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# *the* Canadian Journal *of* Addiction Medicine

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*an official publication of the Canadian Society of Addiction Medicine*



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## Message from the Editor:

Dear CSAM members and Journal readers:

It is my pleasure to bring to you the 4th issue of the “Canadian Journal of Addiction Medicine”, the “CJAM”.

We are now well along into our 2nd year of publication, and the “Best is yet to come”...

I thank all of those that have contributed to the Journal, and 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 are well on our way towards inclusion in MEDLINE, and will update you all with further developments.

In this current issue of the CJAM, you will find original articles, commentaries, and research manuscripts contributed by our fellow colleagues.

In the “Bulletin” section of the Journal, you will find updates on various CSAM activities, Terms of reference of various CSAM committees and other provincial news.

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.

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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### CSAM Website:

All contents and materials found in this and every issue of the Canadian Journal of Addiction Medicine can also be found on the CSAM web site at [www.csam.org](http://www.csam.org)

### Manuscript Submission:

All materials for submission and manuscripts must be submitted to the CJAM Editorial Board at [admin@csam.org](mailto:admin@csam.org). On line manuscript submission will be made available in future issues of the CJAM.

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# *the* Canadian Journal *of* Addiction Medicine

*an official publication of the Canadian Society of Addiction Medicine*

## 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”.

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## 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

# Letter to the Editor: Scientists, MDs critical in fight for evidence-based drug policy / The Vienna Declaration

## Evidence-based Drug Policy Needs Evidence

Chris Shorrock, MA

I fully agree with using scientifically obtained evidence to lead decisions and actions, including policy change, as I pride myself on utilizing a scientist/practitioner model (constantly reviewing updated, sound research to guide practice). In my own investigations I have found significant peer-reviewed, published research supporting the numerous and extensive benefits of using opiate agonist therapy (OAT) specifically\*, and as such I fully support the call to governments around the world to increase access to OAT treatment. The Vienna Declaration<sup>i</sup> provides evidence that a significant reduction in HIV transmission can be obtained by providing condoms and sterile injection equipment<sup>ii</sup>; data is reported projecting significant economic savings that could have been realized by reducing HIV transmission via needle exchange programs and presents estimates of new HIV infections, if no new policy is created<sup>iii</sup>. While there are reliability problems with statistics involving projecting expected results, taking the literature provided in the declaration in sum, the argument for removing government bans on funding needle exchange programs seems much needed and scientifically sound.

The argument for “decriminalizing drug users” does not share the same empirical, scientific support. Upon reviewing the cited literature of the Vienna Declaration, it appears most contain articulate statements recommending changes to government drug policies; the majority of these (i.e. excluding those mentioned above) appear to lack empirical data supporting these impassioned orders. Only one article in the research appeared to provide a *causal* description of the relationship between law and potential HIV rates, by correlating a decrease in the use of a needle exchange with the implementation of a street level police intervention<sup>iv</sup>. It should be acknowledged that, as per the decrease in drug trafficking that occurred with increased police presence, a decrease in intravenous drug use could have occurred. Yes, if there are no police officers in the area, use of the needle exchange will remain constant, and possibly even increase, as it would with the legalisation of intravenous drugs, but so would numbers of people using intravenous drugs and the associated damages to both users and non-users, including the spread of HIV.

It is incomprehensible that practitioners working in addiction

medicine, whom constantly see the significant harms inflicted on people by illegal drugs (both direct patients and indirect victims of crime), would call for making these same drugs legal and thus more readily accessible and likely used more frequently. The authors, and many others, argue that steadily climbing incarceration rates of drug users is a sign of failure for the “war on drugs” and they conclude that the legal system must be changed<sup>v</sup>. The reality is that law enforcement is successfully removing at least some drugs and drug users from free society and thus removing some harm. It is a sign of success that rates of drug-related incarcerations are growing, as is the population, including the intravenous drug-using population. Law enforcement and treatment need to be used in collaboration for the same goal of reducing HIV infection via intravenous drug use, as the problem is simply too large to be adequately resolved with either approach in isolation; treatment needs to be increased, without decreasing or eliminating legal enforcement controlling drugs.

### References:

- i *The Vienna Declaration. The Canadian Journal of Addiction Medicine 2010 (1) 3: 12-13.*
  - ii *Wolfe D, Malinowska-Sempruch K. Illicit drug policies and the global HIV epidemic: Effects of UN and national government approaches. Report. New York: Open Society Institute; 2004.*
  - iii *Drucker E. Population impact under New York's Rockefeller drug laws: An analysis of life years lost. Journal of Urban Health 2002;79:434-44.*
  - iv *Davis C, Burris S, Metzger D, Becher J, Lynch K. Effects of an intensive street-level police intervention on syringe exchange program utilization: Philadelphia, Pennsylvania. American Journal of Public Health 2005;95:233.*
  - v *Montaner M, Werb D, Wood E. Scientists, MDs critical in fight for evidence-based drug policy. The Canadian Journal of Addiction Medicine 2010 (1) 3: 14-15.*
- \* *Please contact me directly at cshorrock@toxpro.ca for a list of references, not included here for economy of space*

## CALL FOR ABSTRACTS

### CONFERENCE THEME:

CSAM's 2011 theme, "21st Century Addiction Treatment – Advancing the Canadian Perspective" explores the unique viewpoints of Canadian caregivers engaged in the practice of treating those suffering from substance and behavioural dependencies. The conference will examine the policies and perspectives that will help shape the future direction of addiction practices across the nation. Through a number of plenary, workshop and interactive sessions, delegates will have an opportunity to share ideas and enhance personal insights. The conference theme draws on the notion that as a country, we have a range of expertise resulting in a common perspective that can be called our own.

