Message from the President

Dear Members,
As I write this the holiday season is approaching and I hope it brings peace love and joy to you and all your families. Then we look forward to the New Year and a time of reflection and anticipation of change. This is particularly true for the Society as we contemplate 2006 for the year ahead is expected to bring significant changes for CSAM.

To begin, you’ll notice a change in the format of the Bulletin. Along with this, we are more actively seeking sponsorship for the production of the Bulletin. The editors welcome your constructive feedback on all aspects of the content and presentation of the Bulletin. We hope it is not only a vehicle for communication to the members but also facilitates a dialogue within the membership on important topics in the field of Addiction Medicine.

You will see later in this bulletin the results of the recent call for nominations to the board. We have successfully filled several vacancies and the board has reached the largest size in some years. I am pleased to say that the group is also committed, energetic and enthusiastic about working on your behalf. I also wish to thank Frank Evans for agreeing to assume the role of President-Elect when Ross Wheeler found he would be unable to continue in that capacity. Fortunately, Ross is remaining on the board to bring us the perspective of colleagues practicing in the North.

Also later in the Bulletin you will see more information on the 17th annual scientific conference held in Vancouver this past October. In a departure from our approach over most of the past several years, we worked with a professional organizing group this year. For the first time, the board has decided to make the commitment to using such a group every year and we are negotiating with the company who helped us this year for a three year period of support. We anticipate this allowing us to have a more consistent approach to conference organization and to work towards meeting your needs each year. Brian Fern, as chair of the conference committee would welcome your opinions and feedback on all aspects of the conferences.

Another important change now upon us is the addition of a new category of membership. Approved at the Annual General Meeting, Associate Membership is now open to anyone who shares the goals of the Society. Continued on page 2.
The CSAM SMCA Bulletin

Cont’d from page 1

We hope this will serve as a way for the broader multi-disciplinary team working in the area of addiction treatment to become engaged in the life of the Society. It promises to enrich our debates and strengthen the voice CSAM can have when addressing policy makers. This change will also bring challenges as we strive to ensure that all members of the Society are included equally in decision-making even though, because of our CMA-affiliation, full voting rights are restricted to the smaller group of full members.

The board values your advice and support on this endeavor.

Finally, after many years of dedicated support, Rhonda Hajela has decided to step down from the position of Secretariat. Rhonda has had an enormous influence on the growth and development of our Society and her energy, effort and reliability will be sorely missed. The Board is taking this opportunity to evaluate the possibility of working with a professional society support company. You can anticipate many changes arising from this from a change in address for the head office to revisions in the website and the possibility of on-line payment of annual dues. The board and I want to thank you for your patience as we go through this transition but also for your active participation in the change by providing feedback on all positive and negative impacts of this change you experience.

Sincerely,
David C Marsh CCSAM ASAM
CSAM President

Message from the Editor

Michael Varenbut MD, CCFP, FCFP, DABSM, CASAM, CCSAM, MRO

It is with great pleasure that I took over the role of Editor In Chief for the “Bulletin” from Dr. Kumar Gupta. I would like to take this opportunity to thank him sincerely for all his great contributions and commitment to the Bulletin thus far, and I hope that he continues to contribute further to our publication in the future.

I would also like to thank all of those individuals that have assisted me in providing articles, commentary, “pearls of wisdom” and additional materials for this issue of the Bulletin. This publication would not have been possible without their assistance.

The Bulletin is the voice of CSAM and Addiction Medicine in Canada, and it is vital that we continue to demonstrate our commitment to our field, by an ongoing and open communication channel between all Provincial Chapters and among all those practicing in the field of Addiction in Canada.

With this in mind, I strongly urge you, and sincerely request of all CSAM members to consider contributing to our publication. I welcome all materials that our members feel would be important to add to future issues, and personally vow to consider each and every submission.

Much time and effort has gone into this issue of the Bulletin, and I sincerely hope that you find it informative and enjoyable.

I value your opinions, comments, and suggestions for improvement. Please don’t hesitate to communicate with me directly via email at mvarenbut@toxpro.ca or via the CSAM email address at csam@kingston.net.

Please allow us to extend a warm welcome to the new CSAM Board Members

Alberta
Charl Els, MD — Edmonton, AB
Ontario
Jeff Daiter, MD — Richmond Hill, ON
British Columbia
Jennifer Melamed, MD — Vancouver, BC
Québec
Charles Mackay, MD — Montreal, PQ
CSAM Honourary Membership

Definition of Honourary member status
Honorary Life Membership is awarded to members of the Society who have demonstrated distinguished service to the Society and the field of Addiction Medicine.

Listing of all past Honourary members, with date of status:

- Dr. R. Gordon Bell of Toronto ON in 1989 - deceased 2005 June 15
- Dr. Joseph MacMillan of Toronto ON in 1996
- Dr. Sheldon Cameron of Summerside PE in 1997
- Dr. Anna-Mary Burditt of Moncton NB (formerly of Halifax NS) in 1997
- Dr. Maurice Dongier of Montreal QC in 1999
- Dr. Jim Rankin of Suffolk Park, NSW Australia (formerly of Toronto ON and 1st president of CSAM) in 1999
- Dr. Douglas Talbott of Atlanta GA in 1999
- Dr. Nady el-Guebaly of Calgary AB in 2001
- Dr. Graeme Cunningham of Guelph ON in 2004
- Dr. Raju Hajela of Kingston ON in 2005

Short Bio from Dr. Raju Hajela

I obtained my medical degree (MD) from Dalhousie University, Halifax, Nova Scotia, in 1982 and have been a duly licensed physician in the province of Ontario since 1983. I have completed post-graduate training in Public Health - Master of Public Health (MPH), Harvard University, Cambridge, Massachusetts, USA, 1988; and in Addiction Medicine - Clinical Residency in Alcohol and Drug Dependency, Addiction Research Foundation, Toronto, Ontario, 1988-89. I hold a specialty certification in Family Medicine (CCFP), granted after examination, by the College of Family Physicians of Canada, a specialty certification in Addiction Medicine (CASAM), granted after examination, by the American Society of Addiction Medicine; and a specialty certification in Addiction Medicine (CCSAM), granted by the Canadian Society of Addiction Medicine. I have been awarded the status of a Fellow of the American Society of Addiction Medicine (FASAM) and a Fellow of the College of Family Physicians of Canada (FCFP).

I have had extensive training in dealing with patients with drug and alcohol problems throughout my years of clinical practice. From August 1991 to October 1994, I was the Director of an In-Patient Addiction Treatment Unit for the Canadian Forces, in Kingston, Ontario. I was on the Associate Staff at the Kingston General Hospital and Hotel Dieu Hospitals, Kingston, from 1992-2004. I was an Assistant Professor in the Departments of Family Medicine and Psychiatry, Queen’s University, Kingston from 1992-2001. I am a Past-President of the Canadian Society of Addiction Medicine, the Past-Treasurer and Past-Chair, Standards Committee that is responsible for reviewing credentials and recommending Certification by the Canadian Society of Addiction Medicine. I am a Board member of the American Society of Addiction Medicine; and a Board member/Vice-President of the International Society of Addiction Medicine. I was the Chairperson for the Advisory Committee to the Ontario Medical Association (OMA) Physician Health Program (PHP) from 1996-2002. I have been involved with several community agencies including the Kingston, Frontenac, Lennox & Addington District Health Council.

I regularly give lectures, seminars and workshops in prevention and treatment of Addiction related problems, including Concurrent Psychiatric Disorders and Chronic Non-Cancer Pain to health care professionals and members of the community. I have been a reviewer of CPSO documents related to these matters and a consultant to various corporations in matters relating to the employment of people suffering with Addiction, Concurrent Psychiatric Disorders and/or Chronic Pain.
Dear Dr. Hajela,

First of all, please allow me to congratulate you on this extraordinary achievement. As I am sure all CSAM members will agree, you are well deserving of this great honour which has been bestowed on you.

Thank you, Michael. It is very humbling to receive this honour; and it is a reminder how the years have gone by!

To begin this interview, I would like to ask you about who have been your role models in your professional career?

