



# FEASIBILITY ASSESSMENT

of Home Detoxification Services in Quebec First Nations Communities

FINAL REPORT



FIRST NATIONS OF QUEBEC AND LABRADOR  
HEALTH AND SOCIAL SERVICES COMMISSION



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## TERMINOLOGY

ASAM	American Society of Addiction Medicine
CCSA	Canadian Centre on Substance Abuse
CHRTTR	<i>Centre hospitalier régional de Trois-Rivières</i>
CIWA-Ar	Clinical Institute Withdrawal Assessment of Alcohol Scale, Alcohol Revised
CPLT	<i>Comité permanent de lutte à la toxicomanie</i>
ICAAT	International Centre for Advancement of Addiction Treatment
CRAT-CA	<i>Centre de réadaptation en dépendance de Chaudière-Appalaches</i>
CRD	<i>Centre de réadaptation en dépendance</i>
CRPAT	<i>Centres de réadaptation pour personnes alcooliques et autres toxicomanes</i>
CRUV	<i>Centre de réadaptation Ubalde- Villeneuve</i>
CSSS	<i>Centres de santé et services sociaux</i>
FNQLHSSC	First Nations of Quebec and Labrador Health and Social Services Commission
FQCRPAT	<i>Fédération québécoise des centres de réadaptation pour personnes alcooliques et autres toxicomanes</i>
APIRG	Aboriginal Psychosocial Interventions and Research Group
MSSS	<i>Ministère de la Santé et des Services sociaux du Québec</i>
NNADAP	National Native Alcohol and Drug Addiction Program
RISD	<i>Réseau intégré de services en désintoxication</i>
PSW	Psychoactive substances withdrawal

## **BACKGROUND**

The Quebec First Nations regional detoxification services needs assessment is an initiative of the First Nations of Quebec and Labrador Health and Social Service Commission (FNQLHSSC). The FNQLHSSC secured the necessary funding for conducting a multi-stage research project aimed to develop an action plan for Quebec First Nations detoxification services. The Aboriginal Psychosocial Interventions and Research Group (APIRG) was hired to carry out this mandate.

The process led to identifying First Nations detoxification needs as well as best practices in detoxification while taking into account services offered in the Quebec network and their availability to First Nations. In addition, this project provided a picture of Quebec First Nations needs in this field. Thus, the range of services was established according to their availability in administrative regions in the Quebec network (including outpatient detoxification services). Furthermore, the process included identifying existing assessment tools and protocols relating to detoxification services.

Finally, the mandate consisted in conducting a feasibility analysis of an outpatient detoxification service, as suggested by a model developed by a First Nation in British Columbia.

## **INTRODUCTION**

This report was prepared by the Aboriginal Psychosocial Interventions and Research Group (APIRG) for the FNQLHSSC.

It is divided into several sections, the first of which describes the methodology used in conducting the needs assessment. The next section describes and analyses current services in the provincial and First Nations networks in the Quebec Region and describes best practices in detoxification. The third section addresses the results of structured interviews conducted with key stakeholders in Quebec First Nations communities. The fourth section analyses the feasibility of outpatient detoxification services.

This report provides recommendations relative to the implementation of detoxification services for Quebec First Nations communities.

**CAUTION**

One of the challenges that arose in developing this needs assessment was to identify existing services and practices in First Nations communities not listed in the documentation and references used. Given the scope of the work involved in conducting an exhaustive investigation of services and practices in each First Nations community in Canada, and since this lay outside the mandate given to APIRG by the FNQLHSSC, it is therefore possible that some of these practices and services may not be listed.

As regards structured interviews, the level of knowledge of issues, practices and processes relating to detoxification services may vary from one respondent to the next. The goal of this study was not to determine this level of knowledge but rather to examine the feasibility of outpatient detoxification services.

Readers are advised to keep this in mind.

## SECTION 1 : METHODOLOGY

In order to analyse the feasibility of outpatient detoxification services as suggested by a model developed by a First Nations in British Columbia, the goal of the study was, first, to collect information pertaining to detoxification services and best practices to then try to identify Quebec First Nations needs in this area.

Carrying out this mandate required a flexible and adaptable methodology. The study was primarily conducted in two stages: a literature review followed by structured phone interviews.

### Literature Review

Research was done in electronic documentation to identify services available and best practices employed in non Aboriginal services and in the Quebec network. This section allowed examining the feasibility of using a tool for assessing the risk associated with withdrawal as well as treatment protocols used in Quebec. Then, the same type of research was done to identify existing services and best practices in a First Nations context.

Information sources consulted to complete the literature review include:

- • First Nations-specific databases;
- • Government databases;
- • Scientific databases;
- • First Nations regional organizations websites;
- • Community organizations websites and databases;
- • Collective works and research studies;
- • Grey literature (e.g. unpublished documentation).

### Structured Interviews

In order for information to be collected from respondents from the First Nations community health sector in Quebec, structured interviews were conducted on the phone with key players

of the health sector. Interviews were conducted by a bilingual interviewer from October 16 to November 20, 2009.

### **Measuring Instrument**

A questionnaire (Appendix 1) was administered to key players working in the First Nations community health field in Quebec. In compliance with the First Nations of Quebec and Labrador research protocol, each respondent was asked to give their free consent prior to the interview. A total of 37 respondents were interviewed. Since it was determined that all questionnaires were valid, all the information was used in the data collection process. Topics covered included socio-demographic characteristics, current detoxification services and best practices, and respondents' perceived needs. To adapt to the contents of the study, it was determined a combined quantitative and qualitative approach would be used.

### **Questionnaire Administration**

Although we are aware that we have used non-probability sampling, and because of our concern to obtain a diversity of perspectives, we created a sample of respondents with different professional responsibilities but all related to the health field. Consequently, we can say that our sample is representative of the group of people directly involved in detoxification services.

The questionnaires were administered in English and French by the same person. All the interviews were conducted by phone, by appointment with each participant. The questionnaire was sent to all respondents prior to the interviews.

### **Final Sample Composition**

Although sample size was initially set at fifty (50) respondents, thirty-seven (37) questionnaires were administered. In order to provide a clear understanding of the sample composition, the detailed distribution of topics is presented later in tables and graphs.

Respondent First Nations not covered by an agreement included (in alphabetical order):

- Abenaki
- Algonquin

- Atikamekw
- Huron-Wendat
- Innu
- Micmac
- Mohawk

Please note that this needs assessment included a sample of First Nations communities with a fully functional and fully-staffed health centre. Consequently, some communities could not be included in the final sample.

During the data collection process, the nations covered by an agreement (the Inuit, the Naskapi and the Cree) could not be included in the sample and could not be administered the structured interview questionnaire, consistent with FNQLHSSC guidelines in this respect.

### **Limits of the Assessment**

The main challenges encountered in conducting the project were primarily related to access to key players and to the reliability of the interview schedule. The fact that data collection through structured interviews coincided with the influenza A(H1N1) vaccination campaign represented a major challenge in terms of the accessibility and availability of nursing staff in First Nations communities. As a result of this, some interviews had to be cancelled.

In addition, only the opinions of addiction workers were collected and detoxification services clients have not been surveyed about their needs. Our sample was large enough to safely say that it is representative of the opinions and perceptions of workers, although it does not reflect those of clients.

During the detoxification services needs assessment study process, all the data collected through the literature review and interviews with key players were analyzed and organized around different larger topics that are the subject of this final report.



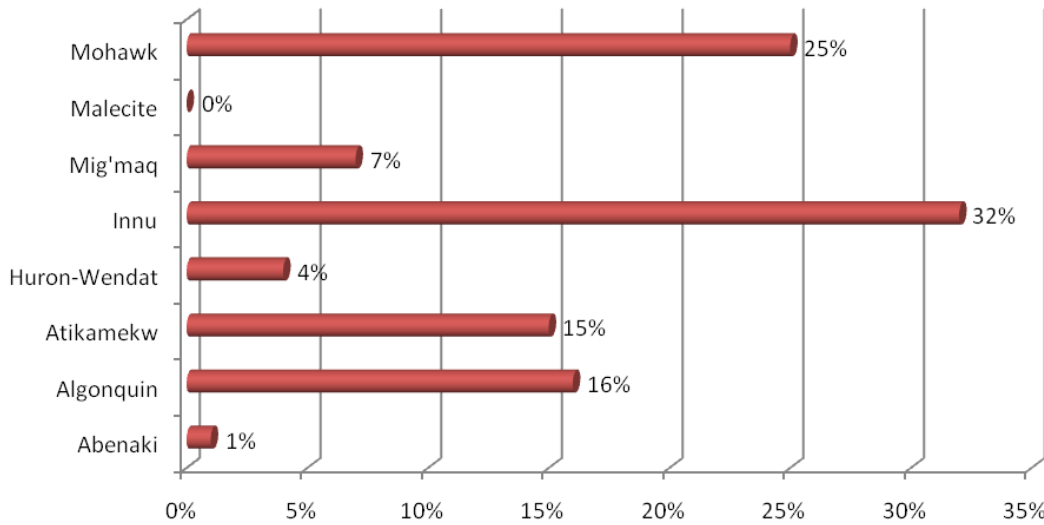
**SECTION 2: DESCRIPTION AND ANALYSIS OF CURRENT SERVICES IN THE PROVINCIAL AND FIRST NATIONS NETWORKS IN THE QUEBEC REGION**

According to demographic data from the Department of Indian and Northern Affairs Canada (2007), the proportion of on-reserve residents for each First Nations covered by an agreement was as follows:

First Nations	On-reserve population (%)	Population
Abenaki	1%	376
Algonquin	16%	5 709
Atikamekw	15%	5 482
Huron-Wendat	4%	1 326
Innu	32%	11 612
Mig'maq	7%	2 579
Malecite	0%	1
Mohawk	25%	8 850
TOTAL	100%	35 975

The figure below shows the distribution of the total on-reserve population in First Nations not covered by an agreement. The Innu Nation has the highest proportion of on-reserve population, with 32% of its members living on-reserve, followed by the Mohawk Nation, with 25%.

**Proportion of on-reserve population for First Nations covered by an agreement**



To illustrate the geographic distribution of specialized detoxification services, the following table shows in which administrative regions First Nations are located as well as the number of communities ('reserves') in each region. The third column indicates the number of specialized detoxification services available in each administrative region. 'Specialized services' include services strictly limited to providing detoxification services. For instance, specialized services do not include hospital emergency services but include hospital detoxification services or addiction centres providing withdrawal management.

<b>Administrative regions where specialized detoxification services are offered</b>	<b>FN communities not covered by an agreement located in each administrative region</b>	<b>Number of specialized detoxification services in the region (based on review of services)</b>
Côte-Nord	9 (Innu Nation)	1
Gaspésie	3 (Mig'maq Nation)	2
Laurentides	1 (Mohawk Nation)	1
Outaouais	1 (Algonquin Nation)	2
Mauricie	2 (Atikamekw Nation)	1
Abitibi-Témiscamingue	8 (Algonquin Nation)	1
Saguenay-Lac St-Jean	1 (Innu)	2
Centre-du-Québec	2 (Abenaki Nation)	1
Capitale-Nationale	1 (Huron-Wendat Nation)	2
Estrie	0	2
Montréal	0	6
Chaudières-Appalaches	0	1
Lanaudière	1 (Atikamekw Nation)	2
Montérégie	0	2
Bas St-Laurent	1 (Malecite Nation)	0

### Analysis of Existing Services

This distribution clearly shows that the majority of specialized services are offered in the Montreal administrative region, where no First Nations community is established. In addition, 11 of the 26 specialized detoxification services in Quebec are offered in administrative regions where no First Nations community (reserve) is established. Consequently, 15 services would be located in administrative regions where First Nations communities are established.

