BRITISH COLUMBIA

Operational Guidance for Implementation of

MANAGED ALCOHOL *for* VULNERABLE POPULATIONS

University of Victoria | Canadian Institute for Substance Use Research

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

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CONTENTS

EXECUTIVE SUMMARY

Individuals who have severe alcohol use disorder or engage in high-risk drinking are at greater risk of experiencing negative health outcomes during the COVID-19 pandemic. These individuals may experience numerous alcohol-related harms, including life-threatening withdrawal, due to a combination of factors, including reduced access to alcohol (i.e., due to isolation, disruptions to alcohol supply), homelessness, poverty, and comorbid health conditions. In addition, these individuals may experience more serious COVID-19 symptoms due to the higher risk of pneumonia and weakened immune function associated with high levels of alcohol consumption.

To mitigate these risks and support individuals to follow public health directives (i.e., physical distancing), healthcare providers and other community support workers should regularly screen their patients/clients for high-risk alcohol use and alcohol use disorder and develop a plan for patients/clients who are at high risk of serious complications related to alcohol withdrawal. Health care providers and other community support workers should create individualized plans to support patients/clients to prevent or manage withdrawal, based on each patient's needs, wishes, and circumstances. In clinical care settings, an approach that includes screening and assessment, brief intervention, and care planning according to the recommendations in the Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder is advised and further information is available in COVID-19: Information for Health Care Providers Regarding Alcohol Use Disorder and Withdrawal Management. Plans to avoid or manage alcohol withdrawal may include outpatient withdrawal management, inpatient withdrawal management (where capacity exists), long-term alcohol use disorder treatment and recovery supports, or—where available—managed alcohol programs.

Provision of managed alcohol may be appropriate for client populations with severe alcohol use disorder or those who engage in high-risk drinking, who have not been retained on treatment for AUD or who are not interested or able to stop or reduce drinking and who are at risk for serious harms due to inability to safely obtain alcohol. Managed alcohol is often provided through low-barrier, non-clinical programs, and this document offers guidance for implementing and providing managed alcohol in both clinical and non-clinical settings. The operational guidance contained herein aims to outline a number of necessary components for providing managed alcohol and offers practical and culturally informed considerations for client care, including screening and individual dosing and management plans, and operational considerations, such as program and staffing models, funding, procurement, delivery, and administration.

Due to the nature of the COVID-19 pandemic and the urgent need to support vulnerable populations, including rural and remote communities, this interim operational guidance was developed rapidly to assist organizations and health authorities seeking to quickly initiate distribution of beverage alcohol. This serves as a companion to the guidance in Risk Mitigation in the Context of Dual Public Health Emergencies. This document contains the essential elements and principles for providing managed alcohol but intentionally does not provide a comprehensive structure or a high level of detail on the requirements to operate a program, nor does it include guidance for embedded services and programming that are typical in a managed alcohol program. The framework contained herein is intended to provide a broad overview and can be tailored based on the availability of resources (e.g., funding, number and type of staffing), number of eligible clients, geographical setting, and type of site, among others.

1.0 BACKGROUND

On March 11, 2020, the World Health Organization declared COVID-19, caused by a novel coronavirus, a pandemic, citing concern over alarming levels of spread and severity across the globe. The novel coronavirus has caused a global outbreak of respiratory infections since its discovery in December 2019. Although the scientific understanding of the effects of COVID-19 continues to grow, it is known that symptoms can range from mild (e.g., cough, fever) to severe (e.g., pneumonia, requiring hospitalization). The situation regarding COVID-19 continues to evolve in BC, Canada, and other jurisdictions around the world.

Some individuals who have severe alcohol use disorder (AUD) or engage in high-risk drinking may face serious alcohol-related harms during the COVID-19 pandemic due to homelessness, economic instability, and comorbid health conditions. Further, these individuals may experience more serious COVID-19 symptoms due to the higher risk of pneumonia and compromised immune function associated with high levels of alcohol consumption. In addition, individuals may have difficulties accessing alcohol (e.g., restricted hours of liquor retailers, distancing measures/isolation, checkpoints in Indigenous communities), or socioeconomic factors may affect purchasing ability (e.g., loss of income from binning, pan handling, and closure of bottle depots; restrictions on using cash). This may shift patterns of drinking in ways that increase harms, such as increasing or initiating non-beverage use or other illicit drug use, or lead to other unanticipated consequences, such as alcohol withdrawal.

Health care providers are encouraged to assess individuals for high-risk patterns of drinking and support patients to follow physical distancing and isolation directives, and avoid alcohol-related harms such as complications from pre-existing health issues and withdrawal, where possible. Information on screening, assessment, withdrawal management strategies, and long-term treatment for alcohol use disorder is available in the Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder and in a condensed bulletin developed for prescribers in the context of COVID-19. Per the Risk Mitigation in the Context of Dual Public Health Emergencies interim clinical guidance, if clinical supports are declined, not appropriate, or not available, other measures to support physical distancing and reduce alcohol withdrawal, such as managed alcohol, should be considered.

