Quality Standards and Competencies for University and Higher Education Addiction Study Programs

MIOVSKY, M.[1,2,3], MULVEY, K. P.[3,4], VOLFOVA, A. [1,2], SEARCY, C. M.[3], LOSOSOVA, A.[1]

1 | Department of Addictology, First Faculty of Medicine, Charles University, Prague, Czech Republic
2 | Department of Addictology, General University Hospital in Prague, Prague, Czech Republic
3 | International Consortium of Universities for Drug Demand Reduction (ICUDDR), Tampa, Florida, USA
4 | Northeastern University College of Professional Studies, Boston, Massachusetts, USA

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BACKGROUND: Exponential growth of addiction specific services accelerated the need and pressure on professionalizing workforce. It is followed by the increasing number of university and higher education programs specifically focused on substance use, hand in hand with curricula development. In such fast condition changes, emphasis on quality assurance is key. The aim of the paper is to describe and reflect the development process of international quality standards and a competency model for clinically oriented university programs in addictions. **METHODS:** The study is based on a process evaluation reflecting internal process of developing quality standards and a competency model for tertiary education programs specifically focused on addictions. It was facilitated and led by a working group (2020-2023) established by ICUDDR and NAADAC/NASAC. The process of development has been described, the final documents presented and the main challenges identified.

RESULTS: The working group has created the final output represented by international quality standards dedicated to educators and curricula developers and evaluators for relatively narrow profile of study programs: addiction counseling, treatment and rehabilitation. Authors reflected on the process of standards development and focused on broader context of emerging educational programs and formulating a roadmap for continual work where prevention, harm reduction and recovery perspectives are still missing. **CONCLUSIONS:** There is a global need to continue developing quality standards for tertiary education on substance use and a need to intensify the dialogue between service providers, professional societies, governmental structures and university and higher education providers in maintaining and improving quality of addiction care.

Keywords | Addiction Studies – University and Higher Education – Study and Training Programs – Sustainability – Quality Standards – Competency Models

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Corresponding author | Michal Miovský, Ph.D., Department of Addictology, First Faculty of Medicine, Charles University, Apolinarska 4, Prague 2, 128 00, Czech Republic. Tel.: +420 224 96 1111 **michal.miovsky@lf1.cuni.cz**

1 INTRODUCTION

Emergence of the first academic study programs specifically focused on substance use (e.g. Butler, 2011; Ferrer et al., 2023) and training of young professionals in clinical work and developing specific skills, were the important consequences of a huge wave of new service providers in the field. It represents very complex phenomenon recognized and described by Babor et al. (2017) in addiction studies and reflected by Miovský et al. (2019) as a specific motor for developing and emancipating of the entire addiction field and vice versa as a specific prerequisite for successful and sustainable development of academic study programs. Increasing number of service providers brings need and pressure on professionalization, quality, safety and efficiency of prevention, harm reduction and treatment and rehabilitation (see Thom, Duke, & Herring, 2017). It logically leads to establishing higher education and university-based programs. The significant growth of these specific programs was not adequately reflected for decades but after the first mapping surveys (e.g. Lososová et al., 2019; Lososová et al., 2021) the interest has significantly increased and led to the establishment of platforms such as the International Consortium of Universities for Drug Demand Reduction (ICUDDR), International Society of Addiction Medicine (ISAM), International Society of Substance Use Professionals (ISSUP) or National Addiction Studies Accreditation Commission (NASAC) where educators (education providers) have a continual dialogue about curricula, standards and other relevant issues. This global process is represented by many parallel projects, reflections, surveys, first competency models and evaluations, for example in Australasia (Roche & White, 2011; Adams et. al., 2017), in Africa (Pasche et al., 2015), in North America (ISAM, 2015; SAMHSA, 2017) or in Europe (Butler, 2011; Miovský et al., 2019).