I feel very privileged to have had the honour to know and learn from so many leaders in medicine and specifically, Addiction Medicine. The list is rather long and a story in itself. From undergrad and medical school years I would pick Dr. Ravi Ravindra, a Professor of Physics, Philosophy and Religion, and Dr. David Shires, Family Medicine, both at Dalhousie University who helped me develop as a human being, in addition to becoming ‘doctored’. Dr. Shires was instrumental in my going to the Harvard School of Public Health in 1987. Then at Harvard, Dr. John Wyon became a great mentor for my interests in Comprehensive Primary Health Care internationally and the bio-psycho-social-spiritual model of health and disease. At the Addiction Research Foundation, I met Dr. Jim Rankin, our founding President, and shared an office with Dr. Graeme Cunningham! I am profoundly grateful to Graeme for his recovery wisdom. Graeme and another AA member, Bud D., assisted me in learning about and appreciating the practical value of the 12 Steps. I had discovered Dr. Abraham T

werski in Boston through his writings and finally had the honour of meeting him a few years later. His book Addictive

Thinking: Understanding Self Deception remains as my first recommendation for reading for patients, friends and colleagues. I also met Dr. Gordon Bell and his daughter, Linda Bell, in 1988 and quickly realized the profound impact the Bell family has had in our field. Two of Dr. Bell’s books – Escape from Addiction and A Special Calling remain very meaningful to me today. Of course, I met Dr. Nady el-Guebaly in 1989 and have appreciated his friendship and wise counsel over the last 16 years in so many projects and activities. There are numerous other family members, friends and colleagues who have been sources of inspiration and guidance that have left an indelible mark on who I am today.

What do you feel have been your greatest achievements in the field to date?

I tend to look at my career as a work-in-progress. Achievements along the way are more like milestones that are never mine alone. Some of the milestones that I think have the potential to be of lasting significance are – the Fundamentals course that I began as a ½ day in 1997, which has now become a full day pre-conference course that is very well received every year; the bio-psycho-social-spiritual definition of Addiction that includes behaviours beyond substances; the establishment of Canadian Certification in Addiction Medicine in 2000; and the opportunities for input in policy matters at the Canadian Medical Association, the College of Family Physicians of Canada, the American Society of Addiction Medicine and the International Society of Addiction Medicine. The collaboration with CMA has helped CSAM have a stronger voice in dealing with some federal government initiatives. I am extremely gratified that the Fundamentals course will be called the Gordon Bell Course in perpetuity as Dr. Bell is CSAM’s first honourary member and a true pioneer in our field going back to the 1940s!

In regard to CSAM, what do you feel are the strengths and possible weakness of our organization today, and how do you feel that we can improve on these?

The strength of CSAM, in my opinion, lies in the membership and Certificants. Rhonda and I have made it a high priority, over the last 8 years, to recruit and retain members with the help of leaders in our field. I hope the Certificants will gain more visibility as our numbers increase and the credibility of Addiction Medicine as a specialty will become more established. A vibrant national organization such as CSAM is essential for this purpose. The voice of CSAM is also necessary for establishment and promulgation of standards, definitions and training programs in our field. The high quality annual meetings have been a testament to what we can achieve together. The challenge is to maintain balance between basic science and clinical practice; and remember at all times, the continuum of treatment services, required for the chronic disease of Addiction, from early intervention and harm reduction in context to the more definitive maintenance and abstinence-based treatment services. The vulnerability, a term I prefer to weakness, lies in the membership and the board becoming under-active or inactive. There is a tremendous amount of time and effort required by a number of people to do the work that is necessary for CSAM. Complacency, busy-ness in individual practices and assumptions regarding how things may or may not be done have been
challenges for me and others in leadership positions with CSAM. I am gratified by the leadership positions that are being assumed by younger physicians, such as yourself, which will lead us to bigger and better things. I hope more members will speak up and work together to build a stronger CSAM.

What do you feel are future challenges for CSAM?

Future challenges for CSAM lie in the direction of building and strengthening bridges with colleagues in Family Medicine and other specialties; and raising the profile and awareness regarding addiction related problems in our society for the general public and politicians.

CSAM also needs to advocate strongly for the establishment of training programs in Addiction Medicine and departments of Addiction Medicine at medical schools across Canada.

I sincerely hope that the charitable donation and charitable activities mandate of CSAM will be pursued more vigorously in the near future.

How do you feel we can improve the profession’s and public’s perception of the field of Addiction Medicine?

Addictionists need to dialogue more with colleagues and present papers/workshops in a variety of medical conferences. We have tried this approach with some success with project CREATE. The public education aspects are more challenging but doable if efforts are put into a viable strategy for fund raising and mounting a campaign with public service announcements, multimedia ads etc. Educational videos, television and radio interviews have the potential to reach wide audiences across Canada. The challenge is to present clear messages of facts about Addiction, the hope that treatment offers and the serenity that follows in recovery.

What would be your personal wishes for the field of Addiction Medicine in Canada?

In most communities across our Country, there is a lot of fragmentation in addiction services and a fair amount of not-so-benign neglect in appropriate patient care among physicians and other health care providers. I hope Addictionists will take on leadership roles to bring more cohesiveness and teamwork in patient care. I hope the membership of CSAM and number of Certificants will grow rapidly. I am happy to see the category of Associate membership being opened up. Working together with other care providers will be mutually supportive of interests of all disciplines individually and collectively for our field. This would lead to the best possible care for our patients and improving the quality of life of individuals and communities across Canada.

What are your professional goals and aspirations for the future?

My career is taking me to Calgary in April 2006 with an appointment at the University of Calgary – Addiction Centre. I hope to continue forward with initiatives that I have been involved in so far, in the community there and have opportunity to be involved in more research. Pain and Addiction, adolescents, Addiction beyond substances and spirituality are areas that I hope to do more work in, including teaching health care providers – students and practitioners. I also hope to pursue my interests in population and public health. I have recently discovered the Canadian Institute of Natural and Integrative Medicine in Calgary, so I hope to pursue some collaboration there as well.

Do you have any closing thoughts that you would like to share?

Yes, I would like to take this opportunity to thank my wife, Rhonda, and my secretary, Pauline, for their invaluable support in helping keep my life manageable! Our daughter, Leah, and son-in-law, Adam, continue to be a source of affection and inspiration. We are going to be blessed with twin grandbabies early in 2006. In closing, I would like to share this quote from Henry David Thoreau – “The true harvest of life is intangible, it is as the tints of morning and evening, it is a little stardust caught... a segment of the rainbow”. Namaste!

I thank you on behalf of all CSAM members for your great contributions to CSAM as an organization, and to the field of Addiction Medicine as a whole.

Best wishes for the future.

Michael Varenbut,
Bulletin Editor
The 17th Annual Scientific Conference of the Canadian Society of Addiction Medicine was held in Vancouver October 27-31, 2005. As in previous years, the first two days were occupied with the board meeting and pre-conference workshops (the Physician Health Day and Fundamentals Course). This year the Fundamentals Course was named in memory of Dr. Gordon Bell and the board has decided to continue this name in perpetuity as an honor for a great leader in the field of Addiction Medicine. The main conference commenced on Friday evening and finished Sunday at noon. This was followed by the first Buprenorphine training course held in Canada.

In several respects the conference was a great success. Attendance this year, at well over 200, was the largest ever. As well, there were significantly more booths and displays from a wide range of exhibitors as well as other forms of sponsorship for the conference. The plenary speakers brought a diverse and challenging range of scholarly information to the meeting. The keynote speaker, Edythe London from UCLA, described the effects of methamphetamine including her groundbreaking work on functional neuroimaging. Her ability to demonstrate the links between brain structures and functions and the short- and long-term impact of methamphetamine use greatly assisted our understanding of the clinical face of stimulant dependence. Anthony Phillips, from UBC, complemented Dr. London’s work with a detailed description of the reward pathways and the links from the amygdala and frontal cortex to the core dopamine pathways. His work with animals is leading to new insights into the mechanisms of dependence, the biological triggers for relapse and the general parallels between addiction and other forms of learning and memory processes.

