REGIONE DEL VENETO
giunta regionale

Progetto
START

Presidenza del Consiglio dei Ministri
Dipartimento Nazionale per le Politiche Antidroga

Osservatorio Regionale sulle Dipendenze

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Cocaine Related Disorders

THE CHALLENGE OF THE CLINICAL MANAGEMENT

RETROSPECTIVE STUDY PRELIMINARY DATA

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WHY IS IT A CHALLENGE?

BECAUSE THERE ARE

HANDFUL OF INTERESTING PROBLEMS

1°

THEY LOOK FOR EXCITEMENT BUT... (1.2.3.)

- Difficult identification with outpatient service for intravenous heroine
- Pre-contemplation stage of change

2°

MANY USE COCAINE
FEW SEEK TREATMENT

3°

DROP - OUT

- The therapeutic alliance is difficult for several reason
- Our treatment "menu" is not interesting enough for those clients

4°

OUTPATIENT SERVICE:
BIG PROBLEMS
FEW RESOURCES

...

SORRY, BUT WHY THOSE PROBLEMS SHOULD HAVE TO BE "MY" PROBLEMS?

IF YOUR ANSWER IS

"BECAUSE IT'S MY JOB"

PLEASE FOLLOW ME

WHERE ARE WE GOING?

WE ARE GOING TO...

THE BEST POSSIBLE

"EVIDENCE BASED"

CLINICAL PRACTICE FOR MY CLIENT

So our goal is

a

GOOD DIAGNOSIS

for a

GOOD TREATMENT

DO WE HAVE A STRATEGY?

