

Multidisciplinarietà ed integrazione tra i servizi per dare risposte al territorio

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5 agosto 1999: Intesa Stato-Regioni

Art. 10 Intesa Stato-Regioni 5 agosto 1999

Al fine dell'accreditamento, i servizi offerti dagli enti o associazioni che intendono accedere all'accreditamento, sono raggruppati nelle seguenti aree di prestazione, in base al programma complessivo:

- 1) servizi di accoglienza;
- 2) servizi terapeutico-riabilitativi;
- 3) servizi di trattamento specialistici;
- 4) servizi pedagogico-riabilitativi;
- 5) **servizi di tipo multidisciplinare integrato.**



Funzione pubblica e sussidiarietà

Con la riforma del titolo V della Costituzione il carattere di “funzione pubblica” non è dato dal soggetto che esercita l’azione, ma dalle caratteristiche dell’azione esercitata.

Se la prestazione di un servizio:

- segue regole stabilite legittimamente;
- è universale, aperta a tutti;
- è continuativa;
- offre beni pubblici

allora è un’azione pubblica.

Sul piano giuridico questo è un dato di fatto e rappresenta il fondamento dell’attuale sistema di interventi basato sulla sussidiarietà.



Servizi ambulatoriali delle dipendenze

Ser.D.

Servizio
dipendenze

Servizi
ambulatoriali
delle dipendenze

Gestione:
pubblica

S.M.I.

Servizio
multidisciplinare
integrato

Servizi
ambulatoriali
delle dipendenze

Gestione: privato-
sociale

ENTRAMBI
SVOLGONO
FUNZIONE
PUBBLICA





La Regione Lombardia recepisce l'Atto di Intesa e delibera l'accreditamento e la contrattualizzazione degli S.M.I. con la DGR 12621/2003 e successive.

Complessivamente in Lombardia sono presenti 12 S.M.I.

In provincia di Brescia ci sono due Enti gestori (Consorzio Gli Acrobati e Cooperativa Il Mago di Oz) per un totale di 4 S.M.I.



Necessità, vizio o
virtù?



BISOGNI SOCIO-SANITARI
COMPLESSI



ASSISTENZA INTEGRATA

EFFICACE

APPROPRIATA



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graph LR; A[DIFFICOLTÀ NELL'ACCESSO ALLE CURE] --> B[TARDIVO RICONOSCIMENTO DEI BISOGNI DI SALUTE]; B --> C[AUMENTO DELLA DURATA DI MALATTIA NON TRATTATA];
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DIFFICOLTÀ
NELL'ACCESSO
ALLE CURE

TARDIVO
RICONOSCIMENTO
DEI BISOGNI DI
SALUTE

AUMENTO DELLA
DURATA DI
MALATTIA NON
TRATTATA





STRUTTURAZIONE DEL
PERCORSO ASSISTENZIALE

RISPONDERE AI BISOGNI
INDIVIDUALI

COORDINAMENTO
ORGANIZZATIVO DEL PERCORSO

Altre problematiche...



La presenza di pluripatologie richiede l'intervento di diverse figure professionali ma c'è il rischio che i singoli professionisti intervengano in modo frammentario, focalizzando l'intervento più sul trattamento della malattia che sulla gestione del malato nella sua interezza, dando talvolta origine a soluzioni contrastanti, con possibili duplicazioni diagnostiche e terapeutiche che contribuiscono all'aumento della spesa sanitaria e rendono difficoltosa la partecipazione del paziente al processo di cura.



Disturbi correlati a sostanze e comportamentali: patologie complesse

- Genesi multifattoriale
- Fortemente invalidanti sui diversi piani del funzionamento
- Andamento cronico e recidivante
- Craving intenso, perdita del controllo, passaggio all'agito
- Conseguenze infettivologiche, sociali, legali...
- La problematica coinvolge l'individuo ed il nucleo familiare ristretto ed allargato