The disequilibrium in the distribution of detoxification services is also felt in those administrative regions with a high density of Aboriginal population such as the Côte-Nord region, which accounts for 32% of the total on-reserve population in Quebec. And yet, this region only has one specialized detoxification service. In the same way, the Abitibi-Témiscamigue region has only one specialized detoxification service while this region has eight (8) Algonquin communities whose on-reserve population account for 11% of the total on-reserve population in Quebec. (Note: out of total of 9 Algonquin communities, 8 are located in Abitibi-Témiscamingue and one in the Outaouais region).

In short, there are only two (2) specialized detoxification services for 43% of the total on-reserve First Nations population in Quebec, and these services are part of the provincial network.

As regards detoxification services in First Nations communities in Quebec, the data collected (Section 4) do not allow to conclude that such services are available, except for withdrawal management initiatives and referral services to regional hospitals.

To conclude, very few programs and treatment centres provide detoxification services specifically designed for First Nations, regardless of the region. In most cases, First Nations receive the detoxification services required by their condition from the provincial health care system. Although some rare initiatives were identified in the literature review, they are essentially offered outside Quebec. Other initiatives may exist but could not be described here due to lack of information in the sources and references consulted..

### SECTION 3 : BEST PRACTICES IN DETOXIFICATION

Pierre Desrosiers, Professional Affairs Advisor with the Fédération québécoise des centres de réadaptation pour personnes alcooliques et autres toxicomanes (FQRCPAT) wrote a document entitled *“Les services de désintoxication dans les centres de réadaptation en dépendances : Meilleures pratiques et offre de services de base dans un contexte de réseau intégré de services”* (Detoxification services in addiction rehabilitation centres – Best practices and basic services offered in an integrated services network). Based on a literature review, Desrosiers presents best practices in terms of clinical, assessment, treatment, organization and services integration models and approaches.

#### Clinical Models and Approaches

According to the Center for Substance Abuse Treatment (CSAT, 2006), there are three theoretical approaches to detoxification: a medical model, a social model and a mixed medical/social model. Medical model programs are directed by a physician and staffed by other health care personnel. They range from hospital-based inpatient programs to free-standing medically based residential programs in hospitals or in community facilities. Social model programs concentrate on providing patients and their families with psychosocial services. Patients who need medical care may be referred to a medical facility where they are taken care of by a physician or a nurse. Counsellors can assist patients in taking detoxification medications, assess their condition, monitor patients' symptoms and call physicians or nurse practitioners if patients become ill. The CSAT (2006) considers that social model programs should not provide detoxification for people who have severe dependence on alcohol or other sedative-hypnotics. Finally, the combined medical/social model refers to social detoxification programs which include an optional medical assistance component. According to the group of experts of the Comité permanent de lutte à la toxicomanie (CPLT, 2004), many authors have pointed out that greater integration of the medical and psychosocial models results in improved quality of services to patients. According to the same experts, recent research on addiction treatments tends to demonstrate the relevance of using a combination model to adequately address withdrawal symptoms. Studies on the different treatment approaches listed by Health Canada

(1999) have supported the effectiveness of pharmacotherapy as an adjunct to comprehensive therapy, including cognitive behavioural and motivational enhancement approaches, social and relapse prevention skills training methods, community support approaches based on patients' social networks, specifically for patients lacking social support. Using the motivational approach is particularly recommended as a way to achieve the third step of detoxification, which is preparing the patient for rehabilitation or promoting access to a continuum of services. A study by Haro et al. (2006) shows that the use of the motivational approach during hospital detoxification is associated with a higher probability of patients going into rehabilitation, more specifically for women and specific substances.

According to the Canadian Centre on Substance Abuse (CCSA, 2007), motivational interviewing is widely used by substance abuse specialists in Canada and internationally across a wide range of treatment settings, including detoxification services. In Quebec, the trans-theoretical model of the change process and its stages (Prochaska et al., 1994) as well as motivational interviewing as proposed by Miller and Rollnick (2003) are now part of the recommended approaches in addiction rehabilitation centres.

According to the best practices described by Health Canada (1999), since all services and approaches do not suit the needs of all patients, it is important to offer services that are adapted to the reality of each person. To ensure successful treatment, one should also consider the importance of the common factors of any clinical approach, that is, those of the patient (personal resources, environment, etc.) and of the worker (skills, empathy, therapeutic alliance, etc.). The DATOS study (2003) pointed out that the therapeutic alliance and the concrete changes achieved by the patient in the early stages of the process appear to be essential factors in retaining patients in treatment.

## Assessment

### A) Criteria

Kasser et al. (1997) pointed out that due to the risk of medical complications, an initial assessment of the patient's condition is essential. It should include an assessment of the predicted severity of withdrawal symptoms and of medical and psychiatric comorbidity. The severity of withdrawal symptoms is not easily predictable and a lot of information needs to be collected at the time of initial assessment: severity and length of substance abuse (especially over the past few months and the last week), severity of previous withdrawal symptoms, psychiatric and medical history. According to these authors, the goal of performing an initial assessment is to facilitate the choice of the appropriate level of detoxification treatment.

In order to determine the level of care required based on the needs and characteristics of substance abuse patients, the ASAM committee of clinical experts (2002) has established six dimensions that need to be assessed.

1. Intoxication/withdrawal risk;
2. Physical health;
3. Psychological health;
4. Treatment acceptance/resistance;
5. Relapse potential;
6. Recovery environment.

Dimension 1 refers to all that relates to the nature of substance abuse and the need for medical care to help ensure successful withdrawal or replacement therapy.

Dimension 2 describes the physical condition of the patient, including any physical illnesses, other than withdrawal symptoms (already covered in Dimension 1), or physical factors, or medications other than psychiatric medication, that need to be taken into account.

Dimension 3 refers to current emotional and behavioural problems the patient may have. Attention needs to be paid to the patient's history of psychological and psychiatric treatment,

his/her emotional stability, ability to express his/her feelings of depression, anger, anguish, etc, or lack of feelings.

Dimension 4 refers to the patient's readiness to change, motivation to actively engage in the process and attitude towards treatment.

Dimension 5 describes the patient's potential for relapse and the degree of knowledge he/she has with regard to the nature and dynamics of his/her addiction and to relapse prevention strategies. It also includes the patient's degree of integration of relapse prevention tools to cope with the problems of day-to-day living or crisis situations.

Finally, Dimension 6 refers to the patient's environment, including the physical environment (neighbourhood, housing) and the social environment, more specifically the existence, or lack thereof, of a social support network in his/her efforts for change. The patient's ability to adequately manage his/her time in day-to-day activities, to find a proper balance between work, recreation and social relations as well as contact with supportive social organizations are also an integral part of this dimension.

Although the ASAM criteria are the most commonly used, they should not substitute clinical judgement and assessment of the specific needs of each patient.

## **B) Tools**

### **\* Order ASAM tool**

The Clinical Institute Withdrawal Assessment-Alcohol Revised (CIWA-Ar) (1989) is the most widely used alcohol withdrawal assessment tool. Rouillard, Tremblay and Boivin (1999) have developed tools for assessing withdrawal severity and determining the required medical care. They are called "level of detoxification" tools (Niveau de désintoxication, NID). In fact, these are two distinct health assessment tools. One is designed to be used by medical staff (NID-ÉM) and the other is an adapted version designed to be used by psychosocial workers (NID-ÉP) with validation by nursing staff.

The assessment tools begin with a section where sociodemographic information is collected, followed by a questionnaire on the patient's medical condition and medication used. The most

important section is the assessment of alcohol and drug use, which includes the Clinical Institute Withdrawal Assessment-Alcohol Revised (CIWA-Ar). The following sections are designed to assess the patient's psychological/psychiatric condition including the risk for suicide and the patient's overall social situation (work, family, social, legal, etc.). At the end of the questionnaire, patients are referred to the appropriate services.

To ensure the objectivity of the decision-making process and in order to refer patients to the most appropriate service so as to avoid providing them with services that are more intensive than they really need, Ménard, Pépin and Saint-Louis (2007) have developed the tool NID-ÉM 2.0, an adapted version of the NID-ÉM. Based on a patient referral algorithm, this tool assesses intoxication and withdrawal signs and symptoms as well as ASAM criteria. These authors have also developed the tool NID-ÉP version 2.9 (2007).

## **Treatment**

### **A) Duration**

Right from the start, we were struck by the scarcity of scientific articles about the optimal duration of detoxification treatment. According to Tremblay (2008), it should be mentioned that several studies define detoxification treatment as a sequential combination of medical treatment designed to safely eliminate psychoactive substances from the system followed by psychosocial intervention focused on behavioural change. In these studies, optimal duration of treatment is hard to interpret.

The duration and intensity of withdrawal are the two major factors for determining standard detoxification treatment duration. According to Raistrick (2000), a clinical alcohol detoxification protocol generally prescribes detoxification treatments of 7 days for severe withdrawal symptoms, 5 days for moderate withdrawal symptoms, and 3 days for mild withdrawal symptoms. The duration of hospitalization for alcohol detoxification treatments is generally  $4.3 \pm 2.4$  days (Sullivan et al., 1991), which is consistent with anticipated clinical protocols (Raistrick, 2000). According to Miller and Kipnis (2006), although withdrawal from opiates produces similar signs and symptoms from one substance to the next, there is variation in onset and duration. For example, withdrawal from heroin typically begins 8 to 12 hours after the last use and

subsides over 3 to 5 days. According to Miller and Kipnis (2006), withdrawal from benzodiazepines and other sedative-hypnotics depends on the half-life of substances a typically lasts for several weeks. As regards withdrawal management, it is often achieved through gradual dosage reduction under medical supervision. A gradual reduction in dosage is generally achieved over several weeks and even several months, especially with long-acting benzodiazepines.

A study conducted in Massachussets (Jonkman et al., 2005) on 21,311 patients during the year 1996 concluded that the main substances that required detoxification treatment were alcohol (48%), heroin (34%) and cocaine (18%). This American state, which is quite similar to the province of Quebec in terms of its geographic and demographic characteristics, has twenty level III.7-D detoxification centres, according to ASAM criteria. There is significant variation in the average length of stay in detoxification from one centre to the next, which varies from four to nine days. According to these authors, part of this variation can be statistically explained by the different sizes of the facilities. The average length of stays was longer in detoxification centers with 35 or more beds (7.7 days) than in centers with less than 35 beds (5.4 days). According to the same authors, these observations raise questions concerning practices such as, for example, in the case of larger centres, offering longer stays to ensure higher occupancy rates and more adequate funding. Despite these organizational variations, Jonkman et al. (2005) have identified significant variations among individuals according to different factors: nature of substance used, previous detoxification episode during the past year, homelessness, being a woman, having mental health problems, being 51 or older, not being Caucasian.

According to Tremblay (2008), there is significant variation in length of stay in detoxification facilities in Quebec. The average length of stay in hospital detoxification facilities was 5.2 days at CHUQ and 8.7 days at CHUM/Saint-Luc (HSFA, 2006). According to Tremblay (2001), the average length of stay in level III.7-D detoxification centres in Chaudière-Appalaches was 3.6 days in 1999-2000 for the treatment phase only. In his literature review, Tremblay (2008) concluded that the average length of stay in level III.7-D detoxification centres was 3.6 to 7.5 days, depending on the type of psychoactive substances used. He also found significant

variation in practice from one facility to the next and pointed to a substantial lack of studies comparing length of treatment in different detoxification facilities.

## **B) Intensity**

Despite the amount of studies published, the scientific literature does not lead to the conclusion that residential treatment provides better results than ambulatory treatment. However, various studies such as those by Kissin et al. and Rychtarick et al. (2001) point to the fact that patients with high social instability and severe substance use problems have better results when they receive residential treatment. According to the Center for Substance Abuse Treatment, the best detoxification treatment is the least restrictive and the one that successfully achieves detoxification outcomes in the most efficient and cost-effective manner for a given patient. The type of detoxification treatment (inpatient or outpatient) should be determined primarily based on the patient's clinical needs.

