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INSIDE

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The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine.

THE ARRIVAL OF DSM-IV

Timmen L. Cermak, MD

It took seven years to move from DSM-III to DSM-III-R, which attempted primarily to resolve inconsistencies and lack of clarity in DSM-III. Another seven years went into creating the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

Allen Frances, MD, chair of the DSM-IV Task Force, said that the major innovation of DSM-IV lies not in any of its specific content changes but rather in the systematic and explicit process by which it was constructed and documented. No changes were made without substantial data to justify the change.

A five-volume sourcebook will detail the clinical and research support underlying each diagnostic category. Volume I (768 pp.), which includes Substance-Related Disorders, is available now (American Psychiatric Press, 800/368-5777; $125).

A note of caution regarding first impressions is in order before proceeding. Although there appear to be no blockbuster changes in DSM-IV, we should remember that even small changes have a way of entering the fabric of our thinking with unexpected consequences. At the time Post-traumatic Stress Disorder (PTSD) appeared in DSM-III, who could have guessed the many ways it would be used and the many populations beyond combat veterans to which it would be applied? It seems nearly impossible to predict the ultimate implications of what appear initially as minor changes in any new edition of DSM.

Substance-Related Disorders

The specifics of how DSM-IV differs from DSM-III-R in the area of Substance-Related Disorders are summarized (see tables on pgs. 2 and 3) in Appendix D of the new volume:

1. In DSM-III-R, there were two different sections: Psychoactive Substance Use Disorders (i.e., Dependence and Abuse) and Psychoactive Substance-Induced Organic Mental Disorders. In DSM-IV it is one section, called Substance-Related Disorders.
2. The DSM-III-R category of Substance Abuse is criticized as a "residual category without a clear conceptual framework." In an effort to sharpen the distinction between Dependence and Abuse, the number of criteria for Abuse is increased from 2 to 4 by moving "failure to fulfill major role obligations" from Dependence to Abuse and adding "recurrent substance-related legal problems" to the criteria for Abuse.

The differences between DSM-III-R (1987) and DSM-IV (1994) are shown in these tables from each volume.

DSM-III-R Diagnostic Criteria for Psychoactive Substance Dependence
A. At least three of the following: (1) substance often taken in larger amounts or over a longer period than the person intended (2) persistent desire or one or more unsuccessful efforts to cut down or control substance use (3) a great deal of time spent in activities necessary to get the substance (e.g., theft), taking the substance (e.g., chain smoking), or recovering from its effects (4) frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home (e.g., does not go to work because hung over, goes to school or work "high," intoxication while taking care of his or her children), or when substance use is physically hazardous (e.g., drives when intoxicated) (5) important social, occupational, or recreational activities given up or reduced because of substance use (6) continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking) (7) marked tolerance; need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount NOTE: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP): (8) characteristic withdrawal symptoms (see specific withdrawal syndromes under Psychoactive Substance-induced Organic Mental Disorders) (9) substance often taken to relieve or avoid withdrawal symptoms B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.
Criteria for Severity of Psychoactive Substance Dependence: **Mild**: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others. **Moderate**: Symptoms or functional impairment between "mild" and "severe." **Severe**: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others[1]. **In Partial Remission**: During the past six months, some use of the substance and some symptoms of dependence. **In Full Remission**: During the past six months, either no use of the substance, or use of the substance and no symptoms of dependence.

[1]Because of the availability of cigarettes and other nicotine-containing substances and the absence of a clinically significant nicotine intoxication syndrome, impairment in occupational or social functioning is not necesary for a rating of severe Nicotine Dependence.

DSM-III-R Diagnostic Criteria for Psychoactive Substance Abuse
A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following: (1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive sutstance (2) recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated) B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time. C. Never met the criteria for Psychoactive Substance Dependence for this substance.

DSM-IV Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occuring at any time in the same 12-month period:

1. tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   (b) markedly diminished effect with continued use of the same amount of the substance
2. withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
   (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present)
Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)

Course specifiers:

Early Full Remission: This specifier is used if, for at least 1 month, but for less than 12 months, no criteria for Dependence or Abuse have been met.
Early Partial Remission: This specifier is used if, for at least 1 month, but less than 12 months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).
Sustained Full Remission: This specifier is used if none of the criteria for Dependence or Abuse have been met at any time during a period of 12 months or longer.
Sustained Partial Remission: This specifier is used if full criteria for Dependence have not been met for a period of 12 months or longer, however, one or more criteria for Dependence or Abuse have been met.
On Agonist Therapy: This specifier is used if the individual is on a prescribed agonist medication, and no criteria for Dependence or Abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from, the agonist). This category also applies to those being treated for Dependence using a partial agonist or an agonist/antagonist.
In A Controlled Environment: This specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted, and no criteria for Dependence or Abuse have been met for at least the past month. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, or locked hospital units.

DSM-IV Criteria for Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
   (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions fom school; neglect of children or household)
   (2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
   (3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
   (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

3. Substance Dependence has 7 criteria (down from 9). Criterion #4 (failure to fulfill major role obligations) was moved to the Abuse category, and the use of substances to relieve or avoid withdrawal is collapsed into the withdrawal criterion.
4. No duration is required for symptoms to qualify as clinically significant.
5. A "clustering" criterion has been added to Dependence to specify that 3 or more criteria must be present during the same 12-month period.
6. Substance Dependence should be subtyped as being either With, or Without, Physiological Dependence.
7. Course Specifiers have been expanded to include the following:
   - Early Full Remission (at least 1 month without meeting any criteria of Abuse or Dependence)
   - Early Partial Remission (at least 1 month without meeting the full criteria for Dependence)
   - Sustained Full Remission (at least 1 year)
   - Sustained Partial Remission (at least 1 year)
   - On Agonist Therapy
   - In a Controlled Environment

The changes are not revolutionary and will present few difficulties in terms of being integrated seamlessly into the practice of most addiction specialists. The potential value of these changes is difficult to assess and it remains unclear whether any will have long-range significance.