Disturbi correlati a sostanze e comportamentali: patologie complesse

Alternazioni
cognitive

Incidentalità e
violenze

Perdita di
produttività
reddituale

Attività
criminale

Problemi
finanziari

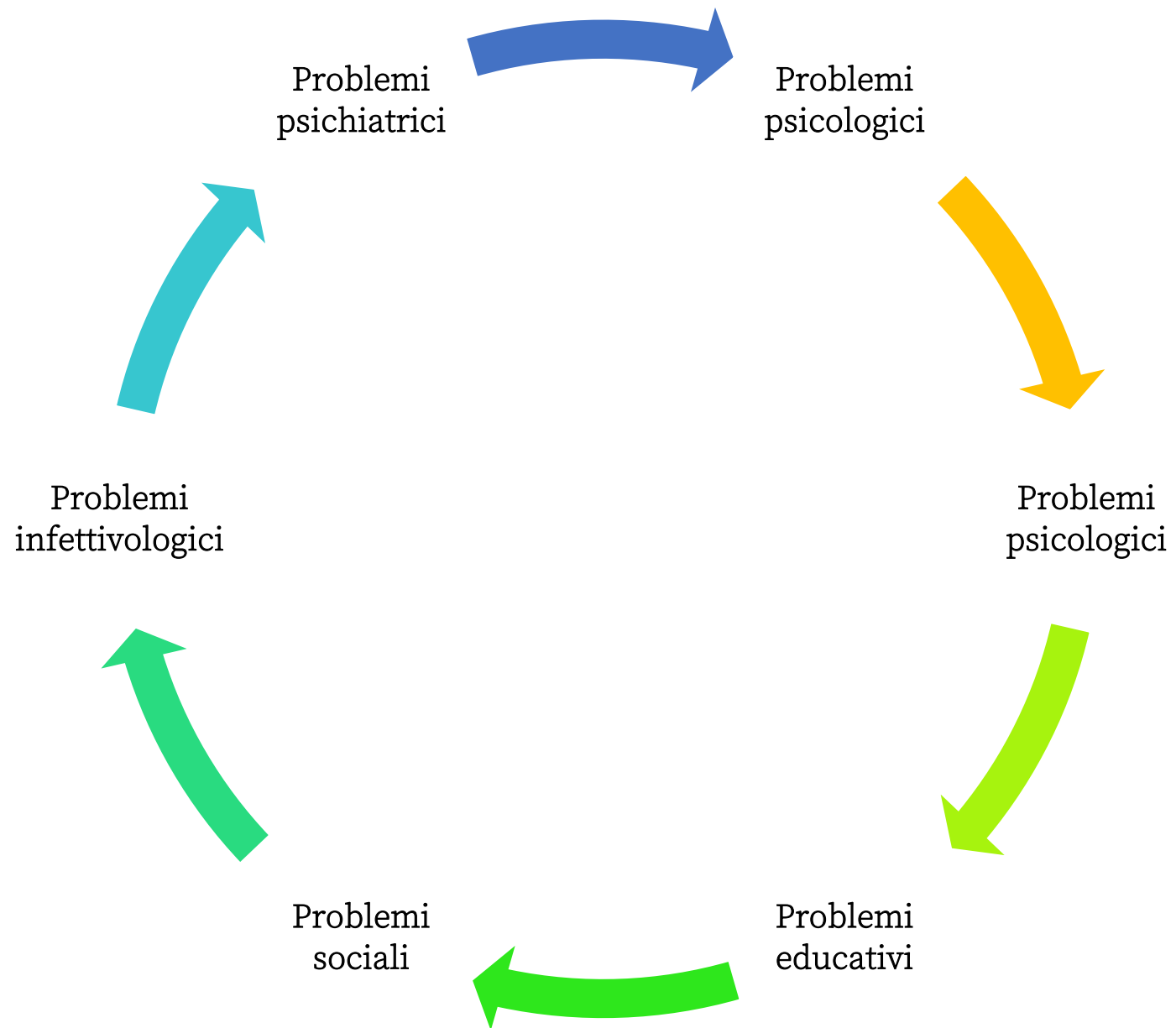