According to Alling (1992), inpatient detoxification has a number of benefits such as providing the patient with a safer and more controlled environment, controlled access to substances, closer monitoring of health status, and shorter treatment (generally 6 days). Outpatient detoxification has the benefits of being less costly and less disruptive for the patient who avoids an abrupt transition from a controlled detoxification facility environment to his/her normal living environment.

Rychtarick et al. (2001) mentioned that some patients can resist treatments that are more invasive and that involve too much control. They agree with other authors (Finney et al., 1996) that inpatient treatment should be reserved for patients with severe addiction (risk of withdrawal) and high psychosocial instability.

In their literature review, Bertrand and Ménard (2004) indicate that there seems to be consensus among clinicians and researchers, that outpatient alcohol and substance abuse treatment meets the needs of a vast majority of patients, is less disruptive and less costly than inpatient treatment, although the latter is also needed and requires further analysis. In fact, outpatient treatment does not preclude the need for some patients to undergo residential treatment when their physical, psychological or social condition needs to be stabilized.

According to ASAM (2001), there are two major criteria for referring a patient to residential detoxification services:

- The severity of addiction and physical health risks;
- High psychosocial instability and/or inadequate rehabilitation environment.

### **Organization and Integration of Services**

A group of clinical addiction experts brought together by SAMHSA (2006) determined that detoxification is an integral part of a comprehensive treatment strategy and should not be isolated from the other stages of the process. They also recognized that providing detoxification services without subsequent treatment or rehabilitation is an inadequate way of using limited resources. In this perspective, detoxification services are viewed as a starting point for further treatment (Teesson et al., 2006). Various studies show that without a continuum of services, a vast majority of patients relapse within three months of completing detoxification.

In a study conducted by Mark et al. (2006) in the states of Delaware, Oklahoma and Washington, twenty-seven percent of the sample was readmitted for detoxification within one year of their detoxification. In another study (Davison et al., 2006), twenty percent of patients were readmitted within one year their detoxification. According to Shanahan et al. (2005), patients with psychiatric comorbidity are more likely to be readmitted for detoxification. For Teesson et al. (2006), multiple admissions might have to be considered as part of a normal detoxification process for some patients, in an adequate process of change.

Experience shows that only a small proportion of patients are admitted to rehabilitation treatment upon completing detoxification. Rush (1990) estimates that 25% of detoxification patients receive subsequent rehabilitation services. Other studies show that variable proportions of patients choose alternative treatment options following detoxification. These proportions range from 20% for Davison et al. (2006) and Rodler et al. (2006) to up to one-third for Span et al. (2006), to up to three-quarters for Blondell et al. (2006). McLellan et al. (2005) reported that about 15% of patients use detoxification services only, several times a year. In a study conducted with young injection drug users, Shin et al. (2007) reported that younger IDUs

were more likely to receive detoxification services only, without subsequently receiving rehabilitation services.

To encourage patients to receive rehabilitation services, best practices recommend increasing their motivation by informing them about their condition and the higher risk of relapse within three months of completing detoxification, and by assessing psychosocial issues relating to family, employment, and other factors that may impact treatment outcomes. O'Farrell et al. (2008) pointed to the involvement of a relative or friend as a promising strategy for increasing the probability of the patient receiving rehabilitation services following detoxification.

Finally, Quebec experts point to the importance of creating bridges between detoxification and addiction treatment, the long-term goal being to increase the number of patients who successfully complete detoxification treatment and who subsequently receive rehabilitation services.

McLellan et al. (2005) suggest that providing detoxification-only patients with individual assessment, guidance and referral to rehabilitation resources results in a 55% reduction in detoxification-only admissions and a 70% increase in use of rehabilitation. The Addiction Research Foundation (1994) suggests planning the referral of the patient at the beginning of the detoxification process by identifying relevant and available post-withdrawal treatment options which promote treatment success and reduce the risk of relapse while strengthening linkages with community resources. This is particularly the case with hospital detoxification services. In this regard, France's Direction de l'hospitalisation et de l'organisation des soins du ministère de la Santé, de la Famille et des Personnes handicapées (2003) developed a best practices guide for hospital liaison and addiction treatment staff. The guide focuses on the importance of introducing an "addiction treatment culture" in hospitals to promote a comprehensive, multidisciplinary and effective management of addiction patients from admission to discharge and ensure subsequent follow-up through partnerships within and outside the hospital setting. This goal can only be achieved through true partnerships with the relevant professionals, as it requires the involvement of specialized services, health care institutions, mental health professionals, ambulatory care or social services.

In their analysis of residential addiction treatment services in Domrémy Mauricie – Centre-du-Québec, Bertrand and Menard (2004) mention that in order to engage patients in a long-term rehabilitation process and therefore to include residential detoxification services in a comprehensive strategy in addiction rehabilitation centres (ARCs), it is necessary to:

- Address the gap between detoxification and rehabilitation programs by combining them together into a single program;
- Establish, in cooperation with residential care patients, intervention plans based on a systematic health and psychosocial assessment;
- Promote the continuity of the process with outpatient services by prioritizing patients already involved in addiction treatment and for whom the necessary resources have already been allocated;
- Offer a standard 21-day treatment period to facilitate the creation of a therapeutic alliance with patients, initiate a process of change and maximize patients' motivation to continue in outpatient treatment.
- Assign a single psychosocial worker who will support the patient throughout the process to promote a therapeutic alliance and continuity of the process.

Tremblay (2008) argues that integration of services under the same roof is one of the ways in which to increase the probability of detoxification patients continuing to rehabilitation services. His literature review of the optimal length of short-term residential services shows that stays of 15 days or more are more efficient than shorter stays and that a 28-day stay is even more efficient than 10- or 60-day stays.

To ensure a continuum of services, the Plan d'action interministériel (2006) points out the importance of concerted action among the partners involved in the continuum of services. The integration of detoxification services is consistent with the guidelines for a transition of the social and health services network based on the principles of accountability to the population and prioritization of services (MSSSQ, 2007). This transition requires establishing local networks of services as well as organizing services around clinical projects and service agreements.

In its description of the 2007 addiction services program, the ministère de la Santé et des Services sociaux sets out the roles of health and social services centres (HSSCs), hospital centres (HCs) and addiction rehabilitation centres (ARCs) in the sharing of responsibilities concerning detoxification services to be established in all regions across Quebec by 2012. Based on the ASAM criteria (2001), the MSSS is planning that HSSCs and HCs will provide non-intensive, outpatient detoxification (level I-D) and inpatient detoxification (level IV-D) while ARCs will be responsible for delivering ambulatory detoxification (level II-D) and residential detoxification (level III-D). In addition, according to the MSSS guidelines, ARCs will have addiction liaison teams in hospital emergency services to provide patients with assessment and referral to appropriate services. This measure is important for detoxification services since part of the patients seeking assistance from hospitals require this type of care.

Due to relatively high rates of hospitalization for psychoactive substance abuse or addiction and the high costs associated with it in Quebec, an experiment was conducted in the Mauricie region to improve continuity and cooperation in detoxification services planning. To improve the accessibility, continuity and quality of care for addiction patients seeking assistance from hospital centres while achieving better cost-efficiency, the Domrémey Mauricie – Centre-du-Québec rehabilitation centre developed, in cooperation with the Centre hospitalier régional de Trois-Rivières, an integrated detoxification services network (RISD).

Concretely, the RISD translates into closer cooperation between the two institutions through the presence, in CHTR, of a liaison nurse from the Domrémey MCQ who meets, on a voluntary basis, patients screened by health or social services to assess their needs and refer them to appropriate services.

According to Bertrand and Ménard's study (2005) of the integrated detoxification services network, the profile of hospital patients can be distinguished from the profile of Domrémey patients in that they demonstrate significantly more severe medical, psychological and employment problems. The results from the evaluation of the integrated detoxification services network show a five-fold increase in the number of patients referred by CHTR since the network was established. The results also showed that 80% of patients met by the nurse apply to Domrémey, one-third use residential services and 66% register for ambulatory services with

Domrémy – the latter may be admitted to outpatient treatment services or rehabilitation follow-up services.

Although Tremblay (2008) did not identify any study addressing specifically the length of outpatient detoxification treatment in his literature review, he reported that a three-month period appears to be the minimum required for treatment to yield any significant results.

The RISD study also sought to analyze the opinions of coordinators, clinicians and patients in each institution. Coordinators and clinicians noted the following changes:

- More efficient use of resources through optimal use of available residential beds in Domrémy, reduced hospitalization times and reduced frequency of recurrent hospitalizations for addiction patients;
- Better screening of substance abuse problems among CHRTR patients, better access to addiction rehabilitation services, patients are more actively engaged in the rehabilitation process and their needs are better addressed;
- A concrete continuum of integrated services between the two institutions, in a hierarchical structure of services;
- Development of mutual trust between the staff of the two institutions and increased openness of Domrémy to accept patients with more complex issues;
- Increased capacity and self-confidence among staff in both institutions who feel more efficient, more competent, better equipped, better supported and less isolated;
- For coordinators and clinicians in Domrémy, patients with more complex issues and characterized by a higher prevalence of concurrent mental health disorders.

For patients:

- The interview with the liaison nurse occurs at a critical time, which helps patients realize the negative consequences of substance use and the need to initiate or continue a process of change in this respect;

- The interview with the liaison nurse provides quick access to appropriate addiction resources

Put together, the results of the study lead to the conclusion that the integrated detoxification services network (RISD) promotes improved accessibility, continuity and quality of addiction services for CHRTR patients.



## SECTION 4 : RESULTS OF STRUCTURED INTERVIEWS

### Highlights

- A total of 37 respondents from eight (8) First Nations across Quebec took part in the process.
- A majority of respondents (37%) worked in the Côte-Nord administrative region.
- 32% of respondents use an Aboriginal language in the daily performance of their job.
- 27% of respondents are NNADAP workers and 21% are medical staff.
- 84% of respondents said their community did not offer detoxification services.
- 86% of respondents said there was no specific agreement in place between their community and the Quebec network for detoxification services.
- 57% of respondents said they had referred patients to detoxification services over the past two years.
- 65% of respondents reported being asked for detoxification services by patients.
- 47% of respondents said they had faced a situation where they could not meet the needs of patients due to lack of detoxification services.
- 75% of respondents said that the “lack of adequately trained detoxification staff” was the biggest challenge they faced.
- “Increasing demand for detoxification services combined with very limited or non-existent resources” was identified as a challenge by 74% of respondents.
- 81% of respondents reported an increase in detoxification services needs over the past five years.
- 39% of respondents considered detoxification support services provided by family members or informal caregivers as not very appropriate or inappropriate.
- 73% of respondents considered detoxification services provided by trained community

staff as extremely or very appropriate for the years to come.

- 89% of respondents considered detoxification services provided in a First Nations-specific regional centre very or extremely appropriate, making it the most appropriate initiative to address detoxification needs for the years to come.
- The top priority identified by respondents for addressing detoxification needs over the next few years is to provide detoxification services in a First Nations regional centre.
- The second highest priority identified by respondents for addressing detoxification needs over the next few years is to offer detoxification services provided by trained community staff..

### **Methodological Background**

Questionnaires were sent to respondents in advance of structured interviews, which were conducted on the phone from October 19 to November 30, 2009 and lasted about 16 minutes each. Of the 37 respondents, 18 (49%) were women and 19 (51%) were men, and their average age was 43 years.

The methodology used in conducting structured interviews gave respondents the opportunity to express themselves freely on specific issues and the information collected was categorized into broader topics for clarity.