Strategy: identify a main target, define the specific goals and resources

Tactics: how to realize the specific goals

LET'S THINK & WRITE OUR

STRATEGY

Writing…

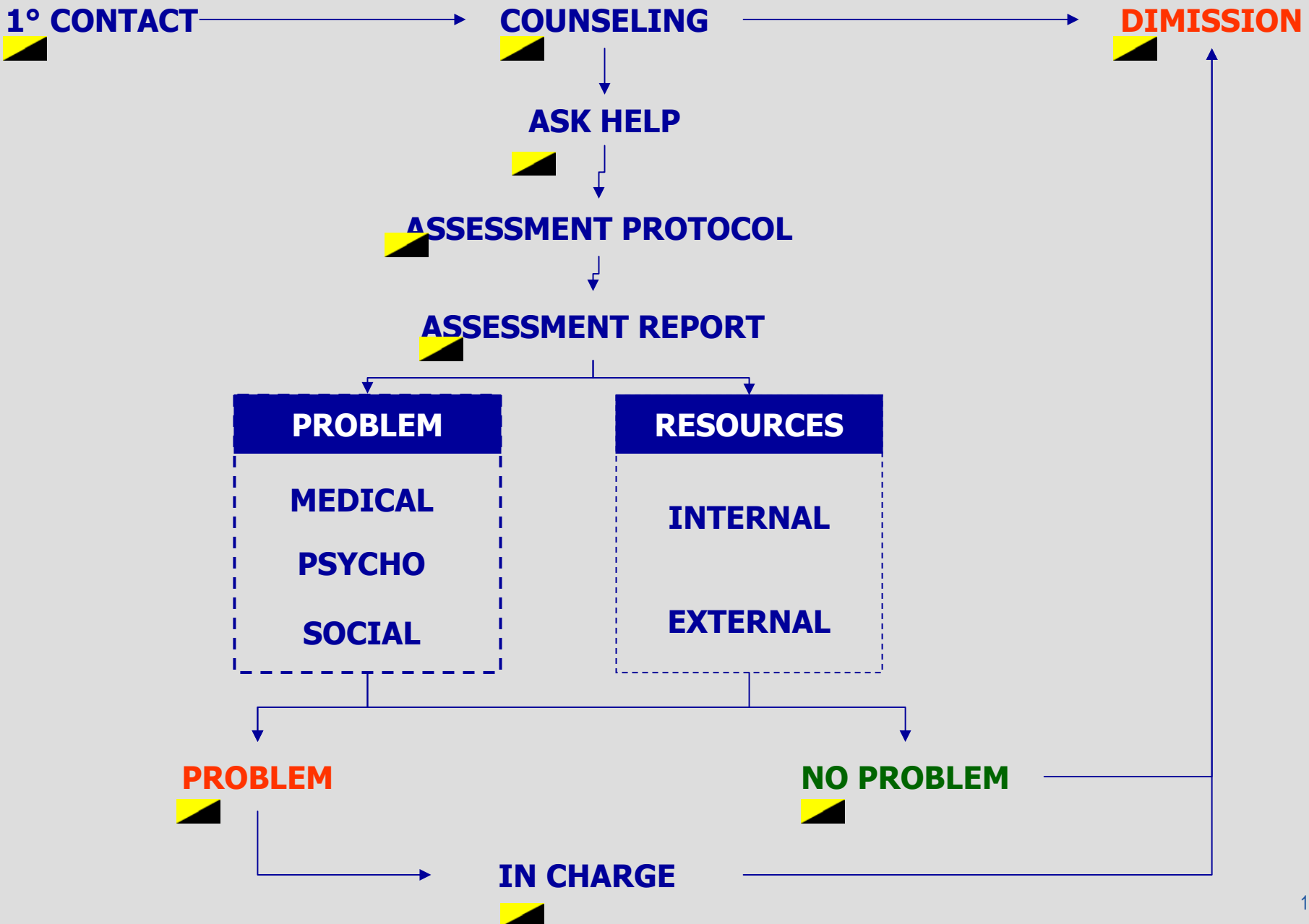
1. Intake

2. Assessment

3. Treatment

4. Outcome

Desing a flow chart....



1. INTAKE

Make the right choice

"STAGE OF CHANGE"

All is moving….

Stage of change is like a GPS, that give you always your position from the intake to the outcome and this is a great resource for the clinical management

2. ASSESSMENT

2. Assessment

Assessment of what?