Managed alcohol programs (MAP) are a harm reduction strategy used to minimize the personal harm and adverse societal effects of severe AUD, particularly as experienced by individuals who may be homeless or unstably housed (see Appendix 1 for an evidence review).[1, 2] Typically, a MAP will dispense small doses of alcohol to clients at regular intervals, as a means of both regulating alcohol intake and reducing unsafe consumption of non-beverage alcohol.[1] In the community, MAPs are often coupled with, and offered within, shelter or housing programs to provide a safer and more inclusive alternative to abstinence-only housing for individuals with severe AUD.[2] This low-threshold approach enables clients to gain access to other health and social services that may be offered within the program.[1] In acute care settings, MAPs have also been implemented to support patients with severe AUD for whom withdrawal management or short-term abstinence during their hospital stay is not feasible.[3] There are several MAPs currently operating

[1] *Fairgrieve C, Fairbairn N, Samet JH, Nolan S. Nontraditional Alcohol and Opioid Agonist Treatment Interventions. Med Clin North Am. 2018;102(4):683-696.*

[2] *Pauly BB, Vallance K, Wettlaufer A, et al. Community managed alcohol programs in Canada: Overview of key dimensions and implementation. Drug Alcohol Rev. 2018;37(Suppl 1): S132-S139.*

[3] *Brooks HL, Kassam S, Salvalaggio G, Hyshka E. Implementing managed alcohol programs in hospital settings: A review of academic and grey literature. Drug Alcohol Rev. 2018;37(S1):S145-S155.*

in BC in both acute care and community settings. There are a wide range of managed alcohol program models, settings, and dosing plans that can be aligned to meet clients' needs.

This document provides guidance on key elements and considerations in order to rapidly develop and implement services that distribute alcohol and manage consumption, including in the context of COVID-19. This includes guidance on planning, principles of care, operational considerations, and care planning. Two service models are outlined here: clinician-delivered and community-delivered. The information contained herein is intended to provide examples that can be adapted as needed.

1.1 Goals of Providing Managed Alcohol

Providing managed alcohol aims to meet the following goals:

- Support wellness and well-being
- Prevent complications of severe alcohol use disorder and high-risk drinking
- Maintain or reduce alcohol intake, in order to prevent withdrawal (and complications of withdrawal)
- Eliminate or reduce non-beverage alcohol consumption
- Promote safer use through harm reduction education and self-management
- And, in the current COVID-19 pandemic, reduce risk or prevent COVID-19 infection and transmission, and support isolation measures for suspected or confirmed COVID-19 cases

2.0 DEVELOPMENT

This guidance document was developed through a collaboration between the BC Centre on Substance Use and Canadian Institute for Substance Use Research, initially as a response to the urgent needs of people who consume alcohol during the COVID-19 pandemic.

The guidance authorship committee developed an early draft following a review of the available evidence and documentation from several existing managed alcohol programs across Canada. Multiple rounds of revisions occurred following reviews by additional clinical experts, health system and government partners, and the Eastside Illicit Drinkers Group for Education. In addition, consultations were held with a clinical advisor, a pharmacy advisor, and several health professional regulatory colleges in BC. The final draft was endorsed by the Ministry of Health and the Ministry of Mental Health and Addictions.

3.0 PLANNING

Planning for a new managed alcohol service should include the following elements: principles of care, sustainability/continuity planning, operational considerations, and care planning.

3.1 Principles of Care

The planning, implementation, and provision of managed alcohol should be guided by the following principles of care:

- Understanding that alcohol use disorder is a chronic, relapsing condition
- Acknowledging and addressing inequities in the social determinants of health of many chronic drinkers
- Incorporating harm reduction and trauma- and violence-informed care
- Incorporating Indigenous cultural safety and the practice of cultural humility
- Inclusion of cultural practices in design and provision to support wellness
- Providing holistic and comprehensive care and referrals where needed
- Involving family and social contacts in care planning when appropriate
- Creating care plans that are individually tailored, patient-centred, and adjusted as needed
- Inclusion of people with lived experience in design and provision

Readers are encouraged to refer to the AUD and High-Risk Drinking Clinical Guideline for more detail and guidance on how to operationalize these principles in the context of alcohol use.

3.2 Sustainability/Continuity Planning

Sustainability is an important element in planning, both during the current COVID-19 pandemic and beyond. Organizations should plan for sustainability beyond the COVID-19 pandemic and should ensure continuity of care is included in care planning. For example, if a client moves, wants to start AUD treatment, or is no longer well-suited to managed alcohol, plans should be in place to safely transition clients to health or other services, as applicable.

Where possible, service planning should incorporate plans for continuous quality improvement and evaluation, to ensure the service is meeting the needs of its clients. Guidance is available at www.cmaps.ca.

3.3 Operational Considerations

This section provides an overview of typical operational considerations needed in order to plan and implement a managed alcohol service. Each managed alcohol service is unique and the factors outlined herein may or may not apply in all cases. See Operational Considerations, below.

