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EDITORIAL

Management of addiction medicine: sharing medicine?

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We recently introduced our opinion on sharing medicine (SM) applied to the modern governance of complex health systems.[1] In this editorial we have emphasized the need for a close integration between health workers, patient, family, associations and public structures in charge of supporting and solidarity in sharing healthcare and social-health care pathways.

SM is to be included in all medical sectors, but certainly a paradigmatic field of application is addiction medicine (AM).[2] This is especially true in the treatment of patients with alcohol use disorders (AUDs) and/or substance use disorders (SUDs). In this context, in fact, several problems converge: psychophysical, family, work and sometimes even judicial. All this imposes a high cost, both in terms of economic and social suffering.

Net of the individual differences that characterize the treatment of addiction, it has undoubtedly been demonstrated that some aspects of the problem can be improved by the application, at least in part, of SM.

Pharmacological and psycho-therapeutic treatment must follow accredited position papers and company guidelines; however, the Services that make the patient responsible and involve families and associations of reference can achieve better results at lower costs.

Indeed, in this field, "the problems arising from the modulation of personalized care and research paths cannot be solved with linear and atomistic methods."[3]

Therefore, SM becomes an indispensable support. Bonino and Collaborators[3] maintain that "the extended community of experts, which is called to explore solutions and practices, is a community that includes everyone, is a community extended to all, since we are all experts at least in relation to our health."

Rigliano[4] stated that "it is astonishing how little is reflected on the need to welcome and involve the patient's significant contexts […] this, despite the now enormous mass of evidence. What seems to be relevant is precisely the responsible and proactive involvement of the whole affective context of people's lives."

Patients and their families must be supported, involved, and persuaded with conviction to actively participate in the recovery project by attending self-help groups (SHGs)[5] and all the activities that can promote change through the achievement of awareness.

This must be favored by the presence of an operator who coordinates relations with families, associations and institutions. To facilitate the information transfer with the Services, which are increasingly suffocated by bureaucracies and technicality.

In the cases of AUDs and SUDs, the SHG Ser-

vice cooperation[6] improves the clinical course, reduces relapses and improper hospitalizations, both in the emergency room and in ordinary hospitalization. This is also true in the case of double diagnosis.

The results can be obtained even in the absence of traditional clinical pathways, sometimes expensive and demanding for the healthcare system.

The cooperation of the health institution, patient, family, associations and communities reduces long-term mortality and complication rates. Smart and Mann[7] have found a reduction in cases of liver cirrhosis in patients with AUDs. This indirectly indicates a reduction in costs.

A three-year prospective study of Humphreys and Moss conducted on patients with AUDs showed that cooperation with SHGs compared to traditional treatment with the same clinical outcome led to increase of 45% in the costs.[8] A further experience found a 64% higher cost in patients subjected to cognitive behavioral therapy as compared to those who attended SHGs.[9, 10]

The activity of coordination on the part of the healthcare service must favor not only the complicity of the family member in the care path, but also their wellbeing.

The wellbeing of the family is positively leveraged on the relationship with the patient, on the wellbeing of the children, on the relationship with the services and indirectly on the whole community (work, justice, etc.).

The main source of information on this cooperation is the international Membership Survey conducted on 8517 Al-Anon members (association for family members of people with AUDs) with a frequency equal or more than 5 years. Ninety-five percent of members reported an improvement in spiritual life.[11] 94% found the experience "very positive," 5% "quite positive."

For Al-Anon members who are wives, long-term contact with groups is associated with a reduction in negative coping, improved knowledge of the AUDs, reduced levels of depression and a better relationship with the partner.[12]

The better relationship with the partner also allows a better management both clinical and family aspects by the health services.

Timko *et al.*[13] have conducted a relevant experience by organizing Al-Anon members into two groups: in the first group the attendance was suspended after six months, in the other group, it continued for up to twelve months. Several parameters improved in the second group in a statistically significant way: better understanding of addiction, better relationship with the alcoholic relative and with children, fewer acts of verbal and/or physical violence, reduction of stress and depressive anxiety, better therapeutic compliance by the patient and an overall improvement in the quality of personal and family life. The 12 steps associations that deal with children must also be involved in an integrated SM system. The Addiction Units must look after the children of patients affected by AUDs and/or SUDs with the taking of charge, the recognition of suffering, the enhancement of resources and the motivation to change. Patients' children are at risk of several negative consequences: maladjusted disorders, low self-esteem, guilt, anxiety-depression, etc. The "phenomenon of inter-generational transmission of addiction" may also derive from this. Here the collaboration with the associations can give excellent results without additional costs.[14, 15]

Thus, even in addiction, governance and SM find an indispensable space. We therefore agree with this statement: "The conventional healthcare professional-expert, the single patient-protagonist of their own history, the family members and all those who give life to contexts, experts in assistance and support, civil society, all are recalled in this participatory space for the construction of their own care process as to the identification of the conditions and purposes of medicine […] Complex medicine seems to indicate the need for participatory practices and approaches. This obliges us to an analysis and a review of the recent history of the concept of governance in order to be able to interact in a participatory scenario of governance."[3]

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