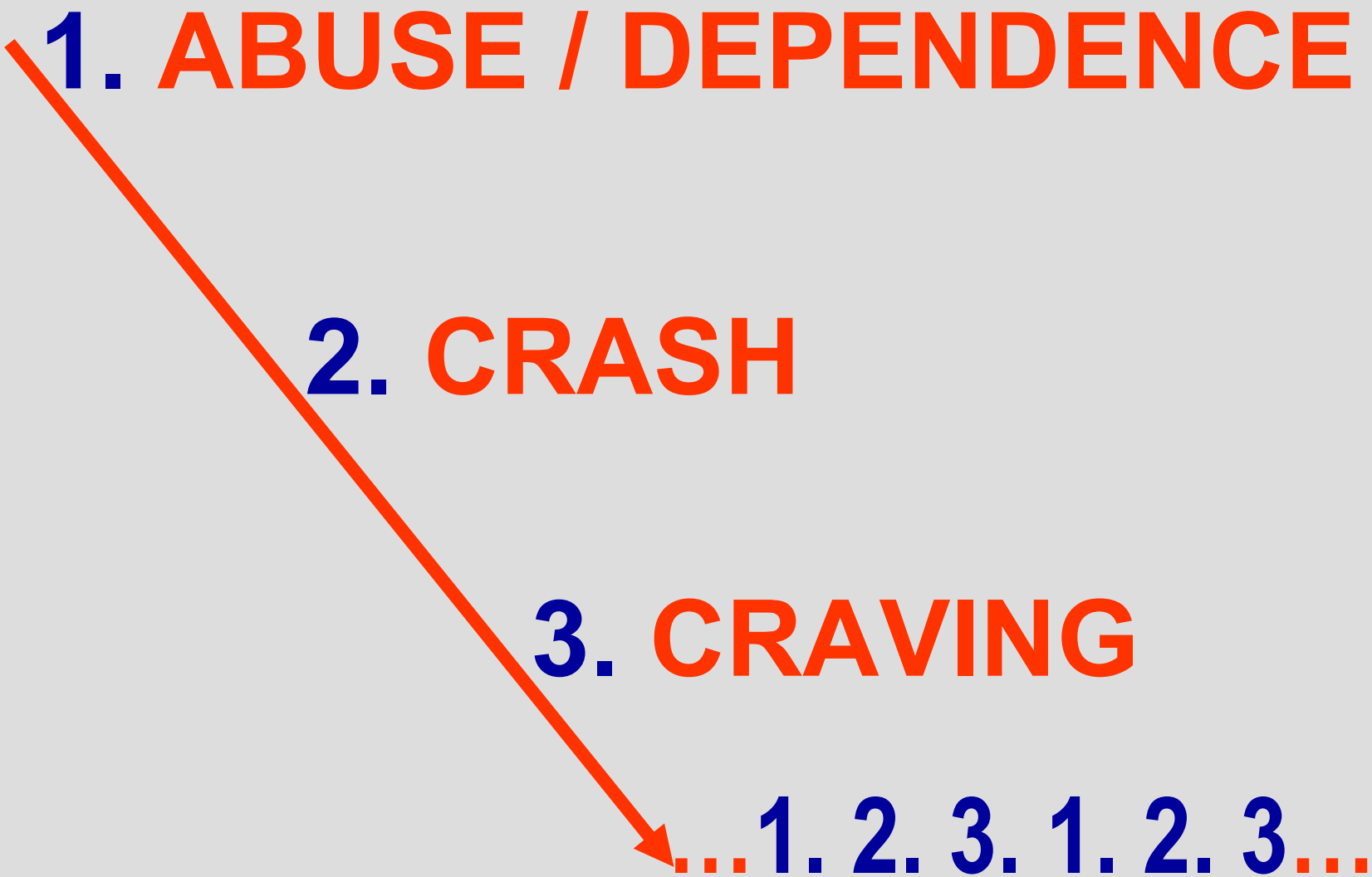
A PERSON

WHO AT THAT TIME

ASKS YOU HELP FOR… COCAINE TREATMENT

THAT PERSON MAY PRESENT THREE DIFFERENT CLINICAL CONDITIONS

2. Assess



2. Assessment

To have a good diagnosis of the follow conditions

1. **ABUSE / DEPENDENCE**
2. **CRASH**
3. **CRAVING**

WE HAVE TO KNOW SYMPTOMS AND SIGNS

SIGNS & SYMPTOMS

2. Assessment

Never forget that:

SYMPTOMS

are "reported" by the client

Insomnia, delusion…

SIGNS

are "watched" by the clinician

Hearth rate, blood pressure, restricted pupils , dilated pupils

2. Assessment

TARGETING ASSESSMENT

1	FULL ASSESSMENT	The goal is: - To record what the person asks - To identify Problems & Resources
2	WORK FOR	having clinical conditions for FULL ASSESSMENT. Watch your client in the management of the 1.2.3 steps
3	DIRECT ASSESSMENT	Explain to your client that you need to make a FULL ASSESSMENT
4	INDIRECT ASSESSMENT	Search information during the management setting

2. Assessment

Short-Term Signs & Symptoms of Cocaine Use

	SIGN	SYMPTOM
Increased energy		SYMPTOM
Decreased appetite		SYMPTOM
Mental alertness	SIGN	SYMPTOM
Increased heart rate	SIGN	
Increased blood pressure	SIGN	
Constricted blood vessels	SIGN	
Increased temperature	SIGN	
Dilated pupils	SIGN	