Malattie
infettive

Disturbi
psichiatrici

Mancato
sviluppo di
social skills



Multi problematicità

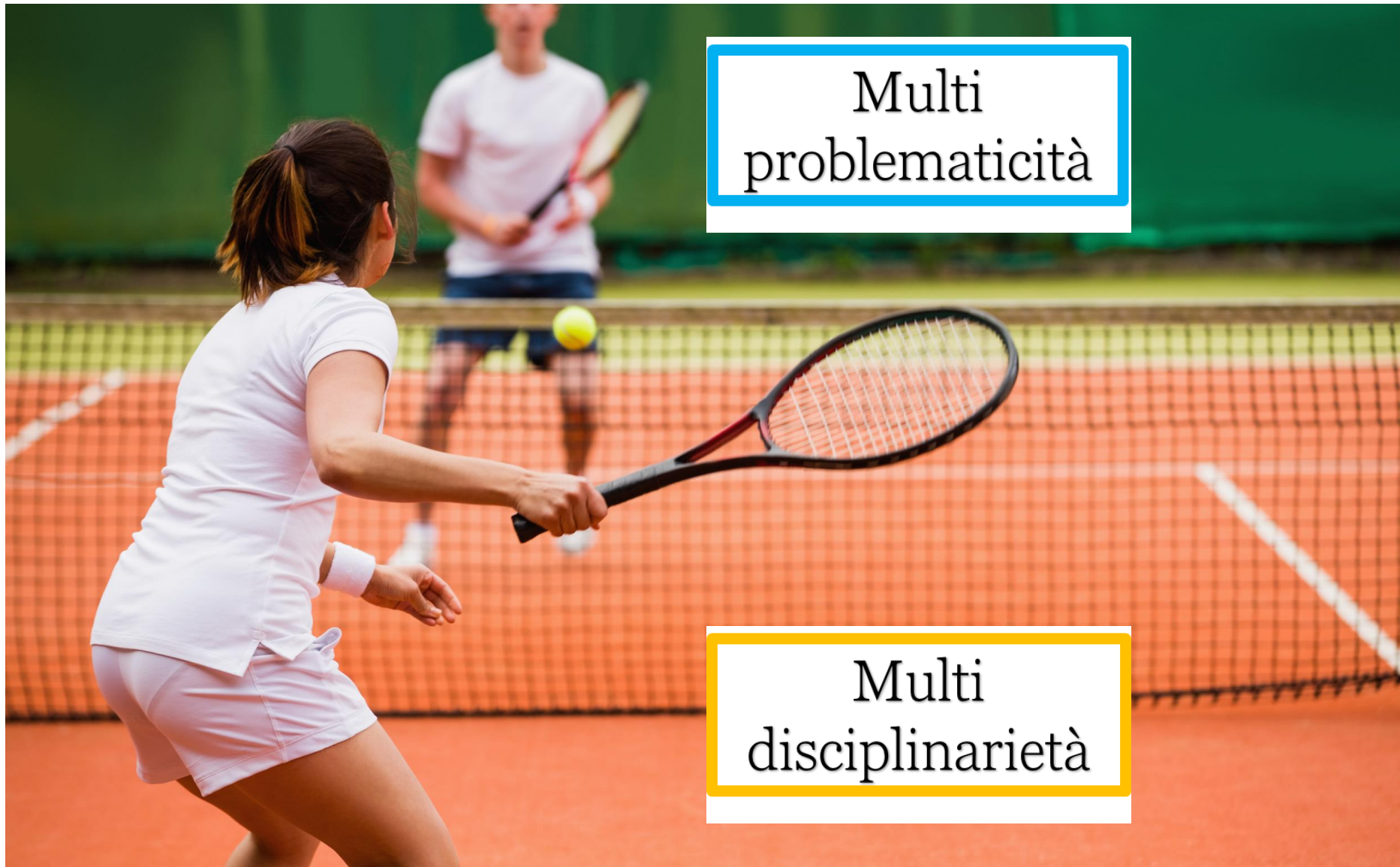


Necessità, vizio o
virtù?



Assoluta
necessità....