Long-range Significance

I wonder about the potential impact of moving the criterion involving failure to fulfill major role obligations from Dependence to Abuse. First, this change does not really succeed in sharpening the distinction between Abuse and Dependence, as it was intended to do. Second, Substance Abuse still seems to lack a clear conceptual framework. Apart from tolerance and withdrawal, what clearly differentiates Dependence from Abuse? Doesn't Abuse also involve a loss of control — especially when a person continues to use despite persistent problems? Does desire, or do unsuccessful attempts, to cut down usage effectively differentiate Dependence from Abuse? The primary distinction between Substance Dependence Without Physiological Dependence and Substance Abuse appears to be that the criteria for Abuse are more fully behavioral, while the criteria for Dependence involve a sense of the patient's internal experience. For example, criterion #3 for Dependence involves an individual's *intentions*, and criterion #4 involves an individual's *desires*, neither of which is observable.

Tolerance and withdrawal are concrete signs of physiological dependence, but their significance must still be determined in context (i.e., is the patient known to be a heroin addict or is this a person exhibiting tolerance to an opioid analgesic used during post-op recuperation?). We should admit that Substance Dependence Without Physiological Dependence is a judgment call. Since we have no clear and verifiable definition for non-physiological dependence (i.e., what has been called "psychological dependence"), we should acknowledge that abuse and non-physiological dependence are two points along a continuum with no clear line of demarcation between the two. In fact, the line of demarcation is probably more determined by sociocultural influences than by scientific research. What one culture (or subculture) considers dependence, another considers abuse, and yet another considers normative. Even the same culture varies in these determinations from era to era.

I wonder whether clinicians will be less likely to diagnose Dependence, and more likely to diagnose Abuse, now that we have moved the criterion of "failure to fulfill major role obligations" into Abuse. It certainly will impact patients if insurance plans pay less to treat Abuse than they do to treat Dependence.

I wonder whether clinicians will be less likely to diagnose Substance Dependence, and more likely to diagnose Substance Abuse, now that we have moved the criterion of "failure to fulfill major role obligations" into Abuse. Will it affect patients to be told that they meet criteria for Abuse, but not Dependence? It certainly will impact them if insurance plans pay less to treat Abuse than they do to treat Dependence. Furthermore, will insurance plans begin to limit payments unless the diagnosis is Substance Dependence With Physiological Dependence? Will coverage be different if there is not evidence of tolerance or withdrawal?

I also wonder about the meaning of Full Remission. Is it possible for a patient with well documented Alcohol Dependence With Physiological Dependence of a severe magnitude to be in Early Full Remission while still drinking? There is potential here for different interpretations and it centers around how the clinician defines "use." After all, an occasional drink may be taken without meeting a single criterion for Dependence or Abuse, unless you invoke the last criterion of Dependence: continued use despite knowledge of having a persistent or recurrent problem that is caused or exacerbated by the substance. Is this the way clinicians will interpret Full Remission? Addiction specialists, relying more on clinical experience, probably will continue

to demand full abstinence before evaluating alcoholics as being in full remission; other physicians relying more on their own interpretation of the DSM may not.

In the final analysis, addiction medicine physicians will barely feel a bump in the road as they glide from DSM-III-R to DSM-IV. On the other hand, whatever reservations we had about DSM-III-R's definitions of Substance Abuse and Dependence will probably remain unaddressed for the rest of this millennium by DSM.

DSM-III (1980) introduced explicit diagnostic criteria for the first time.

Creation of DSM-IV

More than 1000 individuals and numerous professional organizations participated in preparing DSM-IV. The APA Task Force chaired by Allen Frances, MD, coordinated efforts of 13 Work Groups focusing on specific clinical areas. Drafts prepared by the Work Groups were reviewed by between 50 and 100 advisors chosen to represent diverse clinical and research expertise, disciplines, backgrounds and settings. Conferences and workshops were held. Two years ago, the *DSM-IV Options Book* was widely distributed. This book summarized for the public the options being considered for inclusion in order to solicit opinion and invite additional data for the Task Force's deliberations. Last year, a near-final draft was distributed for further critique.

In a sense, the DSM process serves the role of the Senate, while the day to day opinions within the profession are similar to the House of Representatives. While the Senate may at times appear more conservative, it is charged with the responsibility to take positions which reconcile tradition with an overview of the future. The House of Representatives is designed to provide a voice for current public perceptions, just as the court of public opinion among professionals reflects moment by moment changes.

The need for a classification of mental disorders has been clear throughout the history of medicine, but there has been little agreement as to what should be included, and how it should be organized. The process of officially classifying mental disorders for the purpose of collecting statistical information began in the United States with the 1840 census. In 1917, the American Psychiatric Association's Committee on Statistics provided its first input to the census process. The nomenclature at that time was primarily designed for diagnosing inpatients with severe psychiatric and neurologic disorders.

The first edition appeared in 1952 and was developed largely from the sixth edition of the World Health Organization's International Classification of Diseases (ICD) (which for the first time included a section on mental disorders). DSM-I was a glossary of descriptions for diagnostic categories that was the first official manual designed for clinical utility.

There was a second edition in 1968 but DSM-III represented the first major revision. Work began in 1974 and culminated in its publication in 1980. It introduced several innovations, including explicit diagnostic criteria, a multiaxial system and a descriptive approach that attempted to be neutral with respect to theories of etiology. While many people felt that emphasizing a descriptive approach actually moved our official nomenclature in a behavioral direction, it did lend itself more to the development of better research criteria for investigating mental disorders.

One of the most fundamental changes in DSM-IV is elimination of the term "organic mental disorders." The rationale is that the term "implies that the other disorders in the manual do not have an 'organic' component." This seems to be in line with the trend among many psychiatrists to view all mental activity in terms of anatomy, biochemistry and physiology. While this viewpoint holds sway among a substantial number of psychiatrists, many others feel that it is too reductionistic. Wherever one might stand in the debate, we should all acknowledge that it *is* difficult to observe the myriad of ways that the mind rests upon the substrate of the brain without reducing it to being merely a shadow of the brain's physical activity. I suspect psychiatrists and philosophers will kick this debate around for several centuries yet to come. DSM will not settle it, but does take a perspective that has clinical and socioeconomic implications.

