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Message from the Editor:

It is my pleasure to bring to you the second issue of the “Canadian Journal of Addiction Medicine” / CJAM. I must thank all those who wrote and contacted us with kind feedback and comments, and I am grateful for all of your support and encouragement.

We have seen a tremendous increase in submission of materials and original manuscripts from well respected clinicians and scientists in our field, which is further testimony for the significant need of our Journal in bringing our field to light and expanding its appreciation.

I am very pleased to announce and welcome Drs. Meldon Kahan and Bhushan Kapur to our editorial board. Both are much respected Addiction clinicians and are also honourary members of CSAM. We are delighted and privileged to be working with both.

The editorial board of the CJAM has been working hard on developing its peer review process for manuscripts, and I am happy to report that we have been able to achieve a standardized process for same.

In this second issue of the CJAM, you will find original articles, commentaries, and research manuscripts contributed by our fellow colleagues. I urge you to read them closely and consider submitting further commentaries, letters to the editor, or any other materials that you feel valuable to be shared with our members.

We would also like to extend an invitation to all of you to submit your application towards becoming peer reviewers for the Journal. It is only with ongoing commitment and collaboration from our members, that we will be able to continue to expand and improve on our publication.

I thank you for reading our publication, and look forward to your ongoing contributions and support.

Respectfully yours,

Michael Varenbut

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Scope & Mission of the CJAM

The Canadian Journal of Addiction Medicine is the official publication of the Canadian Society of Addiction Medicine. It is a new publication whose goal is to provide a unique Canadian forum for presentation of evidence-based, peer-reviewed clinical information and scientific materials, to clinicians working in the field of Addiction Medicine.

The “Bulletin” section within the CJAM, will contain the traditional sections and materials contained in past issues of the “CSAM Bulletin”.

Submissions to the Journal are invited in the following formats:

Original Articles

This section will include clinical investigations on any aspect of addictive disorders. Manuscripts describing scientific results will be considered for publication provided that there is strong clinical relevance. Typically, articles will contain new data derived from original research. Text should not exceed 12-14 double spaced manuscript pages, or 3000 words (not including an abstract of no more than 250 words). Manuscripts should be prepared in a clear font (12-point Courier is preferred) and double spaced. Each reference should be cited in the text. In the reference list, number the references according to the order in which they are first cited in the text and format them according to the Uniform Requirements.

Short Reports

This may include preliminary communications or case reports on unique, unusual & interesting or otherwise important aspects of addictive disorders. Approximately 1500 words, or 6-10 double spaced manuscript pages, up to 4 figures / tables.

Reviews

This section would typically include In-depth reviews of current understanding, diagnosis, or treatment of addictive disorders. Should not exceed 5000 words or approximately 20-30 double-spaced manuscript pages, up to 8 figures / tables, (not including an abstract of no more than 250 words).

Letters to the Editor

Brief commentaries of alternative viewpoints regarding papers previously published in the Journal. Should not exceed 500 words.

Book Reviews & Meeting Highlights

Additional sections to be added in future issues.
The Psychology of the 12 Steps

How the 12 Step Programs Allow Addicts to Grow up

Dr. Graeme M. Cunningham, MD, FRCPC, FASAM
Director, Addiction Division, Homewood Health Centre, Clinical Professor of Psychiatry, McMaster University

"There is a principal which is a bar against all information, which is proof against all arguments and which cannot fail to keep a man in everlasting ignorance – that principal is contempt prior to investigation." Herbert Spencer

Introduction

Medicine does not know enough about Alcoholics Anonymous and the other 12 Step Programs that have developed from it. This paper outlines some of the knowledge and skill that will help physicians use 12 Step Programs in the treatment of alcoholism and other drug addictions. The first step is the recognition that AA, the original 12 Step Program is a treatment system for alcoholism that aids normal emotional growth and development.

Development of Alcoholics Anonymous:

Physicians have been involved directly and sometimes vicariously in the evolution of Alcoholics Anonymous. Carl Jung in the later 1920’s, with his alcoholic patient Roland H. stated that Roland would only recover from his severe alcoholism with a conversion experience. (1) Roland returned to New York, joined a fundamental religious group and had such an experience. He was impressed with Ebby’s sobriety. Bill W. achieved sobriety in hospital shortly thereafter with a spiritual experience that arose from his despair and depression.

He carried this information to a Mr. Ebby T. who also joined this fundamental religious group and in November 1934, visited his friend Bill W., a failed stockbroker with advanced alcoholism who was impressed with Ebby’s sobriety. Bill W. achieved sobriety in hospital shortly thereafter with a spiritual experience that arose from his despair and depression.

Following discharge from hospital, Bill W. attempted to help other alcoholics. After many failures, he shared his frustration with Dr. Silkworth, his physician, and a second medical stimulus for the formation of Alcoholics Anonymous was provided. Silkworth said, in part “for God’s sake, stop preaching. Tell them about the obsession and the physical sensitivity they are developing – say it’s lethal as cancer – a drunk must be led not pushed”. In May 1935, Bill W. recognizing his own need to talk to other alcoholics, met Dr. Bob Smith, a surgeon in Akron, Ohio and the two became co-founders of Alcoholics Anonymous. (2)

It took several years to develop the 12 Steps and the big book of Alcoholics Anonymous entitled “Alcoholics Anonymous”. Groups of alcoholics supporting each other and using the 12 Step Program gradually sprung up throughout North America. During this process, AA separated itself from the fundamental religious group to which it had been connected and separated from any association with religion. The spiritual nature of the program is so personal and accepting of any or no religious experience that atheists and agnostics can easily participate.

Over the next fifteen to twenty years, the business aspects of Alcoholics Anonymous developed including the 12 Traditions, 12 Concepts and 6 Warranties. These are sometimes referred to as the “Constitution” of AA.

The outcome of this process was a program that is still the most effective method for maintaining sobriety. Vaillant, in a prospective thirty-year follow-up, found that the number of AA visits made by people explained 28% of clinical outcome with sobriety. Of interest in this study, medical or psychiatric treatment did not explain any of the clinical outcome for recovering alcoholics. (3)

The development of the Minnesota Model of Treatment, combining professional treatment with AA, resulted in improvement in treatment effectiveness. A recent prospective study of employed alcoholics found that treatment plus AA was more effective than the AA alone in helping employed alcohol abusers attain and continue abstinence. This study confirms the value of combining professional treatment with AA. (4)

With roots in medicine, psychoanalysis and religion, AA is compatible with psychiatric treatment. It is important for psychiatrists and other physicians to have a working knowledge of what happens in AA more so than to know about surgery, obstetrics or other disciplines in which we have all received training. The big difference is that AA is not under professional control. It is however protected by a set of Traditions that have maintained the organization and its program successfully for over sixty years.

We need to understand that AA does not:
- Solicit members
- Charge user fees
- Control or follow-up members
- Provide housing, meals or transportation
- Provide medical, psychiatric or nursing care
- Join councils or social agencies
- Accept money from non-members

How AA Works:

Khantzian & Mack provide strong theoretical backing for considering AA as specific treatment. They describe AA as a “sophisticated psychosocial form of treatment that addresses human psychological vulnerabilities that alcoholics and others share related to problems of self-regulation”. (5)
The therapeutic aspects of AA emphasized by them are:
• The installation of hope through contact with others
• The encouragement of openness and self-disclosure
• Repeated emphasis on shared experiences
• A focus on abstinence
• An insistence that one cannot get better on one's own
• A spiritual dimension that helps move a person from self-centredness towards a capacity for humility and altruism

The above contributes to a positive shift in ego defense mechanisms and characterological change.

Program Elements

There are three major elements to AA's Recovery Program:

1. Meetings

Are of various types and if a particular individual does not like one type of meeting they are encouraged to try others until they find a group with which they are comfortable. Some examples are:

- Open – for anyone who wants to know more about Alcoholics Anonymous.
- Closed – for those who have a desire to stop drinking.
- Speaker – where one or more AA members share their experience, strength and hope.
- Discussion – where a subject or particular topic pertaining to sobriety is discussed.
- Big Book Study – where sections from the Big Book are read, discussed and studied.
- Step Study – where one of the 12 Steps is chosen for study and discussion.
- Women, Gay/Lesbian – for individuals who have trouble participating in mixed or regular meetings.

Newcomers are considered the most important people at AA meetings.

Patient resistance to attend 12 Step Meetings is usually highest when we first make the diagnosis and referral. There are however many ways to deal with this resistance. As Sisson & Mallams suggested, it is not enough to suggest that a patient should attend AA while the patient is attending the physician's office, they should be put on the phone with an AA member who could offer to take them to a meeting. Physicians are encouraged to keep names and phone numbers of AA members willing to be of assistance in this fashion.

A useful metaphor for AA meetings is “medication”. To be effective they need to be taken daily in the first three months of sobriety. Most treatment programs now recommend ninety meetings in ninety days in recognition of the high risk of relapse in the first three months and the need for an intensive experience to break through the defenses of denial, projection and isolation.

2. The Fellowship

Meetings introduce alcoholics to other alike folks in various stages of recovery. An important aspect of recovery in the fellowship is obtaining a sponsor who has experience of the program as well as an experience of living sober.

This individual can act as a mentor and guide on the journey of recovery. Studies have shown that having a sponsor is significantly associated with a reduced risk of relapse and also acting as a sponsor has similarly been shown to improve outcome.

3. Step Work

The 12 Steps provide the core of the program (Table 1). Each step presents a specific problem and each one can be assisted by the family doctor or specialist physician. In return, as the step is worked, it can facilitate psychotherapy provided by the doctor. (7)

Step 1 means becoming comfortable with a new identity as a recovering alcoholic and marks the beginning of sobriety.

Step 2 requires a belief that someone greater than or different from him/herself can be of help. This is left up to the individual and basically requires an acknowledgement that “I cannot deal with this problem myself and need help”. This common human experience can help reduce the resistance stemming from an unrealistic self-image that requires a person to solve every problem alone.

Step 3 is a difficult step and requires a conscious surrender of one's will in life to the “power” one has begun to appreciate in the previous step. This step often manifests a struggle between prior religious experience and the entity of spirituality. The alcoholic is encouraged to trust the individuals in his home group and at meetings to help him or her until they begin to experience some healthy inner control.

Step 4 is also difficult but for different reasons. Working this step usually triggers guilt, shame and grief and it should be done with a sponsor. Support by physicians, without medication, can also be very helpful and the benefits of self-knowledge and self-awareness that come from working this step are extremely valuable.

From my own experience, recovering alcoholics who have worked this step are more comfortable with and responsive to psychotherapy and this step significantly helps in the maturation of ego.

Step 5 is also a form of preparation for psychotherapy. It arouses anxiety with anticipation of a negative response in
the person to whom the individual is speaking. In many cases, however, sharing with another human being is usually a relief. Individuals hearing 5th steps never reject or punish and, although therapeutic, this is not true psychotherapy.

Step 6 is derived from Step 4. Behaviours directly associated with the use of alcohol will usually stop with abstinence but other character traits remain and this step shows a willingness to develop behavioural change. Self-awareness, without feedback from one’s social support system is much more difficult than self-awareness of ego dystonic behaviour.

Psychodynamic psychotherapy and psychoanalysis, both individual and group, interact in a positive way with this step.

Step 7 is a fascinating step. It seems to take place internally but is observed by external observation. As my wife once put it “it’s in their eyes”.

The humility required for this step reawakens the experience of Step 1. The difference is that alcohol use is easier to stop than changing your personal characterological behaviours. Change does occur in selfish, blaming or grandiose behaviours. It serves as a great source of hope for others. Physicians can be of great assistance in helping people walk through the characterological behaviours at this stage. This is why alcoholics continue to attend AA meetings for many years after abstinence has begun. Not because they are worried of returning to drinking but rather they find working on their own pathological issues to be a positive and rewarding experience albeit a challenge and at times painful.

Step 8 develops from Step 4 and puts the alcoholic in a state of preparation for relational repair. This step may also help the individual develop the capacity for empathy and it is basic to developing relational skill that can assist the gains made in individual therapy with their physician.