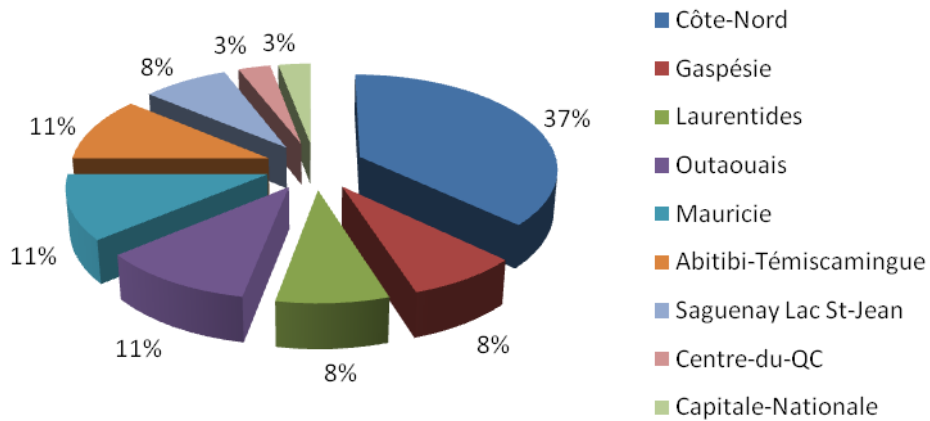
### **Sociodemographic Aspects**

A large majority (81%) of respondents were First Nations members.

### **Administrative region of work**

As shown in the figure below, 37% of respondents worked in the Côte-Nord region while 11% worked in the Outaouais, Mauricie and Abitibi-Temiscamingue regions respectively. Eight percent (8%) worked in the Saguenay-Lac-St-Jean, Laurentides and Gaspésie regions and 3% worked in the Capitale-Nationale and Centre-du-Québec regions.

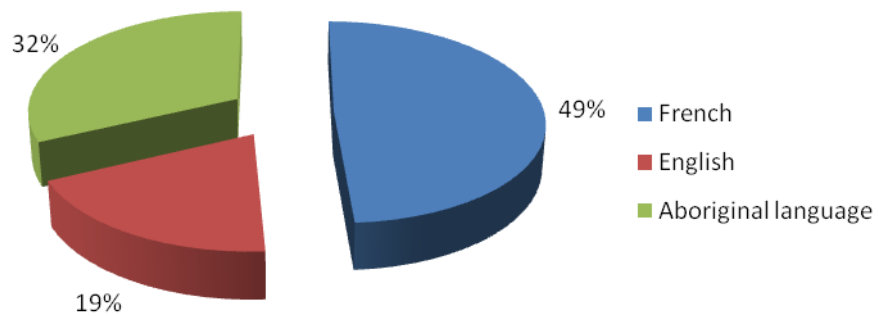
### Distribution of respondents by region



### Working language

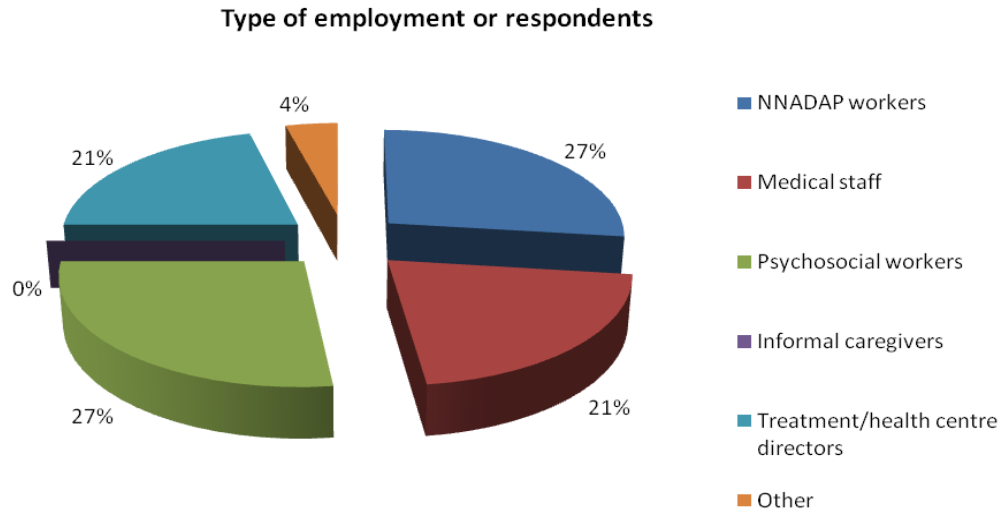
When asked about which language respondents used in their daily work, most respondents (49%) reported using French, 32% reported using an Aboriginal language, and 19% reported using English, as shown in the figure below.

### Languages used by respondents in their daily work



### Type of employment

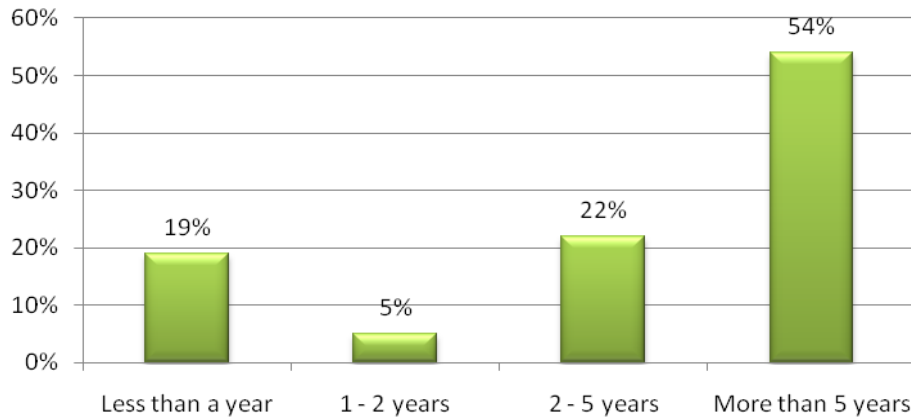
When asked about their occupation (type of employment), 27% of respondents said they were NNADAP workers and 27% said they were psychosocial workers. 21% of respondents were treatment/health centre directors and 21% were medical staff. Only 4% of respondents answered “other” and there was no informal caregiver.



### Number of years in current employment

The figure below shows the distribution of respondents by number of years in current employment. When asked how many years they had been in their current position, 54% of respondents reported more than five years, 22% reported two to five years, 5% reported one to two years and 19% reported less than one year of experience.

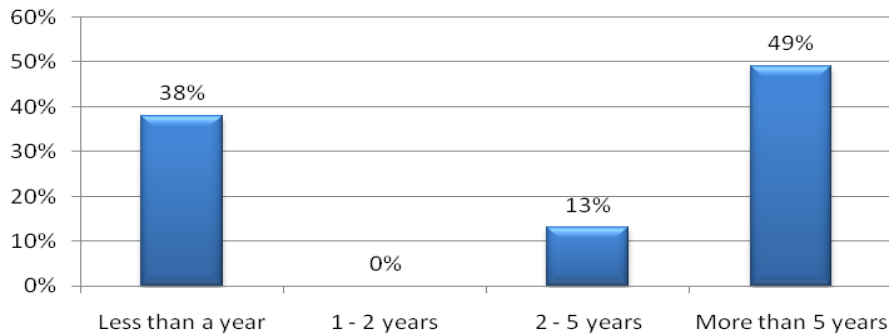
**Distribution of respondents by number of years in current employment**



### Years of experience in the addiction field

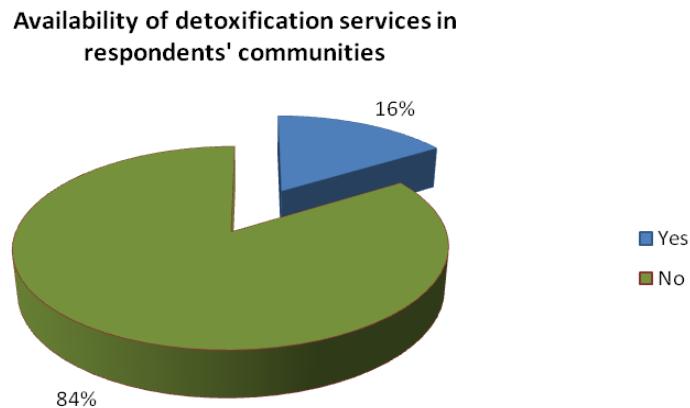
As shown in the figure below, when asked how many years they had been working in the substance abuse prevention/treatment field before taking up their current position, 49% of respondents reported more than five years, 13% reported two to five years, 0% reported one to two years and 38% less than a year.

**Distribution of respondents by number of years of experience in the substance abuse prevention/treatment field**



### Availability of detoxification services in the communities

Respondents were asked about the availability of detoxification services in the communities where they worked. As shown in the figure below, when asked if detoxification services were available in the communities in which they worked, 84% of respondents answered “no” and 16% of respondents answered “yes”.



The respondents who answered “yes” to the question above were asked to specify the nature of the services available. Below is a list of the different types of services identified:

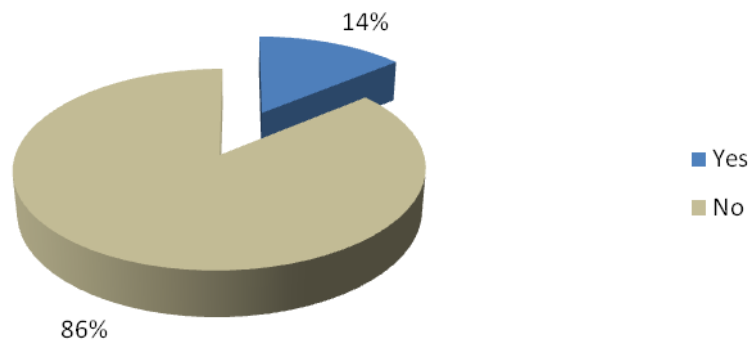
- Patients are referred to the local hospital.
- Patients are referred to Gatineau (Hull Sector) hospital.
- The patient is put on an IV drip and receives medication (pills) for four days. Treatment is limited to reducing withdrawal symptoms. No other detoxification service is available.
- The Mashteuiatsh health centre nurse meets the patients who do not require medical detoxification and provides follow-up (vital signs assessment at home or in the health centre). Patients who require medical detoxification are referred to the CRAP in Jonquière where the LE SÉJOUR centre provides more structured detoxification services.
- Detoxification in a natural environment in Mashteuiatsh (non-medical).

- Patients are taken to the La Romaine clinic where they receive Ativan and are put on an IV. Patients who are in a suicidal crisis and need detoxification are transferred to Sept-Îles hospital by air ambulance (MEDEVAC).
- Although the community of Lac Simon does not offer detoxification services, health centre staff can refer patients to a physician who visits the community on a weekly basis.

### Specific agreements with the Quebec network

Respondents were asked if there were specific agreements in place between their communities and detoxification services in the Quebec network. As shown in the figure below, the majority (86%) of respondents answered “no” and 14% answered “yes”.

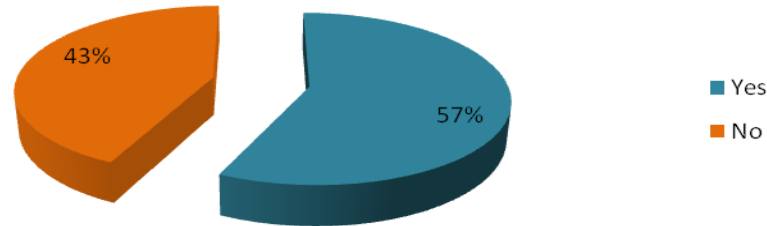
**Existence of specific agreements between respondents' communities and detoxification services in the Quebec network**



### Referral to detoxification services

Respondents were asked if they had referred any patients to detoxification services over the past two years. As shown in the figure on next page, 75% of respondents answered in the affirmative and 43% in the negative.

