The Birth of SBIRT"H": Incorporating Harm Reduction Strategies into the SBIRT Model

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Disclosure Information

- Namrata Walia, MD
  - Commercial Interests: No Disclosures
- Daryl Shorter, MD
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- Michael Weaver, MD, DFASAM
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Learning Objectives

- Recognize harm reduction strategies such as needle/syringe exchange programs, naloxone opioid overdose rescue kits, bridge clinics, low-barrier medication for opioid use disorder, etc.
- Describe various strategies that would include harm reduction while using SBIRT model in clinical practice
- Address ethical dilemmas around harm reduction
- Apply skills gained from the workshop to address the unique challenges in various practice settings

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Introduction to Harm Reduction

Historical perspectives on harm reduction

- United Kingdom (Merseyside) Model
  - 1920s: Rolleston Committee
  - 1980s: “Cautioning”
- Dutch Model
  - 1972: Narcotics Working Party
  - 1976: Dutch Opium Act
  - 1980: “Junkiebond”
  - 1984: First needle exchange program
- US Model
  - Early 1990s: Introduction of harm reduction principles
  - 1995: Policy statements/recommendations to Office of National Drug Control Policy

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Early principles of harm reduction

- Public health alternative to moral/criminal and disease models of addiction
- Model recognizes abstinence is an 'ideal outcome' but accepts alternatives that reduce harms
- "Bottom-up" approach based upon advocacy for/by persons who use drugs rather than a top-down policy
- Low-threshold access to services as an alternative to traditional high-threshold approaches

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Contemporary approaches to harm reduction (1)

- Accept drug use as a part of our world and choose to work to minimize its harmful effects rather than ignore or condemn
- Recognize drug use as a complex, multi-faceted phenomenon that encompasses a continuum from severe use to total abstinence & acknowledges some ways of using are safer than others
- Criteria for successful intervention/policy = Quality of individual and community life, not necessarily cessation of drug use
- Non-judgmental, non-coercive services and resources to PWUD and their communities to reduce attendant harm

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Contemporary approaches to harm reduction (2)

- Ensures PWUD have a real voice in creation of programs and policies designed to serve them
- Affirms PWUD as the primary agents of reducing the drug-related harms and empowers information sharing and support of each other in strategies which meet conditions of use
- Recognizes that poverty, class, racism, social isolation, past trauma, sex-based discrimination, and social inequality affect vulnerability to and capacity for dealing with drug-related harm
- Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with drug use

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Contemporary approaches to harm reduction (3)

- Housing First
- Autonomous health movements: “people have reclaimed autonomy over their own and their community’s health by looking past stigma and institutionalized ideals of health [in order to] meet people’s actual needs.”
- Pillars
  - Use medical knowledge of the community
  - Relocate power & return resources to the community; balance the power dynamic
  - Rejection of legality

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Harm reduction programs & strategies

- Services
  - Overdose reversal education & training
  - Navigation services to ensure linkage to HIV, viral Hep prevention, testing, and care
  - Referral to Hep A/B vaccination
  - Provision of information on local resources and/or referrals for HIV PEP and/or PrEP
- Supplies
  - Overdose reversal supplies (e.g., naloxone kits)
  - Substance test kits (including fentanyl strips)
  - Safer sex kits, including condoms
  - Sharps disposal, medication disposal kits, and medication lock boxes
  - Wound care supplies
  - Supplies to promote sterile injection
  - Safer smoking kits
  - Home testing kits for HIV, viral Hepatitis
- *Note: These interventions now represent allowable costs covered by SAMHSA funds*

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Harm reduction effectiveness (1)

- Alcohol
- Interventions to reduce road trauma – well supported
- Limited research to support alcohol HR interventions
- Managed Alcohol Programs (MAP) - alternative to zero-tolerance, incorporates drinking goals compatible with patient needs
  - 2012 Cochrane analysis found NO studies eligible for study inclusion
- Tobacco
- Medicinal nicotine products – harm reduction or treatment?
- Smoking substitution – Electronic cigarettes, snus, heated tobacco
- Limited research to support tobacco HR interventions reduce tobacco-related exposure, morbidity, or mortality
- Physical activity – delays occurrence of disease, premature death initiated by tobacco use