DSM-IV also pays increased attention to cultural factors, relies upon research data (i.e., prevalence rates, age of onset, course of diseases), and has a V code (Other Conditions That May Be a Focus of Clinical Attention) for Religious or Spiritual Problems. We will leave discussion of this new category for a later review.

The most significant change that will occur as a result of DSM-IV will probably result from the sourcebooks, which could immensely strengthen the process of public review of empirical evidence. We will all have access to the theory and data underlying our official nomenclature. The theories can be debated. The validity of data can be challenged. Their interpretation can be modified. New data can be sought to clarify or undermine old data. Neglected theories and data can be brought to light and championed.

DSM-IV includes a new code for Religious or Spiritual Problems as other conditions that may be a focus of clinical attention.

As an official nomenclature, the DSM must be of use to clinicians with a wide variety of orientations — biological,

psychodynamic, cognitive, behavioral, interpersonal, family/systems. And it must be usable by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. Creating a framework to define and organize something as complex as the whole of mental disorders in a way that is compatible for all these disciplines and orientations is a daunting project. Over the years, DSM has often been scorned for being simplistic, biased, or too much of a compromise among competing positions to be of value. This attitude ignores the fact that DSM is presented by the APA as a work in progress, in an immensely complex field — psychiatry — that is still in its early childhood. The DSM process is an important effort to incorporate the scientific method into our official nomenclature for mental disorders. And, with the changes introduced by DSM-IV, the opportunity for scientific inquiry to contribute more than ever to the next inevitable revision has been enhanced. □

The major innovation of DSM-IV is the reliance on data and the publication of the sourcebooks. Now the theories can be debated. The validity of data can be challenged. Their interpretation can be modified.

NOTE: Substantial portions of DSM-IV have been quoted directly or with minor modifications. Although the use of quotation marks would follow strict editorial guidelines, they were not included in this article for ease of reading.

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MBC Guidelines for Prescribing for Pain

The Medical Board of California (MBC) will consider guidelines for prescribing controlled substances for pain management at its meeting on July 28-29, 1994. (Copies of the guidelines are available from the California Society office.) Earlier this year, the Board's Task Force on Appropriate Prescribing, chaired by Jacquelin Trestrail, MD, of San Diego, heard testimony indicating that some physicians are reluctant to use opioid medications in the treatment of pain, especially in difficult cases, because they fear becoming the target of investigation by the Board. At the conclusion of its hearings, the Task Force recommended a number of steps to promote effective pain management. Among the steps were the "Summit" meeting on this subject held in March of this year, reported in the last issue of *CSAM NEWS* (Spring 1994, 21(1): 21), and development of guidelines to help physicians "avoid investigation." Following are excerpts from a statement adopted by the MBC in May of this year and reported in the July, 1994 issue of *Action Report*, the publication of the Medical Board.

Opioid analgesics and other controlled substances are useful for the treatment of pain, and are considered the cornerstone of treatment of acute pain due to trauma, surgery and chronic pain due to progressive diseases such as cancer. Large doses may be necessary to control pain if it is severe. Extended therapy may be necessary if the pain is chronic.

The Board recommends that physicians pay particular attention to those patients who misuse their prescriptions, particularly when the patient or family has a history of substance abuse that could complicate pain management. The management of pain in such patients requires extra care and monitoring, as well as consultation with medical specialists whose area of expertise is substance abuse or pain management.

The Board believes that addiction should be placed into proper perspective. Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. Addiction is a behavioral syndrome characterized by psychological dependence and aberrant drug-related behaviors. Addicts compulsively use drugs for non-medical purposes despite harmful effects; a person who is addicted may also be physically dependent or tolerant. Patients with chronic pain should not be considered addicts or habitues merely because they are being treated with opioids.

The Board will judge the validity of prescribing based on the physician's diagnosis and treatment of the patient and whether the drugs prescribed by the physicians are appropriate for that condition, and will not act on the basis of predetermined numerical limits on dosages or length of drug therapy.

The Board hopes to replace practitioners' perception of inappropriate regulatory scrutiny with recognition of the Board's commitment to enhance the quality of life of patients by improving pain management while, at the same time, preventing the diversion and abuse of controlled substances. □

— Gail B. Jara

LETTERS TO THE EDITORS

Re: Zolpidem: An Addiction Medicine Perspective
Donald Wesson, MD; Walter Ling, MD; David Smith, MD
***CSAM NEWS*, Spring 1994, 21(1): 14-15.**

To the Editors:

I am writing this letter in response to the article by Wesson and co-workers concerning the addiction potential of zolpidem, Searle's new imidazopyridine hypnotic.

At the molecular level, it is somewhat of an oversimplification to state that zolpidem and hypnotic benzodiazepines bind to the same "GABA-BZ complex" (1). There are numerous findings demonstrating that not only does zolpidem have a very low affinity for certain GABA-A receptor isoforms, but that its efficacy can also be significantly lower than that of benzodiazepines in circumscribed brain regions. Furthermore, the pharmacological significance and structural basis for GABA-A receptor heterogeneity point to a striking specificity of zolpidem as well as other ligands. Thus, the unique molecular neurochemical profile of zolpidem is presumably effected through the heterogeneity among GABA-A receptor isoforms (2-8).

In a preclinical study it has been shown that zolpidem, as well as triazolam, decreases brain metabolism of glucose (9). The doses used in that study, however, were at least 10 times higher than hypnotic doses and, therefore, any specificity of receptor binding would be expected to be lost. Furthermore, it has been shown repeatedly that sleep in itself determines brain glucose utilization (10), and consequently, two hypnotics acting by theoretically completely different mechanisms would induce identical metabolic effects. In other relevant preclinical comparisons, the muscle relaxant, anticonvulsant, and anti-conflict actions of 1,4 benzodiazepines were found to be produced at doses several fold lower than required to produce hypnotic effects. In contrast, zolpidem produces a sedative action at doses 10-20-fold lower than those required to produce anticonvulsant and myorelaxant actions. In direct comparisons of different benzodiazepines in mice, the sedation produced by triazolam, midazolam and flunitrazepam required doses 2-6-fold higher than necessary to effect an anticonvulsant and myorelaxant action.