**Distribution of respondents who referred patients to detoxification services**



The respondents who answered “yes” to the question above were asked to identify the facility or facilities to which they referred their patients. Below is a list of the different facilities identified:

- Maniwaki hospital.
- Gatineau hospital.
- The community dispensary provides alcohol detoxification services to relieve withdrawal symptoms.
- Campbellton Hospital (New-Brunswick) (it very difficult for a patient to be admitted there due to a limited number of beds and the priority given to New-Brunswick residents).
- Detoxification centres outside the community
- Maria hospital (services available in French).
- Cornwall, Ontario, detoxification services. Non-medical public services. Only one detoxification bed is available in Montreal for Anglophones. If wait time is too long, we lose the patient.
- La Tuque hospital.
- Due to geographic factors and the availability of beds, our patients are referred to the Élisabeth Bruyère Health Centre in Ottawa. Maniwaki hospital accepts patients

depending on which doctor is on duty. Occasionally, the doctor on duty happens to be the patient's family doctor, in which case the patient is admitted.

- CRAP in Jonquière (hospital setting)
- Le SÉJOUR in Jonquière.
- Natural environment (Mashteuiatsh).
- Baie-Comeau hospital centre (can refer to specific services).
- Supervised detoxification services after a delirium tremens episode and padded room available at Lourdes Blanc Sablon hospital.
- The community of Wendake has an agreement in place with Villa Ignatia for 3-day detoxification services. Wendake also has an agreement in place with the CASA centre where a nurse is available. CASA offers medically supervised detoxification services.
- The Matimekush health centre refers patients to Villa Ignatia.
- Natashquan refers patients to Havre-St-Pierre hospital or Sept-îles hospital for extreme cases.

It should be noted that respondents from the same region or organization sometimes provided contradictory answers when asked about the availability of detoxification services in their regions or communities. This might reflect a lack of knowledge of existing services or different perceptions of what a detoxification service is.

### **Reasons for not using detoxification services**

The 43% of the total number of respondents (n=37) who said they did not refer any patients to detoxification services were asked to provide their reasons for not using detoxification services. As shown in the figure below, respondents were asked to indicate whether each of six (6) statements applied to them or not.

Of the total of 17 respondents who indicated whether the statement: "None of my patients asked for detoxification services" applied to them or not, 13 respondents (76%) responded that

the statement applied to them. The above statement was the main reason for not using detoxification services. This represents 35% of the total number of respondents to the survey (n=37). It can be inferred that 65% of the 37 respondents had patients who asked for detoxification services.

When asked to indicate whether the statement: “The region where my community is located has no detoxification service available” applied to them or not, 11 (75%) of the 15 respondents answered “yes”. 6 of the 15 respondents indicated that the statement: “I don’t know about detoxification services available in my region”, applied to them, which was not the case of the 9 remaining respondents.

When asked to indicate whether the statement: “There are services available in our region, but because of our specific status as Aborigines, such services must be provided by our own health services” applied to them or not, only 3 (20%) of the 15 respondents answered “yes”.

When asked to indicate whether the statement: “Services are only available in one language, which is a problem for the patients I might refer to them” applied to them or not, 9 (53%) of the 15 respondents answered in the affirmative.

No respondent reported having had a bad experience with the Quebec network or believing that detoxification is unnecessary.

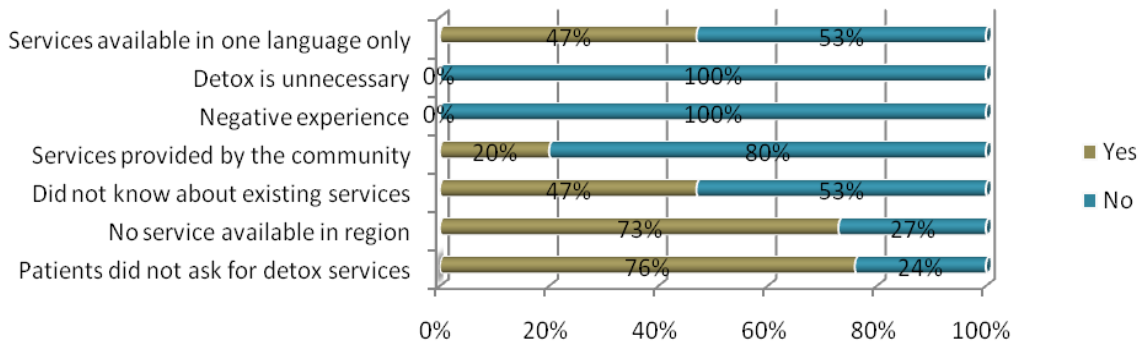
In addition to the reasons suggested in the questionnaire, three (3) respondents identified other reasons for not using detoxification services, including:

- Detoxification services are not an ideal solution because clients are admitted for one day or two and are then discharged from hospital.
- As a Chief Nurse, I do administrative work.
- In smaller communities, people do not inform against one another (drug dealers can be family members).

- There are no detoxification services. Services are available in Val d’Or hospital but patients must first go to Centre Normand.

To summarize, the figure below illustrates the distribution of reasons for not using detoxification services for the 43% of respondents who did not refer any patients to detoxification services over the past two years.

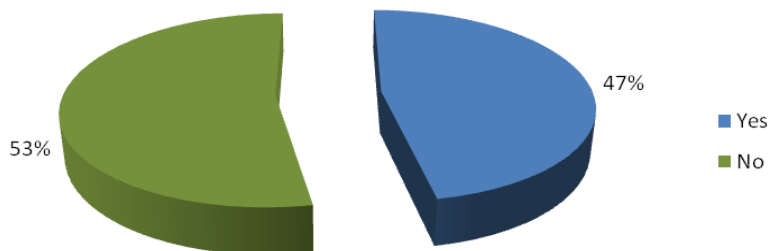
**Reasons why 43% of respondents did not refer any patients to detoxification services**



**Occurrence of not being able to meet the needs of a patient due to lack of services**

Respondents were asked to indicate whether they had ever been unable to meet the needs of a patient requiring detoxification services due to lack of services. As shown in the figure below, 53% of them reported that this had never happened to them while 47% reported being faced with this situation.

**Distribution of respondents who were unable to meet the needs of a patient due to lack of services**



### Challenges faced by respondents with regard to detoxification needs

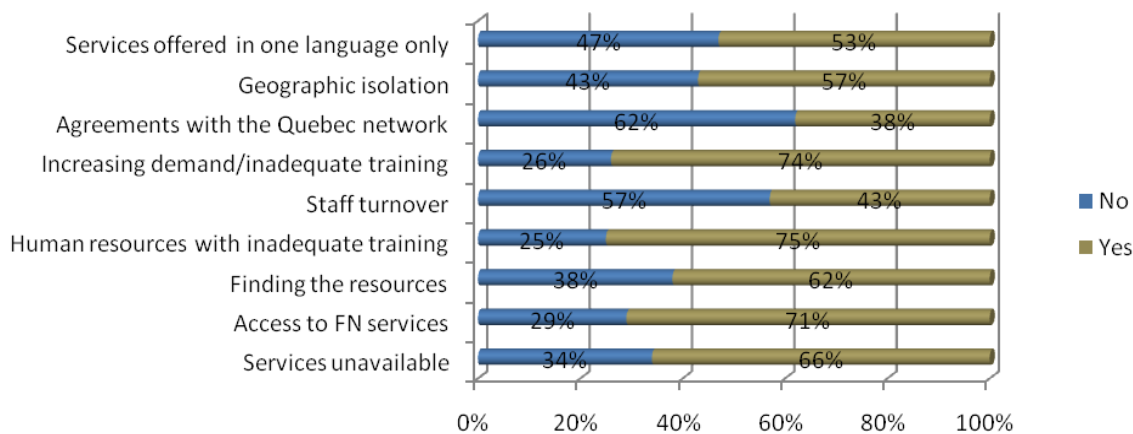
Respondents were asked about the challenges they faced with regard to detoxification services. They were asked if they had ever faced nine (9) types of challenges.

As illustrated in the figure below, a large proportion (75%) of respondents reported having to deal with “human resources with inadequate training in detoxification procedures”, followed by “a growing need for detox combined with inadequate or non-existent resources” (74%). Access to services designed to address the specific needs of First Nations was also lacking according to 71% of respondents.

Apart from the “challenges associated with agreements with the Quebec network” (38%) and “excessive health centre staff turnover” (43%), all the challenges listed were reported by more than half of respondents.

It should be noted that the lack of agreements with the Quebec network may be construed by respondents as a “challenge associated with agreements with the Quebec network”. Therefore, some respondents may have categorized the lack of agreements with the Quebec network as a challenge. It should be reminded that a majority of respondents (86%) said there was no specific detoxification services agreement in place between their communities and the Quebec network.

Challenges faced by respondents with regard to detoxification needs

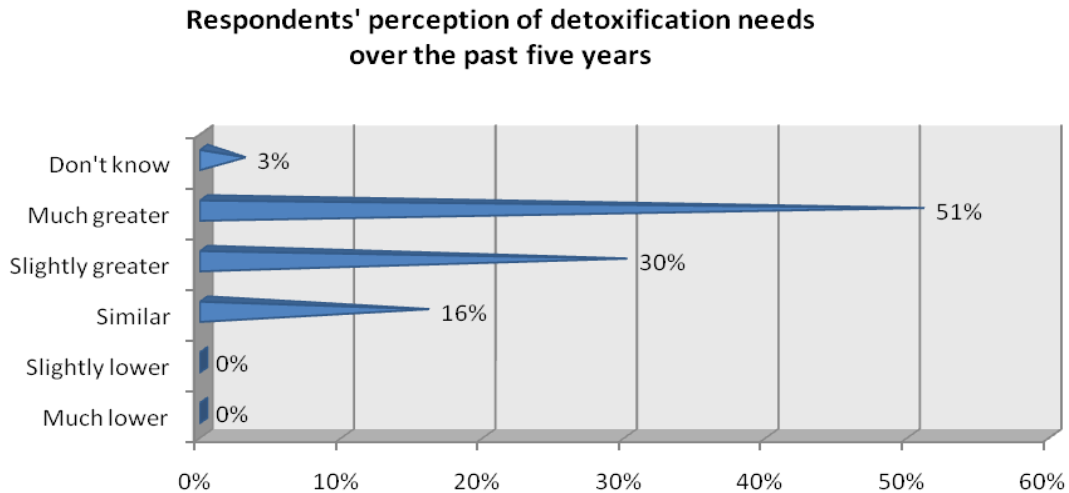


In addition to the challenges listed in the questionnaire, respondents could mention other challenges they faced with regard to addressing detoxification needs. They included the following:

- There are only three (3) beds available for Anglophones in the province of Quebec and they are located in Montreal.
- In New-Brunswick, Quebec residents are not given priority and therefore, no beds are available for them. We can't help people.
- Communication between the communities is an issue.
- There is nothing available for Anglophones in Montreal.
- Patients are not detoxified prior to entering treatment.
- Very few detoxification beds are available.
- In the communities, people can't preserve their anonymity.
- Prescription drug abuse is growing and so is the need for detox. First Nations treatment centres don't accept patients needing detoxification services.
- Lack of beds and excessive wait times.
- Language barriers.
- Lack of information on detoxification services.
- Health Canada policies are too rigid.
- People lack motivation.

### **Perceived needs for detoxification services**

When asked about the importance of detoxification needs, more than half (51%) of respondents said detoxification needs were much greater than five years ago while 30% of respondents said detoxification needs were slightly greater than five years ago. 81% of respondents reported an increase in detoxification needs over the past five years.



In this regard, and in order to illustrate the increase in alcohol and substance abuse over the past five years, a nurse who has been working for many years in an isolated community reported that back in 1975, men in the community would hide to drink. There was no police and neither women nor youth would drink alcohol. Today, almost everyone uses substance in broad daylight. Drug dealers are members of the community and people are afraid of reporting them so they can be expelled from the community. The nurse suggests that the solution is to offer alternatives to youth and keep them busy with interesting activities.