### Abstract Presentation Formats

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Abstracts may be presented in one of three formats and also under either the. Please note your preference of:

- Oral Presentation - 20 minute talk
- Poster Presentation
- Workshop - 1 hour workshop (including small group discussion & skill building)

#### Abstract Content

- o All abstracts must be submitted by electronic copy by May 15, 2011.
- o The abstract body must not exceed 350 words (including tables and references), and must include title, list of authors and affiliations, and content including concise introduction. Statements of the empirical studies are to include a brief statement of the objective, rationale, methodology, results, and conclusions.
- o There is no limit to the number of abstracts you can submit. Notice of abstract acceptance will be sent to authors at least two months prior to the conference.
- o All presenting authors must register for the meeting.
- o **Every abstract will require 2 learning Objectives to be stated at beginning of presentation and a slide with Future Directions in research or Initiatives at the end of the presentation.**

**Abstract Submission:** electronic format in Microsoft Word .doc or .rtf file format by e-mail to [admin@csam.org](mailto:admin@csam.org)

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| - Full name of all authors with presenting author underlined | - Institution and department |
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**ABSTRACT DEADLINE IS MAY 15, 2011**

# Treating Substance Dependent Police Personnel: A Discussion

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

**Wendi L. Woo**, M.A., Psychological Associate, Addiction Division, Homewood Health Centre.

Prevalence rates for substance abuse among police officers have been shown to at least match, or exceed that of the general population (Violanti, 1999). In a review article by Al-Humaid, el-Guebaly and Lussier (2007), the use of substances as a way of coping with policing stress among international police was discussed. Some individuals in policing occupations seeking treatment for a substance use problem have access to support geared specifically to police officers, e.g. through Peer Support Programs or Cops only AA meetings. However, the majority of those seeking residential treatment receive treatment in civilian facilities. This can pose special issues for a police officer as a patient, and unique challenges to the treating clinician. The following is a discussion of some special considerations when treating such individuals in a civilian facility, and is based on the experiences of two clinicians working at the Homewood Addiction Division (HADS) at the Homewood Health Centre.

The Homewood Health Centre is a 312-bed psychiatric facility located in Guelph Ontario. Eighty-seven of these beds are devoted to the Homewood Addiction Division (HADS), which provides specialized inpatient treatment for individuals with substance dependence or gambling addiction problems. Program delivery is primarily group based and a therapeutic community milieu is encouraged. This is a 12-step modelled program whose therapeutic aspects parallel those of AA and include the installation of hope through contact with others, the encouragement of openness and self-disclosure, and a repeated emphasis on shared experiences (Cunningham, 2010). The program attracts individuals from all over Canada and from all different walks of life. As such, within the same treatment group it is not unusual to find a physician, an accountant, someone with a prison record, a factory worker, and a police officer. While group members are encouraged to identify and focus on how they connect with each other in order to promote the above stated therapeutic factors, serving in law enforcement can pose some unique challenges with respect to accepting treatment and being able to fully engage in the therapeutic milieu.

**Perception of Addiction:** The addicted police officer has a unique perception of what addiction is that is distorted by the work environment they inhabit. The role of the police officer is to uphold the law, acting as arbitrator of what is considered right and wrong, and to initiate punishment through the process of arrest and incarceration of the perpetrator. They therefore see addiction as an act of criminality. Although alcohol, as opposed to other drugs of abuse is legal, this sense of criminality is not transcended because their interaction with the intoxicated

individual is often within the context of punishment. The addicted police officer therefore experiences addiction not as a disease but as a profound moral deficiency. They are not “ill” but “bad”. And if the addicted officer engages in acts of aggression or criminal behaviour such as selling or stealing drugs, acts that are often reported in the media, the perception of addiction as a moral deficiency is strengthened. As such, with this population the first stage of treatment is to accept addiction as a disease. It is imperative that the treating clinician make it clear that addiction is a genetically mediated change in brain circuitry which is expressed in abnormal behaviours. If this concept is not made clear, the work-related consequences of their addictive behaviour will generate shame and negatively impact treatment.

While a necessary component of treatment is to engage in open and honest self-disclosure, many officers opt not to disclose about work-related consequences in group therapy and recovery meetings, focusing only on the personal, civilian costs of their addiction. A deliberate decision is made to not reveal to others how they have tarnished the police badge.

**Perception of Self and Others:** Vincent (1994) describes in detail the social structure and environment that shapes and reinforces the persona of the police officer and how they see themselves. This persona is not only molded by the internal structure of the police force itself but also by the expectations of the public they serve. In general, the ideal police officer is expected to be brave, possess good judgment, to maintain control of their emotions and the situations they encounter, and above all to be morally beyond reproach. Unlike other occupations, such as health professionals where interactions with the public tend to be affirming, positive interactions between police officer and the public are infrequent. The public is viewed as critical, rarely satisfied and not to be relied upon for assistance when an officer is in need. Civilians fall into one of two dichotomies: perpetrator or victim.

A basic tenet of recovery is that an alcoholic/addict cannot recover alone. One not only needs the fellowship of other recovering addicts to recover, but also needs to be willing to engage in open and honest disclosure with members of the fellowship. In a residential treatment setting, perceiving co-members as either victims or perpetrators encourages the officer to maintain the persona of the police officer as protector, rule enforcer, and advocate. Co-patients who are viewed as vulnerable are not therapeutically confronted by the police officer in therapy groups, and staff members who do so may be given the message to “back off”. The police officer may take the initiative to advocate for these patients rather than to allow them to take responsibility for their own actions and recovery. Acting in this way has the added benefit of helping the officer retain a sense of control over their environment and represents an attempt to re-establish an honourable reputation.

Conversely, the officer may see members of the therapy group as hostile and untrustworthy. Those who are viewed as perpetrator by the officer may be deemed so for good reason. For many patients, interaction with the law may have precipitated the referral to treatment and some may consequently regard the police officer patient with suspicion and contempt. In such cases,

individuals may attempt to antagonize the officer simply for being a cop, a representative of those who have initiated punishment in the past. When treating individuals in heterogeneous groups, the possibility that the officer is in treatment with someone with whom they have a past professional history is always present. In such cases, treating clinicians need to be sensitive to safety and confidentiality issues. Regardless of whether co-patients are viewed primarily as victim or perpetrator, this world view has the effect of silencing the officer and encouraging an emotionally distant stance. For the officer, there are aspects of their lives that they never speak about in therapy with respect to work-related events and identity issues.