Multi
problematicità

Multi
disciplinarietà



Multi
disciplinarietà

Educatori

Medici
specialisti

Infermieri

Psicoterapeuti

Assistenti
sociali



Treatment of opioid use disorder in primary care

Megan Buresh,^{1,2} Robert Stern,¹ Darius Rastegar¹

thebmj | BMJ 2021;373:n784 | doi: 10.1136/bmj.n784

Introduction

Opioid use disorder (OUD) is a common problem that contributes to morbidity and mortality worldwide.^{1,2} Moreover, many people with OUD use needles to administer the drug, leading to infectious complications including HIV and hepatitis B and C.³ Over the past few decades, the United States has seen a rise in the prescribing of opioids and, with it, a rise in non-medical use of prescription opioids (taking opioids for purposes or in a manner other than intended by the prescriber), OUD, and opioid overdose.⁴ Although the opioid overdose epidemic began with an increase in mortality related to prescription opioids, with tightening of access to those it shifted to heroin in 2010 and then synthetic opioids such as fentanyl since 2013. This review is aimed at clinicians caring for patients with OUD and researchers interested in advances in treatment.

Deaths in the US due to opioid overdose have increased sevenfold from 2000 to 2015, leading to a decrease in life expectancy.⁵ Recent increases in deaths due to opioid overdose in the US have been primarily driven by illicit fentanyl use.⁶ The covid-19 pandemic has led to an increase in deaths due to overdose in 2020,⁷ adding urgency to the need for screening and treatment in primary care settings.

As with other chronic medical conditions, primary care clinicians are on the front line of identifying and treating people with OUD. Moreover, the need for OUD treatment in the US exceeds the capacity of specialty programs.⁸ Substance use disorders (SUD) have traditionally been treated in specialized programs separate from other healthcare, but an increasing move toward the integration of SUD treatment into primary care is supported by evidence.⁹ SUDs have much in common with other chronic medical conditions treated in a primary care setting; for example, type 2 diabetes, like SUD, is the consequence of a complex interplay of genetics, environment, physiology, and behavior. In addition to decreasing OUD related morbidity and mortality, providing buprenorphine for OUD in a primary care setting improves the care and outcomes of other chronic medical conditions, particularly HIV and hepatitis C virus (HCV).¹⁰⁻¹²

The segregation of OUD in the US into federally regulated opioid treatment programs separates care from other medical treatment, perpetuates the stigma associated with this condition, and is a barrier to getting treatment. In particular, receiving treatment at sites that only treat patients with OUD, such as opioid treatment programs, explicitly identifies a

Treatment of opioid use disorder in primary care

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Conclusions

Opioid use disorder is a common, treatable chronic disease that can be managed effectively in primary care settings. Untreated OUD is associated with considerable morbidity and mortality—notably, overdose and infectious complications of injecting drug use. Withdrawal management and medication tapers are not effective and are associated with increased rates of relapse and death. Treatment with pharmacotherapy is the mainstay of OUD treatment, and evidence strongly supports its integration into primary care settings. The strongest evidence is for

the opioid agonists buprenorphine and methadone, with less evidence for the opioid antagonist extended release naltrexone. Treating OUD in primary care settings is cost effective and improves medical outcomes, particularly in patients with HIV and HCV. More research is needed on the role of behavioral interventions in supporting pharmacotherapy. Further work is also needed to promote the integration of OUD treatment into primary care and to overcome regulatory barriers to integrating methadone into primary care treatment in the US.



Integrating Primary Medical Care With Addiction Treatment

A Randomized Controlled Trial

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THE PREVALENCE OF MEDICAL and psychiatric conditions is high among individuals with alcohol and other drug disorders. Medical conditions related to substance use include hypertension, coronary artery disease, chronic liver disease, and hepatitis C¹⁻⁶; psychiatric conditions include depression and anxiety disorders.⁷⁻¹¹ However, medical care, even screening, is seldom provided as part of substance abuse treatment, and medical and substance abuse services are most often separate and largely uncoordinated.¹²⁻¹⁸ Most addiction treatment is “carved out” of health plans, ie, provided by contracted behavioral health organizations. Even in health plans in which addiction treatment is provided internally, it is not often integrated with medical care.

Studies have suggested that medical services may benefit substance abuse treatment outcomes if medical staff are knowledgeable about addiction disorders and involved in treatment.¹⁹ Ease of access and more appropriate medical care may facilitate more, or more ef-

Context The prevalence of medical disorders is high among substance abuse patients, yet medical services are seldom provided in coordination with substance abuse treatment.

Objective To examine differences in treatment outcomes and costs between integrated and independent models of medical and substance abuse care as well as the effect of integrated care in a subgroup of patients with substance abuse–related medical conditions (SAMCs).