Zolpidem, unlike several benzodiazepines, induced physiological sleep and produced discriminitative properties in rats which were not identical to those produced by benzodiazepines.

As Dr. Wesson indicated, there are specific preclinical studies on the abuse potential of zolpidem in the literature (11), but there are also others. In additional studies in mice, the lack of production of physical dependence on zolpidem was confirmed (12-13). Chronic administration of zolpidem resulted in only a small degree of tolerance (2-fold) as compared to midazolam (greater than 6-fold) in rats (14). The lack of development of tolerance to the sedative actions of zolpidem was subsequently shown in rats (15) with one study using 30 mg/kg, a dose 10-fold higher than that needed to completely suppress animal responses.

In addition to the study on self-administration cited by Dr. Wesson (16), there are two other preclinical studies that also indicate that zolpidem is self-administered. In one study, zolpidem was self-administered by a successive substitution procedure in cocaine-self-injected baboons (17); the other is a study in rodents (18). In this comparative study, there were strong indications that zolpidem is self-administered, but in a qualitatively different fashion than other compounds with abuse potential. Only a sub-population would self-administer in a widely variable pattern. The author came to the conclusion that "zolpidem will have low, if any, abuse potential in humans." Notwithstanding or minimizing the fact that zolpidem was self-administered to baboons at rates similar to those attained with cocaine, this study does have one major shortcoming. Both drugs were restricted in number of possible injections and, thus, no comparative or even maximal assessment could be reached.

The addiction potential of a newly introduced drug can only be assessed after at least one year of commercialization.

It is obvious that even the most voluminous preclinical assessment of abuse liabilities cannot predict accurately the drug abuse potential in humans. Even the clinical studies in former drug abusers suffer from artificial conditions and limitations that do not reflect the real-life situation of the chronic multi-drug abuser.

We can only agree with your conclusion on the use of zolpidem in the US, namely to be cautious and vigilant about the potential abuse and misuse of zolpidem. The introduction of any new psychotropic drug is bound to be followed by its being tested by chronic drug abusers. This risk is not new to the scientific and medical community. In fact, it is universally accepted that the addiction potential of a newly introduced drug can only be assessed after at least one year of commercialization (19).

Clinical efficacy trials of a hypnotic, or for that matter of any CNS-active drug, are not designed to and do not typically reveal much about dependence and withdrawal, primarily because individuals with histories of drug abuse are usually excluded from participating in efficacy trials. Consequently, the initial labeling of a new drug usually cannot provide much information on this subject.

In the course of the US development of zolpidem, however, in addition to those studies assessing hypnotic efficacy, specific clinical trials were included that assess the potential abuse liability of the drug. Two such trials were conducted with zolpidem in known drug abusers with a history of specifically abusing sedative-hypnotic drugs (20,21).

One such trial compared zolpidem in increasing doses to diazepam, the other trial compared zolpidem to triazolam. Both trials were randomized, double-blind, and placebo-controlled. In both trials zolpidem was found to share with the benzodiazepines certain subjective effects indicating potential abuse. However, both studies also concluded that high doses of zolpidem were perceived differently than the comparator benzodiazepines. In the case of diazepam, the investigators concluded that the unique profile of zolpidem raises the possibility that with larger doses, or with repeated administration, adverse somatic effects like nausea and vomiting or behavioral disruptive effects, greater than those observed with diazepam, occurred. The second study demonstrated that both triazolam and zolpidem produced dose-related increases in several subjective effects that are considered to reflect the likelihood of abuse. In addition, this study also showed that higher doses of zolpidem produced negative subjective effects and negative somatic effects like vomiting.

These studies convinced the Drug Advisory Committee of NIDA that the abuse potential for zolpidem was less than for other sedative-hypnotic drugs.

These studies, coupled with the extensive preclinical data on zolpidem, convinced the Drug Advisory Committee of the National Institute of Drug Abuse (2-27-92) that the abuse potential for zolpidem was less than for other sedative-hypnotic drugs. Nevertheless, zolpidem is a Schedule IV drug, and, as such, carries a certain potential of producing dependence and consequently, of being abused.

Fortunately, six years of European postmarketing experience with zolpidem is available. Zolpidem has been marketed in Europe since 1988 and, to date, over 700 million doses have been prescribed. There have been sporadic cases of drug abuse in the countries where zolpidem is available and there are, also, sporadic reports of perceptual distortions (hypnagogic hallucinations), similar to those described or cited by Wesson and colleagues. Such events are part of the expected side effect spectrum of a hypnotic. Over the six years of marketing, however, no gross or excessive abuse has emerged. Over the same time period, prescribing regulations for all hypnotics in the European labeling have included a warning about their potential abuse. In addition, prescribers were cautioned that a potential withdrawal reaction cannot be excluded in at-risk patients like drug abusers or alcoholics.

Although, the postmarketing experience in the US is of admittedly short duration (approximately one year), no withdrawal reaction from zolpidem has been reported. Thus, given the worldwide paucity of case reports of zolpidem abuse and dependence relative to the extensive use of the drug, one could, in fact, take comfort in the safety of zolpidem.

Nevertheless, Searle is committed to making every attempt to limit potential abuse in the US. In collaboration with sleep specialists and the relevant authorities, Searle is actively involved in programs of education about sleep and drug abuse alike.

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To the Editors:

I recently saw your article on zolpidem (Ambien), and I wanted to share my experience with it with your physician members.