The difficulties described above are not always obvious. Police officer patients generally present as compliant, motivated, and engaged. They tend to be highly task oriented, with homework assignments always completed well and on time. A work culture of providing service to others extends to the therapeutic milieu with the officer readily volunteering to do their share. The officer will take time and share in groups, but only about issues to which civilians can relate. Even when asked to discuss the impact addiction has had on their work, the police officer patient will generally keep to more general consequences such as absenteeism, messing up paper work, and getting into conflict with others. Seldom will they talk about issues such as no longer feeling deserving of the uniform and doubting their own judgement and instinct.

**Perception of the Work They Do:** Police Officers for the most part have significant trauma exposure, although most would not label these experiences as traumatic but instead simply call it “part of the job”. This includes being present at accident scenes, attending scenes of murder and violence, as well as being in situations of threat to themselves. As the officer becomes sober and the numbing and mood altering effects of their substance of choice are no longer present, the full emotional impact of police work can flood the individual. In our work, we have often found that once sober, those involved in traumatic forms of work suddenly find themselves experiencing nightmares and intrusive recollections of past cases. Listening to co-patients speak of episodes of victimization can also trigger trauma memories and feelings of anger or powerlessness within the officer. While in treatment, the officer may not voluntarily disclose that they are having these memories. Just as addiction is viewed as an inherent weakness, so are traumatic stress reactions. The clinician needs to be prepared to detect signs of distress or dissociation, a challenge with individuals who have been trained to portray neutrality. In many cases, these memories along with the associated emotional distress begin to abate in a week or two. However, for others, trauma memories may intensify, become more vivid and persist. When trauma memories fail to fade, assessing for and subsequently treating the posttraumatic stress disorder is imperative.

While needing to be watchful for the potential of a possible

posttraumatic stress reaction, at the same time the clinician should be equally aware that traumatic memories are also cravings. As Vedelago (2010) points out, “...a craving is a story that the alcoholic or addict will tell themselves when they pick up that next drink or drug...” The horror, terror, or helplessness associated with the story becomes the reason for using again. While needing to validate the reality of the traumatic experience, the clinician and the patient must not lose sight of keeping addiction recovery in the forefront of treatment.

A final point of caution. While monitoring for suicidal ideation is always important, doing so with the police officer is imperative. Years of responding to suicide scenes has taught the officer which methods have the highest probability of suicide completion. As well, they also have ready access to firearms. Violanti (1995), in his review of police suicides, speaks of alcohol abuse as a contributing factor in police suicides. With relapse comes an increased risk of suicidal behaviour, and as such, regular safety assessments with this population is vital.

**Conclusions:** The nature of police work raises challenges that must be understood by the treating clinician when the addicted police officer enters treatment. They are a unique subset of the patient population with an established professional persona that can influence strongly how they interact in therapy. Providing at least some aspects of treatment in cohort groups of just police personnel may provide a therapeutic environment in which police officer patients can more fully and freely address their addiction and related issues. In the absence of such an opportunity, encouraging police only AA meetings where available or obtaining a sponsor who is also with the police may be beneficial. Much has been researched and written regarding treating the addicted health care professional. Similar attention needs to be paid to the men and women in blue.

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# Intravenous Methadone Abuse Causing Pulmonary Hypertension: A Case Report.

**Dr. Dino Smiljic**, Lecturer, Department of Family Medicine, University of Ottawa

## Key Points

- Methadone mixed with Tang<sup>®</sup> can be abused intravenously
- Urine drug screening may erroneously corroborate patients' claims of abstinence
- IV drug abuse can cause pulmonary hypertension and right heart failure
- Visually inspecting abstinent patients' skin for venipuncture may suggest IV methadone abuse

A 32-year-old male patient on long-term opiate replacement therapy, presented to his Methadone Maintenance Treatment (MMT) prescriber, with a history of malaise, anorexia, diarrhea, chills, exertional dyspnea, and pedal edema, that prevented him from walking to the pharmacy to get his methadone. He was well known to the staff, and for years had been submitting clean, directly observed urine drug screens. Because of his stability, he had earned six take-home methadone unit dose "carries." In the preceding weeks, he had been complaining of symptoms compatible with a syndrome of mild opiate withdrawal, and had been granted an increased dose of methadone. Apart from regular marijuana use, he claimed to have been "clean," or abstinent from any drugs of abuse. Negative results on point-of-care urine dipsticks and examination for needle track marks had been consistently corroborating his claims of abstinence. He had a remote history of IV heroin use, and had been on methadone for addiction for almost ten years. He was a hepatitis C carrier with undetectable viral load.

On the day of presentation, he appeared ill; pale, and anxious, he had a temperature of 37.8 degrees, a regular pulse of 88 beats per minute, BP of 160/88 mmHg and weight of 111.5 kg. Chest exam revealed clear lung fields on auscultation, with normal heart sounds and no murmurs. Jugular venous pulse was 3cm above the sternal angle. His abdomen appeared distended, and the liver enlarged to approximately 6cm below the costal margin in the mid-clavicular line. He had pitting edema of both ankles. Antecubital fossae exam revealed only old, well healed track marks. Point-of-care drug screen urine dip confirmed presence of methadone, but no cocaine, benzodiazepines, morphine, or oxycodone. He agreed to outpatient investigations of presumptive viral illness, pedal edema, and hepatomegaly after refusing to proceed to the local emergency department.

He was reassessed in clinic nine days after presentation and reported feeling much better, with resolution of his dyspnea. His energy had returned, and had received his methadone doses without interruption. Examination revealed improved

hepatomegaly, pedal edema, and 12kg weight loss.

## Investigations

An ECG revealed normal sinus rhythm with query left atrial enlargement, and incomplete right bundle branch block. Relevant abnormal biochemical and hematologic assays included alkaline phosphatase, lactose dehydrogenase, gamma glutamyl transferase, and the transaminases, which were all mildly elevated. HIV, hepatitis B, and syphilis screenings were negative. Increased interstitial edema and peri-bronchial cuffing with cardiomegaly was apparent on the chest radiograph. Echocardiogram completed 11 days after initial presentation reported normal valves, mild to moderate right ventricular enlargement and reduced systolic function. There was evidence of moderate pulmonary hypertension.