Design Randomized controlled trial conducted between April 1997 and December 1998.

Setting and Patients Adult men and women (n=592) who were admitted to a large health maintenance organization chemical dependency program in Sacramento, Calif.

Interventions Patients were randomly assigned to receive treatment through an integrated model, in which primary health care was included within the addiction treatment program (n=285), or an independent treatment-as-usual model, in which primary care and substance abuse treatment were provided separately (n=307). Both programs were group based and lasted 8 weeks, with 10 months of aftercare available.

Main Outcome Measures Abstinence outcomes, treatment utilization, and costs 6 months after randomization.

Results Both groups showed improvement on all drug and alcohol measures. Overall, there were no differences in total abstinence rates between the integrated care and independent care groups (68% vs 63%, $P=.18$). For patients without SAMCs, there were also no differences in abstinence rates (integrated care, 66% vs independent care, 73%; $P=.23$) and there was a slight but nonsignificant trend of higher costs for the integrated care group (\$367.96 vs \$324.09, $P=.19$). However, patients with SAMCs (n=341) were more likely to be abstinent in the integrated care group than the independent care group (69% vs 55%, $P=.006$; odds ratio [OR], 1.90; 95% confidence interval [CI], 1.22-2.97). This was true for both those with medical (OR, 3.38; 95% CI, 1.68-6.80) and psychiatric (OR, 2.10; 95% CI, 1.04-4.25) SAMCs. Patients with SAMCs had a slight but nonsignificant trend of higher costs in the integrated care group (\$470.81 vs \$427.95, $P=.14$). The incremental cost-effectiveness ratio per additional abstinent patient with an SAMC in the integrated care group was \$1581.

Conclusions Individuals with SAMCs benefit from integrated medical and substance abuse treatment, and such an approach can be cost-effective. These findings are relevant given the high prevalence and cost of medical conditions among substance abuse patients, new developments in medications for addiction, and recent legislation on parity of substance abuse with other medical benefits.

JAMA. 2001;286:1715-1723

www.jama.com

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The ASAM NATIONAL PRACTICE GUIDELINE For the Treatment of Opioid Use Disorder

2020 Focused Update



ASAM American Society of
Addiction Medicine

Part 7: Psychosocial Treatment in Conjunction with Medications for the Treatment of Opioid Use Disorder

1. **MAJOR REVISION** Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment, based on their individual needs, in conjunction with any pharmacotherapy for the treatment of, or prevention of relapse to, opioid use disorder. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of opioid use disorder, with appropriate medication management. Motivational interviewing or enhancement can be used to encourage patients to engage in psychosocial treatment services appropriate for addressing their individual needs.
2. Treatment planning should include collaboration with qualified behavioral healthcare providers to determine the optimal type and intensity of psychosocial treatment and for renegotiation of the treatment plan for circumstances in which patients do not adhere to recommended plans for, or referrals to, psychosocial treatment.