2. Assessment

Long-Term Signs & Symptoms of Cocaine		
	SIGN	SYMPTOM
Nervousness	SIGN	
Mood disturbances		SYMPTOM
Restlessness		SYMPTOM
Paranoia		SYMPTOM
Auditory hallucinations		SYMPTOM

2. Assessment

SUBSTANCE STORY

PRIMARY SUBSTANCE AT THE MOMENT

OTHERS SUBSTANCES

STORY OF SUBSTACE RELATE DISORDERS

PSYCHIATRIC

SIGNS AND SYMPTOMS: check at the moment

CONDITIONS: how to manage 1.2.3 abuse/dependence, crash, craving

SPECIFIC COMORBIDITY: ADHD, PTSD

PSYCHOSIS: hallucinations, delusion

PSYCHOLOGICAL

STAGE OF CHANGE: stage of the change

COGNITIVE: IQ

2. Assessment

PROBLEMS / DIAGNOSIS	RESOURCES
Cocaine Related Problems	/
Neurological	/
Cardiovascular	/
Psychiatric	/
Psychological	IQ, Contemplation, Action
Enviorment	Job, Family, School..

ADHD & PTSD

ADHD

ADHD

A)	**Either 1 or 2**
1)	Six or more of the following symptoms of **inattention** have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level: **INATTENTION** Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities Often has difficulty sustaining attention in tasks or play activities Often does not seem to listen when spoken to directly Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions) Often has difficulty organizing tasks and activities Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework) Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools) Is often easily distracted by extraneous stimuli Is often forgetful in daily activities
2)	Six or more of the following symptoms of **hyperactivity/impulsivity** have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level **HYPERACTIVITY** Often fidgets with hands or feet or squirms in seat Often leaves seat in classroom or in other situations in which remaining seated is expected Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) Often has difficulty playing or engaging in leisure activities quietly Is often "on the go" or often acts as if "driven by a motor" Often talks excessively **IMPULSIVITY** Often blurts out answers before questions have been completed Often has difficulty awaiting turn Often interrupts or intrudes on others (e.g. butts into conversations or games
B)	Some hyperactive, impulsive or inattentive symptoms that caused impairment were present before 7 years of age
C)	Some impairment from the symptoms is present in two or more settings (e.g., at school or work and at home)
D)	There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning
E)	The symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder, and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder.)

Attention-Deficit/Hyperactivity Disorder	
314.XX	Attention-Deficit/Hyperactivity Disorder
314.01	Combined Type
314.00	Predominantly Inattentive Type
314.01	Predominantly Hyperactive-Impulsive Type
314.9	Attention-Deficit/Hyperactivity Disorder

PTSD

PTSD

A) The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. (2) the person's response involved intense fear, helplessness, or horror.
Note: In children, this may be expressed instead by disorganized or agitated behavior.

B) The traumatic even is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, and/or perceptions.
Note: In young children, repetitive play may occur in which these or other aspects of the trauma are expressed. (2) recurrent distressing dreams of the event.
Note: In young children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and/or dissociative flashback episodes, including those that occur on awakening or when intoxicated).
Note: In young children, trauma-specific re-enactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

(1) efforts to avoid thoughts, feelings, and/or conversations associated with the trauma (2) efforts to avoid activities, places, and/or people that arouse recollections of the trauma.

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (*e.g.*, inability to have loving feelings)

(7) sense of a foreshortened future (*e.g.*, does not expect to have a career, marriage, children, or a normal life span)

D) Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

(1) difficulty falling or staying asleep (2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

PTSD CLASSIFICATION	
ACUTE	If duration of symptoms is less than 3 months
CHRONIC	If duration of sympthoms is 3 months or more
WITH DELAYED ONSET	If onset of symptoms is at least 6 months after the stressor

BENEFITS

To know

To treat

RISKS

Too much easy / difficult to identify

Unknow

Untreat

Najavits LM, Gastfriend DR, Barber JP, Reif S, Muenz LR, Blaine J, Frank A, Crits-Christoph P, Thase M, Weiss RD. Cocaine dependence with and without PTSD among subjects in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study.Am J Psychiatry. Feb;155(2):214-9.