3.4 Care Planning Considerations

A key component of designing and implementing managed alcohol is developing an appropriate service model, that incorporates screening, intake and referral, and working with clients to develop individualized managed alcohol plans. Given the context and setting, these features may include clinical or non-clinical interventions. See Care Planning Considerations, below.

4.0 OPERATIONAL CONSIDERATIONS

4.1 Community Managed Alcohol Service Models

Managed alcohol can be provided in a range of settings, which can accommodate clients' needs to remain at home, and support physical distancing and self-isolation. Existing program models range from low barrier, harm reduction programs to clinician-involved programs delivered from within clinical settings. In the context of COVID-19, all services should follow guidance and directives from public health officials. Staffing requirements will vary depending on setting, model, number of clients served, and whether transportation and delivery are part of the service. Implementation in rural and remote settings may require innovative approaches due to staffing limitations, distance between sites, and availability of resources.

4.1.i Example Models

Two example models are provided below, but every managed alcohol service will need to be tailored based on available resources, capacity, and organizational policies. These examples should be viewed as part of a continuum with many existing variations. The following examples focus predominantly on delivering or providing alcohol and may not require robust onsite monitoring or programming.

Model Type	Community-led harm reduction model	Clinician-initiated team-based model
Primarily run by	Harm reduction staff and people with lived experience (PWLLE) in community organizations with expertise in alcohol harm reduction	Collaborative team of clinicians (i.e., nurses), MHSU or harm reduction staff, and/or PWLLE staff
Aims	Low barrier to maintain engagement with individuals who face challenges are uncomfortable accessing traditional health services; focus on harm reduction and wellness, PWLLE support, self-management, and safer drinking education	Aimed at engaging individuals who may meet the criteria for AUD but are not able or interested in pharmacotherapy or other approaches to AUD care. Focus is on preventing alcohol-related harms, including those related to survival drinking, alcohol withdrawal; maintaining or reducing use; and harm reduction
Participants	Ideally suited for those who do not require or are uncomfortable accessing additional health care supports and are at low-to-moderate risk for complicated withdrawal. Note that individuals at higher risk for complicated withdrawal that decline additional health care supports could access managed alcohol through this model	Well-suited for those at higher risk of health complications and/ or complicated withdrawal and who are already engaged or require engagement with the healthcare system to meet their needs

Frequency of provision	Alcohol is often stored in one central, secured location, with 1-2 times daily provision—either through client pick-up (if appropriate) or delivery (to a single or multiple sites) If providing from within housing, housing providers may be able to store alcohol for clients	
Funding models	1. Fully funded by organization or health authority 2. Partially funded by organization or health authority and partially by client contributions	
Day-to-day oversight	Community organization, housing provider, or contracted service provider	Staff nurse, with harm reduction, housing, or community outreach staff
Settings	1. Onsite program at community organization, supported housing, or shelter 2. Delivery program for encampments or scattered temporary or permanent sites (e.g., housing, hotels, shelters)	1. Clinical, health centre, hospital, nursing station, or COVID-19 emergency response centre 2. Supported housing or hotel/motel
Staff requirements	Depends on specific setting and capacity. Example for an onsite program: • 1.0 FTE harm reduction manager with additional PWLE/housing support in a community program could support 20-30 members • PWLE workers or housing staff can provide support and assist with wellness checks • Access to health care providers (nurse, physician, social worker) should be provided, where possible, for clients with medical or health needs who are not already engaged in care	Depends on specific setting and capacity. Example: • 0.5 FTE nurse (7 days per week), 1.0 FTE harm reduction or community outreach staff (7 days a week), and addiction medicine support (1 half-day per week) could support a 15 to 20-person case load • Screening, assessment, intake, and alcohol management and monitoring plan by RN in consultation with prescriber • Example case load would be feasible with client pick-up or staff delivery to client (max 3 sites in close proximity) • During initiation, screening and intake may require increased staffing or reduced case load

4.1.ii Staffing

Each managed alcohol service will determine what level of staffing is appropriate, depending on setting, capacity, model, and specific client needs. Considerations should include who can provide screening (for example, physician, nurse, or non-clinicians, such as harm reduction staff, or outreach staff, with appropriate training), who can provide alcohol (the provision of alcohol for medical purposes is not a restricted health care activity), and whether written orders are required (in clinician-led models). In clinician-led models, staffing roles should be clearly defined, including when and how to consult with another health care professional. It should be noted that diagnosis of alcohol use disorder can only be performed by a physician or nurse practitioner.

Any questions or concerns about scope should be discussed with the relevant regulatory college and professional practice, if applicable.

4.2 Storage

For settings that have a secured space, alcohol can be stored on-site (e.g., locked office or closet). For settings that do not have storage capabilities or staff who are available to administer alcohol (e.g., encampments), an off-site storage location is needed and delivery services should be considered, where resources are available.

4.3 Funding Considerations

Funding considerations will vary by service model and setting. Costs will be based on number of clients served, number and type of staff required, and volume of alcohol required monthly.

