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Message from the Editor:

Dear CSAM members and Journal readers,

It is my pleasure to bring to you the third issue of the “Canadian Journal of Addiction Medicine”, the “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 new members to our Editorial Review Board, whose names are listed below. Many new members have been already involved with the peer review process, and we are grateful for their time and contribution.

We have also taken the next steps towards inclusion in MEDLINE, and will update you all with further developments.

In this third issue of the CJAM, you will find a complete set of abstracts from the recent CSAM Annual scientific conference which took place in PEI in October. You will also find additional 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, if you would like to take part in this exciting and professionally rewarding opportunity.

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.

Please note that it is the responsibility of the author to proof read their manuscripts / submission materials to ensure accuracy, formatting, spelling, etc. The final copy of the materials submitted by each author will be used in print.

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
Preferential integration of alcohol and sucrose intake by CRF1 and CRF2 receptors.

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Abstract

Accumulated evidence suggests that alcohol may concurrently invade the brain neuronal network designated historically for seeking and consuming high-energy palatable sweet food. This concurrent invasion results in a decrease in sugar intake during heavy alcohol consumption. Conversely, sweets are craved more during early stages of recovery from alcohol addiction, suggesting that palatable food may to a certain degree substitute for alcohol use and satisfy cravings. An overlapping in the neuronal mechanisms regulating alcohol and sucrose intake was suggested by preclinical and clinical experiments showing that consumption of food and alcohol is affected by the brain corticotropin releasing factor (CRF) system. The neuronal effects of CRF and CRF-related peptides, urocortins, are mediated by the CRF type 1 (CRF1) and type 2 (CRF2) receptors. The experiments involving selective ligands for CRF1 and CRF2 receptors revealed that excessive intake of alcohol or palatable food can be prevented by the blockade of the CRF1 receptor and activation of the CRF2 receptor. This apparent mirroring of the effects of CRF1 antagonists and CRF2 agonists can be explained by the involvement of CRF1 and CRF2 receptors in the different neuronal circuitries. CRF1 receptors are expressed in the stress-related network, and the blockade of the CRF1 receptor is effective in preventing stress-induced relapse to binge eating and alcohol intake. CRF2 receptors are highly expressed in the lateral septum (LS), a particular brain region involved in the modulation of motivated behavior. In the LS, the selective agonists of the CRF2 receptor can effectively decrease the intake of food and alcohol at the basal non-stressed conditions in non-addicted animals. Conversely, sucrose-overeating and alcohol-prefering animal models show decreased CRF2 receptor expression or low density of urocortin neuronal fibers in the LS. Therefore, CRF1 antagonists may have therapeutic value for treating anxiety experienced during acute ethanol withdrawal and stress-induced relapse in ethanol-dependent individuals. Similarly, CRF1 antagonists may be effective in preventing stress-induced binge eating. Selective CRF2 agonists may probably be used for preventive therapy, though the CRF2-related neuronal mechanisms require a better understanding at the fundamental level. Moreover, development of specific compounds affecting CRF receptors might be done with careful consideration of a wide spectrum of the central effects of CRF. This review discusses a role of the brain CRF system in alcohol and sugar intake.

Evidence accumulated over the last few decades suggests that alcohol may take over and invade the brain’s natural reward system designated historically for seeking and consuming of high-energy palatable sweet food, which assured the survival of an individual in a hostile environment. Ethanol is a relatively small molecule that easily penetrates various biological membranes, including the blood brain barrier, and affects multiple neuronal mechanisms, including the opioid system and the hypothalamic pituitary adrenal (HPA) axis [1, 2]. An acute intake of alcohol increases beta-endorphin release at the level of the dopaminergic neurons in the ventral tegmental area (VTA) [3, 4]. The VTA is a part of the mesolimbic system, which includes also the nucleus accumbens and the prefrontal cortex (Fig. 1). The mesolimbic system is responsible for generating pleasurable effects for natural reward, the property that may be abused by addictive drugs. Similar to alcohol, sucrose intake also significantly increases the beta-endorphin contents in the mesolimbic system [5], while opioid antagonists produce behavioral and neurochemical signs of opioid withdrawal in the model of sucrose-bingeing rats [6]. The data obtained in clinical research showed that obese and binge-eating participants had increased production of beta-endorphin [7].

Clinical studies have shown that patients with alcohol dependence may have an enhanced preference for highly sweet tastants [8]. Sweats are craved more during early stages of recovery from alcohol addiction, suggesting that palatable food may to a certain degree substitute for alcohol use and satisfy cravings [9, 10]. In contrast to the increased intake of sweets during the early stage of alcohol abstinence, high alcohol consumption actually decreases intake of sugar [11], which has led to a hypothesis that alcohol may concurrently invade the sucrose-related brain network. Some animal models show that greater ethanol intake is positively correlated with the hedonic attractiveness of sweet taste by these animals [12-14].

Genetic vulnerability for alcoholism and sweet preference has been revealed in studies of family history, twin and adoption
cases, as well as in animal models. Compared to alcohol-avoiding animals, alcohol-prefering animals (i.e., mice, rats, and monkeys) consume large amounts of sweet solutions, prefer more concentrated sweet solutions, and have impaired control over the consumption of sweets (for review, see [15], [16]). Human studies have shown that higher consumption of sweets during the early phase of alcohol abstinence was observed in patients with a positive family history of alcohol dependence [17]. In addition, higher sucrose concentrations were rated as more palatable by subjects with a paternal history of alcoholism [18, 19]. However, an increased preference for sweets by itself is not a marker of propensity for alcoholism [20], whereas chronic alcohol consumption may affect the intake of sweets. These non-congruent effects of sweets and alcohol may be explained by stronger pressure exerted by alcohol on the brain reward circuitry compared to the natural rewards such as palatable food. At the end, chronic alcohol consumption may alter the brain reward system that needs more sweetness to release dopamine to levels high enough to compensate for the anhedonia in control subjects.

Studies addressing neuronal mechanisms of relapse to binge eating and drug seeking provide evidence that the mechanisms underlying hunger-independent craving for food and reinstatement of drug seeking partially overlap [21]. Physical or psychological stress is a major factor for reinstatement of alcohol intake after prolonged withdrawal [22, 23], and for triggering episodes of binging on palatable food in patients suffering from or having a history of binge eating disorder [24, 25]. In animal models, the attenuation of anorectic stress effects or even reversal of stress-induced anorexia and the development of stress-induced binge eating have been demonstrated in animals with a history of intermittent eating of palatable food combined with food restriction (analogous to sensitization and withdrawal) [26-28].

The physiological and psychological effects of stress result in changes in emotional functions, modulation of autonomic activity, and the activation of the HPA axis. The neuropeptide corticotropin releasing factor (CRF) is in the core of the emotional, autonomic, and HPA axis responses to stress. The hyperproduction and hyperactivity of CRF in the limbic system, including the amygdala and the bed nucleus of the stria terminalis (BST), have been linked to an increase in anxiety [29-34]. An increase in the expression of CRF in the parvocellular part of the paraventricular hypothalamic nucleus (PVNp; Fig. 2, A, B) results in stimulation of the HPA axis. The neurons of the dorsomedial subdivision of the PVNp secrete CRF into the pituitary portal system (Fig. 3). In the anterior pituitary, CRF stimulates the release into the bloodstream of adrenocorticotropic hormone (ACTH), which regulates the secretion of glucocorticoids, cortisol in humans and corticosterone in rats, from the adrenal cortex [33-37]. The CRF neurons of the dorsal cap and ventral subdivision of the PVNp (Fig. 3) project directly to the preganglionic neurons in the brain stem and intermediolateral cell column of the spinal cord [38-40]. This descending pathway to the pre ganglionic sympathetic and parasympathetic neurons endorses autonomic stress-related CRF effects [41, 42]. The activation of the CRF PVNp neurons during stress is supported by limbic regions. The BST neurons act as a relay between the central nucleus of amygdala (CeA) and the PVNp [43], thereby helping to synchronize emotional, hormonal and autonomic responses to stress (Fig. 3). In addition, the CRF-producing neurons of the BST, CeA and PVNp directly project toward the VTA dopaminergic neurons [44], where CRF is released in response to acute stress and plays a role in stress-induced activation of appetitive behavior [45]. Thus, the neuronal stress-related network can activate the mesolimbic reward system and promote the intake of palatable
food or alcohol. Conversely, high doses of alcohol stimulate the activity of the HPA axis [2, 46]. Interestingly, in contrast to the HPA axis-stimulating effects of high doses of ethanol, moderate doses of ethanol did not alter the basal ACTH and cortisol levels, and decreased the responses of ACTH and cortisol to CRF administration in healthy nonalcoholic subjects [47, 48]. Similarly, sucrose supplement in rats significantly blunted activation of the HPA axis, including CRF mRNA expression in the PVNp, and ACTH and corticosterone plasma levels, in response to acute or chronic stress [28, 49, 50].

The effects of CRF are mediated in the brain by the CRF type 1 (CRF1) and type 2 (CRF2) receptors. The basolateral amygdala and the BST constitutively express CRF1. The PVNp has very low levels of CRF1 at the basal, non-stressed conditions, but the expression of CRF1 in this structure is strongly induced by stress [51, 52] (Fig. 4). The expression of the CRF1 but not the CRF2 receptor in the stress-related amygdala-BST-PVNp network explains the numerous data showing that blockade of CRF1 with specific CRF1 antagonists or CRF1 knockout attenuates stress-induced reinstatement of ethanol-seeking behavior in animal models with a history of prolonged ethanol exposure and in ethanol-dependent rats [53-59].

In contrast to effective suppression of stress-induced relapse to alcohol consumption in ethanol-dependent animal models, specific CRF1 antagonists do not modulate moderate levels of ethanol consumption in non-dependent animals. For example, central administration of non-selective CRF receptor antagonists does not significantly alter ethanol consumption or self-administration in non-dependent rats or mice with a history of ethanol exposure akin to social drinking in humans [60-62]. Similar results have been obtained using peripheral administration of specific CRF1 antagonists [57, 58]. Another experiment has shown that treatment with specific CRF1 antagonists was effective in the attenuation of heavy, binge-like alcohol drinking (with achieved blood alcohol levels of greater than 80 mg/dL), but was non-effective in preventing moderate alcohol intake (raised blood alcohol levels to 40 mg/dL) in mice [63]. Furthermore, central administration of CRF can actually reduce ethanol consumption by non-ethanol-dependent rats [64, 65], while homozygous CRF knock-out mice show enhanced alcohol drinking in the two-bottle choice test [66]. Likewise, central administration of CRF produces an anorectic effect and decreases sucrose intake [65, 67-70]. Interestingly, the anorectic effect of centrally administered CRF was prevented by the selective CRF2 antagonist but not by selective CRF1 antagonist pretreatment [70]. Similarly, the effective doses of intracerebroventricular application of specific CRF2 agonist urocortin 3 for suppression of ethanol consumption in binge-like ethanol drinking mice were 10 times lower than those of non-specific CRF receptor agonist alpha-helical CRF [71].