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Harm reduction effectiveness (2)

- Drugs
- Supervised injection facilities (Canada) - ↓Opioid overdose morbidity, mortality; improved injection behaviors; improved access to treatment; no increase/reduction in crime
- Housing First – preliminary evidence suggests reductions in DT, substance-related mortality; more research needed
- Syringe Service Programs (SSP) - clients may be more likely to seek treatment; direct social services & housing critical components
- Harm reduction agencies as preferred potential sites for buprenorphine maintenance treatment

Barriers to implementation

- Individual level
  - Fear, mistrust of health care systems
  - Attitudes (stigma, lack of acceptance)
- Interpersonal
  - Familial and/or relational barriers to accessing SUD treatment
  - Gender-based violence
- Institutional
  - High organizational expectations of PWUD
  - Lack of available services
  - Limited regulatory knowledge among HCWs; policy and liability concerns
- Population-level
  - Negative stereotypes, racism/sexism, homo/transphobia, stigma
  - Criminalization of substance use/possession

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Facilitators to implementation

- Education
- Openness
- Community support
- Organizational support; policy and addressing liability
- Flexible harm reduction services
- Specialized team, continuity of care
- Specific strategies, supplies (e.g., sharps containers)

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SBIRT – Harm Reduction

- Screening, Brief Intervention, and Referral to Treatment → Harm Reduction
- Conversation with patients, community members
- Collaboration with local partners, HCWs
- Creation of programs, advocacy, outreach
- Familiarity with local laws, programs

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Evolution of SBIRT and the concept of SBIRT“H”

History of SBIRT

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening for persons with substance use disorders and those at risk.
- In the 1980s, SBIRT emerged as a viable public health approach to address substance misuse after the development of effective screening tests for alcohol and drug use.
- With the accumulation of positive evidence, implementation research on alcohol SBI began in the 1990s, followed by trials of similar methods for other substances (e.g. illicit drugs, tobacco, prescription drugs) and national demonstration programs in the US and other countries.
- To date, several studies have shown that SBIRT yields short-term improvements in individuals' health.

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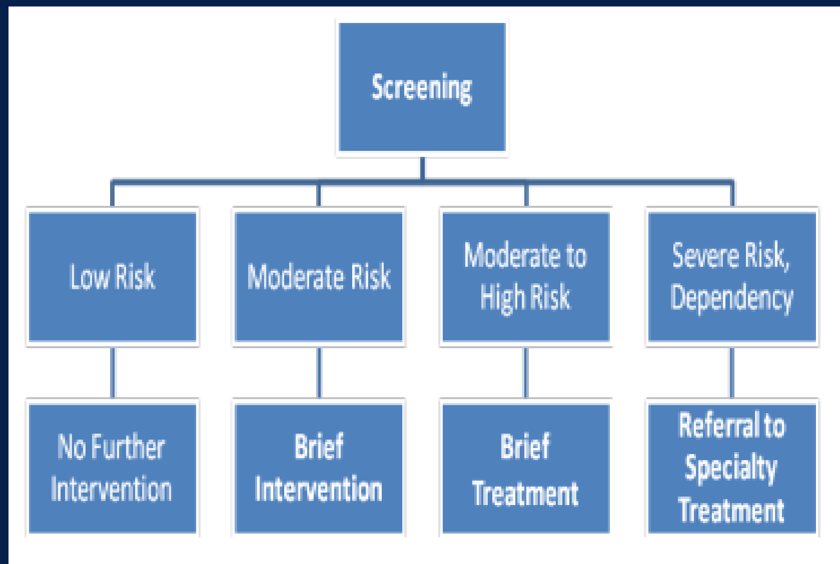
Components of SBIRT



- Screening is a quick, simple way to identify patients who need further assessment or treatment for substance use disorders.
- Brief intervention is a single session or multiple sessions of motivational discussion focused on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to specialized treatment is provided to those identified as needing more extensive treatment than offered by the specialty physician.