I am a recovering alcoholic with five years of sobriety. For the past seven months, I have been taking imipramine, prescribed by my psychiatrist. Imipramine was supposed to help with my difficulty sleeping — which had been a problem for many years — but it didn't. When I told my psychiatrist that the imipramine wasn't working, he suggested that I take 5 mg of zolpidem at bedtime in addition to the imipramine. My psychiatrist knew that I was in recovery. He told me not to worry because zolpidem was not addicting and did not produce dependence. He gave me a prescription for 30 tablets.

The Ambien helped me to get to sleep, but I would wake up after a couple of hours. After several weeks, I told my

If it was the flu, it was not like any I'd experienced before.

doctor what was happening and that the Ambien wasn't helping and that I wanted to stop it. He told me to cut back to one-half tablet for two nights, then stop. By the third day, I began feeling clammy and sweaty and began having stomach cramps. The symptoms were worse on the fourth day, then gradually subsided over the next day or so. If it was the flu, it was not like any I'd experienced before.

Thanks for the article. It's good to know that physicians are paying attention to zolpidem.

Name withheld by request

Reply from the Authors

Our article on zolpidem drew a number of comments from colleagues as well as the two letters here. Colleagues pointed out that our addiction medicine perspective seemed narrow, focusing as it did on zolpidem's potential for abuse and apparently rare adverse reactions and giving no play to the fact that zolpidem is an effective hypnotic that has been widely prescribed in Europe for several years with very few reports of dependence or severe adverse reactions.

Addiction medicine specialists rarely see patients who respond as expected to psychotropic medications or, for that matter, use psychotropic medications as prescribed.

It's hard for doctors in the medical clinic at a ski resort to fully appreciate the joys of skiing. Every skier they see has broken bones or a crushed skull or lacerations. Likewise, addiction medicine specialists rarely see patients who respond as expected to psychotropic medications or, for that matter, use psychotropic medications as prescribed.

From the vantage point of medical therapeutics, the beneficial effects of medications must be considered along with the frequency and severity of adverse effects. But it's also worth remembering that all medications have risks; some we know about now, others we will discover as we go along.

Donald R. Wesson, MD
Walter Ling, MD
David E. Smith, MD

Re: Thinking Seriously About Alternatives to Drug Prohibition
Ethan Nadelmann, JD, PhD
***CSAM NEWS*, Spring 1994, 21(1): 1-11.**

To the Editors

I want to express my appreciation for the article by Professor Nadelmann in the most recent newsletter. As a person involved with this Society from the beginning, albeit little directly involved in substance abuse treatment in recent years, I have been disturbed by the almost complete silence of the substance abuse treatment community about the great harm done by the increasingly severe legal sanctions on drug users and the total ineffectiveness of the current "Just Say No!" drug education that makes no attempt to distinguish the relative dangers of different forms of drug experimentation. It seemed to me that as this specialty matured — moved from T-shirts and blue jeans to black tie — the earlier concerns for social issues gave way to preoccupation with remuneration and grant money. I hope the recent essay signals a return to the idealism of the early days.

I believe President Clinton is looking for a politically viable way to change the way we are so ineffectively and

I believe President Clinton is looking for a politically viable way to change the way we deal with illegal drug use in this country.

expensively dealing with the problem of illegal drug use in this country. Our Society and ASAM could provide him with that opportunity.

William B. Wenner, MD
Kealakekua, Hawaii

Is the War on Drugs Another Vietnam?

Donald M. Gragg, MD, PhD

A gradual escalation of hostilities resulted in failure for the United States in Vietnam. Some people endorsed an all-out offensive to win that war. Others advocated immediate withdrawal, saying this was a war we shouldn't be fighting.

The war on drugs has many similarities. We are not eliminating the nation's drug problems in spite of hundreds of billions of dollars devoted to drug interdiction and law enforcement. There is increasing discussion of legalizing drugs, and more and more people are saying that the drug war is a war we shouldn't be fighting. What are our options? What should we be doing about our nation's drug problem?

One view is that we aren't being tough enough: that we need to take decisive action NOW to stop the importation and sale of all illegal drugs. We need to declare "all-out war." For example, we could mobilize the national guard and military to seal our borders. All drug dealers could be executed. This avenue would make us a more totalitarian state. Some nations — Singapore would be one example — are successfully using this approach. But, are we ready to sacrifice personal freedom in order to achieve a drug-free society?

Dr. Jocelyn Elders, the US Surgeon General, recently suggested that we look into the possibility of legalizing drugs. This suggestion was quickly denounced both inside and outside the administration. Many prominent Americans are advocates of drug legalization, however. They argue for legal controls and taxation on the distribution and sales of drugs, similar to the controls and taxes on alcohol and tobacco. They believe this would (1) allow for the control of purity and potency of the drugs, (2) greatly reduce the crime and violence associated with drugs today, (3) eliminate the drug trade as a source of money for organized crime and street gangs,

Let us be optimists and build a rational program to reduce drug use and its harmful effects.

and (4) produce a source of revenue for the government. They claim that there would be no increase in harm from increased drug use or drug addiction if proper controls were implemented.

Opponents to legalization forecast a massive increase in drug use and addiction and say that such a risk is unacceptable, that the price for a possible reduction in crime and violence would be great human suffering from drug addiction.

If we reject the idea of an "all-out war" in order to exclude illegal drugs and reject legalizing them in order to combat crime, have we any course other than our current chaos?

It has been said that a pessimist is an optimist who has studied the facts. I believe that the proponents of an all-out war on drugs and the advocates of legalization are both optimists. If we study the facts we will find that these "simplistic solutions" are inadequate.

What are the facts that these optimists are missing? FACT 1: Humans seek an altered state of consciousness. Some form of drug use will continue

as it has throughout history. Our goal, therefore, needs to be to control use and reduce harm. FACT 2: The current wave of drug use, crime and violence, especially in our inner cities, is a symptom of social unrest. The foundations of this social unrest need to be dealt with before we can hope to reduce the drug problem significantly.

Neither an all-out war on drugs nor legalization of drugs is the optimal strategy for dealing with our drug problem.

With these two facts in mind, one could easily become a pessimist, but let us be optimists and build a rational program to reduce drug use and its harmful effects.