One month later, a consult report from an internist contained the patient's admission that he had been regularly injecting methadone intravenously. Furthermore, he had been buying extra methadone suspension illicitly, and also injecting it intravenously.



## Discussion

MMT is proven to be a safe, economical, and practical pharmacologic tool in the treatment of opiate addiction<sup>[1]</sup>. In Ontario, the provincial medical licensing authority has published guidelines that support the use of opioid replacement and help physicians licensed to prescribe methadone do so with confidence<sup>[2]</sup>. As part of the recommended assessment of methadone patients, their history of drug use, urine drug screens, and physical examination for signs of intoxication are used to determine patient stability. The case described above reveals that even in patients deemed stable for many years, there is the risk for intravenous methadone abuse to go undetected.

Intravenous opiate use is well documented in the literature<sup>[3]</sup>, and Tang<sup>®</sup> orange crystals is purposefully mixed with methadone to discourage its intravenous abuse. In this case, the intravenous administration of methadone was facilitated by the patient having received carries on the basis of his stability. As the patient only abused illicit-gained methadone, the urine drug screens corroborated his history of abstinence. Further, he controlled his abuse to the extent he could arrive in clinic long

enough after the fact to avoid detection by observing behavior or examining the antecubital fossae.

Once confronted with his own history from the internist, he willingly admitted to boiling down the Tang<sup>®</sup>/methadone suspension to fit in a 50cc syringe, and injecting himself in the right and left basilic veins of the posterior forearms. Simply turning the arms upwards revealed new-appearing and typical scarring from multiple venipunctures. He admitted that after injecting, he would develop burning pain in the arm involved that resolved quickly, and was followed by a prolonged euphoria, relaxation, and drowsiness typical of opiate abuse.

The literature documents various forms of pulmonary hypertension and possible microembolic insults resulting in right-sided heart failure in intravenous drug users, including opiates and methadone<sup>[4,5,6]</sup>. But a literature search found only a letter to the editor raising the alarm of methadone mixed with Tang<sup>®</sup> as an increasingly prevalent form of IV opiate abuse<sup>[7]</sup>.

This case illustrates the particular challenge posed to prescribers of methadone in accurately assessing long-term patients in their practices that are deemed “clean” or abstinent. Prescribers might consider occasionally inspecting for fresh IV track marks in MMT patients. Examining all stable patients for tracks may not be time-effective, and may negatively impact on the doctor-patient relationship. Mixing methadone with Tang<sup>®</sup> does not discourage all patients from avoiding the IV route of abuse.

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3. Cherubin CE. *Medical sequelae of narcotic addiction. Ann Intern Med* 1967; 67:23-33.
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## Canadian Society of Addiction Medicine / La Société Médicale Canadienne sur l'Addiction



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Welcome to the Bulletin Report for the Canadian Journal of Addiction Medicine Vol 2 # 1. Since the last report CSAM has been progressing on several fronts. The Board has held one teleconference meeting 13 Jan 2011, at which all the committees gave reports, and since then several committees have been active.

Over the new year CSAM participated with the CMA in their support of Vancouver's Insite project, the CMA expects the Supreme Court to address the legal issues (such as Federal or Provincial authority etc) to be determined sometime this spring. We hope for a favourable outcome.

The Board agreed to finish the details of the proposed new Bylaws and Terms of Reference, which is now complete, and they will soon be ready for distribution to the membership. The new proposed Bylaws contain the provision for a board position for an Associate member.

The Canadian Pain Society contacted CSAM about potential membership on one of their committees and we have responded to that request with suggested names of suitable candidates. We are pleased to have been invited to join with CPS.

Regarding our financial position, despite a small loss in the PEI conference the overall position is secure. Much work by the new Sponsorship Committee has clarified the sponsorship levels for the conferences, which should result in a good outcome for sponsorship at the Vancouver conference in November.

There has been increased involvement with CCSA and we are pleased to see this continue. In particular they have a Core Competences programme which is attempting to classify the skills needed by those working in the addiction fields. There is also more movement in the general area of standardising the qualifications of such workers.

Your Board meets in person just once a year, immediately before the conference, and there are three teleconferences.

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

CSAM's next conference is in Vancouver, Nov 4-6 2011, at the Hyatt Hotel. The Board will meet the day before, 03 Nov, the conference itself beginning 04 Nov. Much of the conference has been developed already with several very well respected speakers. Mark your calendars!

Our next Board teleconference meeting is Wed, 11 May 2011.

Respectfully submitted,  
**B. J. Fern, M. B. Ch.B**

## News from Alberta

Alberta as a province continues to make effort at improving people's awareness about province wide initiative for mental health and addiction. The hope for this will be a standardized care provided across the board. In April 2011 there will be a back to addiction day conferences in Alberta. Courses will cover broad audiences including all health and allied professionals with interest in addictions. The 2011 Edmonton Addiction Day conference will be held on Tuesday, April 26th at the Bernard Snell Hall at the UofA Hospital. While The 2011 Calgary Addiction Day Conference will be held on Friday, April 29th at the Red and White Club.

**Samuel Oluwadairo**

AB Representative

## News from BC

I have to report that I have been busy since my last report. I have been sitting on conference and sponsorship committees for the 22nd Annual Meeting to be held in Vancouver in November 2011. I am excited about the speakers we have secured and am sure the conference will provide a forum to further the theme of advancing a Canadian perspective in addictions treatment.

From a local perspective, we were happy to see that British Columbia Pharmacare is exploring partial funding of Suboxone. In November the provincial drug funding agency published a document, Pharmacare Coverage of Buprenorphine Plus Naloxone (Suboxone®) for the Substitution Treatment of Opioid Dependence which set out limited criteria for coverage. We hope that results from this initiative will be positive and result in extended coverage.