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Characteristics of SBIRT

- Pre-screening/survey tools are brief, easy to use (2-4 mins), and validated.
- Easier to learn by diverse providers. Can be implemented by nurses, social workers and other healthcare professionals in busy clinical settings.
- Includes referral to specialty treatment, if required. Although location dependent (in rural settings), it is an effective way to refer patients needing more resources to higher level of care.

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Effectiveness of SBIRT components

- Brief interventions and follow-up for alcohol use patterns and levels in primary care settings produce small to moderate reductions in alcohol consumption that are sustained over 6-12 months period or longer.
- Brief interventions when conducted in an emergency room setting lead to reduced hospital admissions, traumas and injuries up to 3 years post-intervention.
- In a recent study published in the journal Drug and Alcohol Dependence, researchers reviewed the impact of SBIRT services at various medical settings across six states over a 6-month period. The study found the following:
  - An almost 68-percent reduction in illicit drug use over a 6-month period among patients who had received SBIRT services.
  - Among those who reported heavy drinking at baseline, the rate of heavy alcohol use was almost 39 percent lower at the 6-month follow up.
  - Those who received brief interventions or referrals to specialty treatment also reported other improvements, including fewer arrests, more stable housing situations, improved employment status, fewer emotional problems, and improved overall health.

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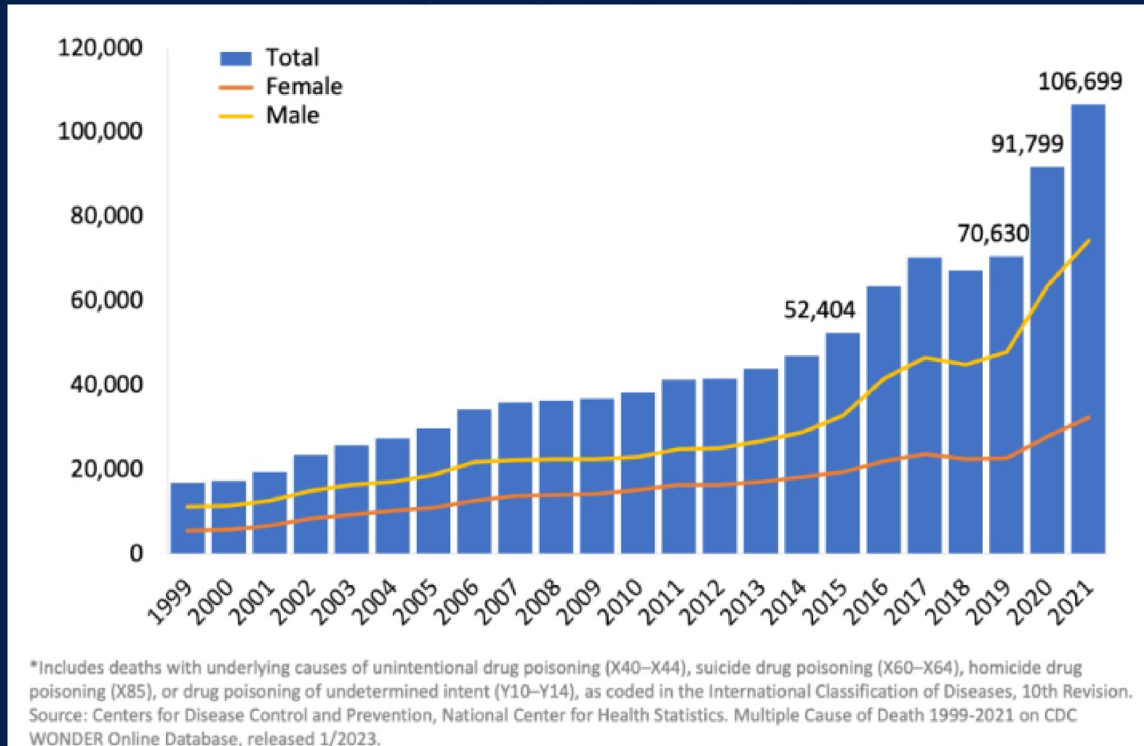
Although SBIRT has helped to reduce the substance use burden by early identification, the annual death toll due to drug overdose continues to rise in the United States.