Potential funding sources may include:

- Existing or emergency funds via health authorities
- Client contributions to supplement costs

Estimated costs, based on retail pricing for one can of beer.[4]

	5 drinks per day	10 drinks per day	15 drinks per day
Daily cost per client	$7.10	$14.20	$21.30
Monthly cost per client	$213	$426	$639*

** Costs may be reduced with wholesale pricing*

[4] Based on $1.42 retail price for 341 ml 5% can of a common brand of beer.

4.4 Procurement

The mechanisms for obtaining and purchasing alcohol are varied and dependent on type and site of the service. Health Authorities or organizations interested in offering managed alcohol should consider the following:

- Source of alcohol
    - Liquor stores (bulk discount possible)
    - Local brewery or winery (bulk discount or lower cost product possible)
    - Donated alcohol
    - U-brewing within the program
    - Pharmacy
        - Vodka and beer are on the BC Formulary and can be dispensed by pharmacy in hospital or other inpatient settings. At this time there is no mechanism for procurement via community pharmacy.
- Type and quantity of alcohol
    - This will depend on the number of clients and their dosage, storage capacity, and funding
    - To reduce risk of COVID-19 transmission and reduce time during delivery and dosing, programs may wish to provide beer or coolers in cans
    - Provision of spirits may be more difficult to manage during the COVID-19 pandemic due to the high dosage of a typical bottle (one 750 ml bottle of 40% spirits is equivalent to 17.5 drinks). Dividing these doses among multiple clients safely will require more resources and supplies

4.5 Delivery and Provision

Each managed alcohol service will have to determine the relevant delivery and provision considerations and protocols, which will be service-specific. Considerations that may be relevant are listed below.

Delivery considerations:

- Delivery procedures may not apply if alcohol is stored on-site
- Frequency of pickup and delivery determined by client needs and feasibility (e.g., staffing, distance to delivery location)
    - Suggested frequency of delivery to site is 1–2 times per day. Individual provision schedules should be tailored and will vary but could coincide with delivery, depending on client self-management
- Transport alcohol in trunk of vehicle or other locked area and keep within possession at all times until delivered to client or returned to storage. If feasible, two staff are recommended for safety and security reasons

Provision considerations:

- Determine hours of alcohol provision (e.g., 8:00am–5:00pm)
- Phone or text client(s) in scattered sites such as housing or shelter to confirm arrival of the alcohol
    - Discuss alternative plans for clients without phone access
- Confirm amount and type, as per alcohol management plan, and record amount removed from storage on Inventory Control form (Appendix 2)
- Conduct brief assessment and wellness check (Appendix 3)

    - If concerned about intoxication (i.e., unsteady on feet; slurring of speech; slow to respond to speech), withhold alcohol dose and determine plan for later provision in order to prevent over-intoxication
    - If withdrawal symptoms present (i.e., tremors/shakes, nausea, anxiety/agitation/sweats, hallucination), consult with program manager or clinician to manage symptoms or adjust dose
    - In the context of COVID-19, ensure physical distancing requirements are maintained, and assess client for symptoms of COVID-19; if symptoms emerge or worsen, contact client's prescriber for follow-up and advise client to stay at home and away from other people
    - Consider regular check-ins with each client about quality of life, goals, COVID-19 planning and precautions, and any other health concerns; connect to services where available
- Document alcohol doses on provision record (Appendix 3)
- Doses do not need to be witnessed

5.0 CARE PLANNING CONSIDERATIONS

Each managed alcohol service should put in place protocols for care planning. Suggested protocols include screening, intake and referral, and developing an alcohol management plan.

5.1 Screening

Each managed alcohol service should determine screening and eligibility criteria. Generally, managed alcohol is appropriate for individuals with severe AUD and those who engage in high-risk drinking. Typically, this includes individuals who drink alcohol daily, are at risk of withdrawal and other alcohol-related harms, and are not engaged in treatment for AUD. In the context of COVID-19, risk of exposure and transmission may also be considerations for eligibility.

A variety of screening tools exist, including the Alcohol Use Disorders Identification Test (AUDIT), which helps identify high-risk drinking or alcohol use disorder, and the Prediction of Alcohol Withdrawal Severity Scale (PAWSS), which estimates the risk of severe withdrawal (see Appendix 4 for these tools). More information on these and other screening tools is available in the Provincial Guideline for the Clinical Management of High-risk Drinking and Alcohol Use Disorder. The Severity of Alcohol Dependence Questionnaire (SADQ) is a screening tool that measures severity and is validated in clinical and community settings. It may be a useful screening tool in non-clinical settings, as it can be self-administered and does not require training for scoring and interpretation.[5] Selection of one or more screening tools will depend on setting, staff (e.g., clinician vs. PWLE worker), and other factors.

For eligible clients who are pregnant or planning to become pregnant, referral or connection to primary care for care planning is advised. Clients who are pregnant should be referred to a health care provider for brief counselling interventions, advice for discontinuing alcohol use, appropriate treatment interventions and support services. If unfeasible, harm reduction and treatment strategies should be offered, in accordance with clinical guidelines.

5.1.i Additional assessment

If feasible and appropriate, additional questions can be used to ascertain further details and other health risks and related harms. These could include patterns of drinking (e.g., history of heavy episodic drinking, non-beverage alcohol use), drinking in unsafe settings, ability to maintain isolation (in the context of COVID-19), and ability to reliably and safely access alcohol.