Step 9 puts relational skill into practice and although usually accompanied by anxiety, again is an extremely positive experience. The recovering person can be helped to learn the importance of forgiving oneself even though working this step does not necessarily result in being forgiven by others.

Steps 10 – 12 are said to be “maintenance” steps. They work by being a continuous stimulus to both personal relational goals and character change. Spiritual health is improved and working these steps also expresses gratitude.

Working the program of recovery in AA or other programs is usually accompanied by periods of emotional distress.

Physicians will get the best results when they look upon these symptoms from a developmental rather than a pathological point of view. AA members view these symptoms as a motivation for change. They are likely to resent and resist efforts to medicate them and many recovering alcoholics now believe that it is important for them to experience and work through these negative feelings in order to change for the better. When we prescribe too quickly, especially with controlled medications, we risk losing the respect of our recovering patients.

**The Goal of Recovery**

Two characteristics of recovering from alcoholism and other addictions are:

1. The ability to manage the stress of living without the support of dependent drugs. This ability is unusual in society where the use of alcohol and prescription medications as stress management is widely accepted.

2. The ability to be around dependence-producing drugs without experiencing craving or engaging in drug seeking behaviour. This explains why drug dependent physicians, particularly anaesthetists, given a recovery process has occurred, are able to return to the operating room and its associated availability of drugs.

The other aspect of recovery that appears to result from 12 Step work is a shift from the immature ego defense mechanisms of denial, projection, minimizing, grandiosity and acting out, to more mature ego defense mechanisms of altruism, humour, suppression, anticipation and sublimation.

The following characteristics occur in individuals working a recovery program over a period of time:

- An honest openness and willingness to learn
- Personal humility with a tolerant acceptance of others
- Compassion and altruistic caring (willing to help others without compensation)
- Gratitude for the experience that we have had, for relationships, and for the program

In summary, recovering alcoholics become the kind of people most of us would like to be.

**Conclusion**

Alcohol and other drug addicted individuals pose a major problem for the medical profession and other health care providers. In meeting this challenge, for which most of us have little preparation, it is insufficient to treat the symptoms and/or complications, we need to treat the primary disease.

In this task, AA and other 12-Step programs provide powerful psychosocial therapies that can enhance psychotherapeutic treatment provided by other care givers including physicians and psychiatrists.

When the physician motivates and supports a patient to actively work a 12 Step program, a complimentary stimulus to growth and development will be added to the psychotherapeutic effect of treatment.

We can help by prescribing carefully to avoid dependence-producing medications that may interfere with recovery. Skill in cooperating with the 12 Step programs by physicians is best obtained by direct experience. Attending open meetings and personal learning from experienced recovering people who are working an active program of recovery are essential.

As an added bonus to increased professional effectiveness, we may also experience some direct personal benefits.
References


Table I

The 12 Steps of A.A.

1. We admitted we were powerless over our chemical – that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to addicted people, and to practice these principles in all our affairs.

Commentary

Dr. H.R. Vedelago, MD, FCFP, ABAM, Senior Staff Physician, Addiction Division, Homewood Health Centre

“We, of Alcoholics Anonymous, are more than one hundred men and women who have recovered from a seemingly hopeless state of mind and body.” The opening line of the Forward to the 1939 first edition of Alcoholics Anonymous is the most profound promise of hope found in recovery literature.

This extension of hope offered to the alcoholic also comes with an invitation to the medical profession to examine the philosophy found within the pages of that first edition. The first five chapters of Alcoholics Anonymous are written in the past tense and provide a historical description of a disease process and its resolution as experience by those first one hundred members. Within those pages the central tenants of all 12-Step Programs are given and it provides an understanding of the etiology of addiction and to its rational treatment.

In this issue of the Canadian Journal of Addiction Medicine, Dr. Graeme Cunningham elaborates on the psychology of the 12-Steps. In his concluding remarks he quite rightly states that physicians are little prepared to meet the challenges posed by the addicted patient. Most of us have never taken the opportunity provided by the invitation given to us by Alcoholics Anonymous over seventy years ago, if even we were aware that such existed.

I have accepted the invitation offered and wish to share three important lessons that the book Alcoholics Anonymous and the 12-Step Programs have taught me over the last decade working with addicted patients in my capacity as a senior staff physician at the Addiction Division of the Homewood Health Centre.

The three lessons learned are: that once an addict/alcoholic, always an addict/alcoholic; that the compulsion to use is an entity unto itself and not a symptom of an underlying psychiatric problem; and that recovery cannot be done alone.

Many would challenge the concept that addiction is a permanent condition. Certainly numerous examples can be given of those who, by DSM criteria, were classified as alcoholic yet returned to social drinking either on their own or through therapy. Unfortunately such arguments against the permanent nature of addiction miss the point of what the nature addiction truly is and in a pernicious way lay the blame on the patient who is incapable of recovery.

The confusion over the nature of addiction is in part, I believe, based on our tendency in medicine to look for a rational explanation for what all intent and purpose seems like a most irrational condition and by the distracting nature of the physiological presentation of the patient in the intoxicated condition.

The 12-Step program makes it clear that the addiction is at its
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core an illness of sobriety. Whereas abuse, which is a time limited behavior, and dependence, which is a natural physiological response to an external substance, are both improved by the removal of the substance, addiction is not. In essence, addiction is at its most dynamic phase during abstinence and that inebriation is merely the symptom of a disease cycle coming to its natural and devastating conclusion. A misunderstanding of this leads use to ignore the condition when the patient needs treatment most lulling us into a sense of security only to be constantly surprised when the patient invariably returns to active use.

Research in the last ten years suggests that addiction is a genetically-mediated permanent re-wiring of brain circuitry that ensures the return to active use of the afflicted individual through the phenomenon of craving thus giving support to the adage of “once an alcoholic always an alcoholic”.

This concept of craving, which is the hallmark of addiction, is quite well described in Alcoholics Anonymous and yet so misunderstood by our profession. Quite simply, a craving is a story that the alcoholic or addict will tell themselves when they pick up that next drink or drug, that will make absolute sense to that individual regardless of the devastation wrought by use in the past.

The 12-Step philosophy makes clear that this craving or compulsion to return to active use is an entity onto itself independent of any underlying mental disorder. Alcoholics Anonymous is quite clear in describing what psychiatry now likes to term concurrent disorders. That such disorders resolve and improve with abstinence is quite evident; that some individuals require extra help, most certainly. Yet we tend to fall into a trap when we lose sight that addiction is an entity onto itself with its own logic. We go from diagnosis to diagnoses, looking for the underlying true reason for the addict’s behavior, never really attending to the actual nature of the patient’s condition. The disservice to the patient is great and the subsequent consequences potentially fatal. To be fair, that is the way that medical education has prepared us. We are quite adept at treating the medical and psychiatric symptoms of addiction but are ill prepared to address the etiology of such.

The lack of instruction in addiction during our medical training I see manifest as a sense of confusion and hopelessness in our clinical interactions with the afflicted patient. However powerful, cunning and baffling the addict’s condition appears to us I can assure you that it is far more incomprehensible to the patient afflicted.

Narcotics Anonymous in its preamble to the opening of each meeting states that the therapeutic value of one addict helping another is unparalleled. It is known in the literature that those that attended 12-Step meetings are on average heavier users than those that enter treatment. I believe that this reflects the end result of those who have tried, either alone or through therapy to recover yet were unable to do so. 12-Step group members are able to show a “new comer” the way, through practical experience, to recovery from a seemingly hopeless state of mind and body.

I encourage each intern and resident I have had the privilege to mentor to read the first five chapters of Alcoholics Anonymous and to attend 12-Step meetings that are open to the public. I do this in hope that they will take the opportunity to accept the invitation given to us as a profession many years ago to examine a phenomenon of recovery that to me still appears miraculous.

Commentary II

Michael Kaufmann MD, Director, Physician Health Program, Ontario Medical Association michael.kaufmann@oma.org

Physicians, including many who practise addiction medicine, aren’t sufficiently familiar with AA and other 12 Step programs to be able to offer its benefits to patients experiencing substance dependence. That is one of the reasons why I welcome Dr. Graeme Cunningham’s insightful article exploring the psychology of the 12 Steps with its intriguing title. Dr. Cunningham reminds us of the enormous potential that “working the steps” has for helping people mature psychologically and emotionally even as they recover from their disease of addiction.

Dr. Cunningham clarifies for the reader what AA is and, perhaps equally importantly, what it is not, for it is quite possible that the misconceptions regarding the latter, held by patients who suffer the ravages of substance abuse, and, unfortunately by many doctors, block access to these life-changing fellowships and principles. AA is not a form of religion. AA is not a cult. AA is not a social assistance service. AA is not a professional treatment program, although those who attend AA meetings and “work the steps” quietly find that their addiction is, indeed, being treated.

Even so, as Dr. Cunningham points out, more is happening in the lives of recovering people who actively engage in 12 Step practice. Beyond disease remission, members of the fellowship are being taught values and practices that have an impact on all aspects of healthy personal development. What are these principles? Dr. Cunningham takes us through the steps and explains how honesty, humility, willingness, gratitude and altruism are but a few. Those in the fellowship learn the value of companionship, mentoring, self-awareness and personal accountability. All of this, and more, taught not by professional therapists but modelled and freely “given away” by one’s fellow recovering addicts!

And the beauty of it is that this is a ubiquitous resource that can be accessed virtually anywhere and is, as Dr. Cunningham explains, compatible with any other abstinence-based treatment model and approach! Why not recommend 12 Step programs for substance dependent patients seeking bona fide disease remission?

Why not, indeed. For health professionals recovering from substance dependence, I believe in the value of 12 Step practice and affiliation – so much so that in the Physician Health Program of the Ontario Medical Association, which I direct, it is our preference to refer health professional clients to primary treatment services that facilitate exposure to 12 Step recovery. Then we expect every individual seeking our monitoring and
advocacy service to integrate this practice into their recovery programs.

I have interviewed countless health professionals who do this. I agree with Dr. Cunningham’s wife: “it’s in their eyes.” And their voices, and their spirits.

Dr. Cunningham’s article is a wonderful synopsis of the history and workings of the 12 Steps. Anyone who practices addiction medicine will benefit from his perspectives and this knowledge…but not more than the countless patients we serve who suffer from the disease of addiction and who need the opportunity to access the life-long, life-enhancing gift of 12 Step recovery.

Characteristics Of Prescription Opioid Abuse In The United States And Canada

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Acknowledgements & Conflict of Interest

The Canadian Element of this study was funded by Jansen-Ortho, Inc., but no company representative had access to raw data. Chaired by Dr. Cicero, other members included Drs. Forster, Bordman, Surratt and Inciardi. Dr. Horbay was an employee of Jansen-Ortho during this grant period. Her role was to provide administrative support to the ISC, co-ordinate meetings, liaise with regulatory people, disperse funds, and to assist in the interpretation of the quarterly/final aggregate data post-analysis. None-the-less, she contributed significantly to the writing and editing of the manuscript.

All other authors received consulting fees reflecting their hours spent on the study. Additionally the company covered any related travel costs. There was no relationship between payments and numbers of subjects approached for demographic data. The study was approved by Washington University’s IRB (Human Protection Committee). The other authors received only derivative data and had no access to the raw data or any protected health information. Thus, the study was exempt and did not need ERB approval. The US component of the study was funded by an unrestricted grant from Denver Health and Hospital System, Denver, Colorado, USA, which is an unaffiliated, non-profit organization.

Abstract

There has been a surge in the abuse of opioid analgesics in the United States and Canada in the past 15 years. Although several risk management programs in the United States have been implemented to assess and characterize the abuse of new opioids - the first Canadian program was implemented at the request of Health Canada in late 2005 as a condition for the approval of Tramacet®. The primary element of this program was a network of drug treatment providers who distributed questionnaires to their patients that explored a number of misuse/abuse questions, including sources of drugs and psychiatric and other medical co-morbidities. To serve as a reference group, comparable studies were conducted in the U.S. in the same time period. Our results indicate that, as expected, tramadol has demonstrably low appeal to substance abusers both in Canada and the US. In a broader sense, our data show remarkably few differences between prescription opioid users in either country, with the exception of primary drug preference. Hydrocodone, the most commonly misused drug in the United States, ranked among the least preferred drugs in Canada, probably because the products were not prescribed in Canada in the time period we examined. Perhaps as a consequence, 20% of Canadian prescription opioid misusers expressed a preference for the more potent opioid, hydromorphone, a rate 10 times higher than in the U.S. Other than issues related to the drug of choice, our data reinforce the growing body of evidence indicating that prescription opioid users, no matter their nationality, have a large number of co-morbid physical and psychiatric issues.