American Drug Overdose Death Rates the Highest Among Wealthy Nations

Ref: NBC news and USC Schaeffer School of Health Economics

The epidemic we are facing!!!



NUMBER OF OVERDOSE DEATHS AMONG ALL AGES BY GENDER, 1999-2021

- More than 106,000 persons in the U.S. died from drug-involved overdose in 2021, including illicit drugs and prescription opioids.
- From 2020 through 2021, the rate for males increased from 39.5 to 45.1, and the rate for females increased from 17.1 to 19.6.

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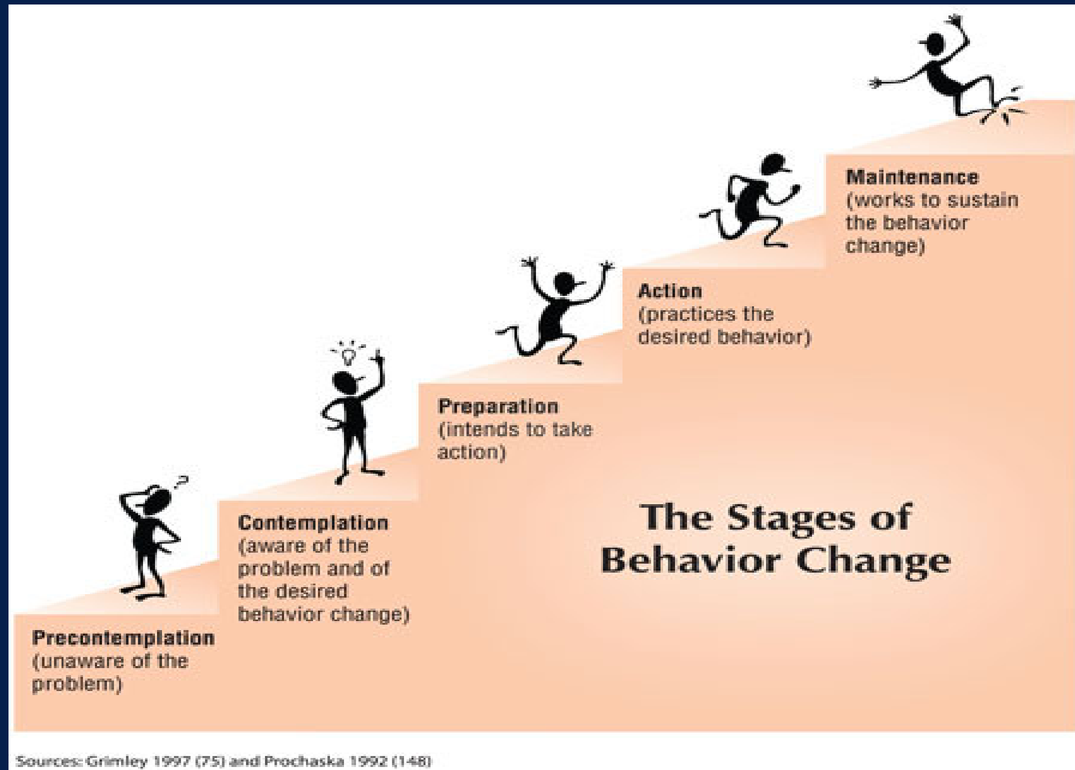
Transtheoretical Model of Change

The transtheoretical model (TTM) is a dynamic theory of change based on the assumption that there is a common set of change processes that can be applied across a broad range of health behaviors.

Ref: (Prochaska *et al.*, 1994, 2002; Prochaska and Velicer, 1997)

Stages of change



Precontemplation - people do not intend to take action in the foreseeable future (defined as within the next 6 months). People are often unaware that their behavior is problematic or produces negative consequences.