Generally, the current trend is represented by focus on quality assurance and improvements, logically, with growing number of educational options and services, and the current world transforming into open and shared space, the need for some form of standardization and global coverage become critical. We witness a lively discussion related to the core of addiction issues and skills that would be acceptable across the regions and traditions. For example Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a competency model describing basic knowledge, skills and attitudes of addiction counselors (SAMHSA, 2017) which can serve as an inspiration and base for educational competencies and standards formulation.

A very important acceleration happened thanks to ICUDDR and the development of universal curricula: Universal Prevention Curriculum (UPC) and Universal Treatment Curriculum (UTC) (ISSUP, 2023). These enable fast and relatively easy spreading of addiction education into all world regions; a lot of programs have been developed since then (Lososová et al., 2024). The curricula could easily serve as facilitated skill-based training concentrated in core skills that are introduced in each UPC/UTC courses.

We may also see an emerging need to educate professionals in different fields, such as psychology, medicine, nursing, in addiction topics as addiction is an interdisciplinary and widespread issue related to all health, social and other areas. For example American Psychological Association (APA) has developed a substance use disorder curriculum for graduate psychologists (American Psychological Association, 2021) and we may also register activities of the American Society of Addiction Medicine (ASAM) formulating their own standards and competency-based models for training in a diverse of addiction topics (American Society of Addiction Medicine, 2015). We see the existence of specialized associations of related disciplines focused clearly on substance use, such as International Nurses Society on Addictions (IntNSA).

In 2015, the Global Centre for Credentialing and Certification (GCCC) has grown to be a key international player in addiction education. Their members come from various regions and represent a body whose mission is to provide experience verification and appropriate exams to ensure that there are the most qualified and competent professionals in the addiction field. This organization collaborates with all those listed above, forming a comprehensive infrastructure for addiction (university) education (Babor et al., 2017; Miovský et al., 2019).

The process of setting the basic knowledge, skills and competencies of addiction professionals is undoubtedly interconnected with the necessity of an open dialogue with the service providers and local policy to reflect the addiction issues reality properly. Without this collaboration, everything created only on the university level will result in an isolated attempt with no chance to change the addiction services reality (similarly to the relation between research and practice, see Marinelli-Casey, Domier & Rawson, 2002). Another key aspect relates to the transferability of addiction education internationally given that the mobility of addiction workers increases. Having a consensus on a minimum of requirements and minimum competencies of addiction workforce could create a base for its global application and enable the workforce movement.

The aim of the paper is to describe and reflect on the process of development of international quality standards and competency models in the context of clinically oriented study programs in addiction counseling, treatment and rehabilitation; and present the final consensual version of quality standards for educators and curricula developers.

2 METHODS

In 2020, the ICUDDR began the process of creating internationally accepted educational standards for addiction study programs. ICUDDR formed an initial partnership1 with the NASAC. NASAC itself was created through a partnership[1] between the International Coalition for Addiction Studies Education (INCASE), and NAADAC, the Association for Addiction

1 | The group was led by Diane Sevening. The group regular members included Diane Sevening, Prapapun Chucharoen, Kim Johnson, Cary Hopkins Eyles, Amalie Lososova, Mita M. Johnson, Michal Miovsky, Joanna Travis-Roberts, Jerry Monroe, Cynthia Moreno Tuohy, Joseph Rosenfeld, Becky Vaughn.

Professionals. In 1998, INCASE created standards for addiction counselor education at multiple levels of post-secondary education, ranging from two-year programs to doctoral level institutions. These standards were then aligned with the United States' SAMHSA's Technical Assistance Publication #21, Addiction counselor competencies (SAMHSA, 2017). The TAP #21 lists 123 competencies that, at least in the United States, are deemed essential for substance use disorder (SUD) treatment professionals. INCASE then proceeded to accredit several SUD recovery counselor education programs. In 2012, INCASE and NAADAC, which had also been accrediting schools, formed NASAC, which today accredits schools across the United States.

In the period 2020-2023, a working group was established consisting of members of the ICUDDR, NAADAC and NASAC. The scope of this group had been to begin the work of identifying elements which college and university programs in substance use should focus on. The group was led by Diane Sevening, representing NAADAC and University in South Dakota.