Closer to the clinical front, Thomas Kerr described the impact of injection drug use on the lives of socially marginalized individuals in the poorest neighborhood in Canada and the benefits for these individuals and society of opening North America’s first medically supervised safer injection facility. David Marsh, Alex Chan both from UBC and Suzanne Brissette of the University of Montreal, shared the background, design and early implementation experiences with the North American Opiate Medication Initiative (NAOMI), a Canadian heroin prescription trial. Both these initiatives aim to reduce the harms associated with injection drug use while facilitating the transition of drug users from uncontrolled use to treatment through connections with the health care system.

On the broader area of social policy and societal consequences of substance use, two of the plenary speakers had informative talks. Tim Stockwell, the Director of the Centre for Addiction Research in BC, reviewed evidence-based approaches to alcohol policy including such novel interventions as taxation based on the alcohol content of beverages (lower tax on lower content drinks leading to less alcohol intake) and dedicated levies the proceeds of which are devoted to prevention and treatment. He encouraged the Society to raise its voice in favor of rational public policy in Canada in this area. Finally Neil Boyd, a criminologist from Simon Fraser University, reviewed the history of drug laws in Canada. Dr. Boyd clearly illustrated the link between the initial prohibitions against opium and both commercial interests and racist pressures in the early part of the last century.

“Attendance this year, at well over 200, was the largest ever. As well, there were significantly more booths and displays from a wide range of exhibitors as well as other forms of sponsorship for the conference.”
In addition to the excellent plenary speakers, there was a wide range of presentations based on the abstracts submitted. The material varied from the controversial to the novel advancement of standard practice but was all based on clinical experience and enthusiastically presented and debated. Overall the conference, including pre- and post-conference workshops, was well attended and very enjoyable. Once again the meeting was an important opportunity to connect with colleagues, make new friends or catch-up with old ones, and to share the support of others working in this potentially isolating field.

We hope those of you who attended greatly benefited from the experience and we invite you all to the 18th conference in Saskatoon, October 12-15, 2007.

Board Members at opening reception L to R: David, Frank Evans, Suzanne Brissette, John Fraser and Ross Wheeler.

CSAM Committee Reports

Opioid Agonist Committee Update
By Michael Varenbut MD, CCFP, FCFP, DABSM, CASAM, CCSAM, MRO

The newly formed Opioid agonist committee (“OAC”) is comprised of the following CSAM members: Brian Fern, Suzanne Brissette, Kathryn MacCullam, Kumar Gupta, Wade Hillier, and is chaired by Michael Varenbut.

With many mandates on its plate, the OAC is glad to present the guidelines below for minimum training requirements for Buprenorphine prescribing and entry to the “National Buprenorphine Registry”.

Some of the additional roles and future goals of the committee will be the Buprenorphine National Registry, Planning and organization of Buprenorphine training sessions, communication and liaison with CSAM board members, the membership at large, as well as the Buprenorphine Expert Advisory Panel.

Guidelines for “Minimum Training Requirements” for Buprenorphine Prescribing and Entry to the “National Buprenorphine Registry”

1. CSAM will establish and maintain a national registry of qualified physicians.

2. CSAM’s Opioid Agonist Committee (OAC) will be responsible for establishing and updating these guidelines, as well as communicating with the “Expert Advisory Board”.

3. Training course contents will at a minimum follow the educational modules established by the “Expert Advisory Board or Buprenorphine”.

4. Access to the registry shall be limited to provincial regulatory bodies and Health Canada.

5. In addition to completion of an approved training course, physicians should obtain at a minimum, one full day (Min. 6 hours) of accredited CME in Addiction Medicine.

6. New physicians on the registry should name a registered physician, as a “mentor”, during their first year of Buprenorphine prescribing.

7. An exemption to prescribe Methadone shall not be a requirement for entry to the Buprenorphine registry. However, we strongly encourage physicians to undertake a methadone prescriber’s course, prior to prescribing Buprenorphine. Individual provincial regulatory bodies may vary in their requirements in this regard.
### Membership Committee Update

By Michael Varenbut MD

The Society welcomes the following new members since the last Bulletin:

CSAM now has 322 members of which there are 56 Associate members, 9 Honourary Life Members, 3 Retired Members and 2 Student Members.

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A recent study evaluated the efficiency of operations at Vancouver Detox, a 24-bed residential detox facility. Clients requiring service are screened through a central telephone intake service (ACCESS 1)* which determines appropriate level of care. Vancouver Detox represents level 4 or those deemed requiring medical management in a residential setting.

The two-year study (July 2003 – June 2005) was extracted from a comprehensive database. The following represents a summary of findings:

- Among the 4741 clients (mean age 41, 65% male) who requested service by ACCESS 1*, 3112 were admitted.
- Of those not admitted they were either lost (67%) or no longer requested service at time of call-back (33%).
- The median wait time was 1 day
- The median length of stay was 4 days
- Treatment completion rate was 79%
- The median detox occupancy rate was 88% although there was a slight decline during the 3-day welfare cheque issue period and during the summer compared to the winter.

Despite the short wait time at Vancouver Detox, there is a high pre-treatment attrition rate (34%) and a relatively lower occupancy rate during both the welfare cheque period and the summer season. The operational accessibility and efficiency could be improved at Vancouver Detox by specifically addressing these issues.

**ACCESS 1**
A centralized telephone intake service introduced in 2002. ACCESS 1 determines whether the client is within the Vancouver region and what type of service is required. There are 4 levels of detox care:

- Medically Managed: Vancouver Detox
- Medically Monitored: Harbour Light (a funded facility with the Salvation Army)
- Intensive Outpatient: Daytox
- Home based detox

For further information about ACCESS 1 the current manager can be contacted at Mary.marlow@vch.ca.

**Alberta News**
Dr. Charl Els

Alberta is experiencing some exciting proceedings with the negotiations between the Alberta Medical Association (Addiction Medicine Section) and the Alberta Alcohol and Drug Abuse Commission. The working group aims to develop a provincial strategy for the engagement of AADAC and primary care physicians and addiction medicine specialists in the care of patients with addiction in the community. Addiction Medicine Specialists have been invited to become involved in the comprehensive and coordinated approach to managing the “crystal meth” problem in Western Canada.

The College of Physicians and Surgeons of Alberta completed the consultation process for “Standards and Guidelines for Methadone Maintenance in Alberta”, and full implementation is anticipated in 2006.

On the front of tobacco control, several health regions are implementing gold standard policies, and the provincial legislation, Bill 201 (although considered weaker than other provinces’ comparable legislative instruments, and arguably not completely in compliance with the FCTC) is slated for implementation in the near future. CSAM members have played, and will continue to play key roles in providing adequate tobacco control support to these processes in...
Alberta. Informal liaison and requests for collaboration with CCTC and CCSA have also started to occur, and building on the solid work done by the outgoing representative, Dr. Dan Ryan, the chapter continues to grow in its influence and performance.

**Saskatchewan News**
B. J. Fern, M. B. Ch.B

Saskatchewan has just held an all day Methadone 101 course at the Sheraton Hotel Saskatoon attended by 125 stalwarts from numerous disciplines, intended to introduce the concept of “Differential Methadone Licensing” – Maintenance only for new docs, full range of services for experienced docs, with the hope that new docs will get into the field as maintenance docs then with experience become familiar with the complexities and then progress to more services.

**Agenda has therefore been:**
1. Methadone “theory” or background issues:
   1. Neuroanatomy and physiology
   2. Patient assessment
   3. Physical, mental, social and legal issues.

2. Methadone “practice” – the same areas.

3. College licensing issues.

We already have some docs in the Maintenance level, especially in outlying areas, and they will become fully licensed within the next year by all account. Their patients are from established practices where they have already been started and stabilized by an experienced doc.

In general the session was successful, was recorded in audio and video, slides are being made available on CD for those interested, and a DVD will be created for the presenters so we can assess what we did and how we did it and whether it was good, bad, or indifferent and so on. Intent of all this is to improve our performance for 2006 sessions, potentially at the CSAM conference.

**Ontario News**
Kumar Gupta MD

The new 2005 Ontario methadone guidelines were recently published in November 2005. The new guidelines are thought to be the most comprehensive to date especially in regard to dosing issues around methadone, and pain control. In the new guidelines, Ontario has mandated a locked box policy with regard to safe keeping of methadone take home doses. Patients are now required to demonstrate a locked box to the methadone doctor before any take home doses are given. Furthermore, a consultation is now required for split doses, and doses greater than 120mg. Ongoing discussions and reform are taking place between corrections and the Ontario College with regard to appropriate methadone prescribing within a correctional facility. The new guidelines make it the responsibility of the correctional physician to ensure continuity of methadone upon release of the patient from the jail back to the community prescriber.