- First, we must undertake a vigorous program to combat the causes of social unrest and poverty centered in our inner cities. This is a complex and difficult task, but is paramount if we are to make a significant reduction in the current wave of drug use, crime and violence.
- Next, we should "decriminalize" drug use. That is, eliminate criminal penalties for drug use, or possession for personal use, and substitute mandatory drug treatment and education programs for jail time.
- We must increase the availability of drug treatment and support research into more effective treatments for drug addiction.
- We need to continue reasonable efforts to reduce the supply of drugs through foreign policy avenues, interdiction efforts and law enforcement.
- Finally, we must maintain and augment drug education programs. We must keep the eye of public attention on the hazards of drug use.

I believe that history will ultimately show that there was an appropriate role for the US in Vietnam, that a study of the facts of the situation could have led to a successful course of action more suitable than either an all-out military offensive or complete avoidance of the area. Similarly, I contend that neither an all-out war on drugs nor legalization of drugs is the optimal strategy for dealing with our drug problem. Instead, we need to launch an offensive against the causes of social unrest in our society, while we enhance our drug education and treatment efforts rather than using criminal penalties for drug use. □

Doctor Gragg is a consultant in continuing medical education and addiction medicine. He is Treasurer of CSAM and Chair of the Committee on Education.

Continue The Drug War Debate

John J. McCarthy, MD

Perhaps the era of drug war ideology is coming to an end. The almost totalitarian silence imposed by politicians and the national media on public debate of drug policy seems to be on the verge of collapse. Surgeon General Jocelyn Elders focused national attention on the obvious connection between drug prohibition and our endemic problems of crime and violence and called for a study of legal alternatives.

It is very important that medicine, and especially addiction medicine, take an active part in this debate. Ethan Nadelmann's provocative essay (*CSAM NEWS*, Spring 1994) contributed to our understanding of the historical parallels between the drug war and the destructive and futile alcohol war of the '20s. We have chosen to remain ignorant of the history we are repeating. His discussion of alternative strategies may seem fanciful in drug-war America, but such strategies could soon be implemented in other countries.

Nadelmann made the very important point that the decision about drug policy is not an either/or choice between total prohibition or total access. This false dichotomy is merely a tool of drug war rhetoric. It closes off discussion by creating the illusion of a doomsday alternative where drugs are "everywhere." There is already a spectrum of approaches toward drug restriction or availability around the world, just as we have a spectrum of approaches to needle availability in different cities and states in this country. The either/or rhetoric belies the diversity that already exists and obstructs the discussion of badly needed domestic alternatives.

It is very important that medicine, and especially addiction medicine, take an active part in this debate.

Yet in spite of the increasingly democratic approach to the national debate, drug war policies are firmly in place and there are forces that seem to be increasing the harmful effects of drug policies, not the reverse. California's new "three strikes initiative" was passed ostensibly because of a public concern with violence, but the legislation has far broader implications. Its main effect will not be on the violent; it will be on users of illicit drugs, thousands of whom have two or more prior non-violent felonies. Some are now facing 25 years to life for a mis-

demeanor, because a misdemeanor with a prior misdemeanor constitutes a felony. Simple possession of heroin or petty theft can now bring a minimum of 25 years' imprisonment. And, there are thousands of untreated heroin addicts at risk since the neglected treatment system can treat only one addict in ten.

The politics of California has been to bankrupt drug treatment, mental health, public health, and education in order to bankroll one of the largest prison systems in the world. And the trend is worsening.

I have watched our local heroin problem at least triple during the last 14 years of the drug war.

Why should we be studying alternatives? What is the problem with the criminalization of drug use? First of all, there is no evidence that criminalization has lead to decreased drug use. The evidence suggests the opposite: where we have focused our war — in our inner cities — hard drug use has consistently increased. I have watched our local heroin problem at least triple during the last 14 years of the drug war. We estimated there were 3,000 heroin addicts in Sacramento in 1980, based on police estimates and admissions to methadone treatment. In 1994 we have already seen about 9,000 individuals in our two methadone programs alone and are admitting new patients regularly. We had minimal cocaine and amphetamine problems in Sacramento before the Reagan drug war escalation in 1982. Now 40% of our methadone treatment admissions are also using stimulants. Drug arrests have quadrupled in the past decade.

A recent RAND report[1] documents that treatment for cocaine use is seven times more cost effective in reducing use and secondary crime than incarceration or interdiction. If the drug war were to be held to the standards of accountability that we expect from medical treatments, it would have been declared ineffective years ago.

This is not to say that alternatives to the drug war are panaceas; they are not. Legal availability — such as we have for alcohol and tobacco — brings with it costly harms to society. We must have a rational debate that balances the harms of availability against the harms of prohibition. A partial list of these harms include: (1) the continuing economic and political disaster of drug money funding criminal elements nationally and internationally, (2) the continued increases in drug use secondary to the very effective and aggressive drug pushing that characterizes the black market, (3) the community problems secondary to incarceration policies that break up families and leave millions of high risk children as drug war orphans, (4) the medical problems from dirty drugs and needles, and (5) the moral and ethical dilemma created when non-criminal behaviors, like personal drug use, are criminalized and dealt with by law enforcement rather than in a more appropriate and effective treatment or pastoral counseling setting.

The American Society of Addiction Medicine's 1994 public policy statement on national drug policy (see p. 13) is a welcome document that supports alternatives to criminalization and is open to less restrictive availability policies based on scientific principles of study and outcome evaluation. We must continue as Dr. Nadelmann has outlined, to discuss ways of taking the obscene profits out of drug dealing if we are ever going to decrease drug-related crime, community destruction, and the costs of a criminal justice system that is growing like a cancer. Those who worry about the adverse consequences of wider drug availability should pause to ponder what California will be like if the costs and failures of the last decade are repeated in the next. □

Those who worry about the adverse consequences of wider drug availability should pause to ponder what California will be like if the costs and failures of the last decade are repeated in the next.