The group met regularly once a month or bimonthly. The Charles University team joined the group at the beginning of 2022 being invited to the process by ICUDDR, in relation to the scope of their work in the project WAVE (GA No. 101045870), then being a stable part of it. The group was working on the standards and minimal competencies preparation yet also discussing a lot of relating issues arising during the process.

The documents used included SAMHSA's TAP 21 Competencies of Addiction Counselor (2017) and the standards and competencies formulated by the NASAC. These documents were reviewed in detail, followed in the first version of international standards proposal.

The focus of this work group was the development of standards for college and university programs specifically focused on substance use issues, and identification of what are the critical areas (Knowledge, Skills and Attitudes) that academic programs must deliver and students attain for a college or university program to be accredited. When finished, the proposal has been sent to a larger group of experts to be approved.

This paper is based on the process evaluation, describing the whole process of development of the international standards in education in the substance use studies with all the issues and challenges arising from that process. Limits and strengths are discussed.

3 RESULTS

The results are presented in the form of description of the process of developing the international standards and related expertise discussions; followed by rooting of this important topic into a broader context of addiction education, requirements and clinical practice.

3.1 Development of the International quality standards for university programs focused on substance use counseling, treatment and rehabilitation

International Quality Standards for Substance Use Studies at higher education and university level were developed by ICUDDR in collaboration with NASAC and NAADAC, supported by ISSUP and GCCC. The list of competencies (*Attachment A*) is addressing the design of International Accreditation Standards for Addiction Studies programs in colleges/universities for the training and education of SUD recovery therapists. Using the NASAC criteria as a starting point, ICUDDR assembled a panel of international experts to modify the NASAC standards to meet the needs of schools around the world. The International Standards Committee held meetings from October 2020 to October 2022 reviewing the NASAC standards and the SAMHSA's TAP 21 (2017) competencies line by line, and by consensus produced a revised document.

The main work consisted of focusing on TAP 21 domains and its up-dating according to globally acceptable models and understanding of substance use disorders and addictive behaviors. When commenting on the 2017 version of TAP 21, we used a published proposal of competencies of the bachelor's program made by Volfová et al. (2020), we also discussed various reality in the regions, availability of addiction studies programs and addiction services through the whole therapeutic continuum. The attempts of avoiding stigmatization were done in terminology, too. The crosswalk has been created, all members of the working group had a space to comment on the areas of competencies, followed by the discussion and looking for a consensus.

The aim was to suggest international (accreditation) educational standards for colleges and universities providing the addiction studies programs, in ideal way valid for all the programs around the world (supported by attendance of representatives of various regions within the group). When talking about minimal requirements or minimal competencies, we mean skills, knowledge and attitudes that are undoubtedly needed any SUD professional should be equipped with. The list of competencies (*Attachment A*) represents a base line educational standards, a minimum what should be taught and included within the tertiary programs' curricula.

The International Standards for Curriculum Guidelines are divided into eight core thematic areas (***Attachment A***):

Standard 1: Substance Use & Addictive Behavior Disorders Counseling Skills

Standard 2: Substance Use Disorder Counseling Skills

Standard 3: Biological Factors of Substance Use Disorders

Standard 4: Clinical Evaluation

Standard 5: Treatment and Service Planning

Standard 6: Information & Documentation Management

Standard 7: Continuing Professional Development

Standard 8: Continuum of Care

The list of International Standards for SUD professional competencies is created by the two levels of competence (transdisciplinary foundations and specific competencies for SUD professionals) and followingly into four subcategories in foundation level and seven subcategories in advanced level ***(Attachment B)*:**

A Transdisciplinary foundations

- Understanding substance use disorders
- Knowledge of continuum of care
- Application to practice
- Professional readiness

B Specific competencies for SUD professionals

- Clinical Evaluation
- Treatment and Service Planning
- Referral and Interdisciplinary Collaboration
- Counseling
- Client, Family, and Community Education
- Documentation
- Professional and Ethical Responsibilities

Table 1 shows the main changes made in comparison to the original TAP 21 publication. The final set of proposed international standards can be seen as the minimal requirements for the tertiary educational addiction studies programs what should be included within the curricula, and what knowledge, skills and attitutes should the students gain to be ready to work (standards of competencies). The accreditation process would review whether and to what extent the program reflects the required standards.