Key Words

Opioid abuse, opioid analgesics, prescription drugs, tramadol, tramadol abuse

Several recent studies have detected a surge in the abuse of
prescribed opioid analgesics in the United States and Canada in the past 15 years. In view of this growing problem in the United States, and a more general concern about drug safety in the face of multiple drug recalls in the 1990’s, the United States Food and Drug Administration (FDA) has mandated that all new opioid analgesics have a Risk Evaluation and Mitigation Strategies program (REMS) in place: first, to detect and characterize abuse or other adverse events in a timely fashion (i.e., risk evaluation); and, second, to develop intervention strategies to mitigate the risk. Fischer et al have called for similar efforts in Canada. After a careful systematic study regarding the growth in prescription opioid use and misuse, these authors concluded that: “Since prescription opioid control measures are lax (especially when compared with measures implemented in the United States) and inconsistent across Canada (only a few provinces have prescription monitoring programs in place), this approach needs to be reconsidered in the interest of prevention.”

Although several risk management programs in the United States have been in operation for the past decade, most notably the Researched Abuse, Diversion and Addiction-Related Surveillance program (RADARS® System), the first Canadian program was implemented at the request of Health Canada in late 2005 with the approval (Schedule F) of the combination analgesic Tramacet® (tramadol 37.5 mg, 325 mg acetaminophen; Janssen-Ortho Inc.). The program was intended to provide uniquely Canadian abuse risk data to guide evidenced-based decisions regarding regulatory controls. Although Health Canada acknowledged that the abuse of tramadol had been found to be low in the United States, and many other global regions, but regulatory agency staff expressed concerns that the populations in the two neighboring countries were very different, despite generally accepted cultural, social and economic similarities, and hypothesized that abuse was more probable in Canada than elsewhere around the world.

The program consisted of recruiting treatment specialists in Canada and the United States whose tasks were to distribute anonymous paper surveys to their patients. The surveys were confidentially completed and directly sent to the research team at Washington University with no access by the treatment center directors to any of the recipient’s answers. The program in Canada was implemented DE NOVO, whereas the SKIP Survey of Key Informant Patients element of the RADARS System was used for the US data.

Methods

Key Informant Network in Canada and the US: A network of Key Informants was enlisted from national databases of drug abuse experts in Canada. The existing SKIP element of the RADARS® system was used for the US counterpart.

Data Collection Instruments: In quarters 2 and 3 in 2007 Key Informants in Canada (N=63) and the US (N=125) were asked to give an anonymous questionnaire to their patients to complete. They were to recruit as many patients as possible who had a diagnosis of heroin or prescription opioid analgesic abuse or dependence using DSM-IV criteria for abuse dependence. The patient received a packet containing: the questionnaire, a self-addressed stamped return envelope and a $25.00 (US) gift card. The process was designed to allow the patient to privately complete the survey, place it in the envelope to be mailed without their treatment specialist having access to it, assuring them of complete confidentiality. The questionnaire contained no identifying information insuring complete anonymity. In addition to routine demographic information (age, gender, race, education and employment status), the questionnaire explored sources of prescription drugs, psychiatric co-morbidities, the rating of pain in opioid use, age at first psychotropic use, drug of choice, and recent use in the past 30 days of both prescription opioids and illicit drugs.

Results

Questionnaires were received from 884 patients admitted to one of 95 treatment programs across the United States and 123 patients in 27 treatment centers across Canada in 2007. Figure 1 shows the location of the treatment centers in both countries and the postal zip code of the SKIP patients. Table 1 shows the demographics of US and Canadian prescription opioid users. Other than moderate differences in gender and age, the two groups were closely matched. As shown in Table 1, there was considerable psychiatric co-morbidity in both groups and chronic pain was found in half the population in each group at an intensity rating of approximately 5 on a 10 point scale (0= no pain; and 10 = the worst possible pain). Canadians and Americans had a very high number of prior treatment episodes for drug dependence/abuse with Canada slightly, but significantly higher than in the US (3.62 in US vs. 4.68 in Canada). Among the most significant differences between the two samples were age at first use of alcohol, first intoxication and nicotine use: Canadians were considerably younger than their US counterparts, but age at first use of prescription opiates was similar in both samples.

As shown in Figure 2, there was extensive use of prescribed opioid analgesics and heroin in the past 30 days in both Canadian and U.S. patients and both groups were clearly poly-substance abusers. The main difference in drug preference was, not surprisingly, the much greater misuse of hydrocodone products in the US. Figure 3 shows the differences in the primary, or drug of choice, in the two samples. There are two major differences, one expected and one not. As expected by its availability from licit and illicit sources, hydrocodone was the most common primary drug in the United States, whereas only 2-3% of Canadians expressed a preference for the drug as their drug of choice. The unexpected finding was that 20% of Canadians listed hydromorphone as their drug of choice, a rate 8-10 times greater than seen in the United States. Oxycodeone and morphine also were both selected with greater frequency as primary drugs by Canadians. Notably, tramadol was, as reported elsewhere, very rarely the drug of choice in either the US or Canada. Regarding illicit drug use, Figure 4 shows that the two populations were poly-substance abusers of both opioids and illicit/other prescription drugs, but crack and...
powder cocaine were far more popular in Canada, with 60% of addicts using these drugs in the last 30 days, compared to half that number in the United States.

**Discussion**

When tramadol was approved for use in Canada in 2005, Health Canada mandated that a post-marketing surveillance program be implemented to assess its assimilation into the Canadian drug culture. Despite the fact that it had been shown in many countries, perhaps most systematically in the United States, that tramadol had very low actual rates of abuse, the regulatory authorities in Canada were concerned that there would be high abuse of tramadol in Canada because of potential differences in the drug culture. The post-marketing surveillance program described in this paper was implemented to serve as a means of measuring the abuse of tramadol, relative to other opioids, and to directly address, in a much broader sense, whether there were in fact differences in prescription opioid abuse populations between Canada and the United States. Our results indicate that, in agreement with the world’s literature, tramadol has demonstrably low appeal to substance abusers: fewer than 5% of the US and Canadian samples indicated that tramadol was their drug of choice.

In a broader sense our data show remarkably few differences between prescription opioid users in the US and Canada, with the exception of primary drug preference. Hydrocodone is the most commonly misused drug in the United States, but ranks among the least preferred drugs in Canada. Hydrocodone products are not available in Canada and thus they are relatively inaccessible to Canadian substance abusers. Since it is clear that diversion of a small fraction of any drug used therapeutically results in enhanced availability on the street for potential misuse, this may explain the rare endorsement of hydrocodone in Canada. Perhaps as a consequence of limited access to hydrocodone, Canadian prescription opioid misusers expressed a preference for far more potent and dangerous drugs with greater abuse potential most notably, hydromorphone. This potent drug with a poor margin of safety was the preferred drug of 20% of our Canadian sample – a rate 10 times higher than the U.S.

Other than issues related to the drug of choice, our data reinforce the growing body of evidence which indicates that prescription opioid users, no matter their nationality, have a large number of co-morbid physical and psychiatric issues, including chronic pain with moderate intensity, mental health disorders, alcoholism, and nicotine dependence. As such, substance misuse and abuse certainly do not exist in a vacuum but rather represent one aspect of what appears to be a constellation of co-morbid conditions. Considered in this light, the growth in prescription opioid abuse in the past 10-15 years may represent a different expression of the age-old disease of opioid addiction. What seems to have changed is the selection of the preferred opioid to get high – i.e., prescribed, legal drugs rather than heroin. We postulate that there is a misguided view that the use/abuse of prescription opioids is in some way vastly different than the use of illicit drugs. For example, it has been shown that users uniformly report that they use these drugs because they fundamentally see no harm in their use in that: (a) they are legal; (b) they are safe since identity and dosage are easily confirmed; (c) they are easily obtained from doctors and friends/family without resorting to street dealers in known drug trafficking areas; (d) they can easily be used orally or snorted, thus eliminating the dangers of IV administration; and (e) there is widespread peer acceptance of this form of “recreational” drug use. Efforts should be made to dispel these misconceptions.

There are many limitations in the approach we used in this study. Most notably, our sample reflects only those individuals who sought treatment for their abuse problems and, thus, we have by little data on “recreational” users or those who do not opt for treatment. In addition, although the US database of KI are reasonably distributed among urban, suburban and rural areas, the availability of treatment centers in less populated area of Canada led to a density of treatment centers in the most populated areas of Canada, but a relative dearth in sparsely populated provinces and territories. It is also possible that, since our data were collected only 2 years after tramadol’s approval, that unexpectedly higher rates of abuse might be found now. However, we believe this is highly unlikely since we know of no indications that tramadol abuse has emerged as a problem in Canada. In the US the highest abuse of tramadol was found in the first 12-18 months which then dissipated rapidly. Finally, our survey instruments were self-administered and thus all of the limitations of such methodology need to be recognized.

6.0 References


Figure Legend

Figure 1. Location of the participating treatment centers and the zip code of their patients completing the anonymous survey (red circles are treatment centers, blue circles are patients).

Figure 2. Opioid drugs used in the last 30 days, expressed as a percent of total sample number, in U.S. and Canadian substance misusers.

Figure 3. The primary drug of choice, expressed as a percent of total sample number, in U.S. and Canadian substance misusers.

Figure 4. Percent of the Canadian and U.S. sample using the licit and illicit drugs listed in the X axis.

Figure 1. Location of treatment centers

Table 1. Psychiatric Comorbidity of USA and Canadian prescription opioid users

Figure 2.

Figure 3. Primary Drug

Figure 4. Illicit and non-opioid prescribed Drugs Used in the Past 30 Days
Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain: A primer for addiction medicine physicians

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Abstract
This article summarizes the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, from the perspective of the addiction physician. The Guideline was developed by the National Opioid Use Guideline Group, which was formed under the umbrella of the Federation of Medical Regulatory Authorities of Canada. A core group of researchers wrote the initial draft, based on a systematic review of opioid effectiveness and adverse effects. A national panel of clinical experts reviewed the draft and achieved consensus on 24 recommendations, 15 of which are relevant to addiction medicine. The guideline advises primary care physicians to take a substance use history and to use addiction screening questionnaires and urine drug screens at baseline, especially for patients at higher risk for opioid misuse. High-risk patients who require opioid therapy should be managed through careful dose titration and close monitoring for aberrant behaviours. Patients with suspected opioid misuse or addiction should be managed with structured opioid therapy (SOT), opioid agonist treatment with methadone or buprenorphine, or abstinence-based treatment. SOT should be reserved for patients who do not access opioids from sources other than the physician, do not inject, snort or crush oral opioids, and are not currently addicted to other substances. With SOT, opioids are dispensed frequently and in small amounts, and the dose is tapered if high. Substance misuse is monitored through urine drug screens and frequent patient assessment. Patients who fail at or are not good candidates for SOT should be referred for an addiction medicine assessment and possible methadone or buprenorphine treatment. Addiction physicians can play a critically important role in diagnosing and managing opioid misuse and addiction among chronic pain patients in primary care, by providing: (a) comprehensive patient assessment, (b) assistance in setting up screening and monitoring protocols, (c) advice and assistance around safe prescribing, opioid and benzodiazepine tapering and SOT, (d) initiation of buprenorphine and methadone treatment and (e) referral to appropriate treatment facilities.

Purpose
The purpose of this review is to summarize the addiction-related content of the guideline, so that addiction physicians can act as a resource for their primary care colleagues about diagnosis and management. Fifteen of the recommendations are relevant to opioid misuse and addiction (see Table 1). These recommendations cover screening and identification, prescribing precautions for patients at high risk for opioid misuse, and management of suspected addiction.