Contemplation - people are intending to start the healthy behavior in the foreseeable future. They recognize that their behavior may be problematic, and a more thoughtful and practical consideration of the pros and cons of changing the behavior takes place, with equal emphasis placed on both.

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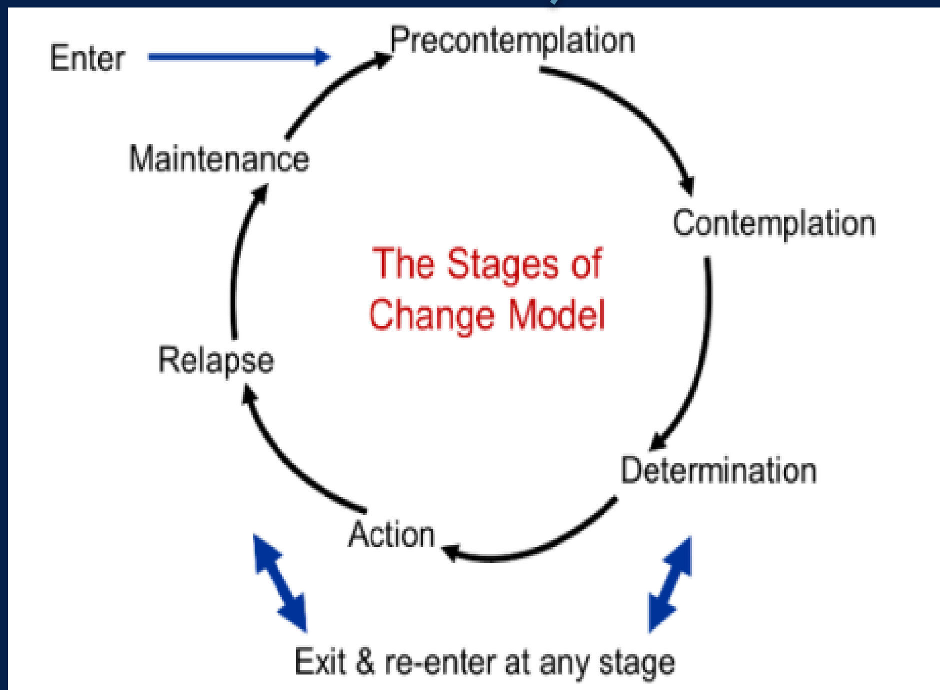
Incorporating harm reduction during SBIRT