In the brain, the CRF2 receptor is highly expressed in the lateral septum (LS), ventromedial hypothalamus, and to a lesser extent in the arcuate nucleus and dorso-medial hypothalamus [72, 73]. So far, in mammals, four structurally related peptides [CRF, and urocortin 1, 2 and 3 (Ucn1, Ucn2 and Ucn3, respectively)] have been identified as the CRF1 and CRF2 receptor ligands. Pharmacological studies have shown different profiles of affinity for the ligands of the CRF1 and CRF2 receptors. CRF has a relatively lower affinity for CRF2 compared to its affinity for
CRF1 [74], whereas urocortin 1 has equal affinity for both receptors, and urocortin 2 and urocortin 3 are highly selective for CRF2 [74-76]. Therefore, Ucn1 is a more specific ligand compared to CRF, and Ucn2 and Ucn3 are selective ligands for the CRF2 receptor. Central expression of Ucn1 is predominantly confined to the brainstem perioloculomotor Edinger-Westphal nucleus (EW) [74, 77]. Interestingly, the neurons of the EW are activated after the intake of sucrose or alcohol by alcohol-prefering mice [78]. The expression of Ucn2 and Ucn3 was detected in discrete regions of the hypothalamus, the amygdala and the brainstem. The expression of Ucn2 neurons in the PVNp, and Ucn3 neurons in the neurons surrounding and projecting to the PVNp was related to the modulation of stress responses [75, 76, 79]. It has been demonstrated that Ucn1 and Ucn3 neurons directly project to the medial portion of the lateral septum [79, 80] that coincides with the septal region displaying the greatest density of CRF2 receptors. The density of the urocortin fibers in the LS may vary in different animal models. Thus, the alcohol-prefering mice showed a lower number of urocortin fibers in the LS compared to alcohol-avoiding mice [78]. The lower density of urocortin fibers in the LS in the alcohol-prefering mice coincided with lower neuronal activation of the LS in response to alcohol consumption in these animals [78]. The stress-induced activation of the LS was also significantly lower in sucrose-overeating rats compared to control animals [28].

Direct administration of Ucn1 at low doses into the LS significantly decreased alcohol but not water consumption [81], suggesting that the activation of CRF2 in the LS specifically targets alcohol intake. Moreover, a history of repeated (once a day during three consecutive days) Ucn1 microinjections into the LS also decreased ethanol intake on the day following discontinuation of Ucn1 administration suggesting a long-lasting effect of Ucn1 on alcohol intake. CRF microinjections in the LS also decreased alcohol consumption in mice, but at doses 10 times higher compared to Ucn1 (at 60 pmol), which were non-alcohol-specific, but also affected water intake [81]. Importantly, the alcohol intake-decreasing doses of Ucn1 and CRF were 40 (6 vs 240 pmol) and 2 (60 vs 100 pmol) times, respectively, lower than the doses of Ucn1 and CRF that induced anxiety-related responses when injected into the lateral septum [81-83]. Therefore, these results suggest that specific CRF2 receptor agonists manifest anti-alcoholic effects in the LS at lower doses with a lower risk of generation of anxiety compared to non-specific CRF receptor agonists. Direct microinjection of Ucn1 (at doses as low as 3-30 pmol) into the lateral septum also suppressed food consumption in rats, and this suppressive effect was longer lasting than that of equimolar CRF [84]. The significant decrease in the expression of CRF2 in the LS of sucrose-overeating rats (Fig. 5, A) [28] and the low density of the Ucn1-positive fibers in the alcohol-prefering mouse [78] may contribute to attenuation of inhibitory control normally exerted by CRF2-related signaling in the LS on alcohol or sucrose consumption.

Neuronal activation, revealed by induction of expression of Fos protein in the LS after alcohol intake seems to be specific for voluntary consumption while passive administration of alcohol using intraperitoneal injections failed to show neuronal activation in the LS [78, 85]. This is supported by 2-deoxyglucose brain mapping procedures in which oral self-administration produced ethanol-specific changes in the LS, whereas passive administration did not [86, 87]. This neuronal response of the LS during voluntary consumption of alcohol is consistent with a role that the LS plays in the modulation of processes related to mood and motivation. Indeed, numerous data accumulated in recent years suggest that the LS integrates sensory stimuli and, according to their relevance and valence, modulates the activity of the brain regions responsible for the direct driving of motivated behavior (such as hypothalamic regions or mesolimbic dopaminergic system) (for a review, see [88]). It is worth noting that the activity of the LS neurons is affected not only by food and alcohol, but also by many drugs of abuse, including cocaine, amphetamine, morphine, tetrahydrocannabinol (THC), methylenedioxymethamphetamine (MDMA), and phencyclidine (PCP) [89-97], and the receptor targets for virtually all of these compounds are expressed within the LS [98-103]. The rats and mice can be trained to self-administer morphine to the LS, suggesting that the direct activity of morphine on LS neurons is positively rewarding [104, 105].

The expression of different types of receptors for stress-related hormones and drugs of abuse in the LS provides a molecular basis for integration of different signals at the level of the LS. These integrated signals are further relayed to the key regions immediately involved in regulation of motivated behavior such
as the hypothalamic centers and the VTA (Fig. 5, B) [106, 107]. Indeed, the electrical stimulation of the LS largely activates the neurons in the hypothalamus and regulates the firing rate of VTA neurons [108, 109]. Whether the same LS CRF2-producing neurons can integrate the plural sensory modalities, or the integration of relevant signals is achieved through the internal neuronal network within the LS, remains to be clarified.

Conclusions

Preclinical and clinical data accumulated in recent years suggest that CRF1 antagonists and CRF2 agonists are promising targets for preventing excessive intake of palatable food and alcohol. This apparent mirroring of the effects of CRF1 antagonists and CRF2 agonists, however, is predisposed by the different alcoholic/sucrose states (i.e., dependent vs. non-dependent, heavy intake vs. moderate intake) and particular psychological and physiological conditions (i.e., stress-induced bingeing episodes vs. social drinking and tasting). The CRF1 antagonists may have therapeutic value for treating anxiety experienced during acute ethanol withdrawal and stress-induced relapse in ethanol-dependent individuals. Similarly, CRF1 antagonists may be effective in preventing stress-induced binge eating. CRF2 is a newly emerged therapeutical target. Selective CRF2 agonists may probably be used for preventive therapy, though the CRF2-related neuronal mechanisms require a better understanding at the fundamental level. Furthermore, the allostatic neuroadaptations in CRF receptors signaling during development of binge eating and drinking require additional characterization. Development of specific compounds affecting CRF receptors might be done with careful consideration of a wide spectrum of the central effects of CRF producing behavioral, hormonal, and autonomic responses.

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Legends for figures.

Figure 1. The components of the mesolimbic system primarily involved in generation of natural rewards: the ventral tegmental area (VTA), nucleus accumbens and the prefrontal cortex. The major neurotransmitters of the projecting neurons in the mesolimbic system: dopamine (in the VTA), glutamate (in the prefrontal cortex), and gamma-aminobutyric acid (GABA; in the accumbens).

Figure 2. A, Stress-induced activation of the paraventricular part of the paraventricular hypothalamic nucleus (PVNp), amygdala (the central nucleus of amygdala; CeA, and the basolateral nucleus of amygdala: BLA), the bed nucleus of the stria terminals (BST), and the lateral septum (LS). The black staining reveals the positive hybridization signal for c-fos mRNA, the molecular marker of neuronal activation, in the rat brain in control, non-stressed conditions (left panels) or after 1 hour of treadmill running stress (right panels). B, The CRF neurons in the PVNp (revealed by detection of CRF mRNA, black silver grains) express Fos protein immunoreactivity (Fos-ir; brown staining) in stressed (right photomicrographs; some double-labeled cells are indicated by arrow heads) but not in non-stressed (left photomicrographs) rats (modified from [51]).

Figure 3. Neuronal network regulating response to stress and triggering stress-induced relapse. The neurons of the dorsomedial (dm) subdivision of the paraventricular part of the paraventricular hypothalamic nucleus (PVNp) release the corticotropin-releasing factor (CRF) to the median eminence and pituitary and regulate the activity of the hypothalamic pituitary adrenal (HPA) axis. The dorsal cap (dc) and the ventral subdivision (v) of the PVNp directly project to the preganglionic autonomic neurons in the brain stem and the spinal cord. The bed nucleus of the stria terminals (BST) relays the signals from the amygdala to the PVNp and thereby synchronizes emotional, hormonal, and autonomic responses to stress. Note, that the BST, amygdala and PVNp express CRF and the CRF type 1 (CRF1) but not the type 2 (CRF2) receptor. This explains that the stress-induced relapse to alcohol intake can be effectively inhibited by the blockade of CRF1 by specific antagonists. PVNm – vasopressin and oxytocin-expressing magnocellular part of the PVN. Microphotograph depicts the PVN stained with thionine.

Figure 4. Induction of the expression of corticotropin releasing factor type 1 receptor (CRF1) in the paraventricular part of the paraventricular hypothalamic nucleus (PVNp) in the rat after stress (1-hour treadmill running; bottom photomicrograph). Note the absence of a positive signal for CRF1 mRNA in the PVNp in control, non-stressed rats (top photomicrograph) (modified from [51]).

Figure 5. A, The levels of expression of corticotropin releasing factor type 2 receptor (CRF2) transcript is decreased in the lateral septum (LS) of sucrose-overeating rat (right microphotograph; high sucrose-licking activity and sucrose binge-like intake was developed during 6 weeks of intermittent access to sucrose combined with food restriction. For details on treatment, see [28]) compared to the control rat (left microphotograph) (modified from [28]). B, Putative network regulating basal (involving the urocortin-CRF2-related hypothalamus-EW-LS system) and stress-induced (involving the CRF-CRF1-related hypothalamus-BST-amygdala system) intake of alcohol and sucrose. Note that CRF2- and CRF1-related signaling can oppositely affect alcohol and sucrose intake. BST – bed nucleus of the stria terminalis. CRF1 - corticotropin releasing factor type 1 receptor. EW - Edinger-Westphal nucleus. Ucn1, 2, and 3 – urocortin 1, 2, and 3, respectively. VTA – ventral tegmental area.
THE VIENNA DECLARATION

The criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences. A full policy reorientation is needed.