Screening and identification
The guideline advises physicians to take a psychiatric and
substance use history on all patients being considered for long-term opioid therapy (LTOT). An interview guide for alcohol and substance use accompanies the guideline. Patients are at higher risk for opioid misuse and addiction if they report current, heavy use of alcohol, cannabis or sedating OTC drugs, any use of cocaine or other street drugs, or any use of non-prescribed benzodiazepines or opioids. They are also at high risk if they have a past or strong family history of addiction, or an active mental disorder. Patients with mood and anxiety disorders such as post-traumatic stress disorder have a higher prevalence of opioid misuse and addiction (Riley 2008, Becker 2008, Edlund 2007, Sullivan 2006, Manchikanti 2007, Wiley 2008).

The guideline’s appendices contain three screening tests to identify patients at high risk for addiction: the Opioid Risk Tool, the Screener and Opioid Assessment for Patients with Pain (SOAPP-R), and the Current Opioid Misuse Measure (COMM). The Opioid Risk Tool (Table 2) consists of six interview questions on family and personal history of addiction, preadolescent sexual abuse, and psychiatric illness (Webster 2005). The SOAPP asks 24 questions about aberrant drug behaviours, craving and emotional ability, drug-using friends, and a history of sexual abuse or drug problems (Butler 2008). The Current Opioid Misuse Measure asks 17 questions about aberrant behavior and symptoms of opioid dependence in the past 30 days (Butler 2007).

Evidence suggests that these tests are somewhat predictive of the risk of developing aberrant drug-related behaviours, although large prospective studies are need to demonstrate that they lead to improved clinical outcomes (Chou 2009). In the meantime, physicians should consider using these tests, particularly for patients not well known to them or who may be at higher risk of opioid misuse. The tests are quick, non-invasive and easy to score. The SOAPP may have the strongest evidence of validity (Moore 2009), although the Opioid Risk Tool is the most commonly used and is the simplest to administer (Table 2).

The guideline advises urine drug screening (UDS) at baseline for high-risk patients or patients who are not well known to the physician. Primary care physicians rarely use UDS (Adams 2001, Bham 2006), yet they can be a useful management tool. In one study, 16% of patients on LTOT had UDS positive for illicit drugs (Manchikanti 2006). UDS is an important component of adherence monitoring (see structured opioid therapy, below). The addiction physician can assist the primary care physician in implementing UDS protocols and interpreting unexpected results (Table 3).

**Suspected Opioid Misuse and dependence**

A recent meta-analysis estimated that the prevalence of aberrant drug-related behaviours in CNCP patients on LTOT was 11.5%, with wide regional variations (Fishbain 2008) (the study’s estimate of confirmed opioid dependence was 3%). Aberrant behaviours vary in their predictive value (Table 4); they could indicate undiagnosed addiction, diversion or inadequately treated pain. In one study of CNCP patients (Passik 2006), illegal activities (double doctoring, buying and selling opioids) and altering the route of delivery (injecting or crushing oral tablets) were more predictive of opioid addiction than running out early. In a large prospective study, patients reporting four or more aberrant behaviours were more likely to be opioid addicted than patients reporting three or less (Fleming 2008). The most common aberrant behaviours/symptoms were early refills, increasing the dose without the physician’s consent, and feeling intoxicated on opioids. Unfortunately, patients may be reluctant to disclose aberrant behaviours; therefore management decisions must sometimes be based on a presumptive diagnosis of opioid addiction.

**Management of high-risk patients**

Patients are at higher risk for opioid misuse or addiction if they have a current, past or strong family history of addiction, and/or an active psychiatric disorder such as PTSD. The three major management strategies for high-risk patients are to limit opioid exposure, control opioid dispensing, and monitor for signs of misuse or addiction. The latter two strategies are discussed in the section on structured opioid therapy.

**Limiting opioid exposure.** Not all pain is opioid responsive, and opioids are not standard therapy for every pain condition. For example, potent opioids (all opioids other than codeine or tramadol) have not been studied and are not recommended for fibromyalgia (Carville 2008). Furthermore, the long-term efficacy and safety of opioid therapy is uncertain. A cohort study found that patients on LTOT had greater disability and mental distress than patients not on opioid therapy, after controlling for the severity of their pain condition (Rome 2004). Two studies on work injuries found that patients on high opioid doses (above 150 mg MED) were disabled for longer periods than those on no opioids, even after controlling for the severity of the injury ([Webster 2007] (Franklin 2008). This suggests that, particularly for high risk patients, LTOT should be restricted to patients with well-defined nociceptive or neuropathic pain conditions.

The explanation for these findings is uncertain. LTOT cause sedation, dysphoria and hyperalgesia (Chu 2006), which counteract the analgesic benefits of opioids and might contribute to pain-related disability. Also, it could be that physicians tend to prescribe opioids to emotionally distressed and disabled patients. Patients with mood disorders are more likely to receive opioids than patients with comparable pain diagnoses but without a mood disorder (Breenridge 2003, Fishbain 2004, Sullivan 2005). Perhaps physicians prescribe opioids at higher doses to depressed patients because they have a heightened perception of pain (Levenson 2008), and diminished analgesic response to opioids (Wasan 2005),
Another reason for limiting opioid exposure is that a euphoric response to opioids may be a risk factor for opioid addiction (Bieber 2008), and experimental studies have demonstrated that opioid-induced euphoria is dose-related, even at therapeutic oral doses (e.g. 10,20 and 30 mg oxycodone) (Lamas 1994) (Zacny 2003, 2005). Particular caution is required in prescribing CR opioids, since they contain much higher opioid doses than IR tablets (one OxyContin 40 mg tablet = eight Percocet tablets in oxycodone content). Also, CR opioids can easily be crushed and injected. Finally, the outer shell of the OxyContin tablet, containing 1/3 of the total dose, is an immediate-release formulation. Thus one 80 mg OxyContin tablet can cause an immediate euphoric effect equivalent to 5 or 6 Percocet tablets, even if the tablet is not crushed or bitten but swallowed whole.

Morphine may be preferred over oxycodone or hydromorphone for high-risk patients who have not responded to codeine or tramadol. Two small placebo-controlled studies with non-drug abusing volunteers found that oxycodone had greater reinforcing effects than morphine at equi-analgesic doses (Zacny 2003, Zacny 2007). These studies may not be generalizable to the pain population, because they used volunteers who were not in pain. However, other types of studies have had similar findings. Drug-using populations tend to prefer oxycodone and hydrocodone over other opioids (Butler 2006). The RADARS surveillance network in the US has documented a high prevalence of oxycodone misuse and addiction in addiction treatment centers and law enforcement agencies (Cicero 2007). It is possible that these findings partly reflect the overall popularity of oxycodone; one study found that rates of oxycodone and morphine abuse in the DAWN network (emergency department events) were similar when controlling for the amount of drug prescribed (Dasgupta 2006).

Clearly the dose and type of opioid is only one of several risk factors for opioid addiction. Most patients on high doses of opioids don’t become addicted to them, and many opioid addicted patients were not exposed to opioids through medical prescriptions. Nonetheless, limiting opioid exposure is prudent for high risk patients, given the evidence for an association between the type and dose of opioid and the risk of addiction.

Opioid tapering (table 6). Opioid exposure can be limited both through initial dose titration and through tapering. The guideline recommends a “watchful dose” of 200 mg morphine-equivalent per day (MED). Opioid tapering should be considered in patients on doses above 200 mg per day; particularly if they are opioid addicted and receiving “structured opioid therapy” (see below). Tapering is also indicated for non-addicted patients who report severe pain and pain-related disability despite reasonable opioid doses. Cohort studies and one controlled trial have demonstrated that these patients experience reduced pain and improved mood and functioning with opioid tapering (Baron 2006; Rome 2004). (Becker 2000) (Miller 2006) (Crisostomo 2008) (Hooten 2007). Tapering may improve pain and mood but reversing opioid-related dysphoria, withdrawal-mediated pain and hyperalgesia. A trial of benzodiazepine tapering is also recommended (Table 7).

Management of suspected opioid misuse or dependence (Table 5)

Primary care physicians have three management options for patients with suspected opioid misuse or dependence: Structured opioid therapy, opioid agonist therapy (methadone or buprenorphine), and abstinence-based therapy. These will be discussed in turn.

Structured opioid therapy (SOT)

In SOT, opioids are prescribed under conditions that limit the possibility for misuse. The ideal candidate is at high risk for opioid addiction or has shown aberrant behaviours and other signs of misuse and addiction. However, the patient is well-known to the physician, has an organic pain condition that likely requires opioid therapy, does not regularly access opioids from the street or other doctors, does not inject, snort or crush oral opioid tablets, and is not currently abusing other substances (Table 5). SOT has five components:

a) Careful opioid titration. Opioid dosing is preferably scheduled rather than PRN, using CR opioids. If feasible, the patient should be switched from the opioid they are currently addicted to, avoiding hydromorphone and oxycodone if possible.

b) Tapering: The dose should be tapered to below 200 mg MED. Benzodiazepines should also be tapered (Tables 6, 7).

c) Frequent dispensing. To limit diversion and/or binging, small amounts of opioids should be dispensed frequently (e.g. every 2nd day, bi-weekly).

d) Careful monitoring for aberrant drug-related behaviours. UDS should be done regularly. At each visit, the patient should be asked about compliance with the dosing schedule, and about non-authorized drug use. Pill and patch counts might be considered.

e) Comprehensive treatment. The physician should use non-opioid treatments for pain and should manage concurrent mood or anxiety disorders.

SOT effectiveness. Observational studies have shown that SOT is associated with reduced aberrant drug behavior, greater compliance with treatment agreements, reduced illicit drug use on UDS, lower opioid dose, and improved mood, pain and disability (Chelminski 2005) Wiedemer (2007) (Manchikanti 2006) Currie et al. (2003). A recently published randomized trial provides perhaps the strongest evidence to date of the effectiveness of SOT (Jamison 2010). In this trial, 42 patients at high risk for opioid misuse were randomized to receive either usual opioid therapy, or SOT with regular UDS, compliance checklists, and motivational counseling. By six months, the intervention group had reduced rates of opioid misuse behaviours and non-authorized drug use on UDS.

These studies are of uncertain relevance to primary care because the clinics were multidisciplinary, usually involving a pharmacist, physician and counselor. However, many physicians now work in family health teams and other interprofessional settings. Drop out rates tend to be high (40-50% in several studies), suggesting
that patients should be expeditiously transferred to an opioid agonist program if they haven’t complied with SOT.

**Opioid agonist therapy**

Opioid agonist therapy is indicated for patients who have failed at or who are not good candidates for SOT (Table 5). There is strong evidence from controlled trials that buprenorphine can safely be prescribed in a primary care setting (Simoens 2005). Buprenorphine has several advantages over methadone in the treatment of prescription opioid addiction. As a partial opioid agonist with a ceiling effect, it has a substantially lower risk of overdose than methadone. It thus may be preferred for the elderly, those on benzodiazepines or other sedating drugs, heavy drinkers, and those who may have a lower opioid tolerance (e.g. non-daily opioid users, or codeine-dependent patients). Buprenorphine is also indicated for patients living in communities with no access to methadone programs, and patients who cannot comply with mandatory methadone take-home protocols because of work or family commitments. Unfortunately, buprenorphine is not yet covered under most provincial drug plans.

Buprenorphine can be prescribed by any physician with appropriate training, whereas methadone requires a special exemption from Health Canada. This means that addiction physicians can initiate buprenorphine, referring the patient back to the primary care physician when stable. This frees up the addiction physician’s practice and the patient’s medical care is no longer split between different doctors.

Methadone is another effective treatment for opioid addiction. It can be used as a first-line treatment, or for patients who have failed at or do not have access to buprenorphine therapy because of cost or other considerations. Although the duration of analgesic action of methadone and buprenorphine is six to eight hours, an initial trial of once daily dosing is suggested for patients with concurrent addiction and organic pain. These patients often experience substantial pain relief with once-daily treatment as their withdrawal symptoms resolve. After the initial titration, the dose may be split if the patient experiences severe pain unrelated to withdrawal several hours after the daily dose.