### Initiatives for addressing detoxification needs

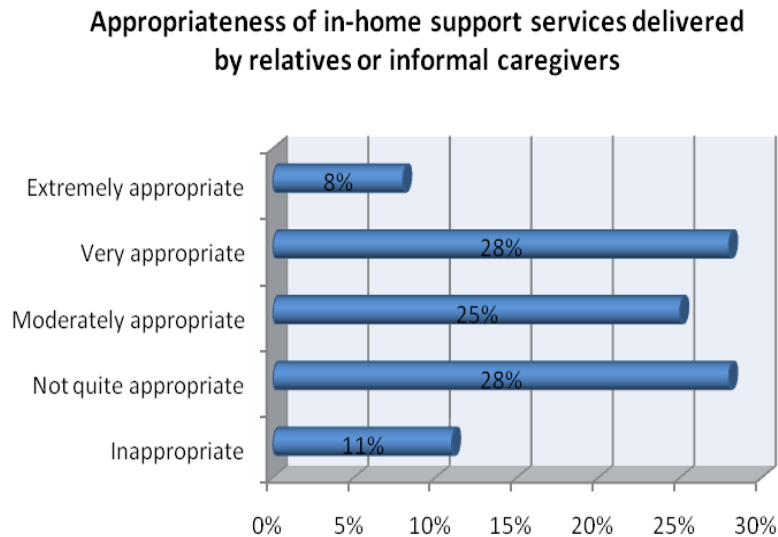
Respondents were asked about the appropriateness of the five (5) following initiatives:

- a) In-home detoxification support services delivered by relatives or informal caregivers.
- b) Detoxification services delivered by adequately trained community staff.
- c) Detoxification services delivered based on a traditional approach.
- d) Detoxification services delivered in a regional centre specifically designed for First Nations.
- e) Detoxification services delivered through agreements with existing resources in the Quebec network.

Respondents were asked to rate the appropriateness of each of the proposed initiatives using the following scale:

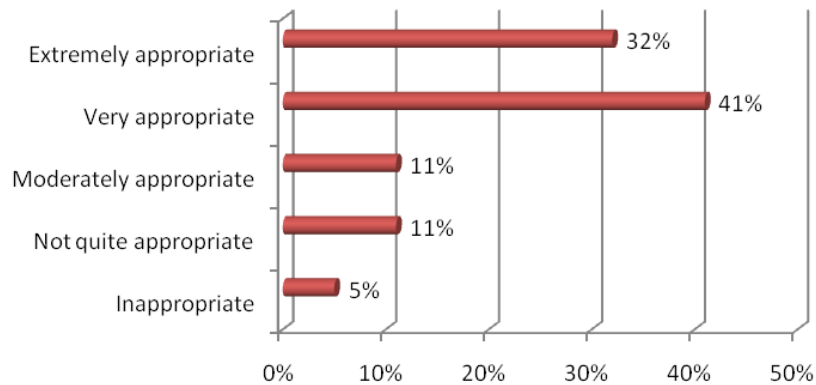
1. Inappropriate
2. Not quite appropriate
3. Moderately appropriate
4. Very appropriate
5. Extremely appropriate

Initiative (a) “In-home detoxification support services delivered by relatives or informal caregivers” was considered as very appropriate by 28% of respondents, but a similar proportion of respondents (28%) considered this initiative as not quite appropriate. In addition, 11% of respondents considered this initiative as inappropriate, as shown in the figure below:



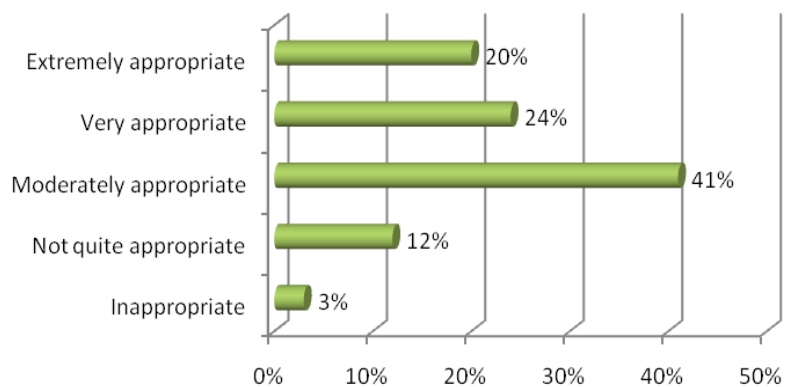
Initiative (b) “Detoxification services delivered by adequately trained community staff” was considered as very appropriate by 41% of respondents and extremely appropriate by 32% of respondents. Combining the two percentages, it is possible to say that 73% of respondents considered initiative (b) as extremely or very appropriate.

**Appropriateness of services delivered by adequately trained community staff**



One of the proposed initiatives was (c) “Detoxification services delivered based on a traditional approach”. Some respondents asked for clarification on what would a “traditional” approach consist of and the contents of the approach. However, 41% of respondents considered this approach as moderately appropriate and 44% consider it as very or extremely appropriate. Only 15% of respondents considered initiative (c) as not quite appropriate or inappropriate.

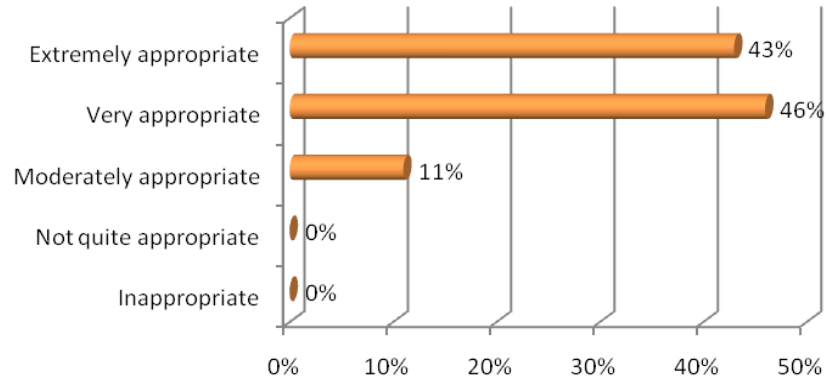
**Appropriateness of services delivered based on a traditional approach**



The fourth proposed initiative was (d) “Detoxification services delivered in a regional centre specifically designed for First Nations”. The results in the figure below clearly show that this initiative was, according to respondents, the most appropriate. 46% of respondents considered the initiative to be very appropriate and 43% of respondents considered the initiative as extremely appropriate. In sum, this initiative was considered as very or extremely appropriate

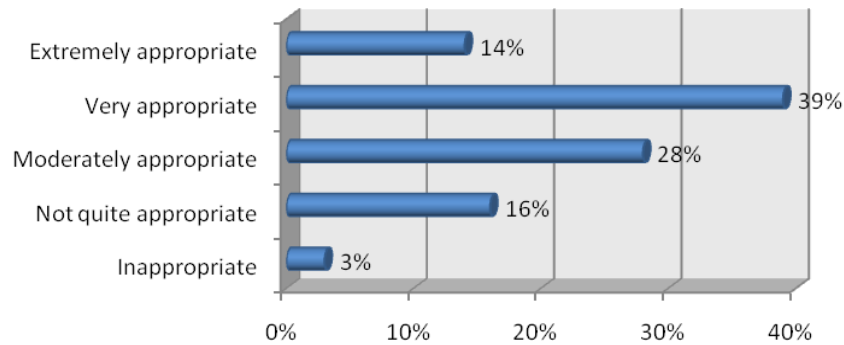
by 89% of respondents. Furthermore, it should be noted that no respondent considered this initiative as being not quite appropriate or inappropriate.

**Appropriateness of services delivered in a regional centre specifically designed for First Nations**



The last initiative was (e) “Detoxification services delivered through agreements with existing resources in the Quebec network”. As shown in the figure below, 39% of respondents considered this initiative as very appropriate.

**Appropriateness of services delivered through agreements with existing resources in the Quebec network**



### Priority of the proposed initiatives

Respondents were asked to rank the five (5) initiatives proposed for addressing detoxification needs over the next few years in order of priority. To do so, they were asked to identify which initiatives should be given first and second priority.

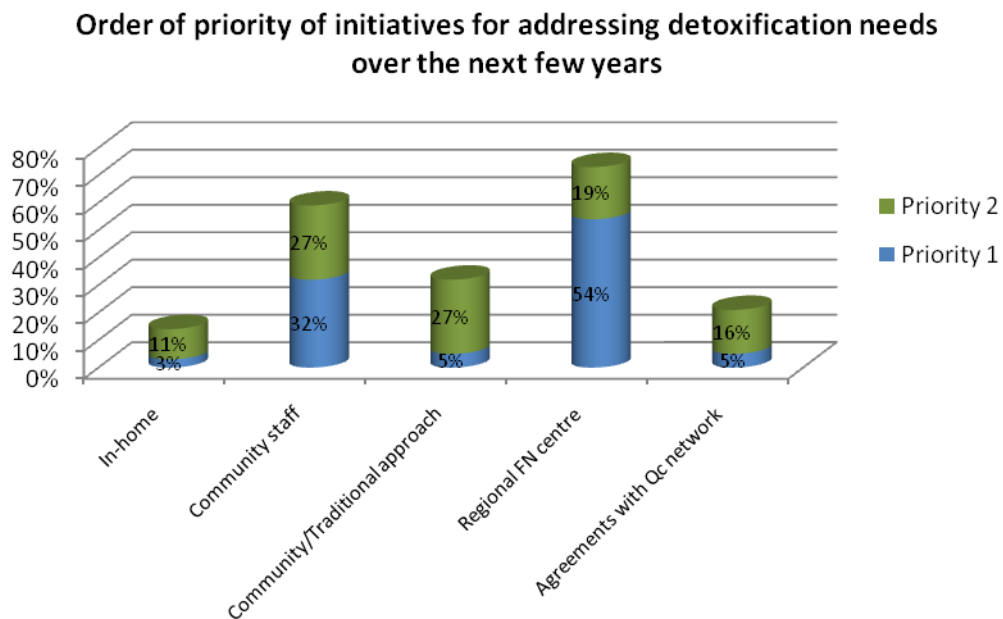
Answers to this question confirmed the results obtained in the previous question. 54% of respondents considered detoxification services delivered in a regional centre specifically designed for First Nations as a top priority and 32% of respondents considered detoxification services delivered by adequately trained community staff as a second priority.

The results obtained for these two top priorities exceed those obtained for the second priority that was most often cited by respondents, that is, services delivered based on a traditional approach (27%).

As regards in-home detoxification services delivered by relatives or informal caregivers, this initiative was considered as a top priority by only 3% of respondents and as a second priority by 11% of respondents.

As shown in the figure below, the two initiatives identified by respondents as priorities in addressing detoxification needs over the next few years are:

- 1) Detoxification services delivered in a regional centre specifically designed for First Nations.
- 2) Detoxification services delivered by adequately trained community staff.



## **Other services and initiatives to be developed**

Respondents had the opportunity to suggest services, activities or initiatives they would like to see developed over the next few years in the field of detoxification. Since this was an open-ended question, respondents' answers were organized around several themes. Please note that some respondents chose to provide comments and opinions rather than suggestions.

