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Journal of Substance Abuse Treatment 124 (2021) 108225

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

COVID-19: Broadening the horizons of U.S. harm reduction practices through managed alcohol programs

Nicky J. Mehtani [a,*], Jessica T. Ristau [b], Joanna Eveland [c]

[a] University of California, Department of Medicine, Division of HIV, ID & Global Medicine, San Francisco, United States of America
[b] University of California, Department of Medicine, Division of General Internal Medicine, San Francisco, United States of America
[c] San Francisco Department of Public Health, United States of America

Mr. R drinks a pint of vodka daily. His last drink was 24 h ago, and he is beginning to experience tremors and sweats. The feeling reminds him of having been in solitary confinement while incarcerated, and it is making him increasingly restless. He is staying at one of San Francisco's Isolation & Quarantine (I&Q) sites—hotels provided to people with confirmed or suspected COVID-19 who do not have a place to safely self-isolate—and he has been referred to me for an addiction medicine consult. I provide him options for medication-assisted withdrawal to reduce his risk of developing seizures or delirium tremens. But he tells me he would rather just leave isolation and get a drink. Now what?

As physicians, we make an oath to "do no harm," and we are acutely aware of the ways in which alcohol use can harm our patients. It is for this reason that when patients with alcohol use disorder are admitted to our hospitals, our typical response is to convince ourselves—if only fleetingly—that we are helping people by instinctively putting them on forced detoxification protocols with benzodiazepines or gabapentin. Yet this approach seems to reject any understanding as to why a person might be using alcohol to begin with: reasons that exist beyond the artificial boundaries of our hospital walls.

Such reasons are the impetus for harm reduction—a set of practical strategies free of judgment or blame aimed at improving quality of life and reducing the harms associated with drug use without the requirement of abstinence or use reduction (San Francisco Department of Public Health, 2020a). While harm reduction in the United States has been historically limited to syringe access programs and naloxone distribution, the spectrum of interventions in other countries has been more expansive.

Canada, for example, employs managed alcohol programs (MAPs), through which regulated amounts of alcohol are dispensed in controlled settings to people with severe use disorders. Preliminary studies suggest such programs improve patient safety and quality of life by increasing housing retention and reducing many alcohol-related harms, including nonbeverage alcohol consumption, hospital admissions, detoxification episodes, and police contacts leading to custody (Pauly et al., 2018; Stockwell et al., 2018; Vallance et al., 2016). Participants have described these programs as environments that counter stigma, loss, and dislocation, thereby enhancing the potential for healing and recovery (Pauly et al., 2016). The U.S. has piloted distinct, but related, programs in some cities, where the Housing First Model has been implemented based on the principle of providing people experiencing homelessness with low-barrier, nonabstinence-based, permanent supportive housing—sometimes colloquially referred to as "wet housing." Studies of one such program in Seattle demonstrated not only substantial declines in alcohol use and occurrences of delirium tremens among participants over two years (Collins et al., 2012), but also cost saving to the health care system (Larimer et al., 2009). However, no programs of which we are aware in the U.S. have adopted formal policies inherent to MAPs, through which alcohol is not simply tolerated but provided to reduce harm at the level of public health.

The emergence of COVID-19 has exacerbated isolation, structural racism, poverty, and other root causes of addiction. In San Francisco, a city known for having the greatest level of income inequality in California—with the wealthiest households earning 12.3 times that of the poorest (Bohn & Thorman, 2020)—COVID-19 has only made things worse. In this context, it is becoming increasingly evident that traditional strategies of addressing addiction are inadequate. Between March 30 and May 24, the city observed three times as many homeless deaths compared to the same period in 2019, the majority of which are thought to be related to substance use (Thadani, 2020b).

COVID-19 has thus warranted the adoption of a more robust framework of harm reduction and led to a shift in how we support people with harmful patterns of substance use in San Francisco. The first locally acquired cases of COVID-19 were reported in early March and, within a week, the city converted hotels into I&Q and "shelter-in-place"

* Corresponding author.
E-mail address: nicky.mehtani@ucsf.edu (N.J. Mehtani).

https://doi.org/10.1016/j.jsat.2020.108225
Received 5 June 2020; Received in revised form 28 September 2020; Accepted 19 November 2020
Available online 3 December 2020

sites—initiatives bearing resemblance to the Housing First Model (American Public Health Association [APHA], 2017; Collins et al., 2012; Larimer et al., 2009). On April 10, news broke that over half of people staying at San Francisco's largest homeless shelter had tested positive—increasing the city's cumulative number of COVID-19 infections by more than 10%. It became clear that for many people at I&Q sites, the pre-existing epidemic of overdose and substance use disorders—which claimed the lives of more than 440 San Franciscans in 2019 (Thadani, 2020a)—was a greater threat to health than COVID-19 itself, which has been directly responsible for 161 deaths in the city as of December 1, 2020 (San Francisco Department of Public Health, 2020b).

In this context, we, as addiction medicine providers, were asked to join the health department's containment efforts to devise a set of substance-specific protocols for I&Q sites. After an intake nurse screens incoming patients for risky use of substances, we offer an addiction telehealth consultation and develop individualized treatment plans. While some patients aspire to pursue sobriety during the pandemic, many others opt to continue using substances. The vast majority identify a goal somewhere in between.

In line with these patient-identified goals, our I&Q protocols for substance use disorder management aim to provide evidence-based treatment, support transition to safer use when abstinence is untenable, and aid patients in staying at I&Q sites to reduce community transmission of SARS-CoV-2. For all patients with alcohol use disorder, we offer medications for treatment and, when needed, medication-assisted withdrawal management. However, for those at risk of alcohol withdrawal who are not ready for treatment, we offer participation in a pilot managed alcohol program—dispensing limited amounts of alcohol to meet patient needs and help them tolerate the I&Q environment. Based on history of use, we prescribe patients a tailored quantity of alcohol for daily consumption. We provide this amount in set doses throughout the day to reduce over-intoxication, avoid withdrawal, and allow for continued health care engagement until the patient's isolation or quarantine period is complete and they can be discharged to a "shelter-in-place" site. We have to recognize that successful management of addiction requires providing patients with the agency to drive their own care. While limited in comparison to many Canadian MAPs, some of which are peer-run and rooted in the dimensions of social and cultural supports in addition to those of alcohol, housing, and health (Pauly et al., 2018), adapting the MAP model into the medicalized context of I&Q sites has highlighted for us that compassion is a key tenet in the practice of clinical addiction medicine. Such a framework has bolstered patient-provider relationships by encouraging mutual respect, reducing perceived stigma, and fostering patient dignity.

Perhaps most remarkably, we have found that when we more fully embrace a harm reductionist philosophy, some patients express interest in behavioral change for the very first time. Mr. R had planned to continue drinking during his stay at I&Q by participating in the MAP—through which we delivered to him the equivalent of a full pint of vodka daily. However, within days, he expressed interest in cutting down on his use. He agreed to a trial of oral naltrexone and reduced his consumption to fewer than two standard drink equivalents daily. After his quarantine period was complete, he planned to follow up at the outpatient bridge clinic to start long-acting injectable naltrexone to help meet his new goal of sobriety.

As part of the city's COVID-19 Containment Response Team, we are grateful to have been able to witness tangible benefits of harm reduction in real-time, particularly with the implementation of a managed alcohol program. We advocate for the opportunity to continue examining the effectiveness of such advanced harm reduction techniques in promoting safe consumption in the U.S., for expanding the reach of addiction treatment, and for reducing the transmission of infectious diseases during this crisis and beyond.

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