The BCMA Guideline and Protocol – Office Based Management of Problem Drinking - garnered front page news in the Vancouver Sun in the last week. I sat on the committee that developed the protocol. British Columbia will be the first jurisdiction in Canada to recognize alcohol dependence as a chronic medical condition. The Guideline will be the first such Chronic Disease Management (CDM) guideline to provide extra funding to family doctors to manage alcohol dependence and will be the first such guideline in North America. I will be formulating the Physician Support Program (PSP) portion of the guideline with Motivational Interviewing experts to further

teach family doctors and their staff how to appropriately use the guideline. I will be presenting the guideline and hopefully data collected from its implementation at the CSAM Annual Conference in November in Vancouver.

A project to determine the efficacy of the ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) tool in psychiatric emergency departments in three hospitals in the Fraser Health Authority will be rolled out in the near future. The project will involve one control and two intervention groups and effectiveness in reducing substance use and service costs. I will report on this project in the future.

**Paul W. Sobey**

BC Representative

## News from Ontario

The Ministry of Health and Long Term Care continues to work through some changes to reimbursement for the methadone program in order to accurately gauge utilization over the upcoming years. MMTP in Ontario continues to treat the largest number of patients in the Country and has always been a model of care envied by other Provinces. While access to care continues to be at the forefront of concern, the fiscal reality of a program that continues to grow has government concerned. Yet, those of us in AddictiOn Medicine must continuously remind policy makers that the cost effectiveness of MMTP is almost unmatched by any other domain in medical care. Every dollar spent on MMTP saves the taxpayers of this province upwards of ten dollars. Improved outcomes such as decreases in victimization, hospitalization, incarceration and death remain the greatest benefits. Much work remains in trying to convince Government what is so obvious to all of us who work in Addictions day in and day out.

**Jeff Dieter, MD**

Ontario Representative

There's some excitement in Ontario for physicians providing services to patients with opioid dependence. The newly released College of Physicians and Surgeons of Ontario (CPSO) revised Methadone Maintenance Treatment Programs Standards and Clinical Guidelines represents progress towards a practice allowing more clinical discretion in decision making for the care of our patients. We are hopeful that this will encourage both retention of physicians in the area of MMT and recruitment

of new physicians to the field. Also, the Ministry of Health has responded to long standing requests and advocacy for the public funding of buprenorphine/naloxone (Suboxone) for the treatment of opioid dependence. Unfortunately this involves Exceptional Access Program application to get approval for coverage, but we will continue to advocate for Suboxone coverage on the regular formulary.

The Centre for Addiction and Mental Health (CAMH) and the St. Joseph's Health Centre Family Practice/Addictions Program continue to provide post graduate training in addictions medicine. CAMH has a relatively new program in their Addiction Medicine Clinic (AMC) providing medical assessment and management of persons with alcohol disorders, this service includes outpatient medical withdrawal management. CAMH is in the final planning stages for a 12 bed inpatient unit for adolescents with concurrent disorders, a program desperately need in Ontario.

**Sharon Cirone, MD**  
Ontario Representative

## Website Committee

The website committee continues to explore avenues to improve access to services. To this end, we recently approve the design and implementation of on-line registration for the next CSAM conference in Vancouver. This feature will further translate into improved payment options for CSAM membership and eventually products and services that may be offered through the website.

**Jeff Diater, MD**

## Report on CCSA NAGWD meeting Thurs, 20 Jan 2011

Members will be aware that CSAM and CCSA have been increasing their involvements in several areas. CCSA has been developing its Core Competences for most of those in the provision of services to people suffering substance disorders.

CSAM was invited to attend a meeting in January 2011 at the CCSA offices in Ottawa.

There were several representatives from provincial Health / Addiction services, CAMH, Salvation Army, Correction Services Canada, Addiction Counsellors Certification Federation, and a number of CCSA members.

This was an opportunity for CSAM to mention our history, certification programme / diploma, our mission to include all aspects of the field (substances and "behaviourals"), educate the profession and public, our attempts to be recognized as

specialists, membership in ISAM, numerous active committees, and next conference in Vancouver with CCSA.

CCSA has defined seven groups of workers in the field, excluding physicians of course, since all seemed agreed that we have little to offer in general in the broader aspects of the field. They are developing a job description questionnaire, with bullets for all the possible tasks different people do, to fill in and help them create a range of jobs which they feel will help better define the worker field.

CCSA also has a powerpoint slide on their site to which all are welcome.

This was a very interesting meeting which we hope will lead to further cooperation between our societies.

**Brian Fern, President CSAM**

## Terms of Reference Membership Committee

### Preamble:

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

### Purpose:

The purpose of the committee is to maintain and increase membership in the society.

This will be accomplished through:

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

### Membership:

The committee will consist of a chair and a maximum of 6 members.

Chair and members must be CSAM members.

Terms of membership are subject to periodic review and Board approval.

### Frequency of Meetings:

The committee will meet quarterly; 3 teleconference meetings and 1 "in person" to coincide with the annual CSAM Scientific Meeting, and more frequently as the need arises. Members are asked to commit to participate in a minimum of 50% of the teleconferences and to attend the "in person" meeting. Quorum at a meeting will be defined as 50% or greater of the committee members.

### **Decision Making Process:**

Consensus. In the exceptional circumstance where consensus is unachievable, decisions will be decided by majority vote (50% + 1)

### **Reporting Process:**

Committee will report on its activity regularly at board meetings and at the CSAM annual general meeting.

## **Economics Committee**

The committee will be made up of full or associate members of CSAM in good standing.

The committee will be chaired by a member of the board of directors

The number of members in the committee is variable between 2 to 8 including the chairperson preferable consisting of members from various regions of the country

The committee is to meet or communicate via any communications means when necessary to perform its function

The chairman usually calls the meeting but any member can request one through the chairperson

The purpose of the committee is to review remuneration and compensations of physicians practicing addiction medicine/ psychiatry including methadone maintenance and all other branches pertaining to addictions across Canada and to determine their fair value. This purpose can be reviewed from time to time as deemed necessary by the committee with approval by the Board of directors.

## **Education Committee**

### **Preamble:**

The Education committee has been convened on behalf of the CSAM board and membership to address issues of concern to the society and its membership with respect to education in addiction treatment and management.