These findings underscore the value of screening substance abusers for PTSD, because it can identify a small but substantial number who might require additional treatment. Further studies of the relationship between PTSD and substance abuse appear warranted.

1998

Schubiner H. Substance abuse in patients with attention-deficit hyperactivity disorder: therapeutic implications. CNS Drugs. 2005;19(8):643-55. Review.

20--30% of adults with SUD have concomitant ADHD

20--40% of adults with ADHD have histories of SUD

Ros Soler A, Valoria Martinez A, Nieto Munuera J. [Cocaine and other psychostimulant consumption: their relationship with the childhood hyperactivity syndrome] Actas Esp Psiquiatr. 2004 Nov-Dec;32(6):346-52. Review. Spanish.

21 % of the cocaine consumers have a comorbid history of ADHD in childhood versus 3% of the control group.

Wilson JJ, Levin FR. Attention-deficit/hyperactivity disorder and early-onset substance use disorders. J Child Adolesc Psychopharmacol. 2005 Oct;15(5):751-63. Review.

Treatment of ADHD among adults, and possibly adolescents, with SUD can reduce their risk of relapse.

ADHD can be an important factor in the pathogenesis and maintenance of SUD; moreover, retrospective studies suggest that treating ADHD during childhood may prevent the development of SUD

Linares TJ, Singer LT, Kirchner HL, Short EJ, Min MO, Hussey P, Minnes S. Mental health outcomes of cocaine-exposed children at 6 years of age. J Pediatr Psychol. 2006 Jan-Feb;31(1):85-97. Epub 2005 Mar 31.

CE children report more symptoms of ODD and ADHD than nonexposed children.

Adoptive or foster caregivers rated their CE children as having more behavioral problems than did maternal or relative caregivers of CE children or parents of NCE children.

Although further studies are needed to understand the basis for the more negative ratings by adoptive or foster caregivers of their CE children, the self-report of CE children indicates a need for psychological interventions.

Back SE, Brady KT, Jaanimagi U, Jackson JL. Cocaine dependence and PTSD: a pilot study of symptom interplay and treatment preferences. Addict Behav. 2006 Feb;31(2):351-4. Epub 2005 Jun 13.

PTSD is present in a sizeable percentage of cocaine-dependent treatment-seeking patients, particularly women. Clinicians might address arousal symptoms in particular, which were the most prominent symptom cluster, and which may be exacerbated by cocaine use.

Eden among those without PTSD, lifetime trauma is substantial and subthreshold PTSD symptoms are common. Vulnerability to PTSD needs further study, as sociodemographic and cocaine use variables did not distinguish between PTSD and non-PTSD groups.

VERONA - IOWA

VERONA – IOWA… WHAT IS COOKING

STUDY	TYPE	STEP
PATHOLOGICAL COMPUTER USE	Review with diagnosis paradigm	Submitted to the editor
	First National Survey	Ending to submit
	Experimentation of the diagnosis paradigm	In progress
	Web clinic	In progress
VULNERABILITY TO ADDICTIVE BEHAVIOUR	Retrospective study	In progress
	Prospective study	In progress
	Communication strategy	In progress

RETROSPECTIVE	
VERONA – IOWA MODEL	A disease come in the life of people in which **RISK FACTORS** are heavier than **PROTECTIVE FACTORS**
LIST	A list of Evidence Based list of **R/P** Factors has been defined
GOAL	To screen the drug abuse clients of outpatient service
COSTS	Funds from Regional Institutions

OUTLOOK

WHAT IS BETTER TO DO?

LEARNING TO KNOW RISKS / BENEFITS

TO MAKE A CHOICE
(don’t make it by ear)

TO MAKE IT STEP BY STEP

THE END