**Quebec News**
Eric Fabrès
Services d’Appui à la Méthadone
Suzanne Brissette
Quebec representative

La rencontre annuelle des personnes-pivots du réseau québécois d’appui pour la méthadone a eu lieu le vendredi 28 octobre dernier à Montréal.

Cette rencontre a permis au docteur Marcel Provost du Collège des médecins du Québec et à madame Josée Morin de l’Ordre des pharmaciens du Québec de faire le point sur les démarches de mise sur le marché de la buprénorphine. Compte tenu des restrictions proposées pour la dispensation de la médication, les professionnels se sont montrés septiques face à l’impact thérapeutique possible de cette démarche. Les professionnels ont par ailleurs conclu que le Guide de référence/guide de bonnes pratiques actuellement en production au MSSS pourrait faciliter l’harmonisation des
pratiques en matière de traitement de la dépendance aux opioïdes avec la méthadone au Québec. Le Sam a reçu le mandat d’organiser des rencontres de travail interrégionales (Montréal, Drummondville, Québec) visant à favoriser la diffusion des recommandations émanant de ce document. Cette rencontre a de plus permis de discuter avec les représentants des services correctionnels provinciaux des difficultés de collaboration rencontrées lors de séjour en détention de patients traités avec la méthadone. Pour finir, c’est avec un grand intérêt que les personnes-pivots ont assisté à la présentation du projet de recherche clinique NAOMI.

The annual meeting of the methadone network group took place on October 28th in Montréal. Dr. Marcel Provost of the Québec College of Physicians and Ms Josée Morin of the Québec Order of Pharmacists commented on the approval of buprenorphine. In view of the many restrictions that will be imposed on the dispensing of this medication, the professionals remain skeptical as to buprenorphine’s impact as a new therapeutic agent. It was also concluded that the MSSSQ’s document on guidelines and good practices on the treatment of opioid dependency, would constitute an ideal tool to harmonize methadone practices, once it becomes available. The SAM has received a mandate to meet with different regional boards (Montréal, Québec, Drummondville) to facilitate the dissemination of these recommendations. Discussions between the provincial correctional services and the professionals involved in methadone programs were also conducted to find solutions to the difficulties encountered when methadone maintained patients are transferred in correctional facilities. Finally, Pascal Schneeberger and Paul-André Guévremont, respectively research and clinical coordinators, presented the NAOMI project.

New Brunswick News
Kathryn MacCullam MD

It has been a busy year for addictions in NB. This past January, the government, through the Department of Health and Wellness, decided to develop and fund a province wide methadone program. Hence we are in the process of developing provincial guidelines, policies and procedures. We will initially have four programs throughout the province with another three to be rolled out over the next 2-3 years. These will be fully staffed with social work/ addiction counselors and nurses with physicians providing fee-for-service or sessional support.

In Fredericton we are currently involved in integrated, harm reduction pilot project of a team approach with our mental health colleagues for clients with concurrent disorders ages 16-20. We hope to complete a program evaluation by the end of January, but to date are observing very positive outcomes in these clients.

We are also involved in a community mobilization process with a local community to empower them to further address substance use in there area.

ISAM Update
By Raju Hajela, MDA, MPH, CCSAM, FASAM, FCFP
Vice-President, ISAM

The 7th Annual Scientific Meeting of the International Society of Addiction Medicine (ISAM) took place in 2005 April in Mar del Plata, Argentina, in conjunction with the meeting of the Argentinean Psychiatric Association, the International Society for Study of Personality Disorders and several components of the World Psychiatric Association. It was a wonderful opportunity to meet our colleagues from South America, in addition to many from various parts of the world. 34 countries were represented making this our most diverse international meeting yet!

Dr. Tarek Gawad of Egypt became President for a 3 year term, as Dr. Nady el-Guebaly completed his inaugural terms as President. Nady has now assumed the position of Executive Medical Director. The ISAM office remains in Calgary at the Addiction Centre-Foothills Hospital.

ISAM continues to grow with the support of individual members and affiliate societies that now include the Canadian Society of Addiction Medicine, the Finnish Society of Addiction Medicine (Paihdelaakketieteen yhdistys ry) and
CSAM & Canadian Centre on Substance Abuse (CCSA)

Garth McIver MD, BC Representative

I recently attended the Canadian Centre on Substance Abuse National Conference (Issues of Substance) held in Markham ON, Nov 13 –17. The conference was followed by the CCSA National Policy Working Group, an advisory committee, on which I attend as your CSAM representative.

The conference was well attended with over 400 participants. An overview of the program identified four main streams—Prevention, Harm Reduction, Enforcement, and Treatment. The conference invited some lively discussion from divergent positions.

Concern had been raised at the CSAM Board level in regarding the lack of CSAM input at a national conference on substance abuse. At least six abstracts from CSAM members had been submitted but none had been chosen for presentation. Discussions in this regard with Michel Peron, the Chief Executive Officer of CCSA, were encouraging. He acknowledged the apparent lack of CSAM involvement and his commitment to work more closely with CSAM in the future. Michel spoke of CSAM as a respected resource and that CCSA would in future, endeavour to include representation.

In general, Mr. Peron discussed including a CSAM representative on the next CCSA Conference Steering Committee and Program Committee for the next conference in 2007. In principle he supports a CSAM plenary presentation at the conference. Michel stated he was open to greater dialogue on the many issues that CSAM/CCSA can work on together and invited a letter from our Board to begin the dialogue in a more formal manner. During the conference closing remarks, he specifically mentioned CSAM as an organization that he valued and wanted a closer relationship. Another appreciated gesture was the application for CSAM membership by Gerald Thomas, CCSA Senior Policy Analyst, and his commitment to attend future CSAM conferences and events.

The Advisory Board meeting followed the conference and reviewed several outstanding past and current policy issues, which can be accessed at the CCSA web page. The importance of a CSAM perspective on this board remains important and future policy recommendations and projects with particular interest to CSAM will continue to be put forward.

the Vereniging voor Verslavings Geneesekunde Nederland (VVGN) – the Dutch Society of Addiction Medicine. There are 58 Canadian members of ISAM now.

One of the major achievements recently for ISAM has been the development of the Certification Examination. The inaugural exam was held in Cairo, Egypt, in 2005 September where 11 Egyptian physicians undertook the 4 hour – two part/two hours each – examination. Another 7 Canadians and a Hong Kong physician sat the exam in Vancouver on 2005 October 31. The exam results for the 19 physicians are expected to be available before the end of the year. The CSAM board has given approval to recognize the ISAM examination as a base, just like the ASAM exam, for CCSAM. The two anticipated exam venues next year are expected to be Oporto, Portugal, in 2006 September; and Saskatoon, Saskatchewan, in 2006 October. Information about the exam and the eligibility criteria are posted on the ISAM website – www.isamweb.com. Eligible physicians who are interested in taking the exam are invited to send an email to nady.el-guebaly@calgaryhealthregion.ca. The 8th Annual Scientific Meeting of ISAM – A World of Drugs, a Universe of Treatment - will be held in Oporto, Portugal, 2006 September 26-30. The 2007 meeting– Addiction Medicine: Current Advances & Future Directions - is scheduled for 2007 October 22-27 in Cairo, Egypt. Interested researchers and clinicians are invited to submit abstracts. Sharing of expertise and experience with colleagues around the world is very rewarding and enriching for professional and personal growth! More details about ISAM and future events are available on the ISAM website.

Cont’d from page 16
Methadone Maintenance Treatment has proven itself a medical alternative to the most harmful consequences of opiate drug addiction. It works well and allows opportunity for a deeply addicted person to regain a foothold in life.

Working with methadone clients on a daily basis teaches important lessons about the consequences of addiction and the benefits of recovery. The most obvious lesson is that of the health and social problems seen on a methadone program most occur in those clients who persist with an addictive lifestyle.

It is also clear that those who do best with methadone treatment – those who regain stability and who assume responsibility for their lives – are clients who make changes to their lifestyle and who are actively engaged in their recovery from addiction.