**Abstinence-based treatment**

Abstinence-based treatment is less effective than opioid agonist treatment, but many patients prefer it, and it may be a viable option for patients with good prognostic factors. Medically-assisted detoxification can be done with clonidine or tapering doses of buprenorphine, methadone, or other opioids. Controlled trials and systematic reviews have demonstrated that buprenorphine is substantially more effective than clonidine and other non-opioid treatments in relieving opioid withdrawal symptoms and retaining patients in treatment (Amato 2004, Gowling 2002) (Brigham 2007, Caldiero 2006). Buprenorphine may be more effective than methadone for inpatient detoxification (Blondell 2007, Gowling 2006), perhaps because the optimal dose can be reached much more quickly than with methadone.

Overall, however, regardless of the method used, detoxification is less effective than maintenance treatment (Kornor 2006, 2007, Horspool 2008). Treatment retention is improved and opioid use is reduced when detoxification is combined with psychosocial treatment (Amato 2008). Patients should be warned that they could overdose if they relapse to their usual opioid dose, as tolerance to opioids is lost within days of abstinence.

**Role of the addiction physician**

Addiction physicians play a critically important role in diagnosing and managing opioid misuse and addiction in CNCP patients. Addiction physicians have the time and expertise to perform a comprehensive assessment; a detailed clinical interview is more predictive of addiction risk than a screening questionnaire (Moore 2009). Addiction physicians can help primary care physicians implement screening questionnaires and urine drug screening schedules, and can provide advice on safe prescribing and opioid and benzodiazepine tapering. For patients with suspected opioid misuse or dependence, addiction physicians can initiate SOT or opioid agonist treatment, and can provide shared care and treatment referral.

**Conclusion**

Opioid misuse and addiction are serious public health problems. Addiction physicians can play an integral role in preventing and treating these problems, by providing consultation and shared care with primary care physician. With the introduction of the new national guideline, addiction physicians will be relied upon further to provide evidence-based and current advice and consultation to primary care physicians.

**References**


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Passik SD, Kirsh KL. Current Pain and Headaches Reports, 2004 Aug;8:289-294


Table 1: Canadian Guideline for the Safe and Effective Use of Opioids for CNCP: Recommendations relevant to addiction medicine.

Cluster 1: Deciding to Initiate Opioid Therapy

Addiction-risk screening: Before initiating opioid therapy, consider using a screening tool to determine the patient’s risk for opioid addiction. (Grade B).

Urine drug screening: When using urine drug screening (UDS) to establish a baseline measure of risk or to monitor compliance, be aware of benefits and limitations, appropriate test ordering and interpretation, and have a plan to use results. (Grade C).

Benzodiazepine tapering: For patients taking benzodiazepines, particularly for elderly patients, consider a trial of tapering (Grade B). If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses. (Grade C).

Cluster 2: Conducting an Opioid Trial

Watchful Dose: Chronic non-cancer pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent (Grade A). Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes. (Grade C).

Risk: opioid misuse: When initiating a trial of opioid therapy for patients at higher risk for misuse, prescribe only for well-defined somatic or neuropathic pain conditions (Grade A), start with lower doses and titrate in small-dose increments (Grade B), and monitor closely for signs of aberrant drug-related behaviors. (Grade C).

Cluster 3: Monitoring Long-Term Opioid Therapy (LTOT)

Collaborative care: When referring patients for consultation, communicate and clarify roles and expectations between primary-care physicians and consultants for continuity of care and for effective and safe use of opioids. (Grade C).

Cluster 4: Treating Specific Populations with LTOT

Adolescent patients: Opioids present hazards for adolescents (Grade B). A trial of opioid therapy may be considered for adolescent patients with well-defined somatic or neuropathic pain conditions when non-opioid alternatives have failed, risk of opioid misuse is assessed as low, close monitoring is available, and consultation, if feasible, is included in the treatment plan. (Grade C).

Pregnant patients: Pregnant patients taking long-term opioid therapy should be tapered to the lowest effective dose slowly enough to avoid withdrawal symptoms, and then therapy should be discontinued if possible. (Grade B).

Co-morbid psychiatric diagnoses: Patients with a psychiatric diagnosis are at greater risk for adverse effects from opioid treatment. Usually in these patients, opioids should be reserved for well-defined somatic or neuropathic pain conditions. Titrate more slowly and monitor closely; seek consultation where feasible. (Grade B).

Cluster 5: Managing Opioid Misuse and Addiction in CNCP Patients

Addiction treatment options: For patients with chronic non-cancer pain who are addicted to opioids, three treatment options should be considered: methadone or buprenorphine treatment (Grade A), structured opioid therapy (Grade B), or abstinence-based treatment (Grade C). Consultation or shared care, where available, can assist in selecting and implementing the best treatment option. (Grade C).

Patient unacceptable behaviour: Be prepared with an approach for dealing with patients who disagree with their opioid prescription or exhibit unacceptable behaviour. (Grade C).

Acute care opioid prescribing policy: Acute or urgent health care facilities should develop policies to provide guidance on prescribing opioids for chronic pain to avoid contributing to opioid misuse or diversion. (Grade C).

Table 2: Opioid Risk Tool

<table>
<thead>
<tr>
<th>Item</th>
<th>Mark each box that applies</th>
<th>Item score if female</th>
<th>Item score if male</th>
</tr>
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<tbody>
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<td>Alcohol</td>
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<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal History of Substance Abuse:</td>
<td></td>
<td></td>
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</tr>
<tr>
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<td>[ ]</td>
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<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (mark box if 16-45)</td>
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<td>1</td>
</tr>
<tr>
<td>4. History of Preadolescent Sexual Abuse</td>
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<td>5. Psychological Disease</td>
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<tr>
<td>Attention Deficit Disorder, Obsessive-Compulsive Disorder, or Bipolar, Schizophrenia</td>
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<td>2</td>
</tr>
<tr>
<td>Depression</td>
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<td>Total</td>
<td>_____ _____</td>
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</tr>
<tr>
<td>Low Risk: 0 to 3</td>
<td>Moderate Risk: 4 to 7</td>
<td>High Risk: 8 and above</td>
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</tbody>
</table>
Table 3: Interpreting Unexpected Results of Urine Drug Screens

<table>
<thead>
<tr>
<th>Unexpected Result</th>
<th>Possible Explanations</th>
<th>Actions for the Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 UDS negative for prescribed opioid.</td>
<td>• False negative.</td>
<td>• Repeat test using chromatography; specify the drug of interest (e.g., oxycodone often missed by immunoassay).</td>
</tr>
<tr>
<td></td>
<td>• Non-compliance.</td>
<td>• Take a detailed history of the patient’s medication use for the preceding 7 days (e.g., could learn that patient ran out several days prior to test).</td>
</tr>
<tr>
<td></td>
<td>• Diversion.</td>
<td>• Ask patient if they’ve given the drug to others.</td>
</tr>
<tr>
<td></td>
<td>• Repeat test using chromatography; specify the drug of interest (e.g., oxycodone often missed by immunoassay).</td>
<td>• Monitor compliance with pill counts.</td>
</tr>
<tr>
<td>2 UDS positive for non-prescribed opioid or benzodiazepines.</td>
<td>• False positive.</td>
<td>• Repeat UDS regularly.</td>
</tr>
<tr>
<td></td>
<td>• Patient acquired opioids from other sources (double-doctoring, street).</td>
<td>• Ask the patient if they accessed opioids from other sources.</td>
</tr>
<tr>
<td></td>
<td>• Assess for opioid misuse/addiction (See Recommendation 12).</td>
<td>• Assess for opioid misuse/addiction and refer for addiction treatment as appropriate.</td>
</tr>
<tr>
<td></td>
<td>• Review/revise treatment agreement</td>
<td>• Ask about medical prescription of dronabinol, THC:CBD or medical marijuana access program.</td>
</tr>
<tr>
<td>3 UDS positive for illicit drugs (e.g., cocaine, cannabis).</td>
<td>• False positive.</td>
<td>• Repeat UDS regularly.</td>
</tr>
<tr>
<td></td>
<td>• Patient is occasional user or addicted to the illicit drug.</td>
<td>• Assess for abuse/addiction and refer for addiction treatment as appropriate.</td>
</tr>
<tr>
<td></td>
<td>• Cannabis is positive for patients taking dronabinol (Marinol®), THC:CBD (Sativex®) or using medical marijuana.</td>
<td>• Ask about medical prescription of dronabinol, THC:CBD or medical marijuana access program.</td>
</tr>
<tr>
<td>4 Urine creatinine is lower than 2-3 mmol/liter.</td>
<td>• Patient added water to sample.</td>
<td>• Repeat UDS.</td>
</tr>
<tr>
<td></td>
<td>• Delay in handling sample (urine cools within minutes).</td>
<td>• Consider supervised collection or temperature testing.</td>
</tr>
<tr>
<td></td>
<td>• Patient added water to sample.</td>
<td>• Take a detailed history of the patient’s medication use for the preceding 7 days.</td>
</tr>
<tr>
<td></td>
<td>• Review/revise treatment agreement</td>
<td>• Review/revise treatment agreement.</td>
</tr>
<tr>
<td>5 Urine sample is cold.</td>
<td>• Delay in handling sample (urine cools within minutes).</td>
<td>• Repeat UDS, consider supervised collection or temperature testing.</td>
</tr>
<tr>
<td></td>
<td>• Patient added water to sample.</td>
<td>• Take a detailed history of the patient’s medication use for the preceding 7 days.</td>
</tr>
<tr>
<td></td>
<td>• Review/revise treatment agreement</td>
<td>• Review/revise treatment agreement.</td>
</tr>
</tbody>
</table>

Source: adapted from Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain 2010

Table 4: Aberrant Drug-Related Behaviours


<table>
<thead>
<tr>
<th>Indicator</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Altering the route of delivery</td>
<td>• Injecting, biting or crushing oral formulations</td>
</tr>
<tr>
<td>*Accessing opioids from other sources</td>
<td>• Taking the drug from friends or relatives</td>
</tr>
<tr>
<td></td>
<td>• Purchasing the drug from the “street”</td>
</tr>
<tr>
<td></td>
<td>• Double-doctoring</td>
</tr>
<tr>
<td>Unsanctioned use</td>
<td>• Multiple unauthorized dose escalations</td>
</tr>
<tr>
<td></td>
<td>• Binge rather than scheduled use</td>
</tr>
<tr>
<td>Drug seeking</td>
<td>• Recurrent prescription losses</td>
</tr>
<tr>
<td></td>
<td>• Aggressive complaining about the need for higher doses</td>
</tr>
<tr>
<td></td>
<td>• Harassing staff for faxed scripts or fit-in appointments</td>
</tr>
<tr>
<td></td>
<td>• Nothing else “works”</td>
</tr>
<tr>
<td>Repeated withdrawal symptoms</td>
<td>• Marked dysphoria, myalgias, GI symptoms, craving</td>
</tr>
<tr>
<td>Accompanying conditions</td>
<td>• Currently addicted to alcohol, cocaine, cannabis or other drugs</td>
</tr>
<tr>
<td></td>
<td>• Underlying mood or anxiety disorders not responsive to treatment</td>
</tr>
<tr>
<td>Social features</td>
<td>• Deteriorating or poor social function</td>
</tr>
<tr>
<td></td>
<td>• Concern expressed by family members</td>
</tr>
<tr>
<td>Views on the opioid medication</td>
<td>• Sometimes acknowledges being addicted</td>
</tr>
<tr>
<td></td>
<td>• Strong resistance to tapering or switching opioids</td>
</tr>
<tr>
<td></td>
<td>• May admit to mood-leveling effect</td>
</tr>
<tr>
<td></td>
<td>• May acknowledge distressing withdrawal symptoms</td>
</tr>
</tbody>
</table>
### Table 5. Management of high risk patient and patient with suspected opioid misuse/addiction