In response to the health and social harms of illegal drugs, a large international drug prohibition regime has been developed under the umbrella of the United Nations. Decades of research provide a comprehensive assessment of the impacts of the global “War on Drugs” and, as thousands of individuals gather in Vienna at the XVIII International AIDS Conference, the international scientific community calls for an acknowledgement of the limits and harms of drug prohibition, and for drug policy reform to remove barriers to effective HIV prevention, treatment and care.

The evidence that law enforcement has failed to prevent the availability of illegal drugs, in communities where there is demand, is now unambiguous. Over the last several decades, national and international drug surveillance systems have demonstrated a general pattern of falling drug prices and increasing drug purity—despite massive investments in drug law enforcement.

Furthermore, there is no evidence that increasing the ferocity of law enforcement meaningfully reduces the prevalence of drug use. The data also clearly demonstrate that the number of countries in which people inject illegal drugs is growing, with women and children becoming increasingly affected. Outside of sub-Saharan Africa, injection drug use accounts for approximately one in three new cases of HIV. In some areas where HIV is spreading most rapidly, such as Eastern Europe and Central Asia, HIV prevalence can be as high as 70% among people who inject drugs, and in some areas more than 80% of all HIV cases are among this group.

In the context of overwhelming evidence that drug law enforcement has failed to achieve its stated objectives, it is important that its harmful consequences be acknowledged and addressed. These consequences include but are not limited to:

- HIV epidemics fuelled by the criminalisation of people who use illicit drugs and by prohibitions on the provision of sterile needles and opioid substitution treatment.
- HIV outbreaks among incarcerated and institutionalised drug users as a result of punitive laws and policies and a lack of HIV prevention services in these settings.
- The undermining of public health systems when law enforcement drives drug users away from prevention and care services and into environments where the risk of infectious disease transmission (e.g., HIV, hepatitis C & B, and tuberculosis) and other harms is increased.

- A crisis in criminal justice systems as a result of record incarceration rates in a number of nations. This has negatively affected the social functioning of entire communities. While racial disparities in incarceration rates for drug offences are evident in countries all over the world, the impact has been particularly severe in the US, where approximately one in nine African-American males in the age group 20 to 34 is incarcerated on any given day, primarily as a result of drug law enforcement.
- Stigma towards people who use illicit drugs, which reinforces the political popularity of criminalising drug users and undermines HIV prevention and other health promotion efforts.
- Severe human rights violations, including torture, forced labour, inhuman and degrading treatment, and execution of drug offenders in a number of countries.
- A massive illicit market worth an estimated annual value of US$320 billion. These profits remain entirely outside the control of government. They fuel crime, violence and corruption in countless urban communities and have destabilised entire countries, such as Colombia, Mexico and Afghanistan.
- Billions of tax dollars wasted on a “War on Drugs” approach to drug control that does not achieve its stated objectives and, instead, directly or indirectly contributes to the above harms.

Unfortunately, evidence of the failure of drug prohibition to achieve its stated goals, as well as the severe negative consequences of these policies, is often denied by those with vested interests in maintaining the status quo. This has created confusion among the public and has cost countless lives. Governments and international organisations have ethical and legal obligations to respond to this crisis and must seek to enact alternative evidence-based strategies that can effectively reduce the harms of drugs without creating harms of their own.

We, the undersigned, call on governments and international organisations, including the United Nations, to:

- Undertake a transparent review of the effectiveness of current drug policies.
- Implement and evaluate a science-based public health approach to address the individual and community harms stemming from illicit drug use.
- Decriminalise drug users, scale up evidence-based drug dependence treatment options and abolish ineffective compulsory drug treatment centres that violate the Universal Declaration of Human Rights.
- Unequivocally endorse and scale up funding for the implementation of the comprehensive package of HIV interventions spelled out in the WHO, UNODC and UNAIDS Target Setting Guide.
- Meaningfully involve the affected community in developing,
monitoring and implementing services and policies that affect their lives.

We further call upon the UN Secretary-General, Ban Ki-moon, to urgently implement measures to ensure that the United Nations system—including the International Narcotics Control Board—speaks with one voice to support the decriminalisation of drug users and the implementation of evidence-based approaches to drug control.28

Basing drug policies on scientific evidence will not eliminate drug use or the problems stemming from drug injecting. However, reorienting drug policies towards evidence-based approaches that respect, protect and fulfil human rights has the potential to reduce harms deriving from current policies and would allow for the redirection of the vast financial resources towards where they are needed most: implementing and evaluating evidence-based prevention, regulatory, treatment and harm reduction interventions.

REFERENCES

Scientists, MDs critical in fight for evidence-based drug policy

Michaela Montaner, Dan Werb, Evan Wood

Decades of scientific research on the impacts of the “War on Drugs” has now been undertaken. As such, addiction specialists, among other scientists and healthcare professionals, are able to state with certainty that basing illicit drug policies on law enforcement has failed. In recognition of the need to move beyond this vast and unsuccessful social experiment, scientists and MDs recently launched the Vienna Declaration (Panel A), the official declaration of the recent XVIII International AIDS Conference held in Vienna, Austria in July 2010. The declaration seeks to improve community health and safety by calling for the incorporation of scientific evidence into illicit drug policies and calls on governments around the world to embrace evidence-based approaches to drug addiction.

As stated in the declaration, there is no scientific evidence that increasing the ferocity of law enforcement meaningfully reduces supply or demand for illicit drugs. In contrast, evidence clearly indicates that criminalizing drug users results in a range of negative public health and social outcomes. By criminalizing users, current drug policies serve to reinforce the intense stigma that drives these persons further from networks of care and support and towards unsafe practices such as needle-sharing, which is the cause of one third of all HIV infections outside of sub-Saharan Africa. They do so while demonstrating no clear positive impact on levels of drug use at the population level.

Sadly, in much of the world, tough-on-crime and “zero tolerance” approaches to drug policy neglect and undermine the effectiveness of evidence-based interventions. Specifically, the legal barriers entrenched in the current international drug control system result in hundreds of thousands of preventable injection-related infections as a result of a lack of access to needle exchange programmes and opioid substitution therapy (OST) among United Nations Member States. Furthermore, the criminalization of people who inject drugs has also resulted in record incarceration rates. These in turn produce a cycle of disease transmission, social inequity and destroyed livelihoods, not to mention a massive tax burden for citizens. This situation, coupled with chronic under-funding of addiction treatment and harm reduction interventions, engenders a dangerous status quo.

In response to these issues, leaders in the fields of academia, medicine, politics and law enforcement have endorsed the Vienna Declaration and called for their peers to do the same. Within weeks of launching the declaration, high-level government representatives in Spain, Georgia, and Mexico have publicly stated their support for the declaration’s call for evidence-based drug policy. Joining them are Nobel Laureates such as Dr. James Orbinski and Françoise Barré-Sinoussi; Dr. Michel Kazatchkine, executive director of The Global Fund to Fight AIDS, TB and Malaria; and Stephen Lewis, a Canadian leader in the fight to defeat HIV/AIDS and former UN special envoy for HIV/AIDS in Africa. This list also includes endorsements from five provincial chief medical health officers in Canada.

Regrettably, the Canadian government has yet to join the movement towards reform and has unequivocally stated its opposition to not only the specific contents of the Vienna Declaration but more broadly to harm reduction as well. Coupled with the Canadian government’s proposed introduction of mandatory minimum sentencing laws for drug crimes, in spite of the fact that these policies are being repealed in many US states, the effectiveness of Canada’s current domestic HIV/AIDS strategy is questionable.

The next International AIDS Conference will be held in Washington D.C. in 2012, the birthplace of the War on Drugs. Before that meeting, governments around the world will be asked to state a formal position regarding the declaration. It is our hope that policymakers will assess the large scientific evidence base on drug policy and choose to advocate for the health of drug users – rather than for the increased levels of HIV infections, imprisonment, and stigmatization that accompany prohibition-based policy approaches.

Georgia is one of several countries in Eastern Europe where injecting drug use is the primary cause of new HIV infections. According to recent United Nations estimates, approximately 60% of HIV infections were a result of injection drug use. During the AIDS 2010 conference, three Georgian political leaders joined the Declaration’s call for evidence-based drug policy, including Deputy Chairman of Parliament George Tsereteli, Minister of Labour, Health and Social Affairs Irakli Giorgobiani, and First Lady Sandra Roelofs.

The above offers hope that other countries – including Canada – will eventually follow suit and support evidence-based drug policies. It is clear, however, that public support, with leadership from the addiction medicine community, will be key to impel governments to address the shortcomings of their current “get tough” approaches and take steps towards policies based on science rather than ideology. As we build momentum towards AIDS 2012, we invite the Canadian addiction medicine community who have yet to endorse the Vienna Declaration to sign on at www.viennadeclaration.com. There is a desperate need for evidence-based approaches to address the illicit drug problem, and it is up to the scientific community to take leadership on this critical public health issue.

Please contact us directly at declaration@icsdp.org to learn more and get involved.
Today drug abuse is a major problem in the world with about 200 million people 12 years or old who use an illicit drug, with >19 million current substance abusers in the US alone. There are 40 million HIV-infected and about 200 million HCV-infected people in the world; about 1 million HIV-infected and 4 million HCV-infected people in the US. Although there are not many cases of TB among drug abusers in the US, almost one-third of the world’s population is infected with TB, with approximately one-half million people dying from TB in India alone. Substance abuse alone costs the American society an estimated $530+ billion annually. Both substance abuse and co-occurring infections (HIV, HCV, TB, STDs, and others) are associated with serious adverse medical/health consequences affecting almost every physiological system. NIDA supports about 85% of world’s research on substance abuse and infections. Currently we support basic, clinical, and translational research on substance abuse and infections in the domestic and international settings. Research programs include but not limited to the incidence and prevalence of HIV/AIDS, prevention and treatment of infections among IDUs, neuroAIDS, neuropsychiatric complications, cardiovascular, metabolic (including nutritional issues) and endocrine consequences of HIV/AIDS and drug abuse, drug-drug interactions between medications used in the treatment of addiction, infections and mental disorders. This presentation will discuss various medical consequences of substance abuse and infections, management strategies, recent findings from published and on-going research, and funding mechanisms available at NIDA/NIH.