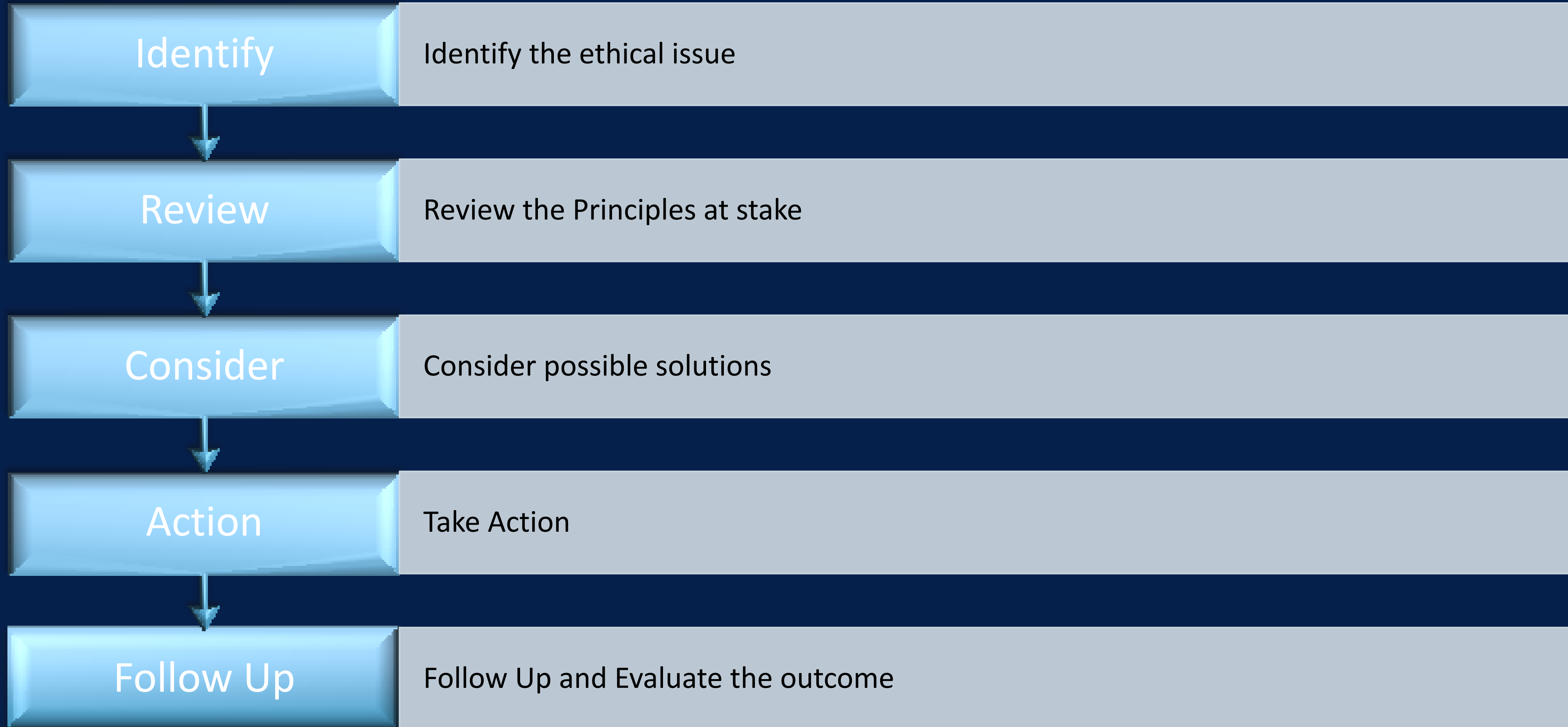
HARM REDUCTION!!!



- SBIRT"H" model can be beneficial to address the individuals in "pre-contemplation" phase of behavior change by providing them with local harm reduction resources.
- This principle is a pragmatic approach to reduce health, social and economic effects of substance use without requiring change in behavior.
- Clinicians can explore patient's goals and motivation to bring a change instead of a traditionally used approach of negotiating a plan to abstinence. This patient-led principal focusses on the problem without insisting on abstinence.
- Goal: to prevent fatal outcomes

Ethics of Harm Reduction

Steps to make ethical decisions



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Autonomy

- Self-determination
- Respect for persons
- Clinicians must respect the right of an individual to determine what action is appropriate for themselves
- Ability to act in accordance with one's authentic sense of what is good, right, and best in terms of one's situation, values, and prior history
- Capacity to make this choice freely

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Beneficence

- Duty to “do good” for the person with addiction
- Responsibility to act in ways that provide the greatest benefit for the patient
- Obligation to help
- Obligation to avoid harm
- Avoid paternalism and respect autonomy
- Shared decision-making with the patient

Is Harm Reduction ethical?

- Respects patient's autonomy
  - Patient's decision to choose to continue to use a substance
- Beneficence
  - Help patient to avoid harm with shared decision-making
- Physician fulfills duty to inform the patient
  - Ideal treatment goal (abstinence)
  - Alternatives that can also reduce risks to health
- Harm reduction strategies can establish the physician's concern for the patient's safety
- Awareness of risks and the physician's concern may enhance the patient's motivation for changing behavior (stop using substance)

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Incorporating harm reduction into practice

- Meet patients “where they’re at”
- Form of outreach to engage the most challenging patients with SUD
- Range of options
  - Safer use
  - Managed use
  - Less use
- Address conditions of use along with the substance use itself
- Raise the issue at subsequent visits to evaluate continuance of risky behaviors