The final product was then put out for review by the ICUDDR Board and NASAC Commissioners from October 19, 2022, through November 21, 2022. Following final approval, the International Standards document was prepared to be distributed through NASAC and ICUDDR autonomously per their organizational goals and guidelines. To the current state, the final version has not been published anywhere yet, it remained in the form of proposal. The activity of the working group was ended then. NASAC is presenting and using for accreditation process the TAP 21 version from 2017 (TAP 21 Crosswalk NASAC Accreditation Packet (5.27.22) as the Addiction Curriculum Evaluation Scales, and not this proposed version with all the changes the working group suggested and prepared.

Table 1 | Changes made in the original reviewed competence list by SAMHSA (2017)

Original TAP 21 2017:	Actualized version 2022/09/02:
A. TRANSDISCIPLINARY FOUNDATION	A. FOUNDATIONS FOR SUBSTANCE USE DISORDER PROFESSIONALS
I. UNDERSTANDING ADDICTION	I. UNDERSTANDING SUBSTANCE USE DISORDER
II. TREATMENT KNOWLEDGE	II. KNOWLEDGE OF CONTINUUM OF CARE
III. APPLICATION TO PRACTICE	III. APPLICATION TO PRACTICE
IV. PROFESSIONAL READINESS	IV. PROFESSIONAL READINESS
PRACTICE DIMENSION	–
B. ADDICTION COUNSELOR COMPETENCIES	B. SUD PROFESSIONALS' COMPETENCIES
I. CLINICAL EVALUATION	I. CLINICAL EVALUATION
Ia. SCREENING	Ia. SCREENING
Ib. ASSESSMENT	Ib. ASSESSMENT
II. TREATMENT PLANNING	II. TREATMENT AND SERVICE PLANNING
III. REFERRAL	III.REFERRAL AND INTERDISCIPLINARY COLLABORATION
IV. SERVICE COORDINATION	–
IVa. IMPLEMENTING THE TREATMENT PLAN	–
IVb. CONSULTING	–
IVc. CONTINUING ASSESSMENT AND TREATMENT PLANNING	–
V. COUNSELING	V. COUNSELING
Va. INDIVIDUAL COUNSELING	Va. INDIVIDUAL COUNSELING
Vb. GROUP COUNSELING	Vb. GROUP COUNSELING
Vc. COUNSELING FAMILIES, COUPLES, AND SIGNIFICANT OTHERS	Vc. COUNSELING FOR FAMILIES AND SIGNIFICANT OTHERS
VI. CLIENT, FAMILY, AND COMMUNITY EDUCATION	VI. CLIENT, FAMILY, AND COMMUNITY EDUCATION
VII. DOCUMENTATION	VII. DOCUMENTATION
VIII. PROFESSIONAL AND ETHICAL RESPONSIBILITIES	VIII. PROFESSIONAL AND ETHICAL RESPONSIBILITIES

3.2 Main issues and challenges during the standards development

A *Comprehensiveness of the standards in coverage of all related areas*

Based in SAMHSA's publication (2017), the question came into account how we should deal with all areas of interests within the addiction field, namely prevention, harm reduction and treatment. Specifically harm reduction (HR) is not a part of any of universal curricula (UPC/UTC), there is also no decision about credentialing related to HR at this time. The group shared a basic consensus that we should not lose harm reduction from the scope as it is necessarily important at the university level. The purpose was primarily to include all areas of the addiction field, i.e. prevention, HR, treatment etc., and so have special competencies focused on these areas in the standards. Finally, we concluded it is not easy and straightforward to formulate all areas in one document. Much more time and expertise would be needed to do so.