REFERENCES:
Presentation Title: Medications Development for Drug Addiction Treatment: Successes, Failures, and Ongoing Efficacy Trials.

David J. McCann, Ph.D., Associate Director, Division of Pharmacotherapies and Medical Consequences of Drug Abuse, National Institute on Drug Abuse (NIDA), NIH, Bethesda, MD, USA.

In 1989, the U.S. Congress statutorily mandated that a Medications Development Program (MDP) be established within NIDA. In 1990, to operationalize the goals of the MDP, NIDA created the Medications Development Division, which, through multiple NIDA reorganizations, became part of today’s Division of Pharmacotherapies and Medical Consequences of Drug Abuse. The NIDA MDP is modeled after a typical pharmaceutical company, with the ability to conduct all phases of medications development: from the synthesis and screening of new chemical entities, to safety and efficacy testing, to the preparation of New Drug Applications (NDAs). NIDA supports its research through grants and contracts, and its resources are leveraged through the establishment of partnerships with pharmaceutical and biotechnology companies. Accomplishments of the MDP include multiple NDA approvals for the treatment of opioid use disorders, the advancement of a nicotine vaccine to late stage clinical development, and the advancement of promising medication candidates to multi-site trials for the treatment of cocaine and methamphetamine use disorders. The presentation will provide a background on the NIDA MDP, review positive and negative clinical findings, and describe ongoing trials.

Learning Objectives:
The participants will learn about:

1. NIDA’s role in developing currently available medications for the treatment of opioid use disorders and the impact of buprenorphine approval in the U.S.

Profile of opioid prescription users in Atlantic Canada

Dr. Caroline Brunelle, Assistant Professor, University of New Brunswick, Saint John (cbrunell@unbsj.ca)

The prevalence of prescription opioid use has increased in Canada and is associated with significant mortality risk [Fischer & Rehm, 2009; Fischer et al., 2006]. The purpose of this study was to examine the patterns of use of analgesic users in Saint John, NB as well as to compare individuals who use these medications recreationally (to alter mood) to therapeutic (pain) users on personality, mental health and drug use. Sixty one prescription analgesic users (57% male, M age = 41.91, SD= 12.63) were recruited to participate in the study. Participants were administered the Substance Use Risk Profile Scale (Woicik et al., 2009), the Addiction Severity Index (McLellan et al., 1985) and the Psychiatric Diagnostic Screening Questionnaire (Zimmerman & Mattia, 2001). The most commonly used opioid (41%) was Hydromorphone. A total of 77% of the sample reported three or more symptoms of opioid dependence. The most frequent route of administration was oral (56%) followed by IV (25%). Drugs were primarily obtained through physicians (42.6%) or via drug dealers (53.2%). A total of 70% of the sample reported pain reduction as their primary motive of use while the remainder indicated a desire to alter their mood. Recreational users were more likely to obtain higher sensation seeking scores (M= 13.28, F (1, 56) = 5.36, p = .02) and suffer from probable post-traumatic disorder (88% vs. 45%, χ² (1, 57) = 9.15, p = .00) and agoraphobia (59% vs. 20%, χ² (1, 57) = 8.32, p = .01) than therapeutic users. Recreational users were also more likely to have used sedatives (65% vs. 26%, χ² (1, 57) = 7.71, p = .01), stimulants (82% vs. 40%, χ² (1, 57) = 8.58, p = .00), and cannabis (76% vs. 35%, χ² (1, 57) = 8.23, p = .01) in the past 30 days. Therapeutic opioid users have elevated mental health ratings and frequent illicit drug use but recreational users have a higher burden of mental health and drug problems that may further complicate treatment interventions.

The Canadian Guidelines on Safe and Effective Prescribing of Opioids for Chronic Non-cancer Pain: A brief summary of the addiction-related recommendations

Meldon Kahan MD CCFP FRCPG, Medical Director, Addiction Medicine Service, St. Joseph’s Health Center, Toronto ON

This presentation will review the addiction-related recommendations of the Canadian Guidelines on Safe and Effective Prescribing of Opioids for Chronic Non-Cancer Pain. The presentation will also discuss the implications of the guideline for addiction medicine physicians and for primary care physicians. The guidelines, released in May, are based on a systematic review and on consensus among clinical experts in primary care, addiction and pain. The guidelines advise primary care physicians to take a substance use history and to use addiction screening questionnaires and urine drug screens at baseline, especially for patients not well known to them or 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. Opioids with a high abuse liability should be used with caution, and the maximum dose should in most cases be well below 200 mg morphine equivalent per day. 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. Compliance 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

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Cutting down one puff at a time: The acute effects of exercise on smoking behaviour

Kelly P. Arbour-Nicitopoulos Ph.D., Guy E. Faulkner Ph.D., & Agnes Hsing B.Sc. Faculty of Physical Education and Health, University of Toronto, Ontario, Canada

Rationale: Quitting smoking is a difficult process which is exacerbated by cravings and withdrawal symptoms. Strategies that specifically target these nicotine withdrawal symptoms and craving may assist in preventing relapse. A systematic review concluded that a single session of low to moderate intensity exercise can be recommended as a smoking cessation aid for the regulation of cravings and withdrawal symptoms (Taylor et al., 2007). However, the majority of studies have relied on self-report measures, with less attention been given to using objective measures of smoking topography (e.g., how an individual smokes a cigarette).

Objective: To examine the effects of an acute bout of walking on cigarette cravings and smoking topography using Clinical Research Support System (CReSS) Pocket.

Methodology: Using a within-subject, crossover design, two 10-minute treatment sessions were conducted on separate days by 19 participants (Mage = 24.6 years): passive and walking conditions. Participants rated craving at baseline, mid-condition, and at 0-, 10-, and 20-minutes post-condition, while subjective measures of smoking topography [puff count, puff duration, puff volume, interpuff interval (IPI), time to first puff] were obtained with the first cigarette smoked post-condition.

Results: A 2 (condition) x 4 (time) ANCOVA indicated lower desire to smoke (p < 0.05) during the walking condition than the passive condition. After the walking condition, a series of ANOVAs demonstrated a significantly increased delay to first puff (p = .05) and trends for reduced puff volume, duration, IPI and puff count in comparison to the passive condition.

Conclusions: Our findings further demonstrate that exercise doses of low intensity and duration reduce cravings in comparison to a passive condition. These results also suggest that a bout of brisk walking may change an individual’s smoking behaviour. Future studies using larger samples could extend these findings by manipulating the exercise dose and the timing of the topography assessment. **The study was funded by a Pilot Grant from the Ontario Tobacco Research Unit (OTRU).**

An evidence-based toolset to Measure & Assess Emotional Health

Edward Hill M.C.S, Pierre Dumouchel Ph.D, Université du Québec, École de technologie supérieure

We present an automated telephone check-in system (emotiondetect.com) to measure and assess emotional health, based on automatic emotion detection and the experience sampling method. Automatic emotion detection in speech consists of extracting acoustic features from speech and then classifying the features to statistical emotion models. Emotional health: the ability to express emotions, identify one’s own emotions, relate to other people’s emotions, and to live life with predominantly positive emotions; plays a major role in addiction, treatment, and recovery. A typical addiction treatment program includes medication and weekly cognitive behaviour therapy (CBT) over a long-term period. A common CBT practice is for a patient to maintain a daily behavioral health journal. Research has recently commenced in evidence-based methods to capture an addiction treatment patient’s momentary emotional state using form-based mobile devices, and analyze their emotional health over time. Emotiondetect.com automatically calls patients at designated times during the day and asks three emotion-related questions. Alternatively, the patient may call in when they have an emotional episode. The check-in frequencies, emotional content of the recorded speech, ability to identify their emotion, and the ability to relate to others are automatically captured, measured and analyzed over time. The call takes less than 25 seconds, thereby avoiding procrastination typically associated with lengthy pen & paper journaling and form-based mobile device entry.

REF:

- DSM-IV (Diagnostic and Statistical Manual of Mental Disorders), 2004.
- Tagade M., Examining the benefits of positive emotions on coping and health. NIH public access, 2004; 72(6): 1161-1190.
Food Addiction: Does it Exist?  
Why do We Care?  

Vera Ingrid Tarman, MD, FCFP, MSc, CASAM, Medical Director, Renascent Center, Toronto ON  

This workshop will utilize the diagnostic criteria of Substance Dependency to food, and aberrant eating behaviors and eating disorders. This is to show how food can be viewed as an addiction. An overview of some of the emerging neuroscience will be presented to validate that food can be as powerfully addictive as cocaine.  

Discussion will follow regarding the usefulness of this diagnosis. Specifically, conceptualizing compulsive over eating and eating disorders as addiction will redirect treatment toward an abstinence approach, rather than the ‘controlled eating’ paradigm, that is prevalent today.  

Effects of Methadone on the heart & Qt interval  

Michael Varenbut MD  

There is currently significant clinical equipoise over the issue of methadone-induced QT-interval prolongation within the MMT prescribing community with wide-ranging opinions on the prevalence of this electrocardiographic (ECG) change and its clinical significance. These opinions impact on the dosing of methadone and the frequency of diagnostic testing for what may be a benign, incidental ECG finding or a primary cause of cardiac arrest in the MMT population.  

The lack of understanding and consensus over the issue of methadone-induced QT-prolongation means that some patients may be wrongly denied effective doses of methadone, thereby diminishing the treatment effect of MMT and increasing the risk of relapse and associated healthcare costs. Similarly, some patients may be prescribed unsafe doses of methadone, thereby increasing the risk of cardiac arrhythmia and associated healthcare costs. Recent guidelines have proposed universal screening of patients requesting or on MMT using electrocardiography, but such screening is controversial, may present financial or operational barriers to the provision of MMT to a vulnerable population, and the significance of electrocardiographic abnormalities is uncertain.  

This presentation will review current knowledge and science in the area, and discuss current recommendations for screening, as well as possible future direction.  

The International Certification in Addiction Medicine: Lessons and Challenges  

Nady el-Guebaly and Claudio Violato, Professor and Head, Division of Addiction, Department of Psychiatry at the University of Calgary  

Background: In 2003, the International Society of Addiction Medicine (ISAM) created an international certification to meet the needs of an international membership of physicians eager for affordable, valid, and comparable credentialing.  