This brief commentary offers a conceptual and practical framework for the integration of methadone maintenance treatment with the day to day process of recovery from addiction.

**Methadone Maintenance Treatment and Recovery from Addiction**

Early in methadone treatment, relief from the driving force of physical dependency, issues of shelter, safety and basic health of course take priority. But symptoms of active addiction will persist and impact negatively on engagement and progress in treatment.

The compulsion to run, to avoid and to use drugs of intoxication endures and is not addressed by methadone prescription. Issues of secrecy, shame, denial and blame are pervasive and powerful determinants of unhealthy choice and behavior. The mind is restless and is distracted by intrusive events of the past and an imagined future. Healthy priorities and routine have long been lost in habits of impulsivity and the demands of addiction.

Basic education on the persistent nature of addiction, the features of Post Acute Withdrawal Syndrome and the principles of recovery help clients to engage in their own treatment. In this early phase of treatment, the most basic principle of recovery – honesty – just means to talk with a new doctor or counselor about what is really going on. Other principles - to stay in the day, to prioritize self care, to take challenges one step at a time and to connect with those who understand addiction - all apply to methadone treatment in the same manner that they apply to other aspects of life in recovery.

Early education about methadone and recovery offers a balanced perspective that challenges the unhealthy assumptions of addiction. Methadone can provide rapid and substantial relief from the physical demands of opiate dependence. But undue reliance on medications to address the many challenges of early recovery only colludes with the addicted mindset that a consumed medication is a solution to whatever feeling or problem may arise.
Recovery from addiction requires active client participation. This may be facilitated by proper medical treatment. But a safe and lasting recovery from addiction will not be manufactured by any medication prescription. Proper education about what medical treatment can and cannot provide will foster a relationship of shared responsibility and will cushion the negative impact of unrealistic expectations on the therapeutic relationship.

An integrated emphasis on methadone and recovery does not obviously follow from a traditional view that methadone maintenance treatment is only for those who have failed repeatedly at other recovery efforts. Such teaching is ill informed and dangerous to those suffering with opiate addiction. Many will now present for treatment at earlier stages of their addiction and deserve to be welcomed with a safe approach to treatment and that is based in a belief that their recovery from addiction is attainable.

The integration of methadone treatment with a personal program of recovery is not different than the temporary use of nicotine replacement medication with behavioral strategies for smoking cessation. The intensity and duration of methadone treatment reflect the biological realities of the condition and the devastating consequences of relapsed opiate addiction.

From an integrative model of methadone treatment and recovery, Phase I of treatment spans the time from entry into treatment through to safe stabilization on a proper methadone dose and early abstinence from drugs of intoxication. This phase may last for a few weeks - or may persist indefinitely with relapsed use and/or active concurrent addiction.

Our facility offers a drop-in Recovery Support Group and makes recovery literature freely available to all clients. Frequent and brief physician reassessment of methadone dose is integrated with topics of counseling that are guided by the current challenges in a client’s life.

Recovery behaviors may be identified when observed. Many are surprised to learn that a personal choice is consistent with traditional recommendations for early recovery. Simply to identify and to name such behaviors will solidify their importance.

A few minutes spent with any person in early treatment offers many opportunities to provide feedback on the simple truths of recovery. Real time counseling that focuses on the challenges of the day will facilitate retention of learning and promotes the here and now and solution oriented approach of recovery. The strategies of *one step at a time* and *first things first* help counteract the common tendency to take on too much too quickly in early recovery.

Attention to boundaries and professional office practice can offer a powerful message of recovery. To repeatedly make exception to usual office practice is usually to support unhealthy lifestyle and lack of priorities in the addicted client. To skew findings on an application for social support or funding may seem a generous offer, but imparts a discordant message that dishonesty is acceptable if it will get you what you want.

Extended and individual counseling sessions are poorly attuned to the condition and needs of those in early recovery. Therapeutic practices that emphasize exploration of distant past trauma do not respect the vulnerabilities of early recovery or the risk of relapse with imposed stress. The use of these techniques in early recovery arises more from the naive beliefs of therapists than a proper understanding of addiction and the strategies of recovery.

Phase II of treatment follows upon stabilization of methadone dose and early abstinence. The learning and practice of recovery can take an extended time to provide safety from relapse. But the consequences of relapsed use may be immediate and devastating. Maintenance treatment provides a safety net during a time that a client integrates recovery into their day to day life, choices and relations. It is a time of realizing the benefits of recovery, solidifying its practices and remaining alert to the many paths to relapsed use.

There are countless recovery topics that may be discussed with clients during this maintenance phase of treatment. But it is also a time to help a client identify their greatest areas of personal risk and to specifically address these. One client’s greatest risk of relapse may relate to issues of co-dependency. For another it may be a hair trigger issue of anger, intrusive memories of past trauma, shame or a concurrent psychiatric disorder.

Contrary to the practice of many residential programs, this Phase II of methadone treatment is an ideal time to attend for intensive group treatment. To recommend the discontinuation of methadone dose prior to program entry - or prior to a client’s demonstrated ability to remain abstinent outside of a treatment setting - seems a common and reckless disservice.

An extended period of time abstinent and on a stable, moderate dose of methadone seems to allow for gradual readjustment of opiate receptor activity. Common experience suggests that a gradual taper is more easily tolerated after an extended time spent in Phase II of treatment. A bare minimum of one year is the standard recommendation at our facility.

Phase III begins with a taper of methadone dose to gradual discontinuation. Many factors will be considered prior to
embracing on this course. These include the length of time in prior treatment, stability of lifestyle and attentiveness to recovery, outstanding issues of chronic pain or concurrent psychiatric disorder, previous history of addiction and intravenous use of opiate drugs. There is no healthy reason for this decision to be pressured.

Methadone should be the last issue of concern if a proper decision has been made to taper at this point. Our facility recommends a background taper of five milligrams once monthly while all other attention is directed to recovery activities and lifestyle satisfaction.

Recovery refers to a process of learning to enjoy life without the use of intoxicating drugs and while minimizing risk of relapsed use. Since relapse risk is never absent, recovery is a lifelong process attended to on a day to day basis.

Not all methadone clients are ready and/or interested to accept the ways of recovery. But just as a methadone program offers easy access to other services - education on recovery and an attitude that recovery from addiction is attainable should be routinely on hand.

Methadone stands its own ground as a harm reduction strategy for severe opiate dependence - and it does so regardless of readiness for recovery. But Methadone Maintenance Treatment is but one medical strategy in a larger and lifelong context of recovery from addiction. Decisions about the initiation and duration of methadone treatment are best made from the perspective of recovery - guided by its principles and its integration into daily life.

In the long run a day to day, personal program of recovery provides the only lasting freedom from addiction and its potential for devastating consequences. And recovery from addiction is of course, the most reliable means of reducing harm.

Resources:


Handbook of Recovery: For Clients of Methadone Maintenance Treatment, Their Families, Friends and Caregivers.

Handbook of Recovery is an excellent resource recently written by John Craven MD and published by SupportNet Studios Inc. of London, Ontario, Canada. It is a 150 page, client centered guide that integrates methadone maintenance treatment with the principles and practices of recovery from addiction. Written in a question / answer style, this reading is easily accessible and directed to clients of methadone treatment. Personal comments from clients in treatment and in recovery from addiction are included on each page. Any reader will find a great deal to relate to in these comments.

The Handbook contains six chapters (About Opiate Addiction, About Methadone Maintenance, About Recovery from Addiction, Early Recovery, Other Challenges and Choices and Concurrent Psychiatric Disorder) and one appendix that contains an educational summary and self report symptom inventory for common concurrent psychiatric disorder to occur in those recovering from opiate drug addiction. A unique aspect of this Handbook is its integration of methadone treatment, recovery from addiction and consideration of concurrent psychiatric disorder. Handbook of Recovery is an excellent resource for any person considering methadone treatment and with motivation for recovery from their addiction. It is well written, printed in a clear and easily readable style - and provides clear explanation of its many topics.