Where possible, clients should receive a comprehensive assessment of current substance use. Concurrent use of alcohol with other CNS depressants (e.g., benzodiazepines, opioids) is associated with a significantly increased risk of overdose. Care planning should prioritize management of the substances associated with risk of severe withdrawal and include overdose response planning. Patients should be informed of the risks of concurrent use, given access to naloxone and instructions on its use.

For programs with limited capacity, priority should be given to those with severe AUD and risk of serious harms from alcohol withdrawal.

[5] *Maisto SA, McKay JR, Tiffany, ST. Diagnosis. In: Allen JP, Columbus M, eds. Assessing alcohol problems: A guide for clinicians and researchers. 2nd ed. Bethesda, MD: NIH; 2003: 55-74. NIH Publication No. 03–3745.*

For clinician-delivered services, it is recommended to follow initial screening with a more detailed comprehensive assessment, which could include medical history; alcohol use, history, current and historical alcohol-related risks and harms, and previous treatment attempts; risk of developing severe complications of withdrawal; substance use history and active use. For individuals with co-occurring substance use or substance use disorders, clinical judgment should be used to determine whether managed alcohol would be safe and appropriate. See Appendix 5 for an example clinical assessment form.

5.2 Intake and Referral

For clients deemed eligible, complete intake and referral form with client's contact information (See Appendix 6 for an example). Where possible, efforts should be made to connect clients to other health or social services if needs are identified during the screening and intake process.

5.3 Alcohol Management Plan

In any program model, individualized alcohol management plans are an important element and can be developed by the client, or in collaboration with a clinician, PWLE or other staff. If clinician-directed, discussion with the client and mutual decision-making is highly recommended. Managed alcohol is often provided outside of medical or clinical settings and a prescription is not required. Clinical programs offering managed alcohol may decide to develop processes that include written orders [6] (see example in Appendix 7).

Typical elements of the alcohol management plan include:

- Discussing harm reduction and client goals
- Determining dose and type of alcohol—if client wishes to reduce drinking, provide advice on safe and gradual tapering (e.g., by one drink per day) or taking breaks
- Determining frequency of alcohol provision (suggested frequency is 1–4 times per day [7])
- Determining frequency of monitoring and wellness checks
- Providing education on harm reduction and safer drinking
- Where possible and appropriate, discussing AUD pharmacotherapy and withdrawal management medications and inpatient withdrawal management if indicated
- Reviewing a client agreement—while managed alcohol is usually offered as an open-ended intervention, discussions may include plans for transition away from managed alcohol in the future

Any adjustments made to the alcohol management plan, due to withdrawal, over-intoxication, or changes in goals, should be made collaboratively with the client. Clients should be supported to develop self-management skills, including counting and pacing their drinks, in order to avoid binging or outside drinking. Plans can include additional elements as needed, such as: exchanging non-beverage alcohol for beverage alcohol, providing client with daily pharmacy-dispensed medications, and access to cultural practices and supports from Indigenous Health teams.

See Appendix 8 for an example alcohol management plan.

[6] *In some clinician-delivered models, orders may be used for documentation.*

[7] *Note: alcohol amount, frequency, and type may need to be adjusted depending on client's goals and if withdrawal symptoms emerge or client becomes over-intoxicated.*

[8] *In cases where the client is not able to self-manage at this rate, 90-minute dosing may be considered, depending on staff capacity and other relevant factors (for example, exposure to COVID-19 and required personal protective equipment).*

APPENDICES

Appendix 1: Evidence Review for Managed Alcohol Programs

Managed alcohol programs (MAPs) are an almost uniquely Canadian harm reduction intervention. MAPs originated as a response to the complex needs of people who were uninterested in reducing alcohol use, unable to undertake or did not respond to abstinence-based programs, and were experiencing homelessness or housing instability.[1] As well, many individuals who consume alcohol have not been screened or offered evidence-based therapies.[2] While wet shelters and "housing first" programs offer safe spaces that allow alcohol consumption, MAPs offer regulated access to beverage alcohol, alongside other health and social supports.[1] Based on a review of 13 Canadian MAPs, six key elements were identified: goals and eligibility, food and accommodation, alcohol management and administration, funding and money management, primary care and clinical monitoring, and cultural and social supports.