The ASAM NATIONAL PRACTICE GUIDELINE For the Treatment of Opioid Use Disorder

2020 Focused Update

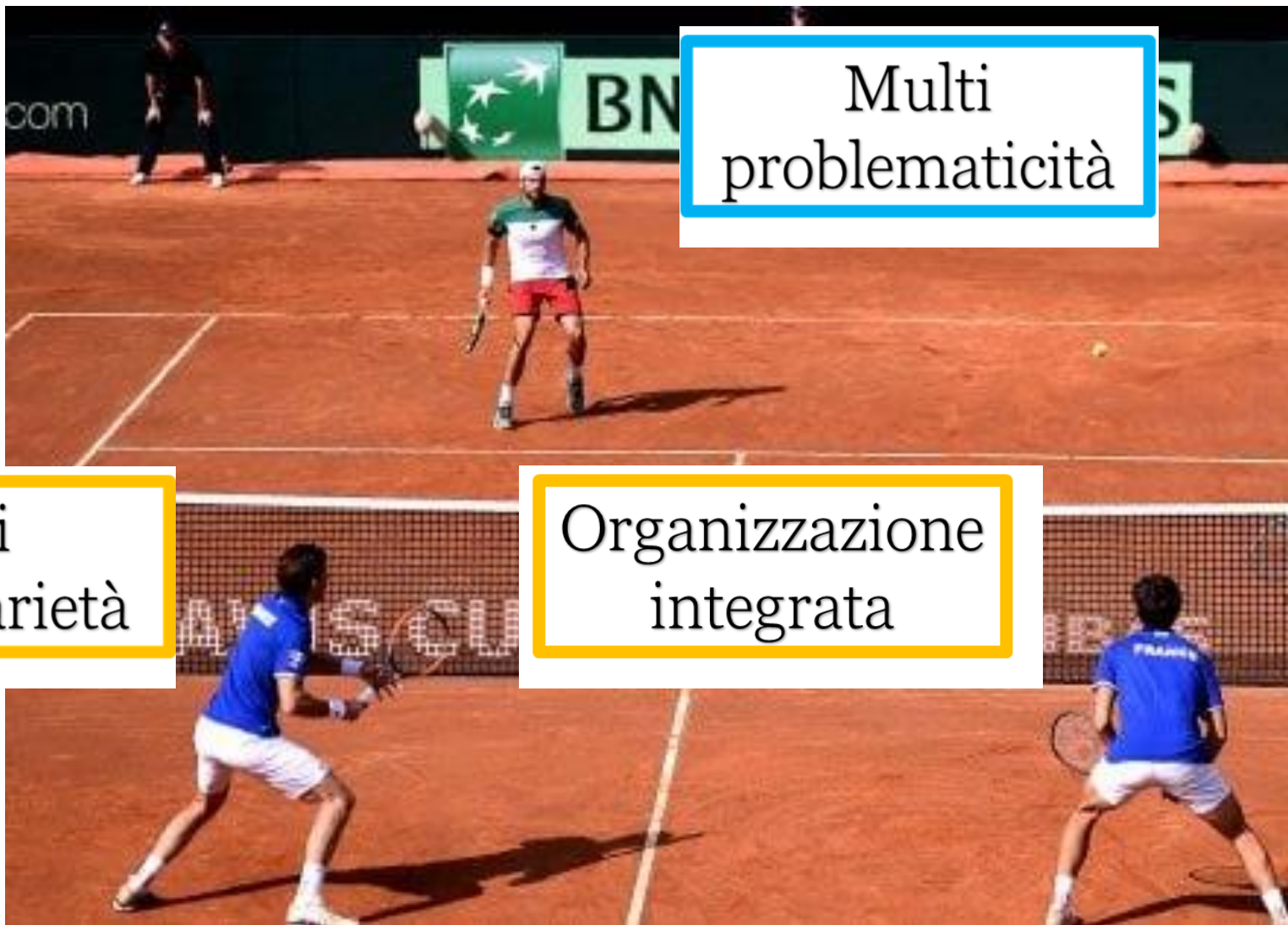


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Addiction Medicine

Part 2: Treatment Options

1. **MAJOR REVISION** All FDA approved medications for the treatment of opioid use disorder should be available to all patients. Clinicians should consider the patient's preferences, past treatment history, current state of illness, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone.
2. **NEW** There is no recommended time limit for pharmacological treatment.
3. **MAJOR REVISION** Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management. Motivational interviewing or enhancement can be used to encourage patients to engage in psychosocial treatment services appropriate for addressing individual needs.