### ***Structure of services***

- Support and follow-up provided to the patient and his/her family during and after the process.
- Detoxification services for border communities located in regions where such services are not available.
- No detoxification service is available in the region at the moment.
- Develop services for Anglophones.
- The federal government only funds in-home detoxification services. Medical detoxification falls under provincial jurisdiction.
- In-home detoxification is not feasible in our communities because it does not provide a sober environment.
- The existing treatment (NNADAP) centre should specialize in detoxification treatment.
- Building a detoxification facility right next to the Onen'To :Kon Treatment Centre in Kanasatake. Patients could thus be admitted to rehabilitation, which could contribute to providing a continuum of care.
- The six existing NNADAP centres should address heavy (mental health) cases.
- Specialized triage of cases (assessment and referral) to patients' needs to be addressed.
- The most appropriate solution is to identify one detoxification centre for each nation which can admit patients as soon as possible.
- Having a crisis centre (the Wapan Centre is being converted into a crisis centre)

- People are in crisis and we need to address their immediate needs.
- We need a safe place to receive patients.
- After the detoxification process has been completed, an assessment should be made in the same facility.
- If this takes shape, we should have a detoxification centre offering methadone treatment to First Nations.
- Therapies should be made more affordable. There are only 3 beds, 3 of 4 times a year. We need ongoing admissions to a First Nations treatment centre.
- We need detoxification support centres and homeless shelters in the communities (some sort of a crisis centre).
- We need host families to keep patients away from unhealthy environments during withdrawal.
- Detoxification is an urgent need. Because treatment centres do not accept patients in withdrawal, we “lose” them due.
- It’s been discussed for a long time and patient follow-up is best achieved through withdrawal follow-up.
- Repatriate the British-Colombia protocol.
- The risk of in-home detoxification services is to lose the patient who will be free to go about in the community and is likely to relapse.
- The detoxification issue is not a new one. Patients are always referred to hospitals, which should always be the point of entry. Severe withdrawal requires the use of physical restraints.
- It would be a good thing to have a detoxification centre for First Nations in each geographic region.

- Although a proportion of patients are likely to successfully complete treatment in their community, this is a matter of motivation. Taking patients out of their communities would increase the chances of successful withdrawal treatment.

### ***Human and financial resources***

- We need a community workers specifically trained to provide post-treatment follow-up in the community.
- It will be impossible to develop in-home detoxification support services as it requires human resources available around the clock.
- Creating in-home detoxification services requires appropriate resources.
- It would be impossible to ensure all needs are being met with our current team.
- The number of cases is too small to justify the creation of any services.
- Patients who have completed detox need a continuum of services and follow-up services to refer them to therapy.
- Support groups and child care services should be offered to encourage adult mothers to go back to school.
- Even if nursing staff had the required training for providing detoxification services, they would not have enough time. The current staff would not have the time to provide such services, as they require flexibility. Substance abuse tends to occur during evenings and week-ends, and nursing staff is not always available to meet all needs. The nurse on duty needs to be available for emergencies and it would be impossible to provide follow-up.
- All services should be coordinated. It is a good thing to provide detox, but what's next? Young people have nothing to do and it is easy for them to relapse. Children are exposed to substance abuse and violence. It is almost a matter of case management. Families also need follow-up. It takes a multidisciplinary approach and a case management team.
- If we are to provide detoxification services, we need adequate budgets..

### ***Knowledge acquisition***

- Prior to delivering in-home detoxification treatment, family members must be informed on how to manage the patient's environment.
- Nursing staff need to receive training on the medical aspect of detoxification.
- Who can provide nursing staff with detoxification training?
- Community staff needs to be trained to recognize symptoms. Referring staff are not adequately trained.
- Post treatment follow-up training.
- We really need is staff adequately trained to manage intoxicated patients.
- Medical staff needs to be aware of what detoxification is about so they can provide professional services.

### ***Awareness and education***

- Educate communities about the difference between detoxification and rehabilitation.
- Health workers need to be better informed on detoxification. This is not only the case in communities, but also in hospitals.
- Prevention activities to reduce the need for detoxification services.
- Referral pathways between services should be better known.

### ***Worker resources***

- A relapse prevention plan should be developed for First Nations.

### ***Research and assessment***

- Examine the feasibility of a client needs assessment project. It would be useful to obtain an overview of clients' needs.

## Youth

- Need to improve youth activities and living conditions.
- Youth have nothing to do: they need leisure and recreation activities. Isolation is a major issue. We need to help youth find a way out of isolation by offering them sports clubs, music clubs, dancing, singing, drawing activities, etc.
- Youth need to be offered alternative activities so they don't relapse.
- A local employment centre, the community should provide courses for all levels, not only university-level education. Youth lack the motivation to attend CEGEP or university. Provide technical training and group activities..

## Traditional approaches

- Organize family meetings and informal counselling.
- Hire sober people to support detoxification patients.
- Sweat tents, traditional approaches, follow-up circles, fumigation.
- We need activities for detoxification patients, such as AA and NA meetings as well as conferences to support them. People need to get the feeling that this is an important process.
- Treat patients in a natural environment with trained professionals.
- Teach patients Aboriginal spirituality and values..

## Niveau politique

- Mettre en œuvre, au plan local, les recommandations du Sommet sur la lutte aux dépendances.
- Renforcer le leadership en matière de lutte à la toxicomanie, et il faut valoriser la dépendance comme priorité.



## **SECTION 5: FEASIBILITY ANALYSIS OF OUTPATIENT DETOXIFICATION SERVICES IN QUEBEC FIRST NATIONS COMMUNITIES**

Analysing the feasibility of ambulatory detoxification services in Quebec First Nations communities is the primary objective of this study. Before analysing the feasibility of such specialized services, it was necessary to examine the need for detoxification services as well as to identify the nature of such services. The need for First Nations detoxification services is not new. In fact, the need has been identified by respondents to a previous study by APIRG commissioned in 2009 by the FNQLHSSC, to assess the National Native Alcohol and Drug Abuse Program (NNADAP). In this study, respondents were asked to identify two services that should, in their opinion, be provided by the network of NNADAP treatment centres in Quebec. 46% of respondents said NNADAP centres should provide detoxification and crisis intervention services. This was considered as the best solution by a majority of respondents.

In addition, the results from the structured interviews conducted in this study confirmed the need for detoxification services delivered by a regional centre specifically designed for first nations. This initiative was considered by 89% of respondents as the most appropriate to address detoxification needs over the next few years. It should also be reminded that 39% of respondents considered in-home detoxification services delivered by family members or informal caregivers as not quite appropriate or inappropriate.

In this regard, some of the respondents who considered this initiative as not quite appropriate or inappropriate raised the fact that an individual willing to receive in-home detoxification treatment would be confronted with many challenges due to an inappropriate family and psychosocial environment (e.g. substance abuse in patient's family or surrounding). The scientific literature is clear on this point: according to the American Society of Addiction Medicine (ASAM) guidelines, a "safe and sober living environment" is an important factor to consider when referring patients to ambulatory detoxification services suited to the patient's condition.

Furthermore, 73% of respondents to structured interviews considered detoxification services delivered by adequately trained community staff as an extremely or very appropriate initiative for the next few years. Such services are to be distinguished from services provided by family or informal caregivers and are to be provided in health care centres.

It is clear from the data obtained through the literature review that detoxification is, first and foremost, a medical procedure that requires the intervention of nurses and physicians. By definition, detoxification is a biological process to rid the patient of a psychotropic drug and which requires assessment of the patient by nursing and medical staff. This study and analysis of the feasibility of in-home detoxification services is based on comments and feedback obtained from First Nations community health staff.

To illustrate the opinions expressed on the issue of detoxification services in the community, a nurse who participated in the study mentioned that people who need detoxifications services do not seek assistance. According to her, people do not consult because they are poorly informed about existing detoxification services. People share their problems only once they have completed withdrawal at home, without seeking help. Another nurse explained that providing detoxification services would result in excessive workload and that services that require 24 hour availability 7 days a week is just unrealistic with the current human and financial resources. According to her, detoxification services provided by a health centre would require staff to be available at all times. In her opinion as a nurse, the additional workload involved would make this situation unmanageable.

In addition to the opinions of the respondents interviewed in conducting this study, several factors need to be taken into consideration in determining the feasibility of outpatient detoxification services in Quebec First Nations communities. The implications of health centre medical and nursing staff having to assess comorbidity in patients with substance abuse problems, health centre nursing staff training in assessing the severity of withdrawal, the additional workload associated with assigning new tasks to medical and nursing staff, human resources required for the provision of in-home detoxification services, management of detoxification drugs, therapeutic follow-up of patients who completed detoxification and who

have been referred to rehabilitation, the potential of a continuum of care that integrates the cultural values of each nation, the flexibility of existing programs with respect to First Nations languages, medical protocols for detoxification procedures, potential agreements with the Quebec network of health services as well as the geographic isolation of some communities are essential factors that need to be considered.

However, the goal of the study was not to determine the extra workload this would create for nursing staff or the type and length of training for community medical staff, let alone the implications of administering medication and providing patients with therapeutic follow-up of. Nevertheless, assessing potential workload increase and detoxification staff training needs based on withdrawal severity are essential steps to be taken if ambulatory detoxification services are to be provided. In addition, a substantial increase in both demand for services and medical and nursing staff workload is to be expected.

International standards for determining withdrawal severity require that medical and nursing staff assess the level of intoxication of their patients. Home-based withdrawal with medical support can only be achieved with patients who do not require residential detoxification treatment.

Furthermore, the results from both the literature review and structured interviews clearly showed that detoxification services are hardly available in First Nations communities, the Quebec health network is taking a regional approach to providing health services with the purpose of providing a continuum of care to effectively assist patients in adopting healthy lifestyles. In addition, best practices and several documents clearly identify success criteria and factors for detoxification services addressing the individual needs of each patient.

In light of the data collected, it appears that the creation of home detoxification services provided by natural or family caregivers in Quebec First Nations communities does not address the needs expressed by the respondents to this study and would be difficult to achieve in the current context with the resources currently available. However, it would be possible to have

outpatient detoxification services delivered by specifically trained medical and psychosocial workers.

As a first step, it would be necessary to bridge the gaps in the continuum of patient support services which, in the case of addiction services, ranges from detoxification to community rehabilitation. Unlike the Quebec network, this continuum of care is not in place at the moment in Quebec First Nations communities. Several steps can be recommended to initiate the process of implementing this continuum of services.

## **SECTION 6 : RECOMMENDATIONS**

The data collected through the literature review and structured interviews do not support the implementation home detoxification support services delivered by informal or family caregivers in Quebec First Nations communities. However, creating ambulatory detoxification services could be a promising solution but requires establishing a continuum of services. First, it will be useful to examine best practices in the field of detoxification. Implementing a mixed medical/psychosocial model of care, assessing patients with recognized tools, and providing ambulatory treatment to patients who do not require medically supervised detoxification are the essential elements of developing an effective and efficient continuum of care.

### **Mixed model**

Various studies define detoxification treatment as a sequential combination of medical treatment designed to safely eliminate psychoactive substances from the system followed by psychosocial intervention focused on behavioural change.

Research-based best practices in the field of addiction treatment tend to demonstrate the relevance of using a combination model to adequately address withdrawal symptoms. ‘Combination model’ refers to social detoxification programs that include additional medical assistance services. Studies on the different treatment approaches listed by Health Canada (1999) have supported the effectiveness of pharmacotherapy as an adjunct to comprehensive therapy, including cognitive behavioural and motivational enhancement approaches, social and relapse prevention skills training methods, community support approaches based on patients’ social networks, specifically for patients lacking social support. Using the motivational approach is particularly recommended as a way to achieve the third step of detoxification, which is preparing the patient for rehabilitation or promoting access to a continuum of services..

### **Patient assessment – A key step**

According to the best practices described by Health Canada (1999), since all services and approaches do not suit the needs of all patients, it is important to offer services that are adapted to each individual. To ensure successful treatment, one should also consider the

importance of the common factors of any clinical approach, that is, those of the patient (such as personal resources, environment, etc.) and of the worker (interpersonal skills such as empathy and ability to forge a therapeutic alliance with clients).

Furthermore, Kasser et al. (1997) pointed out that due to the risk of medical complications, initial assessment of the patient's condition is essential. It should include an assessment of the predicted severity of withdrawal symptoms and of medical and psychiatric comorbidity. Therefore, detoxification necessarily falls within the scope of a medical approach.