Similarly prevention standards in US and European context used to stay separately from those related to treatment and recovery, as in this case. We confirmed not including prevention especially in the meaning of primary prevention into the proposed version of quality standards yet there are mentions about the importance of prevention work within the SUD professional work. But, when prevention and harm reduction should be included, then competencies based on UPC practitioner series could be easily used; and competencies based on public health minimum could be a possible base for harm reduction area (e.g. SAMHSA, 2016).

Another topics underestimated relate to the clients, services and clinical work in prisons and probation, and specific skills for various age, gender or ethnic groups (a number of hours of work in any area could be required). Such conclusions led the group again to the discussion about who is an addiction professional and how are (or would be) the university programs structured and designed to prepare competent workforce for each region and area of interest.

B *(Non-stigmatizing) terminology*

The word "addiction" was eliminated within the crosswalk, as it does not reflect the current status of knowledge and the classification manuals, we decided to use "substance use disorders" instead. Similarly, we unified the word "psychoactive drugs" to "substances"; and the wording "substance abuse" has been changed to "substance use", respecting what we know about stigma in addictions (NIDA, 2021). Discussion about substance use and addictive behavior was led, too, as working with people includes the whole spectrum of behaviors, from experimental use in adolescents, to risky use to substance use disorder. And we do not limit our work only to people using substances but we do care of people dealing with gambling, gaming, possibly eating disorders.

We degendered wording, avoiding his/her and moving to "them" through the document. Key issues for special consideration included the question and borders of counseling versus therapy with all implications and with competencies of health professionals worldwide.

C *Concrete changes in the updated proposal of quality standards*

The important change happened in the focus of the document, originally being oriented on "addiction counselors" we switched to the "substance use disorder professionals". The current model used for explaining the phenomenon of substance use disorder is the bio-psycho-socio-spiritual model, we found it important to implement the spiritual issues into the document.

We suggested a broader context of "treatment knowledge" as the continuity is not only about treatment yet even when having a person in treatment now, we need to think about previous prevention work, plan his care with regard to his risks (harm reduction), to following steps (aftercare, sheltered or supported housing) and also related needs going beyond the borders of our field (self-help, social welfare etc.). Another important point was a missing focus on the organizational management within the standards, including development and quality improvement of institutional infrastructure in addiction field.

The area of competencies, number IV in TAP 21 (2017) has been deleted completely, as we found case management and treatment coordination as a method or procedure which should be included in the treatment processes as it belongs undoubtedly to the service planning, referral and interdisciplinary collaboration. We added education of colleagues and professionals within the field and outside of it, to "client, family and community education".

We also got into an opinion that general knowledge gained in addiction studies should include theoretical knowledge in related fields such as anatomy, pathology, psychiatry and psychology and psychopathology. We cannot miss research and evaluation and specific skills related specifically to it.

3.3 How to work with the proposed quality standards and competency model

The original TAP 21 Curriculum Evaluation Scales are used as a key base for the accreditation process of the university-based addiction programs. NASAC is currently using a non-adjusted version from 2017. This is one of many possible and very practical use of such document.

We could think about the competency models as the minimum requirements for the addiction studies programs' students and graduates, representing the skills, knowledge, attitudes and real abilities for practicing in the addiction field. Concurrently, it could lead the university when developing or adjusting the addiction program in the required direction, setting the curriculum in the way that reflects the reality of addiction practice and services. Lastly, the students themselves are led through studies and professional development in practicing concrete skills and easily confirming if they gain the competency or not.

The attempt to propose the international quality standards for education in the substance use brings an important shift and challenges. The process is not ended, but hopefully supported

by its meaning. The standards serve as the consensus of the professional community in the field on what really creates a base of our field and addiction care through the whole continuum. Global impact should help in workforce movements, experience sharing and collaboration.

When considering types of addiction university programs (Miovský et al., 2021), we can see a limitation of proposed standards in covering all the educational options. They are mostly oriented and useful for clinically focused programs, raising graduates for clinical work in treatment area. But the standards could be used for any degree level of education when distinguishing the level of education and relevant competencies. The differentiation between bachelor's and master's level is strongly dependent on the professional profile of the workforce in the region as it can be a healthcare worker or social worker, and it differs between the regions a lot. But, there is a possibility to use the set of competencies and make it more specific in the level to what the competence is gained (e.g. basic level could be represented by ability to assist in the intervention; the advanced level could reflect the competence and ability to provide an intervention).

