DRUG & ALCOHOL FINDINGS *Review analysis*

This entry is our analysis of a review or synthesis of research findings added to the Effectiveness Bank. The original review was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. The summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

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Implementing managed alcohol programs in hospital settings: A review of academic and grey literature.

Brooks H.L., Kassam S., Salvalaggio G. et al.

Drug and Alcohol Review: 2018, 37(1), p. S145–S155.

Is it feasible (and desirable) to give regular doses of alcohol to hospital inpatients when supervised withdrawal or short-term abstinence from drinking is not a realistic goal?

SUMMARY Abstinence is frequently a necessary condition for receiving inpatient care. However, supervised/medication-assisted withdrawal and short-term abstinence are not always realistic goals, especially among homeless and otherwise socioeconomically disadvantaged groups who experience significant social and structural barriers to accessing adequate care, including care intended to ameliorate withdrawal symptoms (1 2 3 4 5). The featured review aimed to establish the feasibility of implementing an alternative to inpatient care premised on abstinence – 'managed alcohol programmes', which provide a harm reduction framework for dispensing regular doses of beverage alcohol to people who have been drinking heavily for a long time prior to hospital admission, and for whom abstinence is not realistic (eg, because they have not responded well to pharmacological management with benzodiazepines).

While no research has explicitly described the implementation of formal managed alcohol programmes in hospitals, reviewers found that 28 studies have examined the administration of alcohol in hospitals in order to prevent alcohol withdrawal syndrome, and 14 studies have examined managed alcohol programmes in the wider community, which were typically part of a broader package of health and social care services, including permanent supportive housing or shelter-based accommodation.

Key points
From summary and commentary

Abstinence is frequently a necessary condition for receiving inpatient care, but may not always be a realistic goal – particularly among people who are homeless or otherwise socioeconomically disadvantaged.

An alternative is to implement managed alcohol programmes in hospitals, whereby patients can be given tailored doses of alcohol to address their cravings and prevent withdrawal.

Studies in hospitals and the wider community indicate that this is a feasible approach, though further work is needed to develop and evaluate protocols for the administration of alcohol in acute care settings.

Main findings

Participants in community-based managed alcohol programmes tend to be chronically homeless or lacking stable housing, with severe alcohol use disorders, and unable or unwilling to participate in abstinence-based housing or treatment.

The integration of social support with patient care is an essential component of community-based managed alcohol programmes, which have reported positive social outcomes among their participants, including fewer encounters with the police, improved personal hygiene, and uptake of other health and social support.

There are considerable differences in alcohol-dispensing practices in hospitals and community-based managed alcohol programmes. Community studies reported that 148–207 g of alcohol (usually in the form of beer or wine) is typically dispensed every 1–1.5 hours during regular waking hours, whereas doses of alcohol dispensed in hospitals ranged from 30–100 g in the form of spirits, or larger amounts of beer, every 1–4 hours, generally until withdrawal symptoms subsided. Hospital-based studies also frequently described the administration of intravenous alcohol.

In order for a hospital-managed alcohol programme to best replicate the successes of community-managed alcohol programmes, patients should be provided an in-hospital consultation with an addiction medicine specialist and direct referral or access to community support, such as counselling and addiction treatment, primary health care, social services, community-based managed alcohol programmes (when available), and

harm reduction-oriented housing options. They may also need to reconsider the use of intravenous alcohol, which could deter patients, who would probably prefer to drink alcohol, and undermine the objective of stabilising alcohol consumption.

Several hospital studies noted concerns about sending conflicting messages about the detrimental effects of drinking to patients. To mitigate this concern, beverage alcohol could be dispensed in a medicine bottle and the patient monitored while consuming the alcohol. Procedures in community settings that discourage drinking outside of the programme could also be incorporated into a hospital-managed alcohol programme. Participant agreements can ensure hospital staff and patients are aware of their responsibilities and obligations within the managed alcohol programme. Agreements should be flexible enough to accommodate minor infringements, particularly while patients are being stabilised, though flexibility may not always accord with highly regimented and standardised acute care environments.

The authors' conclusions

Managed alcohol programmes in the wider community have been well-described. Findings from these, along with studies of in-hospital administration of alcohol, indicate that hospital-based managed alcohol programmes are feasible and could potentially prevent uncomfortable alcohol withdrawal symptoms, stabilise patients' drinking, discourage non-beverage alcohol consumption, encourage patients to stay in hospital and complete treatment, and connect them to other health and social support. However, further work is needed to develop clear eligibility criteria to help clinicians identify patients appropriate for participation, for example so that patients most at risk of leaving against medical advice and not completing treatment can be engaged.