A full text preview of the Handbook - and order information - is available on the Internet site ‘SupportNet - Resources for Recovery’ at www.supportnetstudios.com. Additional information may be obtained by email to SupportNet Studios at mail@supportnet.ca or by fax to (519) 679-9710. The price of one copy of Handbook of Recovery is $20.00 Cdn or US funds. ISBN: 0-9737241-0-2

Kumar Gupta
The following scenarios present common issues that methadone prescribers are frequently faced with. I have given sample answers to demonstrate ways that these challenges can be dealt with. They are not the definitive “right” answer, but what I feel are reasonable ways to handle these prescribing challenges. Of course, every case is different and your decisions must be based on your client’s own special circumstances.

1) Raquel sees you on a Wednesday, asking you to rearrange her carries for an unexpected trip. With six carries, she picks up every Friday, but wants to pick up her carries on Thursday this week.

If you give her an extra carry for Friday, that would make 13 days in a row that she drinks unobserved. Instead, you could have her use the carry she has already for Thursday on Friday, and she’ll then go to her pharmacy to drink observed on Thursday. This way her pick up day is one day earlier but she still has an observed drink each week.

2) Carlos likes to pick up his 6 carries every Saturday, but you are only in the office on Wednesdays. He complains that every fourth week when he sees you he has to go to the pharmacy twice, as he only receives carries until Wednesday because his prescription ends on the days that he sees you.

You agree to always end his prescriptions two days after the day of the next planned appointment. This way he has already his carries until Friday when he sees you on Wednesday. This is more convenient, but you warn Carlos of the obvious pitfall of this approach - he can no longer rely on the end date of his prescription to tell him when his next appointment is.

3) Your routine temperature check of Rick’s Urine sample today shows it to be 38C. He’s afebrile. When confronted, he acknowledges heating a hidden sample he brought from home with a lighter before he entered the bathroom. He feared that leaving a positive test for drugs would jeopardize receiving his carries.

Prescribing a medication that is potentially harmful to the client and the community if misused involves a physician placing great deal of trust in a client. Tampering with a Urine clearly calls into question this trust.

Explaining to Rick that your relationship with him can be preserved and that lapses can be learning experiences, you will work together to rebuild trust in each other. You agree to hold his carries for one month. DUS testing will also be stopped for this month. You agree to return his carries, one a week after one month, if the current lapse is over and his stability has returned. You also agree that future dus samples will be directly observed, and that future tampering attempts will jeopardize your physician-client relationship.

4) Sonia and her husband Frank are both your clients. They like to be seen together in your office to discuss topics that are of concern to both of them. On one visit Sonia comes alone. She acknowledges, unknown to you, that her drinking has been out of control for the last three months. When you ask her why she didn’t mention it earlier, she replies: “I wanted to, but I didn’t want to mention it in front of Frank!”

After working out a plan for Sonia to receive the support she needs for her drinking, you agree that in the future your visits together will consist of time together as a couple, and then time individually for both Frank and Sonia.

5a) Janice calls to ask you to fax her prescription. An emergency has happened at home and she can’t come to the office today to receive her prescription.

Even the most stable clients can be faced on occasion with unexpected circumstances that prevent them from keeping an appointment. As Janice has never asked for a faxed prescription before, you fax a short prescription running until the next time you are in the office, which includes her regular carries. You note in the chart that the appointment and the required urine for that day were missed. Before faxing, you check with her pharmacy that she hasn’t missed more than two doses.

5b) Janice calls a month later at the end of the day of her appointment asking again that you fax another prescription for her.

Being able to assess a client’s functional stability can be a difficult task for a physician. Assessing stability is especially important when a client is receiving carries. Among the basic “tests” that demonstrate stability are: Can the client record the end date of their prescription on a calendar? Can they make it to your office on the agreed upon appointment day? Can they produce a drug free urine sample on the day you agree? Do they appear stable during your time with them?

Not wanting to precipitate opioid withdrawal and risk (or worsen) a drug relapse, you again fax a short prescription, but this time there are no carries on the faxed prescription. When you meet again you ask her to start seeing you weekly. You agree that you won’t fax prescriptions in near future.

5c) Henry has missed almost every appointment with you. In the past when you refused to fax prescriptions for him, he didn’t return to see you for weeks, and started breaking into cars again to get money for heroin.

Upon returning to your office, Henry explains that with the chaotic life he leads, it is hard for him to keep appointments. You agree that you will no longer fax prescriptions. You write a three month long prescription without carries. Two weeks before the prescription ends, a taper of 5mg/day begins that will taper the dose to zero. You contact his pharmacist and discuss this plan. You ask Henry to return well before the taper begins, but if he doesn’t, the taper will remind him that he needs to come to see you as soon as possible.
The literature regarding co-occurring disorders reveals the notable role of DSM-IV-TR personality disorder(s) in the dual diagnoses of substance dependent individuals. Personality disorders have a significant role based on the degree to which, and ways in which, they are implicated in the etiology, diagnosis, management, treatment and the prognosis of the co-occurring substance-related disorders. (Ball, 1998; Blatt & Berman, 1990; Compton, Cottler, Phelps, Abdallah & Spitznagel, 2000; Flynn, McCann & Fairbank, 1995; Kosten, Kosten & Rounsaville, 1989; Skodol, Oldham & Gallaher, 1999; Verheul, 2001; Walker, 1992).

Substance dependence and personality disorders frequently exist in multiple forms and personality disorders are highly prevalent comorbid conditions among substance dependent individuals (Echeburua, de Medina, & Aizpiri, 2005; Ekleberry, 2000; Verheul, 2001). Rates vary from 50% to 86% (Fernandez Miranda, Gonzales Garcia-Portilla, Martinez, Gutierrez Cienfuegos & Bobes Garcia, 2001; Nace, 1990; Marsh, Stile, Stoughton & Trout-Landen, 1988; Teplin, O’Connell, Daiter & Varenbut, 2004). Cluster B personality disorders, that is, those characterized by dramatic, emotional or erratic traits appear to be common in dual disorders encountered in substance abuse treatment (O’Boyle, 1993; Rounsaville & Krantzler, et al., 1998; Walker, 1992). In particular, Antisocial and Borderline Personality Disorders have been associated with a wide range of substance use disorders (Kosten, et al., 1982; Kosten & Rounsaville, 1986; O’Boyle, 1993; Rounsaville, et al., 1982; Rounsaville, et al., 1998; Skodol, et al., 1999; Stine & Kosten, 1997).

Nace (1990) theorizes that the most severe levels of substance abuse are associated with a character pathology rather than serious mental illness. It has also been suggested that people with a personality disorder use substances for purposes related to the personality disorder, such as diminishing or managing the symptoms of the personality disorder, enhancing self-esteem, decreasing feelings of guilt, managing negative affect and amplifying feelings of diminished individuality (Ries, 1994).

Substance abuse by individuals with a comorbid personality disorder has been considered an indication of a greater personality disturbance and predictor of a higher likelihood that there will be poor outcome of therapy, and greater global impairment (Ball, 1998; Ruegg & Frances, 1995; Skodol, et al., 1999). There is the suggestion that individuals with a personality disorder are more vulnerable to substance abuse than non-personality disordered individuals and that they are more likely to engage in substance abuse at an earlier age and polydrug use with greater frequency than individuals without a personality disorder (Nace, 1990).

There are several societal, diagnostic and treatment features that are common to both substance dependence and personality disorders. In the dually diagnosed individual these factors interact and mutually reinforce each other (Ekleberry, 2000). In most cases the personality disorder is thought to precede the substance abuse. However, the substance abuse can trigger or worsen personality disorders, or produce a syndrome that is diagnostically compatible with personality disorders (Kokkevi & Stefanis, 1995; Nace, 1995; Ries, 1994). Illicit substances can produce toxic effects on the brain and also reinforce regressive behaviour, a combination that may result in a personality disorder secondary to substance dependence (Nace, 1995).

The personality characteristics most representative of this acquired “addictive personality” are narcissistic, antisocial and histrionic characteristics (Miller, 1995). Such an “addictive personality” is marked by impulsivity, decreased frustration tolerance, self-centeredness, grandiosity, passivity and affect intolerance (Koenigsberg, Kaplan & Gilmore, et al., 1985; Nace, 1995). There is the suggestion that when a personality disorder contributes to drug use, the pattern becomes more compulsive and rigid and more likely to continue to become a full-blown addiction (Beck, Wright, Newman & Liese, 1993). Richards (1993) suggests that addiction is related to failures in self-regulation and notes that the most important mediator of self-regulation is the personality. Therefore, personality pathologies related to cognitive style, affective tolerance, activity, interpersonal style and relationships all contribute to vulnerability to addiction (Richards, 1993).