### **Purpose:**

The purpose of the committee is to define the minimum content for the Fundamentals course and to advocate and support ongoing training in addiction treatment and management

This will be accomplished through:

- Establishing and updating curriculum for the Fundamentals course
- Exploring and developing new educational tools (ie. Computer-based learning)

- Engaging in two way communication with CSAM board and membership to ensure all involved are aware of changing issues in the educational arena

### **Membership:**

The committee will consist of a chair and a minimum of 4 members.

The Committee Chair must be a CSAM Board member and all committee members must be CSAM members.

Terms of membership are subject to periodic review and Board approval.

### **Frequency of Meetings:**

The committee will meet by teleconference on an ad hoc basis. The committee will be given at least two week's notice for each teleconference meeting. The committee will have 1 in-person meeting to coincide with the annual CSAM Scientific Meeting. Members are asked to commit to participate in a minimum of 50% of the teleconferences and to attend the "in person" meeting.

### **Decision Making Process:**

Consensus. In the exceptional circumstance where consensus is unachievable, decisions will be decided by majority vote (50% + 1)

### **Reporting Process:**

Committee will report on its activity regularly at board meetings and at the CSAM annual general meeting.

## **Opioid Agonist Committee**

### **Preamble:**

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

### **Purpose:**

The purpose of the committee is to advocate the ongoing development of "Best Practices" in Opioid Agonist Therapy (OAT) and to advocate and support training for and delivery of such programs.

This will be accomplished through:

- Establishing minimum criteria for training and education for physicians in Opioid Agonist Therapy. This would not include the delivery of such training.
- Evaluating and reviewing, as requested, training for physicians in OAT, to ensure they meet set minimum criteria.

- Producing a Public Policy Statement re OAT, and ensuring said statement remains current.
- Engaging in two way communication with CSAM board and membership to ensure all involved are aware of changing issues in the field of OAT.

### Membership:

The committee will consist of a chair and a maximum of 6 members. Chair and members must be CSAM members.

Terms of membership are subject to periodic review and Board approval.

### Frequency of Meetings:

The committee will meet quarterly; 3 teleconference meetings and 1 “in person” to coincide with the annual CSAM Scientific Meeting. Members are asked to commit to participate in a minimum of 50% of the teleconferences and to attend the “in person” meeting.

### Decision Making Process:

Consensus. In the exceptional circumstance where consensus is unachievable, decisions will be decided by majority vote (50% + 1)

### Reporting Process:

Committee will report on its activity regularly at board meetings and at the CSAM annual general meeting.

## Standards Committee

### Preamble:

The Standards Committee has been convened on behalf of the CSAM board and membership to address issues of concern to the society and its membership with respect to standards of practice.

### Purpose:

The purpose of the committee is to advocate the ongoing development of “Best Practices” in addiction medicine.

This will be accomplished through:

- Establishing minimum criteria for training and education for physicians in addiction medicine. This would not include the delivery of such training.
- Establishing standards of clinical practice for physicians-in-training and for those practicing addiction medicine
- Evaluating and reviewing, as requested, training for physicians in addiction medicine to ensure they meet set minimum criteria for Certification with CSAM.
- Advocating for the establishment of specialty status in Addiction Medicine with the Royal College of Physicians & Surgeons & with the College of Family Physicians of Canada
- Producing Public Policy Statements related to standards of practice as required on an ad hoc basis, and ensuring said

statements remain current

- Engaging in two way communication with CSAM board and membership to ensure all involved are aware of changing issues with respect to standards.

### Membership:

The committee will consist of a Chair that is a member of the CSAM Board, and a minimum of four members. Chair and members must be CSAM members and CSAM Certificants with a minimum of five years of recognized leadership in the field. Terms of membership are subject to periodic review and Board approval.

### Frequency of Meetings:

The committee will meet on an ad hoc basis by teleconference and 1 “in person” to coincide with the annual CSAM Scientific Meeting. Members are asked to commit to participate in a minimum of 50% of the teleconferences and to attend the “in person” meeting.

### Decision Making Process:

Consensus. In the exceptional circumstance where consensus is unachievable, decisions will be decided by majority vote (50% + 1)

### Reporting Process:

Committee will report on its activity regularly at board meetings and at the CSAM annual general meeting.

## Conference Committee

### 1. Purpose and Scope:

To plan and implement all aspects of the current year’s Annual Scientific and provide preliminary planning for the next year’s conference.

### 2. Key Functions:

- 2.1 To choose the location of future Annual Scientific meetings based on promoting CSAM as a national organization.
- 2.2 To select and promote a conference theme that is relevant to national addictions issues.
- 2.3 To identify, solicit and select speakers that can support and promote the conference theme and that are regionally and nationally recognized.
- 2.4 To provide a forum for national and international investigators to present original research.
- 2.5 To provide a forum for addiction medicine professionals to share information, problem solve, investigate and evaluate research, clinical practices, addictions policy and service provision.
- 2.6 Other key functions??

**3. Organization:**

- 3.1 Standing Membership: Membership will be made of the current and past president and a minimum three board members, one of who will act as chair.
- 3.2 Reporting and Accountability: The Conference committee will report to the Executive on a quarterly basis and to the Membership at the Annual General Meeting
- 3.3 Meetings: Phone conferences will be held at a minimum of every sixty days or sooner as need dictates.
- 3.4 Chair: The Conference Committee will be chaired by a board member that has at least one year experience sitting on the committee and will rotate yearly. The committee chair will be chosen at the Annual General Meeting.

**Sponsorship Committee**

**1. Purpose and Scope:**

To solicit and select sponsors for financial support for the Annual Scientific meeting and the Journal of the CSAM.

**2. Key Functions:**

- 2.1 To identify, solicit and select sponsors for various levels of sponsorship at the Annual Scientific Meeting and for the CSAM journal. Other indications??
- 2.2 Other key functions??