Method: The knowledge content was primarily derived from ASAM’s Principles of Addiction Medicine. The nomenclatures of DSM-IV TR and ICD 10 were also recommended. Criteria of eligibility for challenging the examination are available on the ISAM website at http://www.isamweb.com/. It was clearly stated that the Certification would be a test of KNOWLEDGE with some vignettes about Clinical Judgment.  

Regarding the choice of Multiple Choice Questions (MCQ’s), an effort was made to select as many “culture-neutral” questions as possible. Questions about national legislation were excluded in favor of questions about International Conventions. We employed a modified Nedelsky procedure for setting cut-off scores using Minimal Performance Levels (MPL’s).  

Results: So far, the examination has been held 9 times in Canada, Egypt, and Saudi Arabia with 77 candidates. The overall pass rate is currently 80%. Based on reliability analyses with the first 65 candidates conducted on the total test, reliability is good (alpha = .84), with the subtest reliability from 10 content areas ranging from .83 to .48. The subscale scores all have adequate dispersion. The pattern of correlations between and among the subscales provides empirical evidence of validity.  

Conclusions: An International Certification Examination can be both reliable and valid with the questions showing good discriminatory performance. An “a-cultural” examination may be only a goal to strive for, particularly in areas such as psychosocial management.  

REF:  
- Nedelsky L. Absolute grading standards for objective tests. Educ & Psych Measure, 1954; 14:3-19  

Methadone and Neonatal Abstinence Syndrome  

Dr. Jeff Daiter, Chief Medical Director, Ontario Addiction Treatment Centres  

Methadone, in addition to many other drugs, can result in complications at birth resulting in what is known as Neonatal Abstinence Syndrome. This oral presentation reviews the early identification and management of NAS as it relates to methadone, other drugs and breast feeding.
Chronic Pain, Depression and Addiction: Managing the Triage

Samuel Oluwdairo, MD, FRCP, Consultant Psychiatrist, Foothills Medical centre, Clinical Asst. Prof., Faculty of Medicine., Consultant addiction centre and Clinical Medical Director Adult Program, Consultant Psychiatrist. Calgary Chronic Pain Centre.

The risk of addiction to opioids developing in the course of opioid therapy of pain is thought to be very low, especially for individuals with no past history of addiction. However the lifetime prevalence of addictive disease is estimated at 7% to 15% of the general population. Therefore it is reasonable to expect that this portion of the population may be at risk for development of addiction when opioids are used for pain. Thirty percent point prevalence and 45% lifetime prevalence in chronic pain patients that are affected by major depressive disorder. It may be as high as 85% depending on the study setting. Therefore it is important to understand management of these triad of Chronic Pain, Depression and Addictions.

Cost effectiveness of Methadone Maintenance Treatment in Ontario, Canada

Gregory S. Zaric, Michael Varenbut, Jeff Daiter, Chen Xu, Andrew Brennan, Executive Clinical Director, Ontario Addiction Treatment Centres

Objectives: To estimate the incremental cost of methadone maintenance treatment in Ontario, Canada.

Methods: We analyzed a database of all patient clinic visits, laboratory tests and methadone scripts from a group of methadone clinics in Ontario. The database consisted of patient visits and visit information from January 2, 2004 to December 31, 2006. We estimated the cost of methadone maintenance treatment as the sum of physician costs, laboratory test costs, methadone costs, and pharmacy costs, which include dispensing fees and markups. All costs are expressed in 2008 CAD.

Results: The database consisted of 7503 unique patients. The average age was 39.2 and 64% were male. There were approximately 2,987,000 patient-days of treatment, and the total cost of all treatment-related services was $44,551,389. The total cost was comprised of physician billing (23.4%), pharmacy costs (62.8%), methadone (12.2%), and laboratory tests (1.6%). The average cost per day in treatment was $14.92, corresponding to $3444 per year if patients were to remain in treatment continuously.

Conclusions: The incremental cost of providing methadone maintenance treatment in Ontario is comparable to estimates from the United States and Australia. This information is important to policy makers as part of a full cost-benefit or cost-effectiveness analysis of methadone.

Provincial MMT Program in PEI

Dr. Don Ling & Associates

The Prince Edward Island Provincial Program of Methadone Maintenance Treatment for Opioid addiction began in 2004. It has operated from the Provincial Addiction Treatment Facility (PATF) in Mount Herbert (outside of Charlottetown since that time. All inductions are done with a 5-7 day admission to the PATF Detox Unit. The increasing demand from Islanders with Opioid addiction as resulted in a doubling of case load numbers each year of the past two years to the current 160. Trend analysis reveals and increasing percentage of cases being female and residing in rural communities.

While the Program is representative of a harm reduction model the ultimate objective is abstinence to use of all addicting substances. A urine test positive for Cannabis only restricts carry doses to once weekly. Holding firm to Program Policies like this minimizes client complaints while once weekly facilitated group sessions have proven both appealing to clientele and beneficial. The current challenges for PEI MMTP include increasing regional centers involvement in regular activity such as group sessions and urine screens and an enhancement of human resource at the PATF for MMTP work. Current staffing for the Program includes 1.8 FTE Nursing, 1 Social Worker, 0.7 FTE Clerical and 0.8 FTE Physician time involving two physicians. Program outcomes have been encouraging.

Suboxone Therapy: Pearls

Dr. Jeff Daiter, Chief Medical Director, Ontario Addiction Treatment Centres

Opioid agonist therapy has traditionally involved the use of methadone. Over recent years, Buprenorphine / Naloxone (Suboxone) has become readily accessible throughout the Country. This oral presentation will discuss a variety of treatment tactics that will improve your ability to manage your patients on Suboxone.

FRIDAY OCTOBER 22, 2010

Strategies for Defining Behavioural Addictions

N. el-Guebaly, D. Hodgins, T. Mudry, C. Martin, C. Wild, S. Patten, I. Colman, D. Schopflocher, Professor and Head, Division of Addiction, Department of Psychiatry at the University of Calgary

Background: The overall goal of our research group is to contribute to the conception of what counts as an “addiction” and how such problem behaviours are classified and measured, leading to empirically-based prevalence estimates.

Method & Results: Of some 8,000 articles retrieved, a
systematic review of the empirical studies underpinning the conceptualization of a set of addictive behaviors was conducted. The search yielded a number of such studies, i.e., Internet addiction = 28; Exercise addiction = 18; Eating addiction = 23; Buying/Shopping addiction = 27; Work addiction = 8; etc. The majority of studies favoured an addiction conceptualization, but alternate conceptualizations were also available, such as impulse control and obsessive compulsive syndromes.

The above search was complemented by a summarized overview of available measures for each behavioral addiction that: had been used in prevalence research; had cut scores; was based on a conceptual model; was sufficiently brief, sound psychometric properties; and were self-completed. Of the 253 distinct scales/measures retrieved, 135 fit some of the above criteria and 25 were rated as useful in their current state. No “off the shelf” test battery was available to describe a general population prevalence of addiction problems.

A third research strategy was to conduct a public opinion survey of Albertans age 18+ to obtain crude estimates of the prevalence of a wide array of problem behaviors and attitudes toward social responses to such problems. Using an IPSOS online panel, target quotas were set and 4,000 completed the survey (21% of invited and 62% of accessed). Problems with work, tobacco, and eating were the most prevalent self-reports, but perceptions were, overall, higher than national survey figures. A longitudinal data linkage with major Canadian population surveys is underway for the purpose of investigating some early childhood determinants. Based on the above experiences, the next research phase will be outlined.

REFERENCES

Prevalence of Illicit Methadone Use as shown in New Patients entering a Methadone Maintenance Treatment Program

Michael Varenbut, MD, Carolyn Plater-Zyberk (MSW Can.), Andrew Worster, MD, Jeff Daiter, MD, Executive Clinical Director, Ontario Addiction Treatment Centres

Objectives: Annual deaths from methadone are rising and the literature indicates that a significant number of these deaths are directly related to illicit methadone use. Given this, methadone diversion should be a primary concern for all methadone maintenance treatment professionals.

While there are significant harms and dangers associated with illicit methadone use, the exact scope of the problem is largely unknown. The work presented represents a wide scale study that reviewed the records of all new admissions to a large methadone maintenance treatment program, with multiple clinics across Ontario, Canada, over a 4 year period. The overall objective was to look at the incidence of illicit methadone use prior to entry into Methadone Maintenance treatment programs.

Methods: A retrospective chart review was conducted. In total, 5805 records were examined of which 1062 were identified via urinalysis to have illicit methadone present, prior to initiation onto the program.

Results: These results further illustrate a four year incidence of illicit methadone use to be between 16.6% – 22.8% (with an overall average of 18.3%) and overall 95% confidence Intervals of between 14.7%-25.7% (with an overall average Confidence interval of 17.7%-19.3%)

Conclusions: This study demonstrates that illicit methadone use is prevalent and the problem does not appear to be improving. Implications and limitations are also discussed.

URINE OXYCODONE: COMPLIANCE MONITORING

Bhushan M. Kapur, D.Phil, C.Chem, FRSC (UK), FACB (US) and FACBC (C)

Kapur, Bhushan. M1, Anita Borm2 and Patel, Ketan.2.

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Background: Oxycodeone is commonly prescribed to manage pain. Unfortunately it is also available illicitly on the street and available to patients. Patients also divert the drug to the street. Compliance to treatment and usage of non-prescribed oxycodone can be monitored by doing quantitative urine oxycodone testing. Systematic review of patient urine data, from a compliance perspective, to our knowledge has not been reported.

Method: We had access to 5578 urine oxycodone results from 914 (439 male; 475 female) patients where both oxycodone and creatinine results were available. In some cases we had only a few urine results available and in others we had up to 25 urine results. Samples were collected over the year 2009. All urine assays were done using the Diagnostix MGC-240 analyser using Thermo Fisher DRI reagents from Thermofisher, Mississauga, Canada. Using the manufacturer supplied calibrators, all urine results were quantitated

![Graph showing urine oxycodone levels over time]
Results: We reviewed data on patients where a minimum of 10 data points were available. Review of patient records showed that some of the patients genuinely ran out of their medication and were not self-sourcing extra oxycodone. This was reflected in urine screen. Most of the positive values were between 600ng/mL and 1000ng/mL, the upper limit of the calibration curve. Urine creatinine correction did not seem to be necessary.