It has also been shown that presence of personality disorders substantially increases the individual’s risk of failure to achieve abstinence and to relapse. Moreover, these individuals have difficulty working cooperatively and collaboratively with service providers (Beck, et al., 1993; Ekleberry, 2000; Kosten, et al., 1989; Ruegg & Frances, 1995).

In summary, personality disorders are highly prevalent comorbid conditions among substance dependent individuals. They have a significant role based on the degree to which, and ways in which they are implicated in the etiology, diagnosis, management, treatment and the prognosis of the co-occurring substance-related disorders. Therefore, it is imperative that substance dependent individuals being seen in treatment are routinely screened for multiple non substance-related disorders, including personality disorders.
REFERENCES


The International Association for the Study of Pain (IASP) has defined pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (www.iasp-pain.org). This definition highlights that pain is an emotional experience in addition to the significant role of sensory somatization; and tissue damage may be actual or perceived, thus making patient self-report to be of utmost importance in the pain experience.

Traditionally, the fundamental key that initiates the neural processing that leads to the sensation of pain has been thought to be the relay between primary sensory neurons and neurons in the dorsal horn of the spinal cord. Excitation and sensitization processes connected with enhanced pain impulse transmission have been thought to mediate persistent, chronic pain of nociceptive, inflammatory or neuropathic origin.(1) Further research has identified pathways in the spinal cord that provide central modulation of the afferent signals. The role of central sensitization has also been delineated in acute and chronic pain situations highlighting the role of conditioned responses and memory!(2) It is becoming evident that bi-directional control over afferent nociceptive pathways modulate pain perception and a decision to respond or not to a noxious stimulus, determines whether the pain facilitating pathway is activated or inhibited.(3) The decision to respond enhances pain perception, speeds the escape responses and elicits analgesia mediated by endogenous opioids in the reward circuitry of the mesolimbic dopamine system.

The variety of pharmacological approaches available for the treatment of pain, including opioids, attempt to address the peripheral and central neural pathways in acute and chronic conditions. The beneficial responses, in terms of decreasing pain and/or increasing function, from any pharmacological intervention, are difficult to predict despite the predictable pharmacological actions of particular drugs.

Some interesting research related to patient awareness and expectations demonstrates that the pain perception is decreased if the intervention is done openly and not when the pharmacological intervention is done in a manner hidden from the patient. Further, pain perception is worsened if the pharmacological intervention is interrupted (e.g. discontinuation of morphine) in an open fashion as opposed to when the patient is not told when it is done.(4) As much as the placebo effect has been understood with inert pharmacological or medical treatment producing a positive result because of patient expectation, it is important to appreciate that the central modulation may also counter a pharmacological effect when a patient is not expecting or aware of the administration or removal of a drug. The worsening of symptoms when a patient is told about an interruption in treatment has been called the nocebo effect, which is likely mediated by similar central mechanisms. Research in this area is pointing out pretty clearly that meaning and meaning-induced expectations, resulting from the interaction between the care providers and patients, have a very profound effect on the outcome of any pharmacological therapy.

It has been well known in medicine and specifically in the area of psychotherapy that the provider-patient relationship has a huge impact on therapy outcomes. As much as physicians often downplay the importance of the placebo or nocebo effects, current neuroscience and clinical research in this area is fascinating. Better understanding of these mechanisms will likely allow us to enhance the effectiveness of existing therapies and point the way to new vistas. As a minimum, we need to be more attentive to how our attitudes and interactions may enhance the effect of particular interventions, including pharmacotherapy. Further, negative attitudes among our patients or care providers with inadequate dialogue with the patients may block anticipated positive treatment effects.

2. Treede, R-D. Pain Memory and Central Sensitization in Humans – Plenary Session, 11th World Congress on Pain, Sydney, Australia, 2005 August 22.
Research Corner

By Dr. David Teplin, C.Psych., Lead Psychologist, Ontario Addiction Treatment Centres

Childhood Abuse History and Substance Use among Men and Women Receiving Detoxification Services

According to data collected from women and adolescents, a strong link exists between childhood abuse history and substance abuse. Using a sample of 274 women and 556 men receiving detoxification services, we explored whether the same pattern emerged across genders and types of abuse. Results revealed 20% of men and more than 50% of women reported childhood physical or sexual abuse. Sexual or physical abuse had negative sequelae, regardless of gender. Individuals with abuse history reported earlier age of onset of drinking, more problems associated with use of alcohol/drugs, more severe psychopathology, and more lifetime arrests, arrests related to substance use, and arrests related to mental health. Prevention and proactive intervention activities are crucial to prevent negative sequelae of childhood victimization.


Variables associated with perceived sleep disorders in methadone maintenance treatment (MMT) patients.

To characterize sleep disorders in methadone maintenance treatment (MMT) patients, the authors evaluated sleep quality of 101 non-selective patients from our MMT clinic in Israel between July, 2003 and July, 2004 by using the self-report questionnaire Pittsburgh Sleep Quality Index (PSQI). Patients’ urine tests were analyzed for methadone metabolite, opiates, benzodiazepine, cocaine, cannabis and amphetamines. Their urine results for drug abuse throughout the months prior to filling in the questionnaire and their maintenance methadone doses were recorded. Drug abuse was defined by at least one positive urine test. Methadone serum levels were available in 55 patients, assessed by Gas Chromatography Mass Spectroscopy. The patients’ self-reported chronic pain questionnaires and their diagnosed psychiatric disorders were analyzed. Out of the 101 study patients, 78.2% were male, 52.5% had psychiatric disorders, 46.5% reported having chronic pain and 46.5% had positive urine for benzodiazepine. The mean daily methadone dose was 157+/-.52.9mg. The mean PSQI score was 9+/-.4.8 (75.2% had scores >5 indicating “poor sleepers”). PSQI scores were higher in patients with positive urine for benzodiazepine, chronic pain and psychiatric disorders and they correlated with years of opiate abuse before admission to MMT, and with the methadone dose (r=0.48, p<0.0005). The latter two also correlated with each other. The PSQI was not correlated with duration in MMT, gender, age, abuse of opiates, cannabis or cocaine. We concluded that sleep disorders should be evaluated and treated among MMT patients, particularly in those with psychiatric disorders, benzodiazepine abuse, chronic pain and high methadone dose.


Novel approaches to the treatment of cocaine addiction.

Cocaine addiction continues to be an important public health problem with over 1.7 million users in the US alone. Although there are no approved pharmacotherapies for cocaine addiction, a number of medications have been tested with some promising results. In this review, we summarise some of the emerging targets for cocaine pharmacotherapy including dopaminergic and GABA medications, adrenoceptor antagonists, vasodilators and immunotherapies. The brain dopamine system plays a significant role in mediating the rewarding effects of cocaine. Among dopaminergic agents tested for cocaine pharmacotherapy, disulfiram has decreased cocaine use in a number of studies. Amantadine, another medication with dopaminergic effects, may also be effective in cocaine users with high withdrawal severity. GABA is the main inhibitory neurotransmitter in the brain, and accumulating evidence suggests that the GABA system modulates the dopaminergic system and cocaine effects. Two anticonvulsant medications with GABAergic effects, tiagabine and topiramate, have yielded positive findings in clinical trials. Baclofen, a GABA(B) receptor agonist, is also promising, especially in those with more severe cocaine use. Some of the physiological and behavioural effects of cocaine are mediated by activation of the adrenergic system. In cocaine users, propranolol, a beta-adrenoceptor antagonist, had promising effects in individuals with more severe cocaine withdrawal...
symptoms. Cerebral vasodilators are another potential target for cocaine pharmacotherapy. Cocaine users have reduced cerebral blood flow and cortical perfusion deficits. Treatment with the vasodilators amiloride or isradipine has reduced perfusion abnormalities found in cocaine users. The functional significance of these improvements needs to be further investigated. All these proposed pharmacotherapies for cocaine addiction act on neural pathways. In contrast, immunotherapies for cocaine addiction are based on the blockade of cocaine effects peripherally, and as a result, prevent or at least slow the entry of cocaine into the brain. A cocaine vaccine is another promising treatment for cocaine addiction. The efficacy of this vaccine for relapse prevention is under investigation. Many initial promising findings need to be replicated in larger, controlled clinical trials.