**3. Organization:**

- 3.1 Standing Membership: Membership will be made of the current and past president and a minimum three board members, one of whom will act as chair.
- 3.2 Reporting and Accountability: The Sponsorship committee will report to the \_\_\_\_\_ on a \_\_\_\_\_ basis.
- 3.3 Meetings: Phone conferences will be held at a minimum of every sixty days or sooner as need dictates.
- 3.4 Chair: The Sponsorship Committee will be chaired by the a board member that has at least one year experience sitting on the committee and will rotate yearly. The committee chair will be chosen at the Annual General Meeting.

**Membership Report**

*Renewals to date for 2011*

**Total 211**

Hon .....	10
Retired.....	2
Student.....	3
Associates .....	125
PhD .....	1
Physicians .....	70

**By Province**

Alberta.....	15
British Columbia .....	17
Manitoba.....	3
New Brunswick .....	2
Nova Scotia .....	5
Ontario.....	146
PEI .....	1
Quebec.....	10
Sask .....	9
International .....	3

# CSAM 2011 Committees & Membership

## Board of Directors

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President: Dr. Brian Fern

Past President: Dr. Don Ling

President-elect: Dr. Michael Varenbut

Treasurer: Dr. Ron Lim

Secretary: Dr. Jeff Daiter

Alberta: Dr. Samuel Oluwadairo

British Columbia: Dr. Paul Sobey

Saskatchewan: Dr. Wilna Wildenboer-Williams

Manitoba: Dr. Hanka Hulsboch

Quebec: Dr. David Luckow

Quebec: Dr. Charles Mackay

New Brunswick: Dr. Jeff Hans

Nova Scotia: Dr. Bill Doran

Ontario: Dr. Sharon Cirone

Member-at-Large: Dr. Nady el-Guebaly

## Executive Committee

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President: Dr. Brian Fern

Past President: Dr. Don Ling

President-elect: Dr. Michael Varenbut

Treasurer: Dr. Ron Lim

Secretary: Dr. Jeff Daiter

## Bilingual Committee

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Dr. Charles Mackay, Chair

Dr. Leo Lanoie

Dr. David Luckow

## Bylaws Committee

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Dr. Charles Mackay, Chair

Dr. Rob Cooper

## Conference Committee

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Dr. Jeff Daiter, Chair

Dr. Nady el-Guebaly

Dr. Don Ling

Dr. Garth McIver

Dr. Paul Sobey

## Economics Committee

---

Dr. Ron Lim, Chair

Dr. Hugh Colohan

Dr. Nady el-Guebaly

Dr. Ramm Hering

Dr. Ryan Yermus

## Education Committee

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Dr. Sharon Cirone, Chair

Dr. Peter Butt

Dr. David Crockford, Consultant

Dr. Bill Doran

Dr. Nady el-Guebaly, Consultant

Dr. Frank Evans

Dr. Ramm Hering

Dr. Hanka Hulsboch

Dr. Mel Kahan

Dr. Denise Lea

Dr. David Luckow

Dr. Mandy Manak

Dr. Karine Meador

Dr. Marina Reinecke

## Journal Committee

---

Dr. Michael Varenbut, Chair

Dr. Sharon Cirone

Dr. Jeff Daiter

Dr. Nady el-Guebaly

Dr. Bhushan Kapur

Dr. Mel Kahan

Dr. Alice Ordean

## Membership Committee

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Dr. Don Ling, Chair

Dr. Charles Mackay

Dr. Samuel Oluwadairo

Dr. Paul Sobey

Dr. Michael Varenbut

Dr. Rita McCracken

## Nominations Committee

---

Dr. Don Ling, Chair

## Opioid Agonist Committee

---

Dr. Michael Varenbut, Chair

Dr. Suzanne Brissette

Dr. Bill Doran

Dr. Ramm Hering

Dr. Wade Hillier

Dr. David Luckow

Dr. Wilna Wildenboer-Williams

## Sponsorship Committee

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Dr. Charles Mackay, Chair

Dr. Hanka Hulsboch

Dr. Paul Sobey

## Standards Committee

---

Dr. Nady el-Guebaly, Chair

Dr. Jeff Daiter

Dr. Leo Lanoie

Dr. Ron Lim

Dr. Samuel Oluwadairo

## Website Committee

---

Dr. Jeff Daiter, Chair

Dr. David Luckow

# 2011 Membership Renewal Form

<b>Membership Type</b>		
<input type="checkbox"/> Regular Member – MD	<input type="checkbox"/> Regular Member – PhD Scientists	<input type="checkbox"/> Medical Student/Intern/Resident
<input type="checkbox"/> Retirees – MD or PhD	<input type="checkbox"/> Associate Member	

<b>Contact Information</b>				
<input type="checkbox"/> Dr.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss	<input type="checkbox"/> Mr.
Name:				
<i>(First Name)</i>		<i>(Middle Initial)</i>		<i>(Last Name)</i>
Work Address	<input type="checkbox"/> Preferred Mailing Address			
Address:				
City:			Province:	Postal Code:
Work Phone:		Fax:		
Home Address	<input type="checkbox"/> Preferred Mailing Address			
Address:				
City:			Province:	Postal Code:
Home Phone:		Email Contact*		

<b>Email Contact*</b> (please provide password you would like)
Are you interested in Canadian Certification in Addiction Medicine? (Member – MD only) <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Positions in the Society You Would Be Willing To Consider in the Future</b>				
<input type="checkbox"/> Board Member (Please note: Associate members are not eligible for board positions)				
<input type="checkbox"/> Committee Membership:	<input type="checkbox"/> Standards	<input type="checkbox"/> Website	<input type="checkbox"/> Opioid Agonist	
	<input type="checkbox"/> Education	<input type="checkbox"/> Membership	<input type="checkbox"/> Conference	
I will allow my name & contact information to be in a password-protected Member's Section directory on the CSAM webpages?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signature:				