<table>
<thead>
<tr>
<th>Patient category</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient has pain due to medical reasons and is at high risk for opioid addiction (e.g. past or strong family history of addiction)</td>
<td>• Use opioids after adequate trial of non-opioid treatments</td>
</tr>
<tr>
<td></td>
<td>Prescribe small amounts, confirm pill counts</td>
</tr>
<tr>
<td></td>
<td>Do regular UDT</td>
</tr>
<tr>
<td></td>
<td>Use caution with opioids having a high abuse liability (oxycodone, hydromorphone, hydrocodone)</td>
</tr>
<tr>
<td></td>
<td>Keep dose well below 200 mg morphine/day</td>
</tr>
<tr>
<td>2. Patient is currently addicted to non-opioid drugs such as cocaine, alcohol</td>
<td>Opioids usually contraindicated</td>
</tr>
<tr>
<td></td>
<td>Refer for formal addiction treatment</td>
</tr>
<tr>
<td>3. Suspected opioid misuse in a patient who:</td>
<td>Trial of structured opioid therapy is indicated:</td>
</tr>
<tr>
<td>Has pain due to medical reasons requiring opioid therapy</td>
<td>Dispense frequently (daily, alternate day, twice per week)</td>
</tr>
<tr>
<td>Family physician is only source of opioids</td>
<td>Regular UDT (1-4 times per month)</td>
</tr>
<tr>
<td>Use opioids only orally (no injection or crushing tablets)</td>
<td>Pill or patch counts</td>
</tr>
<tr>
<td>Is not currently addicted to cocaine, alcohol or other drugs</td>
<td>Switch the patient to controlled-release preparations</td>
</tr>
<tr>
<td></td>
<td>Avoid parenteral use, and short-acting agents</td>
</tr>
<tr>
<td></td>
<td>Consider switching to a different opioid, while avoiding oxycodone, hydromorphone, hydrocodone</td>
</tr>
<tr>
<td></td>
<td>Taper if on dose above 200 mg/day morphine equivalent</td>
</tr>
<tr>
<td>Suspected opioid misuse in a patient who:</td>
<td>Methadone or buprenorphine treatment:</td>
</tr>
<tr>
<td>Fails structured opioid trial, or</td>
<td>Institute daily supervised dispensing</td>
</tr>
<tr>
<td>Not eligible for structured opioid trial (injecting, crushing tablets; addicted to other drugs; acquiring opioids from other sources)</td>
<td>Gradually introduce take-home doses</td>
</tr>
<tr>
<td></td>
<td>Frequent urine drug screens</td>
</tr>
<tr>
<td></td>
<td>Provide counseling and medical care</td>
</tr>
</tbody>
</table>

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### Table 6: Opioid Tapering

Reference: adapted from Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain 2010

**Precautions for Outpatient Opioid Tapering**

1. **Pregnancy:** Severe, acute opioid withdrawal has been associated with premature labour and spontaneous abortion.

2. **Unstable medical and psychiatric conditions that can be worsened by anxiety:** While opioid withdrawal does not have serious medical consequences, it can cause significant anxiety and insomnia.

3. **Addiction to opioids obtained from multiple doctors or “the street”:** Outpatient tapering is unlikely to be successful if the patient regularly accesses opioids from other sources; such patients are usually best managed in an opioid agonist treatment program (methadone or buprenorphine).

4. **Concurrent medications:** Avoid sedative-hypnotic drugs, especially benzodiazepines, during the taper.

**Opioid Tapering Protocol**

**Before Initiation**

1. Emphasize that the goal of tapering is to make the patient feel better: to reduce pain intensity and to improve mood and function.

2. Have a detailed treatment agreement.

3. Be prepared to provide frequent follow-up visits and supportive counselling.
Type of Opioid, Schedule, Dispensing interval
1) Use controlled-release morphine if feasible (see 2.3 below).
2) Prescribe scheduled doses (not p.r.n.).
3) Prescribe at frequent dispensing intervals (daily, alternate days, weekly, depending on patient’s degree of control over opioid use). Do not refill if patient runs out.
4) Keep daily schedule the same for as long as possible (e.g., t.i.d.).

Rate of the Taper
1) The rate of the taper can vary from 10% of the total daily dose every day, to 10% of the total daily dose every 1-2 weeks.
2) Slower tapers are recommended for patients who are anxious about tapering, may be psychologically dependent on opioids, have co-morbid cardio-respiratory conditions, or express a preference for a slow taper.
3) Once one-third of the original dose is reached, slow the taper to one-half or less of the previous rate.
4) Hold the dose when appropriate: The dose should be held or increased if the patient experiences severe withdrawal symptoms, a significant worsening of pain or mood, or reduced function during the taper.

Switching to Morphine
1) Consider switching patients to morphine if the patient might be dependent on oxycodone or hydromorphone.
2) Calculate equivalent dose of morphine (see Appendix B-8: Oral Opioid Analgesic Conversion Table).
3) Start patient on one-half this dose (tolerance to one opioid is not fully transferred to another opioid).
4) Adjust dose up or down as necessary to relieve withdrawal symptoms without inducing sedation.

Monitoring during the Taper
1) Schedule frequent visits during the taper (e.g. weekly).
2) At each visit, ask about pain status, withdrawal symptoms and possible benefits of the taper: reduced pain and improved mood, energy level and alertness.
3) Use urine drug screening to assess compliance.

Completing the Taper
1) Tapers can usually be completed between 2-3 weeks and 3-4 months.
2) Patients who are unable to complete the taper may be maintained at a lower dose if their mood and functioning improve and they follow the treatment agreement.

Table 7: Benzodiazepine Tapering
Reference: adapted from Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain 2010

1. Benefits of Benzodiazepine Tapering
   • Lower the risk of future adverse drug-related risks such as falls.
   • Increased alertness and energy.

2. Approach to Tapering
   • Taper slowly: slow tapers are more likely to be successful than fast tapers.
   • Use scheduled rather than p.r.n. doses.
   • Halt or reverse taper if severe anxiety or depression occurs.
   • Schedule follow-up visits q 1–4 weeks depending on the patient’s response to taper.
   • At each visit, ask patient about the benefits of tapering (e.g., increased energy, increased alertness).

3. Protocol for Outpatient Benzodiazepine Tapering
3.1 Initiation

- May taper with a longer-acting agent such as diazepam or clonazepam, or taper with the agent that the patient is taking. (Diazepam can cause prolonged sedation in the elderly and those with liver impairment.)
- There is insufficient evidence to strongly support the use of one particular benzodiazepine for tapering.
- Convert to equivalent dose in divided doses (see CPS)
- Adjust initial dose according to symptoms (equivalence table is approximate).

3.2 Decreasing the Dose

- Taper by no more than 5 mg diazepam equivalent per week.
- Adjust rate of taper according to symptoms.
- Slow the pace of the taper once dose is below 20 mg of diazepam equivalent (e.g., 1-2 mg/week).
- Instruct the pharmacist to dispense daily, twice weekly, or weekly depending on dose and patient reliability.

Source: Adapted from Kahan 2002.

Table 8. Opioid tapering

<table>
<thead>
<tr>
<th>Type of opioid</th>
<th>Switch from current opioid if patient misusing or dependent on it (eg oxycodone, hydromorphone, hydrocodone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formulation</td>
<td>Sustained release preferred (until low dose reached after which you can use immediate release to complete taper)</td>
</tr>
<tr>
<td>Initial dose</td>
<td>If switching, initiate new opioid at 50% of current opioid dose (if the dose is high) and 75% of current opioid dose (if the dose is low) and titrate upwards</td>
</tr>
</tbody>
</table>
| Dosing interval | - Scheduled doses rather than PRN  
|                 | - Keep dosing interval the same for as long as possible (BID or TID)  
|                 | - Advise patients not to skip or delay doses* |
| Rate of taper   | - Taper slowly (eg 10 mg controlled-release morphine q 2 weeks). Alternatively, taper 10% of daily dose every 7-14 days. Taper even more slowly when 1/33 of the total dose is reached. Let patient choose which dose is decreased (AM, PM or HS) |
| Frequency of pharmacy dispensing | If patient runs out early, increase frequency to weekly, alternate day or daily |
| End point of taper | - Less than or up to 200 mg of morphine or equivalent at which point dose should control pain with minimal side effects |
| Frequency of visits | - Depends on rate of taper  
|                 | - If possible, see patient prior to each dose decrease |
| Approach at each visit | - Ask not just about withdrawal symptoms and pain but also benefits of tapering: more alert, less fatigued, less constipated  
|                 | - Be optimistic; pain, mood and activity often improve with tapering |

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As I reflect on the past six months for the Canadian Society of Addiction Medicine, two major issues dominate. One positive and the other not.

The first is the financial situation for CSAM, and jointly, our day to day management. In this area we have advanced. By changing management companies, CSAM has greatly reduced its overhead operational costs, and has not sacrificed any efficiencies or personal touches. In fact, I feel the organization, with a smaller more individually dedicated management company, has returned closer to the grassroots that helped found the Society. I have not heard any views to the contrary, and if my assessment of things in this area is not shared, please provide feedback.

I can advise the membership that your Board of Directors is extremely satisfied with the first year’s service from “Above the Mark” management company and its principal Marilyn Dorozio. From near bankruptcy our treasury has now swelled to over $50,000. - a necessary sum to guarantee continuous operation. Many factors have contributed to this turnaround, not the least of which was our share of the profit from the joint ISAM/CSAM Calgary conference. Let’s hope our annual Scientific Conference in Charlottetown, PEI from October 21 - 23 is another success - both academically and financially.

The second item foremost in my CSAM mind is membership. An organization can only be as strong and vibrant as its membership support permits. And at this point in 2010 we have cause for concern. The most recent Secretariat Report revealed that total paid membership to May 18 this year is 215, down from 249 at this same month in 2009. But even more alarming in my mind is that paid up MD members have fallen from 138 to 92 at this juncture. Associate membership has actually gone up this year - from 85 to 109, thanks in large part to a deep commitment to CSAM by the Ontario Addiction Treatment Centre (OATC).

A closer look at the MD membership list reveals that only 31 Ontario physicians have activated their membership in CSAM for 2010, while 45 more have yet to renew. If you are one of this vital group please take the time to renew now. I expect it’s not the cost (our CSAM fees are much less than those for ASAM), but rather the action of doing same. I have requested that our manager forward a copy of this Journal to all 2009 members who have failed to renew - as a goodwill gesture and gentle reminder that CSAM needs your involvement.

The Board of Directors have agreed to personally make contact where possible with non renewed members from their individual provinces. You can avoid this call by acting now. Marilyn will be updating our active membership list on a regular basis. And I don’t mean to be picking on Ontario - it’s just that our most populous province has the greatest impact on membership numbers and provides the clearest barometer of society health. I personally would like to encourage addiction professionals from two of the leading Ontario facilities - CAMH and Homewood - to become more actively involved. CSAM needs your contributions.

And, most importantly, make plans now to be in Charlottetown from October 21 - 23. The annual CSAM Scientific Conference themed “Basics and Beyond” has the makings of something special.
News from Across Canada

News from British Columbia

Dr. Paul Sobey

It was with enthusiasm that I accepted the position of BC representative to CSAM. I was asked to stand for the position by the former BC representative, Dr. Garth McIver, whom I have known for many years. I come from a background of twelve years of family practice and then completed fellowship training in Addiction Medicine in Cleveland, Ohio in 1999. Since this time my practice has been limited to treating patients with addictions. The core areas of my practice have been addictions in the criminal justice system, opiate agonist treatment, hospital and office based addiction medicine, residential treatment, teaching and occupational addiction medicine.

Stepping Forward – Improving Addiction Care in British Columbia, March 2009 [https://www.bcma.org/files/Addiction_Stepping_Foward.pdf] was the first policy paper published by the British Columbia Medical Association on the state of addictions and resources for treatment in the last ten years. The paper identified nine gaps in the continuum of care and made broad recommendations to government. The paper was received enthusiastically by government and garnered excellent media coverage. The first BCMA Guidelines and Protocols addressing an addictions issue, Guideline for Management of Problem Drinking, flowed from this paper and will hopefully be rolled out this summer. I had the opportunity to work on both of these initiatives and continue to be involved with roll out of the new Guideline.