Substance abuse in patients with attention-deficit hyperactivity disorder: therapeutic implications

Attention-deficit hyperactivity disorder (ADHD) is a common disorder in children that frequently persists into adulthood. Studies have found that substance use disorders (SUD) are seen more commonly in those with ADHD than the general population. Although treatment with stimulant medications has been shown to be effective for individuals with ADHD, concern about the use of these agents in this population persists. This review article highlights the research in this area with a focus on the treatment of individuals who present with concomitant ADHD and SUD. Although stimulants can be abused, studies have shown that adolescents who are prescribed stimulants for ADHD have lower rates of SUD than those who are not treated with stimulants. It may be particularly difficult to evaluate adults for the diagnosis of ADHD when SUD is a co-morbid factor. Studies show that 20-30% of adults presenting with SUD have concomitant ADHD and approximately 20-40% of adults with ADHD have histories of SUD. Therefore, it is critical to perform careful diagnostic interviews to discern if patients have either or both of these disorders. Many clinical experts suggest that adults with ADHD and active SUD be treated for the SUD until a period of sobriety persists prior to initiation of specific treatment for ADHD. Since individuals with ADHD and active SUD are more likely to have more severe SUD and a worse prognosis, this approach may not serve many patients, as they relapse prior to obtaining ADHD treatment. Therefore, research has been directed towards determining if the treatment of ADHD with stimulant medications can be safe and effective for the individual with active SUD and concomitant ADHD. An initial trial of methylphenidate in a population of adults with active cocaine dependence and ADHD indicates that this is the case. Individuals with ADHD and SUD can present difficult diagnostic and therapeutic challenges. It appears that the most effective treatment option is to create a programme that uses the most effective treatment modalities available, including both behavioural and medical therapies, along with close supervision and monitoring. Newer medical treatment options of long-acting stimulants and non-stimulants (e.g. atomoxetine) offer effective treatment with a lower risk of abuse potential.


Methadone's impact on libido hurts compliance between 30% and 100% of patients using methadone report sexual dysfunction problems.

Increased doses of methadone may be good for opioid dependence, but they might not be good for a patient’s sex life. “Although it hasn’t been well studied in [methadone patients], we know that sexual dysfunction as a side effect can interfere with compliance in a clinical setting,” Randall Brown, M.D., said at the annual conference of the Association for Medical Education and Research in Substance Abuse. Methadone is among the most popular treatments for opioid dependence; it has been shown to reduce opiate use and mortality, and psychosocial outcomes for patients include lower crime rates and improved employment status.

Side effects from methadone use include weight gain, insomnia, and constipation, but sexual dysfunction could be a “deal breaker” for some patients. Between 30% and 100% of methadone patients report sexual dysfunction problems, with men mostly reporting problems with libido and maintaining erections, said Dr. Brown, who conducted a cross-sectional study as part of a primary care fellowship at the University of Wisconsin.

Dr. Brown’s work was funded in part by an NIH research grant. To assess whether the likelihood and severity of sexual dysfunction increased with higher doses, he compared 16 new patients who started methadone as therapy for opioid addiction with 76 men who had been involved in methadone maintenance for at least 60 days.
Overall, 14% of the men across both groups reported some sexual dysfunction, which is similar to male sexual dysfunction rates in the general population. A dose increase was significantly associated with orgasm dysfunction, before and after adjusting for the duration of methadone treatment. However, no significant increase in dysfunction was associated with either serum testosterone or serum prolactin levels.

There was a significant association between TSH and duration of treatment, but levels remained within the normal range. Sexual function was evaluated with a 28-question form using rating scales from 1 to 100 for libido, erectile dysfunction, and orgasm dysfunction, and with patient interviews about medical history and ongoing use of alcohol or other drugs. “We didn’t find the alterations in testosterone [with methadone dosage] that we expected,” Dr. Brown said.

In the 1970s, several studies measured testosterone levels of methadone patients without relating it to dosage, he noted at the conference, also sponsored by Brown Medical School. Some studies showed a drop in testosterone associated with dosage greater than 60 mg, but other studies failed to show any difference.

“Sexual dysfunction in men on methadone maintenance should be evaluated in accordance with guidelines established for the general population,” he said.

However, if orgasm dysfunction negatively affects a patient’s quality of life to the extent that he considers discontinuing the methadone, a trial short-term dose reduction may be helpful.


Effectiveness of Venlafaxine in the treatment of alcohol dependence with comorbid depression

There is no conclusive data on the effectiveness of antidepressant drugs in the treatment of comorbid cases of alcohol dependence and depression. Objectives: To determine the effectiveness of venlafaxine on depression and on severity (need of treatment) of alcohol dependence and related problems. Methods: Observational, open-label, multicenter, 24-week follow-up study. Patients: 90 outpatients with diagnosis of alcohol dependence and associated major depression disorder (DSMIV criteria). Outcomes measures: the Hamilton Rating Scale for Depression (HAM-D17), European Addiction Severity Index (EuropASI) and Clinical Global Impression, severity and improvement subscales, (CGI-S and CGI-I). Evaluations were performed at baseline and at weeks 2, 4, 8 and 24. Results: Mean age was 44.94+-9.74 years; 73.3 % were male. HAM-D17 mean scores significantly decreased from baseline (24.85+-5.94) to week 24 (5.976+-4.68) and at each of the follow-up visits vs previous visit (p < 0.0005). Significant decreases from baseline to week 24 were obtained in four areas of EuropASI: medical status (2.12+-2.45 to 1.07+-1.68), alcohol use (5.29+-2.24 to 3.04+-2.35), family/ social relationships (3.68+-2.36 to 1.71+-2.06) and psychiatric status (5.61+-1.81 to 2.67+-2.03). Tolerance was excellent or good in 76.7% of the patients. Conclusions: Venlafaxine demonstrated to be effective in the treatment of depressive alcoholic patients. Furthermore, it seems to be useful to decrease the severity of problems related with alcohol use.

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ISAM'S INTERNATIONAL CERTIFICATION EXAMINATION IN ADDICTION MEDICINE

Following the first and second sitting of the exam in Cairo, Egypt and Vancouver, BC, respectively. We are planning to offer the exam at the 2006 CSAM Annual Meeting in Saskatoon. The deadline for applications for this sitting is August 1st, 2006. 2006 sessions will be determined by interest and numbers (minimum 8 candidates).

This examination is a test of knowledge. While it does not certify clinical skill or competence, it does identify a physician who has demonstrated the degree of knowledge in the diagnosis and treatment of substance and other addictions commensurate with expertise in the field. The ISAM exam has been deemed acceptable for CSAM Certification. An analysis of individual results conducted by the University of Calgary is provided to each candidate. So far, congratulations to Drs. Rodney Glynn-Morris, Anthony Hammer, Martyn Judson, Lindy Lee, Ronald Lim, David Marsh, Hasan Moolla, Wayne Moran on their success in the exam held in Vancouver Oct 2005.

Details on eligibility Criteria, application form, fees and recommended textbooks can be found on the ISAM web pages: www.isamweb.org

ISAM ANNUAL MEETING

A World of Drugs, a Universe of Treatment
Oporto, Portugal — Sept 26-30, 2006

Host: Oporto Medical School
Local Organizing Committee Chair: Dr. Antonio Pacheco Palha
Conference Contact: psiquiatria@med.up.pt
Venue: Sheraton Porto Hotel & Spa
Accommodation costs: Single E 130/Double E 150
Registration (Euros): Early E 250; Late E 350; Workshops E150;
ISAM members receive E50 reduction

PRELIMINARY TOPICS:
• State of the art in drug addiction treatment
  • Design drugs, a new challenge • The reality of dual-diagnoses
• Harm reduction: what more can be done •Alcohol addiction and Primary care delivery
  • The drugs, the addicted and the Law
• Addiction in the Portuguese speaking countries around the world
• Community based programs • Drugs, History and Culture
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