While the majority of MAPs in Canada are delivered by the community not-for-profit sector, there is a wide range of models, from community programs led by people with lived experience to programs in shelters, transitional and supportive housing, and hospitals. An important element of MAPs is the involvement of people with lived experience in design, development, and delivery of programs.[3-6] In Canada, with a few exceptions, MAPs have been developed largely by and for non-Indigenous people. However, the Indigenous programs in existence are unique in that they are informed by Indigenous knowledge and governed by Indigenous people. As described by Child et. al., Indigenous-led MAPs prioritize the issues that impact their communities, such as colonization, assimilation, racism, and intergenerational trauma.[7] Indigenous-led and informed programs have been found to increase participants' experiences of home, family, cultural reconnection, and healing through ceremony.[8,9] A literature review of Indigenous healing methodologies and MAPs is available.[10] Several feasibility studies have been conducted for specific populations and settings, including Indigenous Peoples,[7,11] Sydney, Australia,[12] and hospitals.[13] There has been limited research on programs that incorporate sex and gender considerations; the majority of the existing programs serve primarily men. While MAPs have been deemed feasible and acceptable, barriers for implementation have been identified and include issues such as the need for appropriate eligibility criteria, tailoring of programs to individual needs along with self-management, and ability to manage outside drinking.[14]

Podymow and colleagues first documented the impacts of MAPs in 2006 based on a program in Ottawa and found benefits related to reduced hospital and policing costs, improved hygiene and nutrition, and increased medication compliance.[15] The Canadian Managed Alcohol Study (CMAPS) began in 2011 and is the largest study in the world of MAP implementation and outcomes (www.cmaps.ca). Initial studies of MAPs found evidence of reduced alcohol-related harms, reduced use of non-beverage alcohol, improved quality of life and safety, increased housing stability, and reduced demands and costs for the health and criminal justice systems.[8,16-19]

In a comparison of 175 MAP participants and 189 controls in five cities, Stockwell et al. found that long-term MAP residents (>2 months) drank significantly fewer drinks per day than controls over the previous 30 days.[20] In this same analysis, long-term MAP residents reported significantly fewer acute alcohol-related harms in the domains of health, safety, social, legal, and withdrawal symptoms. The same participants reported that when unable to afford alcohol, they would use coping strategies, such as re-budgeting (53%), waiting for money (49%), or going without (48%), and engage in activities with negative or harmful consequences, such as use of illicit drugs (41%) and/or non-beverage alcohol (41%).[21] Compared to

controls, the long-term MAP residents were less likely to use illicit substances, steal, or go without alcohol, and they were more likely to seek treatment. Additionally, qualitative analysis of MAP participants shows that being in a MAP disrupts survival drinking and cycling through multiple settings (which is particularly important to reduce movement in the context of COVID-19), as well as enhancing feelings of safety, belonging, sense of place or home, and hope for the future.[22-24] In summary, MAPs have been shown to enhance housing stability, reduce acute and social alcohol-related harms, improve safety, and create opportunities for reconnection with families, communities, and healing. MAPs fill an important gap for those who require additional support to manage alcohol use in order to maintain stability and—during COVID 19—adhere to physical distancing measures.

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Appendix 2: Alcohol Inventory Control

Date	Time	Client Name	Prescriber	Dose Amount	Vodka 375mL	Vodka 750mL	Beer 341-355mL (1Can)	Wine 2L	Wastage	Signature
		Baseline Inventory								
		Balance								

Client Name:	**Address:**				**Contact number:**		
Date and time of client contact							
Symptom assessment (If new symptoms have developed or worsened, please call physician; if client is in distress, call 911)							
COVID-19 SYMPTOMS (If symptoms have appeared to develop or become worse, contact client's care provider to consult)							
Cough Fever Shortness of breath							
WITHDRAWAL SYMPTOMS (If symptoms present, contact program manager or prescriber to evaluate dosage)							
Tremors/shakes							
Nausea							
Anxiety/agitation/sweats							
Hallucination							
SYMPTOMS OF INTOXICATION* (if symptoms present, withhold alcohol dose and consult program manager or prescriber)							
Unsteady/lack of balance							
Slurred speech							
Slow response time							
Unusual demeanor							
Alcohol Delivery							
Was alcohol provided? Y/N							
Type and qty. of alcohol provided — Wine: Beer:							
Staff initials							
Client signature							
Comments							

*If above client's typical baseline behaviour

Delivery instructions:

1. Confirm quantity of alcohol prior to delivery
2. Phone client to alert that you are on your way for delivery
3. Request client meet at door of delivery location (maintain 2 metres distance)
4. Screen client using verbal inquiries and observations as above

Adapted from Interior Health

Appendix 4: Screening Tools

The Alcohol Use Disorders Identification Test (AUDIT)[9]

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week ☐	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more ☐	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0 ☐	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year ☐
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year ☐
Interpretation: Scores of 8 or higher indicate hazardous or harmful use	Total score: ☐

[9] *Babor TF, Higgins-Biddle JC, Saunders J, Monteiro M. The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care. Second Edition. Geneva, Switzerland: World Health Organization (WHO) Department of Mental Health and Substance Dependence. 2001. Available at: https://apps.who.int/iris/bitstream/handle/10665/67205/WHO_MSD_MSB_01.6a.pdf.*

Severity of Alcohol Dependence Questionnaire (SADQ)[10]

Please recall a typical period of heavy drinking in the last 6 months. When was this? _____

Please select a number (either 0, 1, 2, or 3) to show how often each of the following statements applied to you during this time.