Conclusion: It is possible to monitor compliance with treatment regimens using quantitative urine oxycodone assays. The oxycodone calibration curve needs to be extended.

Workshop: Understanding and Better Utilizing the simple Self-Help and 12 Step Program to aid you and your patient in assessment, motivation for change, treatment and lifelong support

Dr. Frank Evans

Why work so hard? These systems can and will handle all of you and your patient’s needs along the spectrum of change and harm reduction. All one needs to do is to invest a little time to better understand the systems, how they work and then delegate. Once the better understood, then these systems can be utilized at various stages of the doctor/patient interaction and treatment to aid in the process of assessment, treatment, relapse prevention, self change and motivation.

Self-Help programs (AA, NA, Alanon, etc.) do not appear to be utilized as much as they could be given the shortage of treatment and support resources. Patients, assessment personnel and treatment providers have stated that there are various problems with Self-Help Systems and the 12 Step Programs. Some care providers were not familiar enough on how to guide a patient into utilizing these support systems especially patients who have some aversion or resistance to such support systems. Some care providers have no knowledge of these systems, which are such a significant resource for any patient, in any culture, in any country, etc.

OBJECTIVES: Provide a simple overview and familiarization for the addiction specialist. Help eliminate their lack of a basic understanding of the Self Help systems and 12 Step program. Explain what Self Help systems are, how they function and why have they become so large and so respected that even doctors have their own AA. IDAA (International Doctors of Alcoholic Anonymous) is a powerful example of how effective and respective the simple. We will provide you with simple techniques that will allow you to help your patient better utilize these free and universally available resources. Provide an overview of common problem areas that prevent engagement or which cause disengagement of the patient with a self-help program and show how to circumvent these problem areas.

Workshop: Body Piercing: ‘the hole story’

Dr. Craig J. Kuhn, Niagara Addiction Services, Port Colborne/Fort Erie Hospital, Port Colborne ON   Email: kckuhn@vaxxine.com

Body piercing has been in existence for centuries throughout the world. Historically, reasons for piercing have included adornment, rites of passage, religious purposes, and sexual practices. In recent years, body piercing has increased in popularity and social acceptance. Piercing of various body parts with jewellery is no longer limited to teenagers. It is estimated that approximately 7-20 million people in the US have piercings, with women more likely than men to be pierced. Body piercing among teenagers has been shown to be related to a range of high risk behaviours. Recently published data suggests an increase in rates if infection and complications following body piercing. Physicians and other healthcare professionals should be familiar with body piercing practices and associated health risks.

The focus of this multi-media presentation is to provide best practice information regarding:

- History and cultural aspects of body piercing
- Epidemiology and social trends of body piercing
- Sites and types of body piercing
- Medical risks and complications of body piercing
- Medical issues concerning body piercing

This presentation incorporates live music (“Rythmia”), choreographed with powerpoint images and testimonials. Portions of this presentation will be added to the existing “Think ink” educational program regarding tattoos that we present to middle/high school students.

EDUCATIONAL RESOURCES:

(1) Commercial brochures on body modification; (2) www.channing-bete.com; (3) www.etcrg.org; (4) www.healthdeo.com

MEDICAL RESOURCES:

- Complications of body piercing, Am Family Physician, Nov 15, 2005;72(10) 2029-2034
- Body Piercing: medical consequences and psychological motivations, Lancet April 5, 2003; 361, 1205-1215.
- Puncturing, Nursing, Nov 2008, 50-54

REFERENCES:

- Body Piercing and airway management, AAMA J Feb 2008; 76(1) 19-23.
- Body piercing and high risk behaviours in adolescents, J of Adolescent Health 2004; 34, 224-225.
- Infective endocarditis after oval body piercing, Cardiology in review Sept 2003; 11(5): 252-255.

GENERAL RESOURCES:

- Association of Professional Piercers www.safe piercing.org
- Infection Central Guidelines for tattooing and Body Piercing – Niagara www.niagararegion.ca

ADDITION MEDICINE IN CANADA: The road to specialization

Sharon Cirone, University of Toronto, N. el-Guebaly University of Calgary /Foothills Medical Centre, Addiction Centre

In Canada, the training requirements and qualifications of physicians is the jurisdiction of the College of Family Physicians and the Royal College of Physicians and Surgeons. Due to the country’s vast geography as well as a concern regarding the “fragmentation” of medical care, the Colleges have actively promoted the training of “generalists” in family medicine and “sophisticated generalists” among the traditional specialties, including psychiatry. Over the last 20 years, the development of subspecialties, including Addiction medicine, has not been formally encouraged.

Due to the increasing number of family physicians and specialists practicing a range of new subspecialties, including Addiction Medicine, the College of Family Physicians has recognized special interest or focused practices, while the Royal College has recognized, in psychiatry, three subspecialties (including child, geriatric, and forensic) requiring an extra year of training and may offer others a diploma option. Other medical specialties, such as neurology, also require some training in addiction medicine. These new opportunities in both Colleges will shape the training requirements of Addiction Medicine in addition to the availability of certification through both the International and American Medical Societies of Addiction Medicine.

Audience participation is eagerly anticipated to help shape a strategy for CSAM to further the recognition of addiction medicine as a medical specialty in Canada.

REFERENCES:


Workshop: Treatment of concurrent disorders at the Claresholm Centre for Mental Health and Addictions Concurrent Disorders Program

Dr. Ronald Lim MD, CCFP, CCSAM, FASAM, Claresholm Centre of Mental Health and Addictions, Dept of Psychiatry, U of Calgary, Email address: ronlim1@shaw.ca,

Dr. Hugh Colohan MB, BAO, BCh, LMCC, FRCPC, ABAM, ASAM, Claresholm Centre for Mental Health & Addictions, Mental Health & Addictions Calgary Zone, Alberta Health Services email: hugh.colohan@albertahealthservices.ca

The Concurrent Disorders Program at Claresholm Centre for Mental Health and Addictions (CCMHA) specializes in residential treatment of adults experiencing:

1. Chronic pain and addiction to or dependence upon medications and/or other drugs
2. Anxiety and benzodiazepine dependence or abuse
3. Polysubstance abuse with a stable mental health disorder – Axis I or II – that will not interfere with treatment.

This program was started on 2006 and is classified as ASAM’s level III.5: Clinically Managed High-Intensity Residential Service.

Since admitting its first patients on October 23, 2006, the Concurrent Disorders Program has focused mainly on the development and enhancement of both group-based and psycho-educational programming with less time spent on program evaluation. As the program neared completion of its 3rd year of operations, more emphasis was placed on program evaluation, including accessibility, wait times, clinical efficacy as determined by scoring pre- and post-treatment patient questionnaires, patient satisfaction and discharge planning.

This workshop will describe the programming, program evaluation tools utilized and outcome data. We will also describe some of the treatment approaches that are used to manage the chronic pain and opioid dependant individuals as well as the concurrently disordered benzodiazepine patients.

REFERENCES:

Principles of Addiction Medicine 4th ed

Youth & Addiction

Dr. Sharon Cirone

Dr. Cirone will review the recent North American trends in prescription opioid and cannabis use by adolescents and young adults. Further discussion will review treatment approaches for adolescent opioid abuse/dependence, including inpatient versus outpatient treatment options, and opioid tapers versus Opioid
Substitution Therapy. Recent literature on the issue of cannabis use and psychosis will be reviewed. These topics invoke great concern, interest, and challenge for those practicing Addiction Medicine. There will be opportunity for audience discussion of these topics.

Panel Session: Opioid Substitution Therapy in Correctional Service Canada

J. Holland1, Dr. L. Lanoie2, S. Farrell, M. Cheverie & S. Johnson, 1 National Health Services Program Coordinator, Clinical Services, Health Services, Correctional Service Canada, ONT- Regional Headquarters, Kingston ON [hollandjl@csc-scc.gc.ca], 2 National Consultant, Methadone/Addiction; Prairie Regional Consultant, Institutional Physician at Saskatchewan Penitentiary, Prince Albert SK [l.lanoie@sasktel.net]

This panel session will provide a overview of Correctional Service Canada’s (CSC) Opioid Substitution Therapy (OST) program, highlight the unique medical considerations of providing OST in a correctional setting, ad describe research concerning the OST participant population.

CSC provides OST to federal offenders using a multidisciplinary approach, incorporating case-management, psychosocial, social and criminal effects associated with opioid use. Following the principles outlined by provincial Colleges of Physicians ad Surgeons and Health Canada’s Standards for OST, CSC’s guidelines ensure that this treatment intervention incorporates best practice methods ad is at the forefront of opioid maintenance treatment in a correctional setting (e.g. policies on strict dose administration and monitoring, a detailed medical directive for methadone overdose, specific program modules geared to opioid dependence ad ongoing training for staff).

OST in a national correctional setting often presents unique challenges ad opportunities not seen in other settings. OST programs in prisons come under much closer scrutiny than do community programs, and as such, include enhance security protocols to ensure the safety and security of the facility (e.g. requiring offenders to be searched prior to and after dose administration, waiting 20 minutes following dosing, and not being able to provide carries to reduce the potential for methadone diversion). As a result of these enhanced protocols, working within a correctional setting can be challenging which can make developing a therapeutic relationship more difficult than working in the community. CSC has developed policies or the prescription of testosterone, to assist clients experiencing opioid-induced hypogonadism and the use of Suboxone in exceptional circumstances when an individual is unable to tolerate Methadone.

Recent research has compared offenders initiated into CSC’s OST program between 2003 a 2008 with offenders in the general incarcerated population. Results discussed will describe differences between the two groups, as well as specific characteristics of thee participant population by examining trends over time and across CSC region of treatment. These characteristics will include drugs of choice, other problematic drug use. Physical and mental health indicators and prior and current drug use behaviours.

PRIMA (Pregnancy-related issues in the Management of Addictions): Successes and Challenges

Mel Kahan, Mike Franklyn, Marina Reinecke, Department of Family & Community Medicine, University of Toronto, 263 McCaul Street, Toronto, Ontario, M5T 1W7
Email: Prima.medicine@utoronto.ca

This presentation will describe the history and accomplishments of PRIMA (Pregnancy-related issues in the Management of Addictions), and will discuss future directions. PRIMA’s mission is to educate health care professionals on the management of pregnancy and substance use. Launched in 2005, it has been sustained with grants from the Lawson Foundation and Health Canada. Its members include addiction physicians, family physicians, obstetricians, midwives, nurses and nurse practitioners, child protection workers, and social workers.