Since 1980, Doctor McCarthy has been Executive and Medical Director of Bi-Valley Medical Clinic, a methadone maintenance treatment program in Sacramento. He is an Associate Clinical Professor of Psychiatry at UC Davis.

[1]Rydell CP and Everingham, S. *Controlling Cocaine. Supply versus Demand Programs.* Santa Monica: RAND, 1994. To order, contact Distribution Services, (310) 451-7002; Fax (310) 451-6915.

American Society of Addiction Medicine
Public Policy Statement on National Drug Policy

Recommendations

The American Society of Addiction Medicine, as an organization of physicians who have both hands-on experience and deep concern about the victims of alcoholism and other drug dependencies, recommends that the following principles guide the formation and evaluation of national drug policy:

1. National policy should present a comprehensive and coordinated strategy aimed at reducing the harm done to individuals, families and society by the use of all drugs of dependence.
2. Reliance on the distinction between "legal" and "illegal" drugs is a misleading one, since so-called "legal" drugs are illegal for persons under specified ages, or under certain circumstances.
3. Prevention programs should be comprehensively designed to target the entire range of dependence-producing drugs as well as to produce changes in social attitudes.
4. Outreach, identification, referral and treatment programs for all persons suffering from drug dependencies, including alcoholism and nicotine dependence, should be increased in number and type until they are available and accessible in every part of the country to all in need of such services.
5. Persons suffering from the diseases of alcoholism and other drug dependence should be offered treatment rather than punished for their status of dependence.
6. The balance of resources devoted to combating these problems should be shifted from a predominance of law enforcement to a greater emphasis on treatment and prevention programs, as well as programs to ameliorate those social factors that exacerbate drug dependence and its related problems.
7. Law enforcement measures aimed at interrupting the distribution of illicit drugs should be aimed with the greatest intensity at those causing the most serious acute problems to society.
8. Any changes in laws that would affect access to dependence-producing drugs should be carefully thought out, implemented gradually and sequentially, and scientifically evaluated at each step of implementation, including evaluating the effects on:
   - access to young people and prevalence of use among youth;
   - prevalence of use in pregnancy and effects on offspring;
   - prevalence rates of alcoholism and other drug dependencies;
   - crime, violence and incarceration rates;
   - law enforcement and criminal justice costs;
   - industrial safety and productivity;
   - costs to the health care system;
   - family and social disruption;
   - other human, social and economic costs.
9. ASAM opposes any changes in law and regulation that would lead to a sudden significant increase in the availability of any dependence-producing drug (outside of a medically-prescribed setting for therapeutic indications). Any changes should be gradual and carefully monitored.
10. ASAM opposes any system of distribution of dependence-producing drugs that would involve physicians in the prescription of such drugs for other than therapeutic or rehabilitative purposes.
11. ASAM supports public policies that would offer treatment and rehabilitation in place of criminal penalties for persons who are suffering from psychoactive substance dependence and whose only offense is possession of a dependence-producing drug for their own use.
12. ASAM supports public policies which offer appropriate treatment and rehabilitation to persons suffering from psychoactive substance dependence who are found guilty of an offense related to that dependence, as part of their sentence. This goal may be attained through a variety of sentencing options, depending upon the nature of the offense.
13. ASAM supports an increase in resources devoted to basic and applied research into the causes, extent and consequences of alcohol and other drug use, problems and dependence, and into methods of prevention and treatment.
14. In addition, scientifically sound research into public policy issues should receive increased support and given a high priority as an aid in making such decisions.
15. Physicians and medical societies should remain active in the effort to shape national drug policy and should continue to promote a public health approach to alcoholism and other drug dependencies based on scientific understanding of the causes, development and treatment of these diseases.

Adopted by ASAM Board of Directors
April 13, 1994

President's Column

Of Aftershocks and Aftermaths

The last of the rubble that was my pre-earthquake office at Saint John's was hauled off last week. About a month earlier, the Chemical Dependence Center re-opened to the sounds of the Cleveland Wrecking Company knocking down the remains of its former home in the North Wing. In any case, the good news is that the program is once again up and running. And although my role has been reduced from a half-time medical directorship to a consultant providing four hours of clinical supervision each week, things have worked out well for me in ways I couldn't have predicted, including an expanded private practice and *Thursdays off for trout fishing.*

Many members of CSAM have experienced similar or more drastic reductions in the time they spend doing chemical dependence treatment in institutional settings. The earthquake only precipitated changes at Saint John's that had already been set in motion by restrictive insurance benefits and the growth of managed health care. In addition, the persistent statewide recession has reduced the number and variety of chemical dependence programs and services — surprisingly, even in the various California HMOs.

All these changes have meant reduced roles, or at least significantly different roles, for CSAM members who have subspecialized in chemical dependence treatment. Meanwhile, the organization itself is going through its own transformation.

After a year's delay, the implementation of mandatory combined membership in both ASAM and CSAM will take place in January, 1995. To some, forced membership seems unfair and even anti-democratic. The leadership of both groups have struggled long and hard with these concerns and more, but in the end, it seemed critical that the national organization support and be supported by strong local chapters. It is at the state chapter level that most CSAM members first have an opportunity to become active in the committee work that is the heart of our society. This is where the time and energy spent create the personal relationships we all feel are so important to our continued work in this field. I am speaking for all of the CSAM Executive Council when I say I am looking forward to the influx of ASAM members who have never before worked with us on the state level.