Examples

- Avoid use of illicit substances or drinking in hazardous situations
  - Operating heavy machinery
  - Avoid hangovers on workdays
  - Avoid unwanted sexual encounters
- Caution against using and driving
  - Legal consequences
  - Health consequences
  - Harm to others
- Don't combine prescribed medications with alcohol or illicit substances

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Bystander opioid overdose treatment

- Evidence-based prevention for opioid overdose death
- Naloxone rescue kits
  - IV, nasal spray, auto-injector
  - For use by family or friend of patient at risk
- Purpose is to buy some time (20 minutes) to call 911 for ambulance to arrive to provide definitive treatment of overdose

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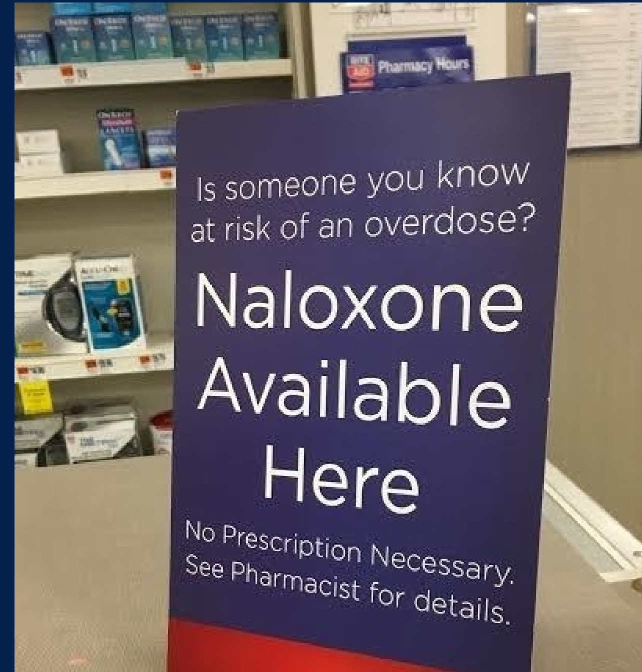
Prescribing naloxone

- Anyone can obtain naloxone from a pharmacist who has completed a 1-hour training
  - Pharmacist can educate person obtaining naloxone about use
- Patient may pay $50 or more, depending on product
  - Covered by Medicaid
- Now approved by FDA to be available over-the-counter without a prescription
  - Products may still be expensive
  - Still need organizations to make available and distribute

- Encourage your patients to obtain naloxone
  - Family members, roommates



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What to tell household members

- >80% of opioid overdoses occur at home when a friend or caregi present
- Naloxone is like a fire extinguisher
  - Hope you don’t need it
  - Glad you have it if you do need it
- Family, friend, or roommate should know where naloxone rescue kit is stored
- After an overdose, do a lot of listening
  - The more you know about what he/she is experiencing and feeling, the easier it is to connect and be supportive

Needle/syringe exchange programs

- Federal law prevents use of federal funds to support these programs
- >500 programs in 45 states
- Programs do much more than exchange needles
  - May exchange other paraphernalia
  - Testing for HIV, HBV, HCV, etc.
  - May distribute naloxone
  - Counseling and referral
- Reduce risk of infection
- Way to engage high-risk or non-treatment-seeking individuals
- North America Syringe Exchange Network

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Navigating the laws

- Paraphernalia laws
  - Vary from state to state
  - May apply to NSEP and restrict availability
  - May be able to legally prescribe syringes for patients (like for diabetics on insulin)
  - Fentanyl test strips may also be illegal
- Warn patients of risks of illicit substance use
  - Then it becomes the patient's responsibility to act accordingly and with due caution
- Physicians open to liability for breach of duty if recommend something (cannabis) to treat a condition that is unlikely to improve from it's use (anxiety, cancer, autism)
- Policy makers make decisions based on the majority will of the electorate, but physicians do not

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Questions?

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