Education: To date, PRIMA has conducted 10 train-the-trainer workshops involving 392 participants in all regions of the country, from Vancouver and Winnipeg to Moncton and St John’s. Post-workshop surveys indicate a high degree of satisfaction with the workshops. PRIMA has also produced a laminated pocket manual containing clinical protocols on screening, assessment, and management of substance use in pregnancy. To date, 20,000 manuals have been distributed to care providers across the country via local community presentations. PRIMA has also set up a list-serv that regularly presents cases and issues for discussion and comment. PRIMA members have also been involved in public advocacy for improved care and more humane attitudes towards pregnant substance users. PRIMA resources are available in both English and French.

Research: In 2008, PRIMA conducted a randomized educational trial involving 115 family medicine residents in Vancouver, Edmonton, and Toronto. The trial demonstrated that the pocket manual was far more effective than a standard computer reference program in improving residents’ knowledge of substance use in pregnancy. PRIMA is also conducting a comparative analysis of patient characteristics and clinical practices at four Canadian methadone programs that care for pregnant patients. PRIMA members participated in a systemic review on the management of pregnancy and substance use, which was accepted for publication by the Journal of the Society of Obstetrics and Gynecology of Canada. PRIMA members also participated in the SOGC guidelines on alcohol
use in pregnancy.

**The future:** While ongoing funding is not assured, we plan to continue PRIMA so that we can maintain and expand the list-server, provide cost recovery one-day workshops (in both English and French) for interested care providers, and regularly update the pocket manual and guidelines.

**Management of Sleep Complaints**

Dr. Jeff Daiter, Chief Medical Director, Ontario Addiction Treatment Centres

Dr. Michael Varenbut, CCFP, FCFP, DABSM, CASAM, CCSAM, MRO, FASAM, DABAM; Exec Clinical Director, Ontario Addiction Treatment Centres

Difficulty initiating and maintain sleep have long plagued those suffering from chemical dependencies. This workshop seeks to improve identification of specific sleep disorders and offers practical solutions, both pharmacological and especially non-pharmacological, for improving sleep initiation and continuity throughout the night.

**CCSA: Core Competencies For Canada’s Substance Abuse Workforce**

Elva Keip (CCSA)

National standards and core competencies were identified as critical for the substance abuse workforce through the first-ever survey of the Canadian addiction treatment workforce in 2004. Following extensive consultations with key stakeholders and subject matter experts across the country, the Canadian Centre on Substance Abuse developed core competencies - both technical (in 2007) and behavioral (in 2009).

Technical competencies refer to those abilities and knowledge required when applying specific technical knowledge in a job function or role - in other words, the “what” of the job. Behavioral competencies refer to those abilities, attitudes and behaviors required to perform effectively - the “how” of the job.

The presenters will describe the research and development phases, including bringing educators and subject matter experts together, and will discuss the implications of the competencies for both the addiction workforce and its employers. The competencies can assist employers both in recruiting knowledgeable and skilled staff and in identifying and addressing staff professional development needs.

Because competencies are transferable from one field/domain to another, the presentation is relevant to allied professionals, such as primary health care providers whose patients have substance abuse issues and who wish to be confident in their proficiency to assist patients.

Participants will discuss various issues and examine the behavioral competencies in relation to their own practices, identifying competencies pertinent to them as well as the appropriate level of proficiency for each competency.
Welcome to the Bulletin Report for the Canadian Journal of Addiction Medicine Vol 1, No. 3. As we near the end of 2010 Don Ling retires from the Presidency after two testing years. The board has deeply appreciated his cool direction under considerable pressure.

Management, by Marilyn Dorozio of Above the Mark, is vastly improved; not just the paperwork and such, but she brings a personal interest in our society in all its aspects.

We enjoyed our 21st Annual Conference in PEI, the first time in that province, and only the second in the Maritimes (Halifax, 2003). We did not achieve high attendance but were not disappointed with 118 registrants. Conference topics, on the theme “Basics and Beyond”, largely reflected Atlantic needs, sessions were well attended, and the hospitality was something special. We await the financial reports, likely available for the next issue. Our thanks to the conference committee for a job very well done!

Your board meets in person just once a year, immediately before the conference. This was a very good meeting. In particular the board is now well represented across the country with few vacancies, and the committee structure is solid. A few new committees were suggested, mainly in the financial area. The board also approved in principle the concept of a board position for an Associate member.

The Annual General Meeting in Charlottetown was handled differently this year; in an informal setting we had a “Tell the Board” session in which members could raise any issues they wished. Several good suggestions were made which the board will consider, and the concept may well be adopted for future Annual Meetings.

Committee reports were then given, in particular the Bylaws have been extensively revised and will be issued in “final” draft format and then distributed to the entire membership for their consideration. At present we are still bound by the 2008 Bylaws. Committees are being encouraged to develop short and long range sustainable plans for their areas.

Given the financial difficulties of the last few years the board struck two new committees – sponsorship, and economics – which, together with the executive committee should help develop a business plan and shore up our balance sheet.

All our committees have chairs, and board members, and we welcome 14 members of CSAM to several committees – the most ever to date. Terms of Reference are being developed by the committees themselves and should help with the short and long term planning.

It’s that time of year again; time to renew your membership ..! The board is keen to identify members’ needs and develop services to match, and to expand the membership especially in Ontario and Quebec where we are under-represented. A new Bilingual Committee was struck to address issues for the potential Quebec membership.

CSAM’s next conference is in Vancouver, 03-06 Nov, at the Hyatt Hotel. The committee is already at work and we are expecting excellent topics and good attendance. Mark your calendars ..!

CSAM’s next conference is in Oslo, Norway, September 6-10, 2011. Their presentations are high powered by internationally respected experts, the meeting is highly recommended and very well worth attending.

It remains my privilege to serve as your president and, on behalf of the entire board and management, to wish you season’s greetings and every success in the 2011.

Respectfully submitted,

B. J. Fern, M. B. Ch.B
News from Across Canada

News from Nova Scotia

Dr. Bill Doran

It was fall in the Maritimes. I was driving solo in the pick up, legal limit plus 10, due East on the two tarmac lanes of Highway 16. The truck was moments from slithering up the back of the Confederation Bridge saying “a bientot” to Nouveau Brunswick and “Hi there” to our little sister PEI.

My destination was Charlottetown, PEI and the 2010 conference of CSAM. I’m the Nova Scotia representative to the Board of Directors of CSAM; In fact, I am one of only two representatives to CSAM from the four Maritime Provinces

The sun was bright and dropping in the heavens. The maples were crimson like Pacific salmon after the spawn, duties done, soon to be compost for another life. But that day they were brilliant, shaking in a stiff and steady westerly blow.

Stompin’ Tom was doing ‘Bud the Spud’ on the iPod. A new generation of spud trucks was out in force, passing in the other direction, loads covered against the elements. No bright red mud on these reflective stainless rigs. Clean as milk tankers.

Farms and fallow fields slipped by hypnotically. Off to the right at 2 o’clock, 500 yards away my attention was drawn to movement. A bull moose was moving across an open fallow field. Fast. He was moving at a canter across the field in front of me. His pace was unwavering. He was silky black in the red rich sunlight. His antlers were flat back over his neck and the one eye I could see from the side was fixed on the far horizon, looking neither to one side nor the other.

His rack was oddly reddish in this light. It had six or seven points on each side. This was a survivor. A veteran.

The pick up was closing on his course now. I could see the muscles of his near side withers powering him forward. He was a ballistic black projectile bent on the far side of the narrow highway. Ten minutes at this velocity would put him in the Northumberland Strait. My senses flipped instantly from admiration to alarm. This old boy was heading for the tarmac! He was not a horse on a quick dash and about to pull up and stop. He was not a deer with a sensible fear of man-made vehicles rolling down the highway.

I stood on the brakes. He cleared the ditch at speed without a look at me or any other useless distraction in his autumn bull world.

He was dead ahead, rack over the centerline, withers at my left headlight, and 20 yards down range. Could I pull this off? I needed to burn speed and it didn’t feel like it was happening. With no warning fear turned to terror. The driver behind me had suddenly decided to lean on his horn! I was startled, frightened and wanting to fight him. If this old bull moose decided he felt the same way, my hopes of avoiding carnage just got much worse. In one heartbeat that bull could drop his head, turn toward me and charge. I would see one eye and his near withers suddenly become an oddly red rack and both withers dead ahead. In two heartbeats that old boy, his rack and withers could be joining me in the cab of the pick up.

But he stayed on course. I blew by him before he reached the far ditch.

The Great Spirit was looking out for one of the old boys, today. Maybe both. Our compost days are still in the future.

The rest of the trip was less threatening. The meeting was small but productive. As always, finances were a concern for CSAM. Membership fees are the main source of income and selling the advantages of a national organization to potential members is an ongoing project.

The Board of Directors had its only face-to-face meeting of the year, addressing policies around Addiction Medicine in Canada as well as education, standards and housekeeping matters.

The conference was small but productive. There were many more Nova Scotia attendees than I had expected. This allowed an exchange of contact info and discussions ranging from the need for more Methadone Maintenance providers to the differing views of addictions program delivery. Not to mention depot hormonal birth control for Nova Scotia harbor seals! Cutting edge, my friends, cutting edge.

Discussions also touched on setting up a multidisciplinary branch of CSAM for Nova Scotia. The consensus seemed to be that it was an OK idea as long as there were no meetings to attend- we all have our quota as things stand.

In closing, I ask you to consider joining CSAM if you are not a member. If you wish to be a voice in Nova Scotia in any area of Addictions, it is effective. If you are interested in e-mailings [no meetings] about a Nova Scotia chapter of CSAM, please let me know.

May all your bull moose be distant!

Respectfully submitted

News from Ontario

Dr. Jeff Daite & Dr. Sharon Cirone

The College of Physicians and Surgeons of Ontario (CPSO) has recently released a document entitled: Avoiding Abuse: Achieving Balance: Tackling the Opioid Public Health Crisis. The document is available on line at www.cpsso.on.ca. Policy makers in other provinces should be advised to review the document as these issues exist across the country. Physician advocates for improved patient access to addictions services and opioid dependence treatment should pay particular attention to the recommendations in the section entitled: Ensuring Province-Wide Access to Addictions Treatment. In Ontario, the efforts to recruit and maintain physicians in treatment of opioid use disorders continues through educational efforts such as the Centre for Addiction and Mental Health (CAMH) Opioid Dependence Treatment Certificate Program and the Medical Mentoring in Addiction and Pain (MMAP) collaborative network, a mentor-mentee model for support and education of primary care physicians in the community.