### Assessment tools

Among the various tools available for assessing withdrawal risk and severity, the Clinical Institute Withdrawal Assessment-Alcohol Revised (CIWA-Ar) (1989) is the most widely used alcohol withdrawal assessment tool. Rouillard, Tremblay and Boivin (1999) have developed tools for assessing withdrawal severity and determining the required medical care. They are called "level of detoxification" tools (Niveau de désintoxication, NID). In fact, these are two distinct health assessment tools. One is designed to be used by medical staff (NID-ÉM) and the other is an adapted version designed to be used by psychosocial workers (NID-ÉP) with validation by nursing staff. To ensure the objectivity of the decision-making process and in order to refer patients to the most appropriate service so as to avoid providing them with services that are more intensive than they really need, Ménard, Pépin and Saint-Louis (2007) have developed the NID-ÉM 2.0 tool, an adapted version of the NID-ÉM. Based on a patient referral algorithm, this tool assesses intoxication and withdrawal signs and symptoms as well as ASAM criteria. These authors have also developed the tool NID-ÉP version 2.9 (2007).

The assessment tools begin with a section where sociodemographic information is collected, followed by a questionnaire on the patient's medical condition and medication used. The most important section is the assessment of alcohol and drug use, which includes the Clinical Institute Withdrawal Assessment-Alcohol Revised (CIWA-Ar). The following sections are designed to assess the patient's psychological/psychiatric condition including the risk for suicide and the patient's overall social situation (work, family, social, legal, etc.). At the end of the questionnaire, patients are referred to the appropriate services. Those assessment tools are

recognized by the medical community and used by medical and psychosocial staff to assess patients.

### **Outpatient treatment – A possible alternative**

Despite the amount of studies published, the scientific literature does not lead to the conclusion that residential treatment provides better results than ambulatory treatment. However, various studies such as those by Kissin et al. and Rychtarick et al. (2001) point to the fact that patients with high social instability and severe substance use problems have better results when they receive residential treatment. According to the Center for Substance Abuse Treatment, the best detoxification treatment is the least restrictive and the one that successfully achieves detoxification outcomes in the most efficient and cost-effective manner for a given patient. The type of detoxification treatment (inpatient or outpatient) should be determined primarily based on the patient's clinical needs.

In their literature review, Bertrand and Ménard (2004) indicate that there seems to be consensus among clinicians and researchers that outpatient alcohol and substance abuse treatment meets the needs of a vast majority of patients, is less disruptive and less costly than inpatient treatment, although the latter is also needed and requires further analysis. In fact, outpatient treatment does not preclude the need for some patients to undergo residential treatment when their physical, psychological or social condition needs to be stabilized.

According to ASAM (2001), there are two major criteria for referring a patient to residential detoxification services:

- The severity of addiction and physical health risks;
- High psychosocial instability and/or inadequate rehabilitation environment.

### **The importance of the continuum of care**

A group of clinical addiction experts brought together by SAMHSA (2006) determined that detoxification is an integral part of a comprehensive treatment strategy and should not be isolated from the other stages of the process. They also recognized that providing detoxification

services without subsequent treatment or rehabilitation is an inadequate way of using limited resources. In this perspective, detoxification services are viewed as a starting point for further treatment (Teesson et al., 2006). Various studies show that without a continuum of services, a vast majority of patients relapse within three months of completing detoxification.

To encourage patients to receive rehabilitation services, best practices recommend increasing their motivation by informing them about their condition and the higher risk of relapse within three months of completing detoxification, and by assessing psychosocial issues relating to family, employment, and other factors that may impact treatment outcomes. O'Farrell et al. (2008) pointed to the involvement of a relative or friend as a promising strategy for increasing the probability of the patient receiving rehabilitation services following detoxification.

Finally, Quebec experts point to the importance of creating bridges between detoxification and addiction treatment, the long-term goal being to increase the number of patients who successfully complete detoxification treatment and who subsequently receive rehabilitation services.

## **Recommendations**

Based on research-based best practices and the results of the feasibility assessment of ambulatory detoxification services in Quebec First Nations communities, we developed recommendations reflecting both the needs of our sample of community respondents as well as generally-accepted medical principles.

Ideally, implementing a continuum of care in each First Nations community across Quebec would be the recommended solution. However, as several respondents pointed out, limited financial and human resources do not allow for the provision of detoxification services in each First Nations community across Quebec. It is therefore unrealistic to recommend that a comprehensive continuum of services ranging from patient admission to full rehabilitation be implemented in the communities in the current context. These recommendations were made with the objective of helping communities in setting up realistic and viable services, in the best interest of their clients and in compliance with current best practices. Each recommendation is

supported by an action plan which outlines what needs to be done by whom, with which partners and when, for the recommendation to be implemented.

Our recommendations are presented in three categories: supervised residential detoxification services, outpatient detoxification services, and the creation of linkages between Aboriginal and provincial services. For obvious reasons, recommendations of categories 2 and 3 can be achieved in a relatively short time frame. As a result of human and financial constraints, recommendation 1 is a strategy to be implemented in the medium to long term.

### **CATEGORY 1 – Patients requiring residential detoxification treatment**

#### ***Recommendation***

*In the perspective of providing a continuum of care, it is recommended that a regional NNADAP centre offering residential detoxification services be created for First Nations clients with (a) severe addiction and high physical health risks and (b) high psychosocial instability and/or an inadequate rehabilitation environment. This First Nations-specific recommendation promotes the same trajectory of services as that available to Quebec network clients. However, given First Nations' limited access to the services identified above, it seems essential to develop a specialized service specifically designed for First Nations in order to address the needs expressed by respondents to this study.*

As part of the 2009 NNADAP needs assessment survey conducted by the FNQLHSSC, various service structure scenarios were developed based on the data collected through the survey. The scenarios aim at addressing gaps in support services available to substance abuse patients with a view to providing a continuum of care ranging from detoxification services to the rehabilitation of patients in the community. From an intervention perspective, several scenarios have been examined as a result of the current organization of services not meeting the needs of Quebec First Nations clients.

Scenario 1, which was recommended as a result of the NNADAP needs assessment study, appears to be the most appropriate since it provides for the creation of an integrated

continuum of services ranging from detoxification to post-treatment follow-up.

Scenario 1 involves a complete overhaul of services and would require converting an existing treatment centre into a specialized centre providing assessment, detoxification, referral and aftercare (“hub centre”). This scenario would require a redefinition of the roles and responsibilities of community workers, the professionalization of treatment centre workers, and greater collaboration among treatment centre managers. The ultimate goal of this scenario is to bring all services under the same coordinated and integrated organizational structure which would provide consultation, assessment, detoxification, treatment and aftercare. This would be a true continuum of services which would adequately meet the specific and individual needs of each patient in a comprehensive and holistic perspective. This intervention approach is client-oriented and no longer focuses only the common alcohol and substance use issues shared by treatment centre clients. In light of the data collected, there seems to be consensus that the best way of addressing clients’ needs is to establish a continuum of care such as presented in this scenario. We believe this scenario would allow for the provision of truly diversified and specialized services focusing on the real needs of individuals.

**CATEGORY 2 – Patients who do not require residential detoxification treatment (IMPLEMENTATION OF THE BRITISH-COLUMBIA PROTOCOL)**

***Recommendation***

*Recommendation: Implement a pilot project in at least two First Nations communities in Quebec.*

The British-Columbia Protocol developed by a nurse can be implemented in some communities. However, given the scope of the work required and limited financial and human resources in Quebec First Nations communities, it would be unrealistic to believe that such services could be implemented in all the communities at the same time.

Consequently, it is recommended that the British-Columbia Protocol be established as part of a pilot project to provide ambulatory detoxification services for patients who do not require residential detoxification treatment in a First Nations community.

This recommendation is the most efficient solution for evaluating and testing the scope of the work and of the financial and human resources required for implementing detoxification services in a community. The pilot project will also allow communities to offer a service that will address a significant gap in the continuum of care sought. Yet, the communities in which the pilot project will be implemented will have to meet some of the following criteria:

- Language characteristics (Anglophone or francophone)
- Geographic location (level of isolation)
- Strong demand for detoxification services;
- Availability of health services and sufficient and stable nursing staff;
- Community leaders motivated to create a continuum of care for addressing addiction issues;
- Willingness to invest time in training medical and psychosocial detoxification staff;
- Willingness to actively participate in evaluating pilot project results.

### ***Implementation of Recommendation 2***

Due to the importance of setting up a pilot project, it is necessary to set a number of guidelines for implementing this recommendation in the short term. Some of the required actions include:

- Making representations to the various levels of government to obtain necessary funding for implementing the pilot projects;
- Hiring a pilot project coordinator associated with the FNQLHSSC;
- Identifying community selection criteria;
- Developing a plan for the implementation of the protocol between the FNQLHSSC and the communities (prevention and awareness activities, legal and liability aspects, agreements with hospitals and residential services, training, evaluation, etc.)

- Selecting a clinical assessment tool to be used in the pilot projects and that includes an assessment of psychiatric comorbidity;
- Developing a pilot project evaluation process;.

### Category 3 – Build linkages between Aboriginal and provincial services

#### *Recommendation*

*It is recommended that a regional forum of Aboriginal and Quebec institutions specializing in addiction treatment and detoxification be organized. The forum would provide communities and organizations with an opportunity to share their services and prepare the ground for potential collaboration in the field of detoxification services in the perspective of creating a continuum of care.*

In Quebec, specialized detoxification services are not many and often, several criteria apply for admitting a patient, as withdrawal severity is the main criteria for referring a patient to the appropriate service. Furthermore, most services are concentrated in and around Montreal and are therefore virtually inaccessible to the most remote First Nations communities. Also, English-speaking communities hardly have access to detoxification services, apart from those offered by one specialized centre in Montreal. It is also important to bear in mind that creating specialized detoxification services is not an easy task, since detoxification treatment is a medical process that requires specific skills and knowledge for which the majority of community nursing staff has not been trained.

This recommendation supports the general objective of improving linkages between specialized institutions and the Quebec network in the field of detoxification and would contribute to raising awareness of the challenges faced by First Nations communities among organizations in the Quebec network.

## CONCLUSION

The results of this study show that detoxification services in Quebec are scattered and essentially located in major urban centres. Since the majority of the on-reserve First Nations population in Quebec lives in remote regions, it is not possible to conclude that existing services in the Quebec network adequately meet the projected needs of a majority of communities. Based on what the scientific literature defines as a true continuum of care, it is possible to conclude that there are significant gaps in the provision of services that are essential to the long-term rehabilitation of Quebec First Nations community members.

Furthermore, respondents to this study expressed reservations about home-based support services delivered to detoxification patients by family members. Unhealthy family environments and the lack of financial and human resources in the communities are the main reasons for this. However, it is clear that detoxification services need to be offered through First Nations regional centres under the form of ambulatory community services delivered by adequately trained medical and psychosocial staff.

The recommendations made in this report support – at least in part and in the short to medium term – the implementation of best practices in detoxification while addressing the needs expressed by respondents to the study. Detoxification being first and foremost a medical procedure, the level of intensity of withdrawal symptoms must be properly assessed using tools that are widely accepted in the international scientific community. Patients requiring medically supervised detoxification and meeting the criteria for hospitalization or admission to residential treatment could be treated in a NNADAP centre converted into a crisis and detoxification centre. Concerning those patients whose withdrawal symptoms do not require residential treatment, outpatient services delivered in the community by adequately trained medical and psychosocial staff could be an efficient way to address part of the needs of patients. Yet, the communities do not all have the financial and human resources required for implementing outpatient detoxification services. Therefore, it would be appropriate, as a first step, to test and evaluate this type of services in a pilot project conducted in two communities.

The shared vision of all communities is to create a continuum of care for the treatment of addictions. Due to limited resources, such a structure does not currently exist, contrary to what can be seen in the Quebec network. The gap between the services available to First Nations people on and off reserves is yet another example of the dichotomy resulting from constitutional jurisdiction issues relating to health services.

Nonetheless, it is absolutely necessary to consider detoxification services in a broader perspective in order to obtain positive results for patients who undertake rehabilitation. Without rehabilitation and support both for the patient and his or her family, detoxification treatment may well be of little or no value to patients and their environment in the long run.

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