Questions	Almost never	Sometimes	Often	Nearly always
I woke up feeling sweaty.	0	1	2	3
My hands shook first thing in the morning.	0	1	2	3
My whole body shook violently first thing in the morning.	0	1	2	3
I woke up absolutely drenched in sweat.	0	1	2	3
I dreaded waking up in the morning.	0	1	2	3
I was frightened of meeting people first thing in the morning.	0	1	2	3
I felt at the edge of despair when I awoke.	0	1	2	3
I felt very frightened when I awoke.	0	1	2	3
I liked to have a morning drink.	0	1	2	3
I always gulped my first few morning drinks down as quickly as possible.	0	1	2	3
I drank in the morning to get rid of the shakes.	0	1	2	3
I had a very strong craving for drink when I awoke.	0	1	2	3
I drank more than 1/4 bottle of spirits a day (or 4 pints of beer/1 bottles of wine).	0	1	2	3
I drank more than 1/2 bottle of spirits a day (or 8 pints of beer/2 bottles of wine).	0	1	2	3
I drank more than 1 bottle of spirits a day (or 15 pints of beer/3 bottles of wine).	0	1	2	3
I drank more than 2 bottles of spirits a day (or 30 pints of beer/4 bottles of wine).	0	1	2	3

Imagine the following situation: (a) You have been completely off drink for a few weeks. (b) You then drink very heavily for two days. How would you feel the morning after those two days of heavy drinking?

Symptom	No	Slight	Moderate	A lot
I would start to sweat.	0	1	2	3
My hands would shake.	0	1	2	3
My body would shake.	0	1	2	3
I would be craving for a drink.	0	1	2	3

TOTAL SADQ SCORE = _____

Interpretation:

Score	8-15	16-30	31-60
Indication	Mild dependence	Moderate dependence	Severe dependence

[10] *Stockwell T, Murphy D, Hodgson R. The Severity of Alcohol Dependence Questionnaire: Its Use, Reliability and Validity. Br J Addict. 1983;78(2):145-55.*

Prediction of Alcohol Withdrawal Severity Scale (PAWSS)[11]

PART A: THRESHOLD CRITERIA – Yes or No, no point	
	Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? ***OR*** Did the patient have a positive (+) blood alcohol level (BAL) on admission?
	If the answer to either is *YES*, proceed to next questions.
PART B: BASED ON PATIENT INTERVIEW – 1 point each	
1.	Have you been recently intoxicated/drunk, within the last 30 days?
2.	Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., in-patient or out-patient treatment programs or AA attendance)
3.	Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity?
4.	Have you ever experienced blackouts?
5.	Have you ever experienced alcohol withdrawal seizures?
6.	Have you ever experienced delirium tremens or DTs?
7.	Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, during the last 90 days?
8.	Have you combined alcohol with any other substance of abuse, during the last 90 days?
PART C: BASED ON CLINICAL EVIDENCE – 1 point each	
9.	Was the patient's blood alcohol level (BAL) greater than 200mg/dL? (SI units 43.5 mmol/L)* ***OR*** *Have you consumed any alcohol in the past 24 hours?
10.	Is there any evidence of increased autonomic activity? e.g., heart rate >120 bpm, tremor, agitation, sweating, nausea
Interpretation: Maximum score = 10. This instrument is intended as a *SCREENING TOOL*. The greater the number of positive findings, the higher the risk for the development of alcohol withdrawal syndrome (AWS). A score of ≥4 suggests *HIGH RISK* for moderate to severe (complicated) AWS; prophylaxis and/or inpatient treatment are indicated.	

An online version of the original (unmodified) PAWSS can be found at: https://www.mdcalc.com/prediction-alcohol-withdrawal-severity-scale.

[11] *Maldonado JR, Sher Y, Ashouri JF, et al. The "Prediction of Alcohol Withdrawal Severity Scale" (PAWSS): systematic literature review and pilot study of a new scale for the prediction of complicated alcohol withdrawal syndrome. Alcohol. 2014;48(4):375-390.*

Appendix 5: Sample Clinical Assessment Form

Adapted from Vancouver Coastal Health

PATIENT INFORMATION	
Surname:	Given name(s):
Date of birth:	PHN:

Medical history (Including mental health and substance use)

_____

_____

_____

_____

Substance use

Type: Amount: Frequency:

_____

_____

_____

Note: Concurrent use of alcohol and other CNS depressants (e.g., benzodiazepines, opioids) is associated with a significantly increased risk of overdose. Where possible, clients should receive a comprehensive assessment of substance use. For individuals with co-occurring substance use or substance use disorders, clinical judgment should be used, with priority given to substances associated with risk of severe withdrawal, and patients educated on the risks of concurrent use.