All the changes I've described in this column have had a significant fiscal impact on CSAM. Over a period of several years we had developed a decent savings account, but for the past two years we have had to spend some of the reserve to pay our expenses. None of us is happy about this situation, and at the Executive Council recently we agreed that however we have to "cut back" to protect our reserves — our future, really — we will strive to maintain what we consider to be the critical CSAM functions:

1. the annual review course/state of the art conference
2. the Newsletter
3. the membership directory
4. advocacy on "local" (California) issues (e.g., the Diversion Program, medical school education)
5. maintaining the physician's voice in matters of conscience (e.g., the legalization/harm reduction debate, funding for public programs)

We welcome hearing from our members who may agree or disagree with the CSAM Executive Council's sense of priorities. Comments about the President's fishing will be ignored unless favorable. □

Richard S. Sandor, MD

1994 REVIEW COURSE and CALIFORNIA SOCIETY 21ST ANNUAL MEETING

November 3-5, 1994, Miyako Hotel, San Francisco

Awards Dinner — Friday evening, November 4

Presentation of the 1994 Vernelle Fox Award to
Jack Gordon, MD

Presentation of the 1994 Community Service Award to
Reverend Cecil Williams

APPLICANTS FOR MEMBERSHIP

The names of applicants are published and sufficient time is allowed for comments from the members before the Executive Council acts to accept them as members. If you have comments to bring to the attention of the Executive Council, please contact Richard Sandor, MD, at (310) 392-4644, or write to him in care of the California Society office.

Charles Jenkes Barnes, MD, is an internist/intensivist at Alta Bates Hospital in Berkeley. He graduated from the University of Washington medical school in 1973, and completed a residency at UCSF-SF General in 1976. He serves on the Committee on the Well-Being of Physicians at Alta Bates Hospital.

John Robert Donaldson, III, DO, has just completed his fifth year of training at LAC-USC in general psychiatry and child-adolescent psychiatry. He was Chief Resident in home care services. He graduated from Texas College of Osteopathic Medicine in 1989.

Inna Lamport, MD, is an internist at the Chemical Dependency Recovery Program at Kaiser in Carson and Orange. She graduated from medical school in Moscow and completed a residency at St. John's Episcopal Hospital in New York.

Rebecca A. Powers, MD, is a child and adolescent psychiatry fellow at Stanford University Hospital. She graduated from Loma Linda University Medical School in 1990, and completed a residency there in 1993. □

NEWS ABOUT MEMBERS

Jess Bromley is retiring from practice after 30 years. He plans to continue his work as ASAM's delegate to the AMA House of Delegates.

Kevin Olden has been named head of the GI fellowship at St. Mary's Hospital and Medical Center in San Francisco.

Dan Ferrigno is now the Head of Medical Services for the Jails in Sacramento County.

Walter Ling is now the Chief of the Substance Abuse Program at UCLA. He continues as the Executive Medical Director of Matrix Center in Los Angeles.

Steve Eickelberg began a residency in psychiatry at the University of Arizona in Tucson in July. He left Kaiser Fontana in June.

Gary Levine is moving to Massachusetts to join Northeast Permanente as a Senior Pediatrician in the West Springfield office, where he will be helping to develop programs for adolescent substance abuse for Massachusetts Kaiser.

Medical Consultant for Department of Alcohol and Drug Programs

California's Department of Alcohol and Drug Programs is seeking a physician to serve as a Medical Consultant to provide clinical consultation to the Department on several areas. Among them are:

- the quality assurance/utilization review system, including medical necessity determinations, applied to the treatment programs which receive MediCal funds;
- collaboration with Department of Health Services and recovery homes on procedures addressing TB, HIV, sexually transmitted diseases;
- integration of public and private sytems;
- development of methadone regulations;
- continuing education for employees of treatment programs and other facilities/agencies which provide treatment and/or prevention activities.

CSAM has been asked to assist the Department in announcing the position. The Department is expected to fill the position before the end of 1994. Interested physicians should contact the CSAM office. □

You Can Write For

ASAM has adopted a practice guideline on the role of phenytoin in the management of alcohol withdrawal syndrome with recommendations for four different classifications of patients. Copies are available from ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015.

Laws Relating to the Practice of Physicians and Surgeons is available in a 500-page soft cover book for $12. The 1993/94 edition includes amendments enacted through 1993. Order Stock Number 7540-957-1017-2 from the State of California's Publications Section, PO Box 1015, 4675 Watt, North Highlands, CA 95660; 916/574-2200.

CONTINUING MEDICAL EDUCATION

ASAM MRO Course

The Basics of Being an MRO / The Latest on the Science, Rules & Art of Medical Review

August 26-28, 1994
Crystal Gateway Marriott, Arlington, VA
Sponsored by ASAM
Credit: 4 hours for "The Basics;" 14.5 hours for "The Latest"
Fees: $75 for ASAM members, $100 for non-members for "The Basics"; $450 for ASAM members, $525 for non-members for "The Latest"
Speakers include Ian Macdonald, Donna Smith, Robert Willette, Esq, Alan Jones, Joseph Autry, David E. Smith, Westley Clark, Barbara Johnson, Esq.
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

A San Diego Regional Conference

Understanding and Treating Alcoholism and Other Addictions

Saturday, September 24, 1994
Sharp Cabrillo Hospital, San Diego
Sponsored by CSAM and aaPaa
Credit: 5.5 hours
Fees: $80 for physicians; $50 for other health care professionals; $25 for physicians-in-training/medical students
Speakers include Floyd Bloom, Marc Schuckit, William Brostoff, Donald Gragg
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611; 510/428-9091.

New Roles for Psychiatry in the '90s...Ways to Change

October 7-9, 1994
Sheraton Grande Torrey Pines, La Jolla
Presented by the California Psychiatric Association
Credit: 16 hours
Fees: $250 for CPA members; $320 for non-members; $50 for physicians-in-training
For information, contact CPA, 1100 N Street, #2E, Sacramento, CA 95814; 916/442-5196.

1994 ASAM Review Course in Addiction Medicine

October 27-29, 1994
O'Hare Marriott Hotel, Chicago
Sponsored by ASAM
Credit: 21 hours; 3 hours for pre-conference workshops
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

CSAM-ASAM Review Course in Addiction Medicine

November 3-5, 1994
Miyako Hotel, San Francisco
Sponsored by CSAM and ASAM
Credit: 21 hours; 3 hours for pre-conference activities
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611; 510/428-9091.

ASAM's 7th National Nicotine Conference

November 4-6, 1994
Boston Marriott, Cambridge, MA
Sponsored by ASAM
Credit: 12 hours; 5.5 hours for pre-conference
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.