FINDINGS COMMENTARY Managed alcohol programmes have been widely tested in community settings where they fulfil a range of functions, including reducing harm, giving marginalised (and often homeless) people an alternative to street drinking, and connecting people with health and social services they might otherwise be excluded from. The featured review did not identify any studies of formal managed alcohol programmes in hospital settings, but did find examples of alcohol being dispensed to inpatients in order to prevent alcohol withdrawal syndrome. On the whole, what distinguished these practices from a managed alcohol programme was the lack of access to wraparound social care, and the different approach to or motivation for administering alcohol. The authors concluded that hospital-based managed alcohol programmes would be feasible and appropriate for patients who would otherwise be vulnerable to unmanaged or undermanaged symptoms of alcohol withdrawal, resorting to non-beverage alcohol consumption such as rubbing alcohol or hand sanitisers, and ultimately leaving hospital without completing their treatment.

Evidence regarding the implementation and effectiveness of managed alcohol programmes predominantly comes from Canada, where they emerged "out of a need for a more compassionate approach to care for people vulnerable to the harms of severe alcohol dependence and homelessness".

> *"Toronto's Seaton House, one of the first [managed alcohol programmes] in Canada, was started following an inquiry into the tragic freezing deaths of three men on the streets of Toronto in 1996. The recommendations from that inquiry were to develop a [24-hour] shelter program for men with severe alcohol dependence. In the early days of that program they began by storing personal alcohol for men so that they would stay inside overnight instead of ending up outside in the snow during freezing temperatures. This gradually evolved into inviting men to stay for breakfast and providing them with a glass of wine to 'settle their shakes' while encouraging them to eat. Daily alcohol administration started with one man being offered regular doses of alcohol throughout the day to prevent him from being picked up by the police for public intoxication."*

Though not all managed alcohol programmes are the same, their commonalities tend to include:
- supporting the goal of preventing and reducing the harms of drinking, in particular those associated with 'binge drinking', drinking non-beverage alcohol, and consuming alcohol in unsafe settings;
- catering to a cohort of people experiencing chronic homelessness, frequent public intoxication, repeated (but unsuccessful) attempts at abstinence-based treatment, and high levels of engagement with police or emergency department services;
- integration with housing (eg, shelter, transitional or permanent supportive housing);
- provision of food;
- increasing access to primary care;
- encouragement to access recreational and social activities both inside and outside of the programmes.

The pursuit of abstinence for all homeless people with a history of substance use problems may not be realistic, and furthermore, may overlook the reasons why homeless people drink or take drugs in the first place. While the default assumption might be that drugs and alcohol have a significant role in precipitating or perpetuating homelessness, substance use can also be functional – it can be one of the ways that people survive being homeless (eg, keeping warm and passing time), as well as a way to derive some pleasure while being homeless. This may remain the case even if people drinking and

taking drugs are doing so at harmful levels or through risky means, and even among people whose health is already compromised as a result of their homelessness. Within a harm reduction approach, substance use is accepted "for better or for worse", enabling services to directly "minimize its harmful effects rather than simply ignore or condemn them."

Evidence that managed alcohol programmes can improve the health and wellbeing of homeless dependent drinkers was acknowledged in Scotland's 2018 "Rights, Respect and Recovery" drugs and alcohol strategy, which compared to UK government policy was more willing to centre harm reduction-based interventions.

When abstinence remains a requirement for inpatient care and the person has been drinking heavily for a long time prior to hospital admission, NICE guidelines describe three ways of administering medication to assist with alcohol withdrawal:
• *Fixed-dose* regimens start with a standard dose which is then reduced over several days.
• *Symptom-triggered* regimens tailor treatment to the severity of withdrawal signs and symptoms which are regularly assessed and monitored. Medication is provided if the patient needs it, and treatment is withheld if there are no symptoms of withdrawal.
• *Front-loaded* regimens provide a large dose of long-acting medication at the start and then 'as required'.

NICE found insufficient evidence on front-loading. Compared to fixed-dose regimens, symptom-triggered dosing reportedly involved significantly lower doses of benzodiazepines over a shorter period without an increase in the incidence of seizures or delirium tremens or in the severity of withdrawal symptoms. However, most of the studies were based on patient samples consisting mainly of men who had been admitted to specialist addiction services. Symptom-triggered dosing requires patients to be closely monitored and health care workers with the specialist clinical knowledge needed to identify signs and symptoms that imply a change in severity of withdrawal. In the experience of the expert group that informed the development of the NICE guidelines, acquiring the required skills was not a major task.

The Pennine Acute Hospital Trust in England evaluated a locally-implemented, symptom-triggered approach to alcohol withdrawal management, which, it was hypothesised, would improve care by providing an individualised treatment plan for patients. The change from a fixed-dose regimen was associated with an average reduction of almost 60% in the length of hospital stay and a 66% reduction in the amount of chlordiazepoxide used in detoxification, as well as highlighting that 10% of the sample group did not display any signs of withdrawal and did not require any medication. Even with the reductions in medical treatment, no patient developed any severe signs of withdrawal post-intervention such as seizures or delirium tremens. However, the scope of this study did not include the effectiveness of a symptom-triggered approach among homeless people, for whom medication-assisted withdrawal and short-term abstinence may not be realistic or desirable, particularly when not accompanied by support to materially change their living conditions on leaving hospital.

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