The Methadone Maintenance Handbook, second edition, December 2009 and Recommendations for the Use of Methadone for Pain, February 2010 [https://www.cpsbc.ca/about/programs/methadone-program] came available this year through the Methadone Maintenance Committee (MMC) at the British Columbia College of Physicians and Surgeons. These documents provide the standards of care for methadone used for dependence and pain. As a sitting member on MMC and being a methadone prescriber and medical director at the clinic at which I practice, I can attest to the difficult process of producing these documents. I am hoping to bring some of this experience to CSAM.

Other developments in BC include a long awaited fee code for Point Of Care urine drug testing (POCT). Physicians with an exemption to prescribe methadone can now bill the provincial health services plan for urine drug testing for patients registered on the methadone program or receiving Buprenorphine for opiate dependence. POCT is a well received benefit to opiate agonist therapy practice.

Both the Fraser and Vancouver Coastal Health Authorities have embarked on outpatient withdrawal management strategies that will hopefully address wait lists for these resources and also facilitate a more fluid continuum of care.

The voice of addiction medicine in British Columbia has been lacking coherence and has been represented by many contrasting and at times divergent opinions. We lack clear representation. I see the Canadian Society of Addiction Medicine playing a key role in assisting BC Addiction Medicine Physicians to find common ground. I encourage any British Columbia physician with an interest in addictions to join the society and have his or her voice heard.

News from Alberta

Dr. Samuel Oluwadairo

The CPSA in its official news letter the Messenger May edition talked about the Canadian Guideline for safe and Effective use of Opioids in Chronic Non Cancer Pain. The guideline offered 24 recommendations to help physicians safely use opioids to treat patients with chronic pain.

The recommendations are in five clusters – for easy of reading, the CPSA's monthly newsletter (Messenger) will publish each cluster monthly starting from June 2010.

The Cluster 1: addressed the steps required in Deciding to initiate Opioid Therapy:

• Ensure comprehensive documentation of patient’s pain condition, medical and psychosocial history (Grade C), psychiatric status, and substance use history. (Grade B)

• Use of screening tools to determine the patient’s risk for opioid addiction. (Grade B)

• To be aware of limitations and benefits of Urine Drug Screening.

• Evidence related to effectiveness in patients with chronic non-cancer pain (Grade A)

• Informed consent and explaining potential benefits, adverse effects, complications and risks (Grade B)

• For patient taking Benzodiazepines particularly elderly individuals, consider a trial of tapering, if unsuccessful, titrate opioids slowly and at lower doses (Grade C).

On another note AHS is paying more attention to concurrent issues of mental health and addictions. The new reorganization put mental health and addictions together under same portfolio. These developments will make the management of both conditions in a concurrent manner easier.

News from Saskatchewan

Dr. B. J. Fern

Having written about various vital and pressing issues over the years, this has to be the last submission from your humble scribe from the Prairies. Time to retire from the Saskatchewan position I've held for the last nine years. And time for a new, vibrant, full-of-beans and enthusiastic representative.

My thoughts and experiences in CSAM over the years may help the new candidate. CSAM has been interesting, as are all boards and committees. Back in Banff in 2001 I was perhaps the only
Saskatchewan registrant and got involved and have been on the board ever since. In those days the board was smaller, members knew each other well, only one in-person meeting a year at that annual conference, most business done by phone.

As time went on the board got more members and formed more committees and found more things to do. At the 2003 Halifax conference the then President Peter Mecziems suggested a retreat to think about whence we came and where we might be going, what we should be addressing; issues just as pertinent today.

There are now four board meetings a year, one in person all day event as before at the AGM / conference, and three teleconferences lasting about 2 hours each. In between the committees are supposedly active – this varies with the group and need.

A great deal is now done by email, which the board had barely discovered until about 2005. Committees bring issues to the board for endorsement or suggestions, and there is now an executive committee to handle new issues arising between board meetings.

On the local Saskatchewan scene, as usual I know nothing about any areas other then opioids and methadone. The Sask College has struck a new advisory committee initially for methadone but now for opioids in general. Terms of Reference are not yet finalized but it sound increasingly like CSAM’s Opioid Agonist Committee.

As expected the Jan 2010 Conference held in Saskatoon on Methadone and the Coroner dealt with deaths, police issues like diversion, mostly negative aspects of the scene in general. Well attended of course. No surprise it is so difficult to market methadone and treatment for patients afflicted with opioid dependency. When will we wake up and bring in a marketing team to rectify this ..?

11 June sees another “Methadone Education Day”, almost an annual now, this one a re-run of the one we did in 2005 in preparation for the CSAM Annual Conference held in Saskatoon. Unfortunately none of our presentations were needed at that conference – much regretted, since I firmly believe we should have local content at all our conferences not only to encourage local speakers but also to hear the issues affecting the local scene.

Topics for our current conference include terminology and pharmacology, assessment for methadone, induction, drug interactions, physical and mental comorbidities, pain and dependency, pregnancy, legal issues, urine screening and interpretation, counseling principles, codependency, prescribing and dispensing, and caries / take-homes. All local speakers. A veritable tubful indeed.

19 Jun we have a two day “All about opioids” type limited enrollment conference, similar topics, outside expert speakers. That’s it from Saskatchewan, and thanks to all for their support through these years and wishing my successor all the very best on the board.

With respect, from the prairies.

**News from Ontario**

**Dr. Jeff Daiter**

During the recent OMA Annual General and Council meetings in April, the Section on Addiction Medicine elected a new Executive. Congratulations to Dr. Robert Cooper, who was voted almost unanimously to act as Chair and in doing so, casting Dr. Jeff Daiter into the Past Chair position. Other notable winners included Dr. Michael Lester (Secretary), Dr. Martyn Judson (Member at Large), Dr. Chris Sankey (Vice Chair), Dr. Marni Brooks (Vice Chair). Many changes continue to loom on the forefront of potential shifts for reimbursement strategies for physicians engaged in the practice of Addiction Medicine. Discussion continue to explore a variety of models that will hopefully help to sustain the methadone program in across the province. An effort to get widespread input from members within Ontario will no doubt provide an opportunity for all to share in this important discussion.

The Ontario College of Family Physicians continues to enroll physicians into their Mentoring for Managing Addictions and Pain (MMAP) program. This program links physicians specializing in addiction medicine and pain medicine with family physicians throughout the province to help offer guidance in clinical practice. The program continues to grow and is proving to be a an important element to promote improved care of patients throughout Ontario.

**News from Manitoba**

**Dr. H. Hulsboch**

Good news from Manitoba! Several more physicians have obtained or are working toward their methadone exemption, and Manitoba will be holding its first methadone training program in the near future.

Now the bad news; the need for ever-increasing methadone and addictions services continues to grow, and OxyContin addiction continues to increase. Manitoba addiction services partners are continuing to urge the government to allocate resources to address this.
Website Committee
Dr. Jeff Daiter

The website committee continues to be modified on a weekly basis. Focus is now being directed to converting important sections into French. Again, if there are any novel ideas of how to improve the site, the website committee would welcome any input from any CSAM member.

Standards Committee
Dr. Jeff Daiter

The Standards Committee is again entertaining applications from interested members seeking Certification with CSAM. The elements required are posted on the CSAM website and we strongly encourage those seeking this prestigious title apply as soon as possible and successful candidates are announced at the Annual General Meeting in the Fall.

Education Committee
Dr. Sharon Cirone

The main focus and activity of the Education Committee is to develop and offer the ‘Fundamentals to Addiction Medicine’ course at the CSAM Annual General Meeting. The course has been a popular one-day introduction and refresher course for primary care MDs, Addiction Medicine MDs, nurses, and other professionals over many years at CSAM conferences. The Fundamentals course will be offered again this year at Charlottown in October.

The Education Committee is also working on a few other projects. In November 2009, an application was accepted for establishing an Addiction Medicine working party within the College of Family Physicians of Canada (CFPC) Section of Family Physicians with Special Interests or Focused Practices. The Working Party is made up of Dr. Kingsley Watts, a Family Physician who works with the Addiction Medicine Service at St. Joseph’s Health Centre in Toronto, Dr. Sharon Cirone, the Chair of the CSAM Education Committee and a community Family Physician in an Addictions Focused Practice, CFPC staff and MDs. Drs. Watts, Cirone and Mel Kahan, also a member of the Education Committee, have submitted documentation to the College outlining the population needs for addictions medicine services and expertise, an understanding of the training needs for Family Medicine residents and Family Physicians providing comprehensive care or Focused Practice care in Addictions, as well a vision for examination and certification options in Addiction Medicine.

Any CSAM members who would like to become involved in the activities of the Education Committee as invited to contact Dr. Sharon Cirone at rcirone@sympatico.ca.

Membership Committee Update

Membership Statistics:
As of June 2010 CSAM had 236 members:

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
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<td>Student members</td>
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Membership by province and territory is as follows:

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<th>Number</th>
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<td>International</td>
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<td>Alberta</td>
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Bylaw Committee

Dr. Brian Fern

The Bylaws Committee has concluded its work on the proposed revisions to eliminate confusing areas and duplications and define some of the more troublesome issues the board faced during the last few years. Feedback from most of the board has been received.

All approve the four section format – Corporate Structure, Memberships, Annual and Special meetings, and Board of directors – the much clearer definition throughout, and the additional “Operating Rules” section with terms of reference for committees etc, all connected in one document.

While there are some minor details which can still be worked in as suggested by the board members, a more significant issue concerns Associate Membership Status and whether we wish to remain a pure “medical society” as was founded in 1989 or broaden to include support workers, counsellors etc.

Some years ago we faced limited membership concerns, difficulty persuading doctors to join etc, and it was decided to expand the associate option. OATC in Ontario quickly registered about 80 associates and a few others have joined from other areas.

The existing bylaws give associates no voice at all. They pay a reduced fee but have no authority, no voting rights, no access to the board. Some have questioned the point in joining at all. The proposed new bylaws changes all that.

The issue now requires resolution. Do we want to include them, hear their opinions about the delivery of the services we prescribe, or not ..?

Meanwhile our relations with CCSA are increasing. CCSA are all support staff with no physicians, but several times our size as a society. They enjoy about 600 at their conferences (we number about 250) and are keen to hear more of the heavier presentations we take for granted at CSAM conferences. It also appears possible this relationship could develop further, even to joint conferences or possibly an exchange of board members, which would require some sort of provision to allow that.

Meanwhile we presently face the same very small medical membership – even in the methadone area most doctors see no need to belong because they say they treat dependency not addiction. This may simply be a question of semantics but it remains a fact nonetheless.

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Call for Honorary Membership Nominations

If you would like to submit a nomination for CSAM Honorary Membership for an individual, please forward by September 1, 2010 to the CSAM Office at office@csam.org with a brief bio and reasons for nomination stating contributions made to CSAM and to the field of Addiction Medicine.

Announcements will be made at the CSAM General Assembly during the CSM 2010 Annual Meeting and Scientific Conference in Charlottetown, PEI Oct 21-23, 2010.
Benefits of Membership with CSAM

Vision

The Canadian Society of Addiction Medicine was founded in 1989 as the Canadian Medical Society on Alcohol and Other Drugs. It is a national organization of medical professionals and other scientists interested in the field of Substance Use Disorders and Addictive Behavior.

Vision Goals
(Amended May 2009):

- To advance the education of health professionals in the field of addiction medicine by developing and providing courses and conferences, conducting research and establishing clinical standards
- To educate the public about the assessment, treatment and prevention of addiction by collecting, and disseminating information on that topic.

Membership

FULL Membership is open to applicants who hold a Medical Degree or to PhD scientists with demonstrable commitment to the objectives of the Society. Membership is also available to medical students, interns, and residents and retirees.

ASSOCIATE Membership is open to those persons with a demonstrable commitment to the objectives of the Corporation and the goals of the Society. Applicants for admission as Associate members will have received the sponsorship of an active Full Member of CSAM. Associate members will have all the rights and privileges of membership except the rights to elect and/or become a Board Member and to vote at meetings of members.