Typical alcohol consumption

Number of drinking days in the past 7 days:

On a typical day:

What type do you drink? (circle all that apply) Beer Wine Sherry Spirits Non-beverage

How much (of each type)? _____

_____

Total daily intake[12]:

Alcohol-related harms

In the past 3 months, patient has experienced:

- ☐ Alcohol withdrawal symptoms, including alcohol-related seizures
- ☐ Non-beverage alcohol use
- ☐ Alcohol-related falls or injuries
- ☐ Alcohol-related ER visits
- ☐ Passing out / losing consciousness from alcohol
- ☐ Survival drinking strategies (e.g., panhandling, recycling, sharing with friends)

Assessment for withdrawal risk, AUD, and AUD severity

PAWSS Score:

Optional:
AUD diagnosis and severity:

Number of DSM-5 symptoms:

Hazardous or harmful drinking: AUDIT score:

AUD severity; SADQ score:

☐ At risk of COVID-19, confirmed or suspected case

Eligible for managed alcohol: Yes No

Client's baseline behavior (to be used to assess over-intoxication at time of provision):

Comments:

Completed by: _____ Signature: _____ Date: _____

[12] *Use standard drinks calculator: http://aodtool.cfar.uvic.ca/index-stddt.html.*

Appendix 6: Sample Intake Form

Adapted from PHS Community Services Society

Please fill out and send this form to: _____

REFERRED BY: _____ **DATE:** _____

CLIENT INFORMATION	
Name: _____	**Phone number:** _____
Date of birth: _____	**PHN:** _____
Client or Program address (for alcohol delivery): _____ _____	
Comments on housing situation: _____	
EMERGENCY/FAMILY CONTACT INFORMATION	
Name:_____ **Relation:**_____	
Emergency contact address:_____ **Phone number:** _____	
DOCTOR/CLINIC:	
_____	

Appendix 7: Sample Clinical Care Record

Adapted from similar Interior Health Authority and Providence Health Care forms

MANAGED ALCOHOL

To schedule alcohol delivery for a client, call xxx-xxx-xxxx and fax this completed order to xxx-xxx-xxxx

DATE: _____ **TIME:** _____

MANAGED ALCOHOL DOSAGE:

Please select alcohol type(s) and complete dosing instructions (items with check boxes must be selected to be ordered):

Dosing Guide

Type	**Dose**
Beer	341ml to 355ml = 1 can (1 dose)
Wine	142ml = 1 glass = (1 dose)
Do NOT exceed 18 total doses/24 hours	

Please specify **total daily quantities** for provision (staff will not divide daily doses):

☐ _____ x cans of beer (1 can = 341ml to 355mL = 1 dose)

☐ _____ x bottles of wine (One 750ml bottle = 5.3 doses)

PROVISION:

☐ Client to self-manage intake with once-daily provision

☐ Staff to provide _____ doses q _____h PRN to a max of _____ doses/24 hrs

DURATION:

MONITORING INSTRUCTIONS:

COMMENTS:

_____ _____ _____

Name Signature Contact number

Appendix 8: Sample Client Alcohol Management Plan and Agreement

Adapted from similar Vancouver Coastal Health and Northwest Territories forms

CLIENT INFORMATION

Name: _____	**Phone number:** _____
Date of birth: _____	**PHN:** _____

CLIENT IDENTIFIED GOALS

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Note: If client indicates reduced drinking, AUD treatment, or withdrawal management as a goal, client should be connected to a clinician who specializes in treating substance use disorders.

ALCOHOL MANAGEMENT PLAN

	# of standard drinks[1]	Total Daily Dose:
Beverage Type: **Wine**	Dosage: _____	
Beverage Type: **Beer**	Dosage: _____	
Beverage Type: **Other** (_____)	Dosage: _____	

Sample drinking schedule: 1 drink every _____ hours

Frequency of delivery to client (e.g., daily at 9 am):_____

Plan for if client is in withdrawal or is out of alcohol: _____

_____

Schedule of routine primary care check-up (e.g., weekly): _____

- ☐ Safer drinking education provided
- ☐ Pharmacotherapy options discussed, where feasible

FINANCES (if applicable)

Client contribution: _____

Money management plan: _____

[13] *One standard drink is 1.5 oz vodka, 355 ml can of 5% beer, or 5 oz 12% wine.*

COMMENTS

CLIENT AGREEMENT

1. I agree to receive managed alcohol, as outlined above. This includes the types and amounts of alcohol and the schedule for when I will receive the alcohol.
2. Before receiving alcohol, the staff will do a wellness check to see if I have symptoms of withdrawal or COVID-19, or signs of over-intoxication.
3. I understand that I will not receive alcohol if I am over-intoxicated at the time of delivery.
4. I agree to not access other MAPs or seek additional sources of alcohol outside of the MAP. If I have concerns about my dosage, I will discuss with the program provider. I agree not to share my alcohol with others.
5. [COVID-specific requirements regarding physical distancing]
6. [COVID-specific requirements if suspected infection]
7. I can request help from the staff if I need help with food, medications, communication with family, etc.
8. The staff and I will do a regular check-in on my health, my alcohol consumption, and whether we need to adjust the plan.
9. I am aware that when restrictions due to the COVID-19 emergency are lifted, we may need to discuss a transition plan for my alcohol use.

☐ It is ok to contact me to discuss future research on managed alcohol
☐ I do not want my administrative records to be used for evaluation purposes

I have reviewed and agree to all of the commitments outlined in this alcohol management plan.

Staff Name	Signature	Date
Client Name	Signature	Date

CLIENT DISCHARGE AND NEXT STEPS

Date: Reason:

Next Steps: