorizations, notices and position descriptions. Additionally, advisory support concerning hardware and software is also available.

"Since 1987, Brown & Associates, Ltd. Has been successfully providing accreditation and regulatory compliance services to behavioral healthcare providers. Our alliance with Rx2000 Institute will ensure this same success for our clients with HIPAA, said Mr. Brown in a press release.

Mike Thorsen, EVP and Education Director at the Rx2000 Institute stated that, "Behavioral health care organizations face unique HIPAA challenges, especially in the areas of patient privacy and security of protected health information. Rx2000 is very pleased to join Brown & Associates to better serve this important health care sector."

For information concerning HIPAA consulting services, contact Brown & Associates, Ltd.At 800-495-6786.

LMC Impact and NAATP are pleased to announce a special offering available to NAATP members during the National Association of Addiction Treatment Providers (NAATP) Annual Conference...

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system that prevailed through the early 1990s, when utilization of addiction benefits skyrocketed. "Employers saw a lot of costs without a lot of results," recalled Apgar.

Many large employers have dropped day and visit limits, but lifetime and episode-of-care caps remain in place. And employers have generally not heard the kind of demands from workers that might persuade them to further reform the current system, Apgar said.

"Part of the lack of demand for treatment is that employees don't use their benefits to access treatment: they pay for it themselves because they don't want people to know," she said. "It will take a lot of time and public awareness to change that."

On the other hand, Apgar told Join Together, "Employers don't like employees complaining about health care. If they got a lot of complaints about treatment, they would do something about it."

From an advocacy standpoint, said Apgar, "You need to be sure that employees know about the benefits available, and then deal with the fact that they don't really want them [because of denial], or don't want employers to know they're using them."

While efforts like Join Together's Demand Treatment! and the Alliance Project are trying to increase advocacy among people

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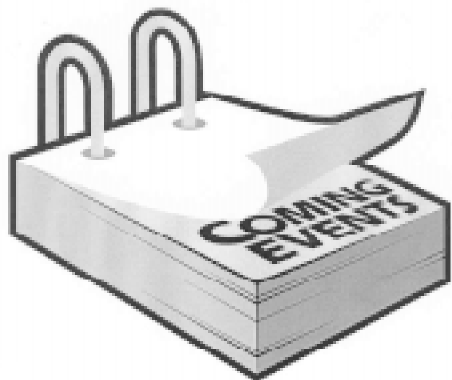
Where do you look for Informaton on Treatment Programs?

Looking for information on a treatment program? SAMHSA (Substance Abuse and Mental Health Services Administration may have just the resource you are seeking. Their updated directory of local alcohol and drug treatment programs is now available. ***National Directory of Drug and Alcohol Abuse Treatment Program*** (2000) can be obtained by calling (800) 729-6686. The cost of this publication is free.

This very handy desk resource is organized by state, and includes contact information. This printed resource complements their online ***Substance Abuse Treatment Facility Locator*** which is available on line at http://findtreatment.samhsa.gov.

The online facility locator's search able data allows individuals to tailor their search according to specific services. Other features include:

- A quick reference of data for substance and mental health hotlines, crisis center, and emergency services;
- Patient referrals for hospitals, healthcare providers and social service agencies; and
- Information on the acceptance of public and private insurance programs at each facility.



Look for the NAATP Salary Survey Later this Fall!

Where you getting your comparative salary information for your organization? For most addiction providers it has been a sampling of multiple sources, none of which match well. Your trade association, the National Association of Addiction Treatment Providers has the answer! Every two years the addiction treatment industry is sampled and a published salary survey report is made available for a modest fee.

The next NAATP Salary Survey will be published in the 4th Quarter of 2002 with the data collection form being sent out in the 3rd quarter.

Be on the alert for notices of how to access the data collection form online and also for the mailing of the form in the middle of the 3rd quarter. This document will be a **must** for organizations who want to stay competitive and knowledgeable around salary issues for addiction treatment staff.

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who need addiction treatment, the WBGH — using a grant from the Robert Wood Johnson Foundation — is working to raise employer awareness about the need for comprehensive addiction benefits.

The good news, the WBGH report concluded, is that "the experiences of the large employers provide strong support for economic analyses that predict that parity can be implemented without significant increases in cost. However, their experiences also suggest that the essential matters of access, quality, and effectiveness of care are not resolved solely through benefit design."

Other Stumbling Blocks: Stigma and Skepticism

Stigma and lingering skepticism about treatment effectiveness present significant stumbling blocks to the reform of existing benefits packages. These barriers are particularly visible in the failure of most employers to come out in favor of legislation that would require insurance plans to cover addictions on par with other diseases.

Making the Case to Employers

The WBGH's research strongly suggests that employers may be receptive to well-crafted arguments in favor of improved treatment services, even if they are not yet willing to embrace parity. But they need better information about effective treatment models, and to learn that addiction treatment has success rates equal to treatment for other chronic disorders, such as diabetes. Employers also need more information on emerging pharmacological interventions that — as occurred in the mental-health field — build confidence that addiction can be treated successfully, and fight stigma by demonstrating the disease's organic underpinnings.eve that contracting with managed-care organizations gives them more control over treatment providers.

FROM THE BOARD ROOM

The addictions treatment field continues to deal with challenges.The patient population has again moved across that undefined horizon of complexity. Colleagues continually note, from year to year, that "I can't believe how much more sick they are from anything I can ever remember. I can't imagine it can get any worse!"

This issue takes on ever more serious proportions as it relates to our young people, my children, your children and all the other "not my kids" that present at our facilities doorsteps at younger and younger ages. Many have already been in several treatment experiences and most haven't gotten what they need. They are enigmas to the treatment field. They defy the current state of the treatment art.

Whatever we have come to believe and/or understand about what treatment is, it is more often than not that current treatment methods are less effective when it comes to adolescents. Our tried and true armament of techniques that are the mainstay of the treatment toolbox including, but not limited to breaking denial, confrontation, attacking resistance, hovering sanctions, 1st, 2nd, 3rd Step and on preparations and workbooks, Psychoeducational/Didactic teaching about the disease of addiction and the myriad of group exercises, experiences and challenges are rendered impotent.

What happened to hours upon hours of classroom time in addictions treatment education; the years of "supervised experience", test's, case presentations and the like, involved in getting CADC's/ LCADC's? Alternatively, what about the years of education and obstacles to achieve academic degrees - Bachelors, Masters and/or PhD's in preparation to help? Interestingly, there appears to be almost no specificity of education and training in the essential and independent knowledge base regarding adolescents. Has any one ever wondered why there is Board Certification in Child and Adolescent Psychiatry and/or specialized training and education in Child and Adolescent Psychology? It seems odd that such knowledge and training somehow does not apply to addictions treatment. It seems analogous to the discovery that women might need something different than men, or those with co-occurring psychiatric or other associated disorders like ADHD and Learning Differences might require adaptation, modifications/accommodations, creativity and alternative but integrated approaches.

What we need, as a profession, to consider is that adolescents are not adults. In fact, they bear little to no resemblance to adults except regarding their belief that they are. Adolescents are fundamentally different from adults in every way and adolescence is a critical developmental period, requiring the accomplishment of profound tasks on the way to what we call adulthood. Adolescents in addiction are at imminent risk of developmental damage or loss of life. We must be respectful of what is important to them but curious about what it means. We must nurture the ability to be empathic and see the world from their vantage point rather than from ours. We cannot assume we know what they think and feel but we can ask them to help us understand as we consider how to be helpful appropriately. We must care enough to set firm and responsible limits reinforced to withstand nuclear assault as a test to see if the limits, and we, are strong enough for them to feel safe and surrender. What is "normal" for adolescents and adolescence is often viewed as pathological and antisocial along with the favorite clinical "diagnostic" designations of non-compliant, resistant, antagonistic, hostile, oppositional and defiant. The harder we push, the more immovable they become. The more we tell them what to do to recover, the less we see them do and the more they divide and conquer, challenge your competency, pit one staff against another with great aplomb, apparent joy and increasing grandiosity. It is just part of the process. Once we engage at their level, they lose. The moral is: as long as we do what we have been trained to do in the treatment of addictions, we will remain impotent and ineffective in the treatment of adolescent Substance Use Disorders.

What is the challenge? The first step may be admitting we are powerless and they have extraordinary skill at making our and their life unmanageable. The second may be that we come to believe that a power greater than ourselves can help us get on the road to sanity and greater age specific competency. The third step may be that we become willing to challenge ourselves with the possibility that we don't know what we don't know and what we do know isn't good enough. I believe the next step is to do a searching and fearless professional and personal inventory with the central questions being: "How good do I want to be?" "How badly do I want to be that good?" "How willing, curious, inquisitive, thoughtful, excited, energized and full of wonder am I, to go to any lengths, to seek what I need to learn?" All of it in the service of being more able to engage just one more kid in the process of recovery through exploration of the often rough and unpaved pathway of self discovery and a little closer to answering each adolescent's most significant question, "Who am I?"

In the current climate of health care and reimbursement manipulation, continued stigma, disregard of science for anecdotal experience is driving our ability to effectively do the work that needs to be done, we cannot stand idly by being less than we can be, and must be.

Philip N. Horowitz, Ph.D., Administrator
Sunrise House Foundation
NAATP Board Member

Upcoming Events for Your Calender

The **University of Nevada, Reno** will host "The Integration of Primary Care and Behavioral Health: Lessons Learned from the Field," **May 17 and 18 in Reno, Nev.** For more information, call (800) 233-8928 or (775) 784-4062; or visit http://dce.unr.edu.

The **National Association of Addiction Treatment Providers** presents the **2002 Annual Conference, May 19-21, 2002 in Scottsdale, AZ.** The theme for this conference will be "**Value-Added**". For more information, call (717) 581-1901 or visit our website at www.naatp.org/scottsdale.

The **New England Institute of Addiction Studies** will present its annualNew England Summer School of Addiction Studies **June 16 to 21 in Rindge, N.H.** For more information, call (207) 621-2549; e-mail neias@neias.org; or visit www.neias.org.

NAADAC, The Association of Addiction Professionals will hold its 26th annual Conference on Addiction Treatment **July 3 to 6 in Boston.** For more information, visit www.naadac.org.

The **American Society of Addiction Medicine** (ASAM) will present a workshop on Forensic Issues in Addiction Medicine on **July 18 in Washington, D.C.** For more information, visit www.asam.org.

Haymarket Center will present the eight annual Summer Institute on Addictions **July 24 to 26 in Chicago.** For more information, contact Carol Blyskal at (312) 226-7984, ext. 396, or visit www.hcenter.org.

The **Institute for Integral Development** will present the 26th annual Summer Institute on Behavioral Health and Addictions, **Aug. 5 to 8 in Colorado Springs, Colo.** For more information, visit www.institutefor training.com.

Pavillon International will present the 2002 Carolina Conference on Addiction and Recovery **Sept. 25 to 28 in Charlotte, N.C.** For more information, visit www.carolinaconference.com or call (877) 392-9973.

The **State University of New York at Binghamton** and **Broome Community College** will present a research conference, "Treating Addictions in Special Populations: Research Confronts Reality," **Oct. 7 and 8 in Binghamton, N.Y.** For more information, contact Jane Angelone, Conference Coordinator, Professional Development and Research, Binghamton University, P.O. Box 6000, Binghamton, NY 13902-6000; phone (607) 777-4447; fax (607) 777-6041; e-mail angelone@binghamton.edu; or visit sehd.binghamton.edu/pdr/index.htm.

The **GAINS Center for People with Co-Occurring Disorders in the Justice System** will hold its second national conference, "Policy and Practice: Expanding Access to Community Based Services," **Oct. 28 to 30 in San Francisco.** For more information, visit www.gainsctr.com.

NAATP VISIONS

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