Of note also, CAMH offers many other excellent CME courses
pertinent to Addiction Medicine. There is a range of course content and CME time commitments, including one day courses on topics such as Motivational Interviewing, Cognitive Behavioural Therapy, or Youth Addictions, and more intensive programs such as the Concurrent Disorders Certificate Program and ranging up to Fellowships in Addictions Medicine. Refer to www.camh.net under Education and Courses.

Ontario physicians continue to be practice in one of the most admired health care environments in the country. However, recent OMA negotiations threaten to potentially destabilize the successful expansion and maintenance of practices involved in opioid agonist therapy. Much effort is currently being directed towards helping the OMA’s Medical Services Payment Committee understand the full scope of the benefits, both social and health economic, of such addiction practices. Changes are inevitable but it is the hope of the Section on Addiction Medicine at the OMA that wisdom will prevail and access to services will not be interfered with. A strong voice at the table is needed and we would encourage all physicians in Ontario to speak up in terms of preventing any compromise in the Program.

News from British Columbia

Dr. Paul Sobey

I indicated in my first letter as the British Columbia Representative to CSAM that it was with enthusiasm that I accepted the position. I have to say that my enthusiasm for CSAM has been bolstered after attending our successful conference in PEI.

I am looking forward to CSAM being in Vancouver in November 2011 and am expecting sunny warm weather typical for that time of year. I will be supporting the conference with my commitment in sitting on the Conference, Membership and Sponsorship committees.

The Riverstone Home and Mobile Detox and Daytox, an outpatient facility offering detox and Daytox services in Fraser Health East, opened its doors on September 1st and has been seeing increasing numbers of clients. I hope to present on this model at CSAM in November 2011.

I am hoping the new BCMA Guideline and Protocol, Guideline for Management of Problem Drinking, will dovetail with the Riverstone program when it is rolled out in the New Year. I will be speaking to doctors in the Fraser Valley about this program and the Guideline over the next few months.

The sobering center slated to be built in Surrey has been making progress. Initial discussions around the model, expected population it will serve and philosophy of care have begun.

Vancouver Health Authority continues to expand physician services with one psychiatric resident and two family medicine residents doing electives in addictions.

Developing an addictions training tract for psychiatric and family medicine residents continues to be an objective for BC.

In May I accepted the position of Interim Physician Lead for Addictions in the Fraser Health Authority. The position is giving me a bird’s eye view of addictions services in the largest health authority in BC and the problems that I’m sure all members in other regions are facing. I continue to believe that it is only with Addiction Medicine physicians playing leadership roles that new doctors will develop an interest in Addiction Medicine and our patients will get access to the services they need.

CJAM Committee

Current members: Sharon Cirone, Jeff Daiter, Nady Elguebaly, Mel Kahan, Bhushan Kapur. Chair – Michael Varenbut

Summary of past year’s activities

1. Completed 2 issues of the CJAM
2. Obtained an ISSN number for the CJAM
3. Registered with the Canadian National Library / archives
4. Completed application for MEDLINE / National Library of Medicine (USA)
5. Expanded Editorial review board
6. Developed a peer review assessment tool, for review of manuscripts
7. Continue to modify submission process and instructions to authors

Membership Committee Update

Current members: Past chair – Michael Varenbut

Members: Don Ling, Charles Mackay, Paul Sobey, Sam Oluwadairo

New chair – Don Ling

The current year of 2010 has seen a slight increase in total membership numbers for CSAM (280 vs 276), but a worrisome decline in MD members to 144 from 163 in 2009. A quick review of the membership numbers by category over the past five years (2006 - 2010) represents more of the same. While Associate membership has grown from 71 in 2005 to 113 this year, our higher fee membership (MD and PhD) has fallen over the same interval from 203 to 147. It is time to act.

The most recent face to face Board meeting in Charlottetown
Oct 20 saw two significant steps taken in response to timely input from a younger non member physician. First, the membership fee for a physician or PhD in their first three years of practice/work in Canada is reduced by 50% ...ie $100/year instead of the normal $200.

And secondly, the membership application form has been revised to remove the section requiring a current CSAM member as a referee with accompanying letter of support. This should remove any perceived barrier to Society membership for younger/newer practitioners who may not know any current members. We want to encourage new faces and voices to participate in the growth of the Society and fulfillment of CSAM’s mandate for addiction medicine in this country.

I assumed Chair of the Membership Committee at conclusion of my Presidential term Oct 23, 2010. Other Board members of the Committee are Michael Varenbut (ON), Charles McKay (QC), and Paul Sobey (BC). A recently joined member from British Columbia has agreed to serve on the Committee, while another two non Board members would be beneficial—one preferably being an Associate member. If you have interest in this important activity please notify the CSAM office via email or telephone (403-944-2350) The Board itself finalizes all committee memberships.

It is proposed that the Membership Committee meet face to face once a year during the annual scientific conference. Other meetings as desired would be by teleconference with much of the deliberating done by email. The only real cost to committee members would be their time, and expenses for attending the annual conference (Vancouver 2011) We hope to make a more personal contact with former members who have not renewed, so a larger committee would better spread out this work. And remember, the best recruiting tool is Society promotion by individual members...PLEASE ASSIST.

**Summary of past year’s activities**

1. Completed “Benefits of Membership with CSAM” brochure
2. Continued to recruit local members / associate members
3. Looking at the opportunity for ASAM / CSAM cross membership
4. New – 50% discount for new MDs in practice for first 3 years.

**Current statistics:**

**Membership Statistics:** At Oct 15, 2010, CSAM has 276 members.

Breakdown by type:

- Associate members: ................................................. 111
- Honorary members: ................................................ 10
- Retired members: .................................................... 3
- Student members: .................................................... 7
- MD members: .......................................................... 142
- PhD members: ........................................................ 3

**Membership by province and territory is as follows:**

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<td>Ontario</td>
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<td>International</td>
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**Education Committee**

**Dr. Sharon Girone**

The Education Committee received a boost of energy with the CSAM Annual Conference. The Committee developed and presented the Gordon Bell Fundamentals of Addiction Medicine course. This annual full-day course offers family physicians, specialists, nurses and addictions counsellors the opportunity to learn about the core content of addictions medicine. The course was well attended and well received. Also, several conference attendees volunteered to join the Committee. Therefore, since out meeting in PEI, the membership of the Education Committee is as follows:

- Dr. Sharon Girone , Chair, Toronto, Ontario
- Dr. Bill Doran, Wolfville, Nova Scotia
- Dr. Ramm Hermin, Nova Scotia
- Dr. David Luckow, Montreal, Quebec
- Dr. Meldon Kahan, Toronto, Ontario
- Dr. Frank Evans, Toronto, Ontario
- Dr. Hanka Hulshoek, Winnipeg, Manitoba
- Dr. Marina Reinecke, Winnipeg, Manitoba
- Dr. Karine Meador, Edmonton, Alberta
- Dr. Mandy Manak, Kamloops, British Columbia
- Dr. Nady el-Guebaly, Calgary, Alberta

The Education Committee shall meet quarterly by teleconference. The first order of business shall be to review our Terms of Reference, so that we may make short and long term plans for the activities of the committee.

Several CSAM members have been very involved in conversations with both the Canadian College of Family Physicians (CCFP) and the Royal College about routes to specialized training and certification in Addictions Medicine.
The Education Committee will play an important role in continuing these discussions.

Bylaw Committee

Charles Mackay, Rob Cooper.

During 2010 the Bylaw Committee undertook a total rewrite of the Bylaws to deal with various issues including the opportunity to create a forward-looking set.

At the PEI meeting in October the board suggested further edits including a place to an Associate Member on the Board.

There are five sections to the proposed new Bylaws:

1. Corporate form and function
2. Membership
3. Annual and Special meetings
4. Board form and function
5. Operating Rules and Terms of Reference.

The committee will finish the edits shortly and present them to the board for their consideration. The final version will then be distributed to the entire membership for potential approval, either at a Special Meeting or at the next Annual General Meeting in Vancouver Nov 2011.

Website Committee

Dr. Jeff Daiter

The CSAM website is expected to undergo some instrumental changes over the next year. Online registration for conferences and renewal of memberships is a priority. Many members continue to express a desire to see French content and the committee is focused on trying to deliver that end. Input into website direction is greatly welcomed by the committee. Please direct any and all suggestions to CSAM head office and we will be certain to try and deliver on them.

Standards Committee

Dr. Jeff Daiter

A record number of Certificates were awarded at the recent CSAM Annual meeting in PEI. This represents a great sign that Addiction Medicine is gaining momentum throughout the country. It was a pleasure to see such growing enthusiasm towards gaining this distinguished designation. The quality of the applicants was outstanding and the Standards Committee looks forwards to seeing a similar, if not better response for this upcoming year.

Another important function of the Standards Committee is to developed Policy statements. This upcoming year will see a review of existing statements and some modifications in keeping with changing times. The Committee would welcome any suggestions from the membership in terms of any future policies that might be of consequence and in need of development.
## 2011 Membership Application Form

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

### Applicant Information
- Dr.
- Ms.
- Mrs.
- Miss
- Mr.

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### Education History
- Undergraduate Degree(s)/University/Year Graduated:
- Graduate Degree(s)/University/Year Graduated:
- Area of Specialty:

### Current Employment:
- Area of Employment: Private Practice, Treatment Centre, Educational Facility, Other (please specify):

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<td>Addiction:</td>
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<td>Other aspects of healthcare:</td>
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## 2011 Membership Application Form

### Addiction Medicine Affiliations

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<th>Member</th>
<th>Certificant</th>
<th>Year of Certification/recertification</th>
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<td>International Society of Addiction Medicine (ISAM):</td>
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Are you interested in Canadian Certification in Addiction Medicine? (Member – MD only)

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<th>Yes</th>
<th>No</th>
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### Topics of Special Interest in the Field of Medicine

Positions in the Society You Would Be Willing To Consider in the Future

- [ ] Board Member
- [ ] Committee Membership: Standards, Website, Opioid Agonist, Education, Membership, Conference, Bylaws, Sponsorship, Journal

Do you agree to have your name and office contact information included in a directory accessible to CSAM members only?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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Signature:

### Payment Information

Annual Fees:

- [ ] Regular Member – M.D.: $200.00
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