HONORARY Membership is an honor bestowed on members of the Society who have demonstrated distinguished service to the Society and the field of Addiction Medicine. Honorary Members include:

Honorary Members

1989  Dr. Gordon Bell of Toronto, ON
1996  Dr. Joseph MacMillan of Toronto, ON
1997  Dr. Sheldon Cameron of Summerside, PEI
      Dr. Anna-Mary Burditt of Moncton, NB (formerly of Halifax, NS)
1999  Dr. Maurice Dongier of Montreal, QC
2001  Dr. Jim Rankin of Toronto, ON
2004  Dr. Nady Guebaly of Calgary, AB
2005  Dr. Graeme Cunningham of Guelph, ON
2006  Dr. Raju Hajela of Kingston, ON
2008  Dr. Bhushan Kapur of Oakville, ON

Governance

The Board of Directors, elected by the membership within each province and territory, governs the Society and its mandate is carried out with the support of several committees. The President of the Society is elected from the Board of Directors and the usual term of office is for a period of two years.

Presidents’ History

1989 – 1991 Dr. Jim Rankin of Toronto, ON
1991 – 1993 Dr. Juan Negrete of Montreal, QC
1993 – 1995 Dr. Bill Jacyk of Winnipeg, MB
1995 – 1997 Dr. Nady Guebaly of Calgary, AB
1997 – 2000 Dr. Raju Hajela of Kingston, ON
2000 – 2002 Dr. Bill Campbell of Calgary, AB
2002 – 2004 Dr. Peter Mezciems of Guelph, ON
2004 – 2006 Dr. David Marsh of Vancouver, BC
2006 – 2008 Dr. Frank Evans of Toronto, ON
2008 – 2010 Dr. Don Ling of Charlottetown, PEI

Annual Scientific Meetings

Annual Scientific Meetings are held every year – usually in mid-October for the purpose of:

- Exchange of ideas – scientific advances, clinical practice
- Networking
- Invite guest to highlight progress in the field
- Awards


1989  Calgary, AB
1990  Montreal, QC
1991  Toronto, ON
1992  Vancouver, BC
1993  Winnipeg, MB
1994  Ottawa, ON
1995  Banff, AB
1996  Toronto, ON
1997  Halifax, NS
1998  Victoria, BC
1999  Victoria, BC
2001  Victoria, BC
2002  Montreal, QC jointly with the World Forum – Drug Dependencies Impacts & Responses
2003  Halifax, NS
2004  Toronto, ON
2005  Vancouver, BC
2006  Saskatoon, SK
2007  Ottawa, ON
2008  Vancouver, BC
The Canadian Journal of Addiction Medicine is the official publication of the Canadian Society of Addiction Medicine. It is a new publication whose goal is to provide a unique Canadian forum for presentation of evidence-based, peer-reviewed clinical information and scientific materials, to clinicians working in the field of Addiction Medicine.

The “Bulletin” section within the CJAM, will contain the traditional sections and materials contained in past issues of the “CSAM Bulletin”.

Members are encouraged to submit articles of interest for review.

Conference Planning Committee

The Planning Committee of CSAM represents a working group of whose focus is to review organize all aspects of the Annual Scientific Meeting, including conference theme, venue, content and presenters.

Constitutional By-Law Committee

The By-Law Committee periodically reviews and recommends updates and changes to the Society By-laws for vote by the Membership.

Education Committee

The Education Committee aims to develop and promote addiction-related education and training. It had significant input into Project CREATE (Curriculum Renewal and Evaluation of Addiction Training and Education) in all five Ontario Medical School’s undergraduate medical education (1994-2000). This program has evolved into CREATE (Community Readiness and Effectiveness in Addiction Treatment Endeavors) Canada. The Committee has also developed and presented the Fundamentals of Addictions Medicine course initially as a half day in 1997-1999. Since 2000 it has become a full day endeavor at the Annual Scientific meetings. Future developments being explored include: input into CME in wider venues, development of more courses and dissemination of CME and public education through electronic media.

Finance Committee

The Finance Committee assists the Treasurer to review financial matters, who then reports to the Board of Directors at every meeting.

Membership Committee

The Membership committee has been convened on behalf of the CSAM board and membership to address issues of concern to the society and its membership with respect to membership in the society.

The purpose of the Membership Committee is to maintain and increase membership in the society. This will be accomplished through:

- Establishing and updating criteria for membership in the society.
- Issuing of membership certificates.
- Establishing campaigns to maintain and increase membership in the society.

Opioid Agonist Committee

The Opioid Agonist committee has been convened on behalf of the CSAM board and membership to address issues of concern to the society and its membership with respect to opioid agonist therapy.

The purpose of the Opioid Agonist Committee is to advocate the ongoing development of “Best Practices” in Opioid Agonist Therapy (OAT) and to advocate and support training for and delivery of such programs. This will be accomplished through:

- Establishing minimum criteria for training and education for physicians in Opioid Agonist Therapy. This would not include the delivery of such training.
- Evaluating and reviewing, as requested, training for physicians in OAT, to ensure they meet set minimum criteria.
- Producing a Public Policy Statement re OAT, and ensuring said statement remains current.
- Engaging in two way communication with CSAM board and membership to ensure all involved are aware of changing issues in the field of OAT.

Standards Committee

The Standards Committee of CSAM consists of four senior members who are longstanding Certificants of CSAM as well as recognized Fellows of the American Society of Addiction Medicine (ASAM). The mandate has been to develop standards of clinical practice for physicians-in-training and those practicing Addiction Medicine.

Considerable effort in the last four years has been devoted to
developing and implementing the Certification process for Canadian physicians who may or may not hold a Certification from ASAM. As our numbers remain small, the idea of developing a Canadian examination has not been viable. Liaison with ASAM continues to be essential in their acceptance of our evaluation process to allow Canadian physicians who have been successful through our process to write the ASAM certification examination.

Future directions for this committee include efforts for Certification and Definitions; Writing policy position papers for CSAM and any other priorities identified by the Board that would promote the development of standards of practice for physicians in the area of Addiction Medicine.

**Certification in Addiction Medicine**

The Board of CSAM began awarding the status of Certificant of the Canadian Society of Addiction Medicine (CCSAM) in 2000. It was decided to accept the Certification by the American Society of Addiction Medicine (ASAM) or International Society of Addiction Medicine (ISAM) Certification as foundation criteria, together with two letters of reference and a letter of good standing from the appropriate licensing authority as essential criteria for our approval process.

To Jan 2010, overall 52 physicians have been awarded the status of CCSAM.

**Certification Process**

Graduation from a Medical School approved by the Committee of Accreditation of Canadian Medical Schools and the Liaison Committee of Medical Education of the United States; and/or hold a license in good standing with a provincial or territorial licensing authority; and continuing involvement in the addiction field at least 50% of practice time.

AND Either Part “A” or Part “B”

**Part “A” - Training**

Holds a certificate from one of the following:

1. Professional Corporation of Physicians of Quebec
2. Royal College of Physicians and Surgeons of Canada

Evidence of successful completion of one year full time involvement, or 50% over two years in the field of Addiction Medicine agrees to sit the American Society of Addiction Medicine (ASAM) or the International Society of Addiction Medicine (ISAM) exam.

**Part “B” - Practice Eligible**

- Membership in the College of Family Physicians of Canada or Royal College of Physicians and Surgeons of Canada in the two years preceding application.
- Membership in the Canadian Society of Addiction Medicine for two years preceding application.
- Successful completion of practice review of clinical addiction practice conducted by an Ad Hoc Practice review team of the Canadian Society of Addiction Medicine
- Agrees to sit the ASAM or ISAM exam within two years of the practice review.
- Has attended the Canadian Society of Addiction Medicine Annual Meeting or equivalent for two years prior to certification.
- Show evidence of annual completion of 50 hours of Main-Pro credits for family physicians and/or approval of diary entry in the maintenance of competence programme (MOCOMP) of the Royal College of Physicians and Surgeons of Canada obtained in the two years prior to presentation for credentialing.
- Physicians currently certified by ASAM or ISAM will get automatic reciprocity for certification by CSAM.

**Website Committee**

The Website Committee of CSAM represents a working group of whose focus is to review and update the current website of CSAM.

**How To Reach Us**

**Marilyn Dorozio**, CSAM Office
47 Tuscany Ridge Terrace NW, Calgary AB T3L3A5
Phone: (403) 813-7217   Fax: (403) 944-2056
Email: admin@csam.org
**CSAM MEMBERSHIP FORM**

**Membership Type**
- Regular Member – MD
- Regular Member – PhD Scientists
- Medical Student/Intern/Resident
- Retirees – MD or PhD
- Associate Member

**Contact Information**
- Dr.
- Ms.
- Mrs.
- Miss
- Mr.

**Name:**
(First Name) (Middle Initial) (Last Name)

**Work Address**
- Preferred Mailing Address

**Address:**
City: Province: Postal Code:

**Work Phone:**
Fax:

**Home Address**
- Preferred Mailing Address

**Address:**
City: Province: Postal Code:

**Home Phone:**

**Email Contact**

**Positions in the Society You Would Be Willing To Consider in the Future**
- Board Member (Please note: Associate members are not eligible for board positions)
- Committee Membership
  - Standards
  - Website
  - Opioid Agonist
  - Education
  - Membership
  - Conference

**I will allow my name & contact information to be in a password-protected Member's Section directory on the CSAM webpages?**
(Member – MD only)
- Yes
- No

**Signature:**

**Payment Information**

**Annual Fees:**
- Regular Member – M.D.: $200.00
- Regular Member – PhD: $200.00
- Student/Intern/Resident: $5.00
- Retirees MD or PhD: $25.00
- Associate Member: $50.00
- Optional: International Society of Addiction Medicine (ISAM) Dues – (US $100.00 effective Jun 2010) $105.00

**PLEASE process payment for:**
- one year
- 3-year membership $549.00
- 5-year membership $900.00

**TOTAL PAYMENT:** __________________

- Cheque, Bank Draft or Money Order Payable to: The Canadian Society of Addiction Medicine
- VISA/MC/AMEX (circle one) # Expiry Date:

**Name on Card:**

**Signature:**

Please forward your application form with cheque or credit card information to:
CSAM Head Office: Attention Marilyn Dorozio, 47 Tuscany Ridge terrace NW, Calgary AB T3L 3A5
Phone 403-813-7217 · Fax 403-944-2056 · Email: admin@csam.org
Preliminary Information

Theme
The theme “Basics and Beyond” draws inspiration from the longstanding vision of the Canadian Society of Addiction Medicine to advance the field through providing education of both fundamental and advanced concepts essential to working with Addictions.

Reflecting our new vision, the 2010 Scientific Conference expands to all aspects of the field, e.g. food, drugs, sex, alcohol, internet, tobacco, gambling, in two threads - Basics (fundamental topics) and Beyond (more complex topics). Abstracts should focus on one or other thread.

The conference is designed to provide opportunities for shared experiences, literature review and knowledge transfer in order to improve the quality of health care for people affected by addictions.

General Information

Venue: Delta Prince Edward
18 Queen Street, Charlottetown, PEI
Phone: 1-866-894-1203    Fax: 902-566-1745
http://www.deltaprinceedward.com/gd0906

Conference Language: English / French language session

Abstract, Poster & Symposium Submission
Deadline: June 30, 2010
Form can be downloaded from www.csam.org/conference

President’s Banquet

The Annual President’s Banquet will be held on Friday, October 22, 2010. Cost is $100/person
About CSAM

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Vision Goals:
To advance the education of health professionals in the field of addiction medicine by developing and providing courses and conferences, conducting research and establishing clinical standards. To educate the public about the assessment, treatment and prevention of addiction by collecting, and disseminating information on that topic. The Board of Directors, elected by the membership within each province and territory, governs the Society and its mandate is carried out with the support of several committees.

Registration

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Fundamentals Course

The CSAM Fundamentals Course will be offered Saturday, October 23rd.
Registration: $300/person  (Students: $75)
CSAM BOARD OF DIRECTORS

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Dr. Don Ling

Past President
Dr. Frank Evans

Secretary/Treasurer
Dr. Ron Lim

BC Regional Director
Dr. Paul Sobey

AB Regional Director
Dr. Samuel Oluwadairo

SK Regional Director
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Member at Large
Dr. Michael Varenbut

Member at Large
Dr. Nady el-Guebaly

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[Image of OATC logo]

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Bronze Sponsors:

[Image of Valeant logo]