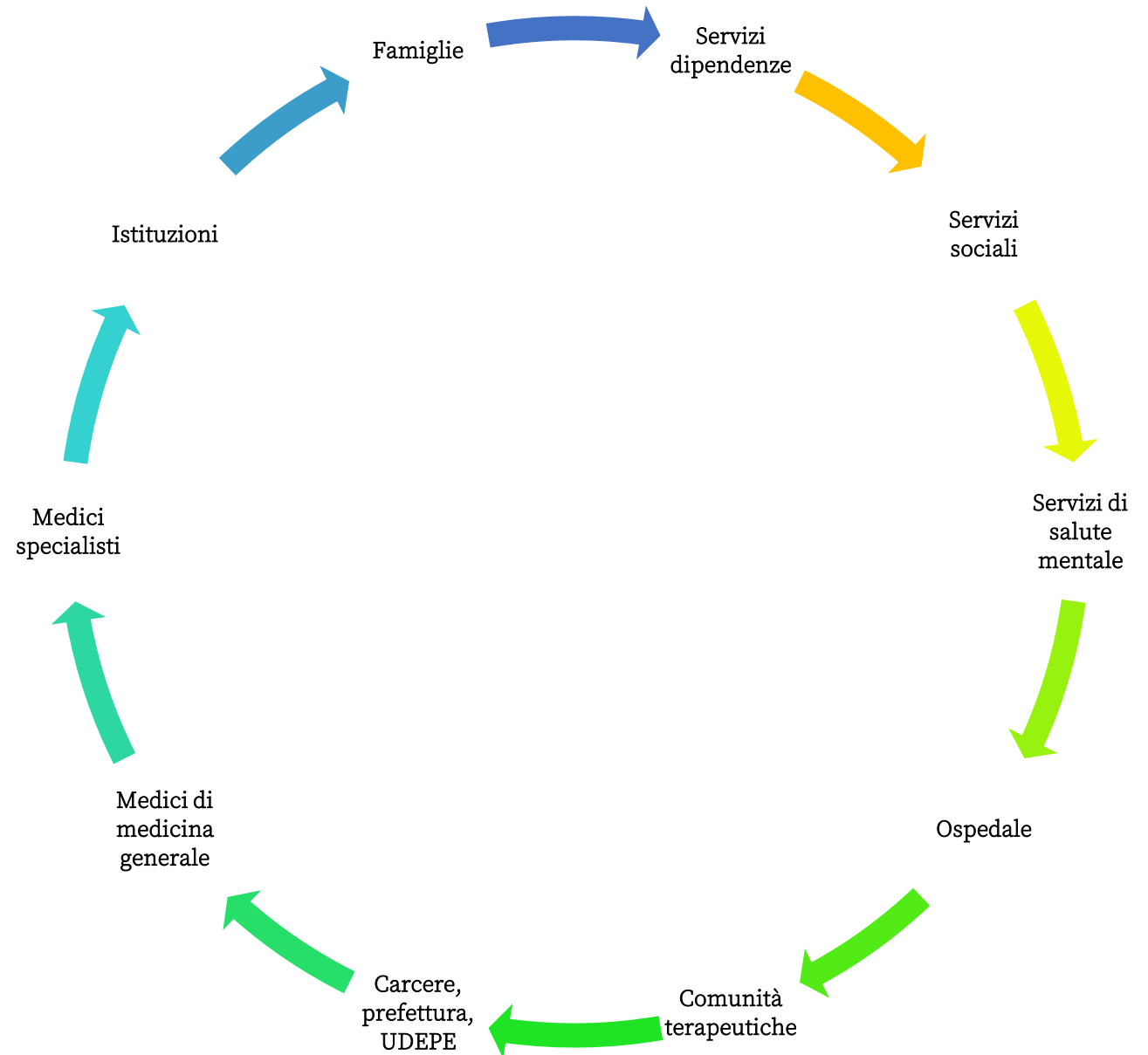
Multi
problematicità

Multi
disciplinarietà

Organizzazione
integrata



Organizzazione e integrata



Per vincere la sfida contro queste “nuove epidemie” è necessario coinvolgere e responsabilizzare tutte le componenti, dalla persona con cronicità al “macrosistema-salute”, formato non solo dai servizi ma da tutti gli attori istituzionali e sociali che hanno influenza sulla salute delle comunità e dei singoli individui.



Si deve partire da una profonda riflessione sulle tendenze e sugli indirizzi dei servizi e dei professionisti, promuovendo una nuova cultura che dovrà impregnare, al di là delle differenze di ruolo, tutte le scelte di politica sanitaria, le strategie assistenziali, la tipologia dell'organizzazione, l'assetto operativo delle strutture e la conseguente offerta dei servizi.



Il riequilibrio e l'integrazione tra assistenza ospedaliera e territoriale costituisce oggi uno degli obiettivi prioritari di politica sanitaria verso cui i sistemi sanitari più avanzati si sono indirizzati per dare risposte concrete ai nuovi bisogni di salute determinati dagli effetti delle tre transizioni (epidemiologica, demografica e sociale) che hanno modificato il quadro di riferimento negli ultimi decenni portando ad un cambiamento strutturale e organizzativo.