<b>Annual Fees</b>			
<input type="checkbox"/> Regular Member – M.D.: \$200.00	<input type="checkbox"/> Student/Intern/Resident: \$5.00		
<input type="checkbox"/> Regular Member – PhD : \$200.00	<input type="checkbox"/> Retirees MD or PhD: \$25.00		
<input type="checkbox"/> Associate Member: \$50.00			
<input type="checkbox"/> Optional: International Society of Addiction Medicine (ISAM) Dues – (US \$100.00 effective January 2011) \$100.00			
PLEASE process payment for:	<input type="checkbox"/> One year	<input type="checkbox"/> 3 years \$549.00	<input type="checkbox"/> 5 years \$900.00
*TOTAL PAYMENT: \$			
<input type="checkbox"/> Cheque, Bank Draft or Money Order Payable to: The Canadian Society of Addiction Medicine or			
<input type="checkbox"/> VISA/Master Card (circle one) #			Expiry Date
Name on Card:		Signature:	

# 2011 Application Form for Certification by CSAM/SMCA

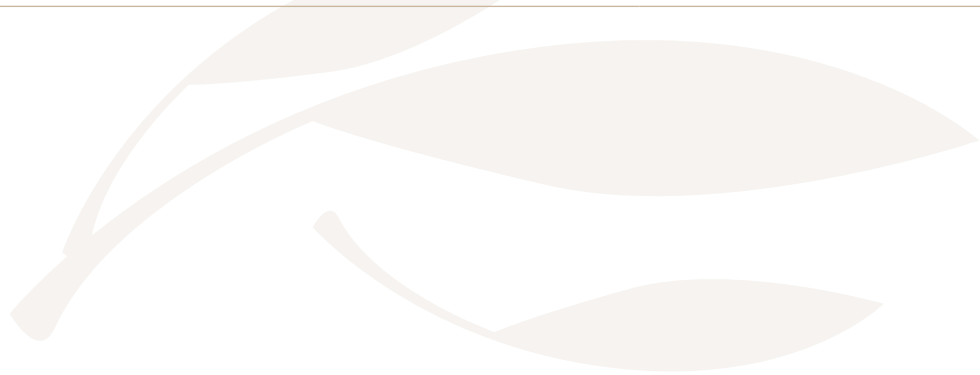
<b>Applicant Information</b>			
Name:			
<i>(First Name)</i>	<i>(Middle Initial)</i>	<i>(Last Name)</i>	
Address:			
City:		Province:	Postal Code:
Work Phone:	Fax:		
Primary Email:			

<b>Education History</b>
Undergraduate Degree(s)/University/Year Graduated:
Graduate Degree(s)/University/Year Graduated:
Area of Specialty:

<b>Current Employment:</b>
Area of Employment:
<input type="checkbox"/> Private Practice <input type="checkbox"/> Treatment Centre <input type="checkbox"/> Educational Facility <input type="checkbox"/> Other (please specify) :
Appointment(s) – Hospital/University/College Including Department:

<b>Addiction Medicine Affiliations</b>	
American Society of Addiction Medicine (ASAM):	<input type="checkbox"/> Member
	<input type="checkbox"/> Certificant      Year of Certification/recertification:
	<input type="checkbox"/> Fellow      Year of Fellowship:
International Society of Addiction Medicine (ISAM):	<input type="checkbox"/> Member
	<input type="checkbox"/> Certificant      Year of Certification/recertification:

<b>Current License to Practice</b>	
Province/Registration Number	
Are there any current restrictions on your license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>*Please attach an explanation on a separate sheet. This information will be treated in strict confidence and not used for any reporting or punitive purposes.</i> <b>PLEASE NOTE: applications will be accepted only till August 1, 2011.</b>	



**Please check appropriate part and attach appropriate documents**

CSAM member for 2 years

**Pathway “A”:**

Letter of good standing certifying membership with the Professional Corporation of Physicians of Quebec OR the Royal College of Physicians and Surgeons of Canada OR the College of Family Physicians of Canada

Letter of reference from a physician in your community who can testify to your successful completion of one year full time involvement, or 50% over two years in the field of Addiction

**Pathway “B”:**

Letter of reference from a physician in your community who can testify to your successful completion of one year full time involvement, or 50% over two years in the field of Addiction

Attendance at the Canadian Society of Addiction Medicine Annual meeting, or its equivalent, for the two years prior to certification and show evidence of annual completion of a minimum of 25 hours of Continuing Medical Education credits in Addiction Medicine for each of the preceding two years prior to application for certification.

**Affidavit**

By signing below, I agree to the following three paragraphs:

I successfully sat the American Society of Addiction Medicine (ASAM) or the International Society of Addiction Medicine (ISAM) exam:  
Date: \_\_\_\_\_

I hereby certify that all the above information is correct and complete. I understand that CSAM officers or their designate may verify the accuracy of information in this application from appropriate organizations. I understand that incomplete applications will not be processed for review by the CSAM Standards Committee.

I hereby release, discharge and exonerate the CSAM Board, its Directors, Officers, Members, Examiners, Representatives and Agents from any actions, suits, obligations, damages, claims or demands arising out of, or in connection with this application or the failure of the CSAM Board to issue me a Certificate. It is understood that the decision to issue a Certificate testifying Certificant of the Canadian Society of Addiction Medicine (CCSAM) rests solely and exclusively in the Board and its decision will be final.

Applicant’s Signature

Date

**Payment Information**

Certification Application Processing Fee: \$100.00 CDN

Fees may be paid by Cheque, Bank Draft or Money Order Payable to *The Canadian Society of Addiction Medicine* or

VISA/Master Card (circle one) #

Expiry Date

Name on Card:

Signature:

## CSAM BOARD OF DIRECTORS

### President

Dr. Brian Fern

### Past President

Dr. Don Ling

### President-Elect

Dr. Michael Varenbut

### Secretary/Treasurer

Dr. Ron Lim

### BC Regional Director

Dr. Paul Sobey

### AB Regional Director

Dr. Samuel Oluwadairo

### SK Regional Director

Dr. Wilna Wildenboer-Williams

### MB Regional Director

Dr. Hanka Hulsbosch

### Ontario Regional Directors

Dr. Sharon Cirone

Dr. Jeff Daiter

### Quebec Regional Directors

Dr. David Luckow

Dr. Charles Mackay

### New Brunswick Regional Director

Dr. Jeff Hans

### Nova Scotia Regional Director

Dr. William Doran

### Newfoundland & Labrador Regional Director

Vacant

### Member at Large

Dr. Nady el-Guebaly

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