The proposed competencies may also serve as a basis for the formulation of addiction specific learning outcomes, which are key when developing an addiction focused study program. Learning outcomes also serve as a "common language" when comparing study programs and profiles in different countries. For example, Volfová et al. (2020) formulated an addiction specific competency model via identifying learning outcomes in an existing program using the European qualification framework. The recommendations of the European Higher Education Area are to identify the competency set at first and then to formulate specific and detailed learning outcomes.

4 DISCUSSION AND CONCLUSIONS

The importance and necessity of setting a minimal requirement on the addiction workforce, and partially on the workforce (university) education are indubitable. We live in a global world and face fast changes, news, and developments, not only in the field of substance use. In a world with permeable borders, any epidemic requires an international response. The epidemic of SUD that directly and indirectly bring suffering to millions, disrupt governments, and embolden illegal cartels deserves no less. The creation of international standards for the education of SUDs recovery professionals will create a workforce dedicated to demand reduction. There are no quick fixes to our global SUD challenge, but a trained workforce dedicated to the eradication of this disease, is a crucial step toward that goal.

The international focus of education is needed and logically, we want students and graduates to be able to collaborate globally, understand the needs and topics of other regions' populations and finally, to be able to work effectively anywhere in the world. These reasons led us to identify key skills of the graduates and characteristics and common areas that should be covered by addiction curricula worldwide. We are aware that prevention is not adequately covered by these standards, being a key part of the SUD field. For future discussion about quality standards of education, this area should be included, for example by using the EUPC curriculum as a base.

The authors aimed at presenting the process of development and the result of it in the form of international standards for the education providers related to the curricula, minimum requirements on the programs and competency model for education programs focused mostly on addiction treatment, recovery and counseling.

We faced many challenges, of course. The main challenges in the creation of global educational standards could be represented by the questions like: Who is an addiction specialist/professional?, or How to formulate the competencies and standards covering all professionals involved? Standards only focus on addiction counseling and treatment; prevention, harm reduction and other areas are not included, the important discussion about the minimal requirements on addiction professionals and on the graduate profiles is needed. We could use a so-called generic concept of an addiction specialist, used for example in the Czech Republic (Miovský et al., 2016), or a model often used in other regions where mostly professionals with the education in other disciplines (see also Edwards & Babor, 2012) become addiction specialists grounded in their original profession (compare to Thom et al., 2017 or Adams et al., 2017). Important issue is also the question what are the very basic and key competencies and what are the advanced ones, and how to differentiate between them. But there still should be a set of core competencies that would cross the borders and be relevant for all SUD professionals.

It is possible to find open questions with focus on age perspective because of emerging wave of establishing new specialized services following specifically age groups and their specific needs. These programs are designed differently and have specific (different) clinical guidelines. The question is when study programs (education providers) will reflect this new perspective and adopt the training and study programs. For example, child and adolescent addiction professionals are already working in some countries and we can expect this new line in education soon. For gerontological profile of addiction specialized services it will probably need much longer time but the first group of services and clinical guidelines shows how fast the process really is. Generally, the issue of not being comprehensive seems to be critical in the current version of the international standards.

The mapping surveys identified 4 general thematic focuses of addiction studies academic degree and higher education programs: (a) prevention, (b) counseling, (c) treatment and rehabilitation and (d) harm reduction. The standards (*Attachment A*) are dedicated specifically only for B (counseling) and C (treatment and rehabilitation).

The Typology (Miovský et al., 2021) added a view on programs from a perspective of their main scope or profile, defining programs theoretically oriented, clinically oriented and research oriented. It is probable that all of these could further differentiate the content, requirements and employability of their graduates. Despite the fact that quite high number of programs

include a meaningful proportion of research topics and some of them identify themselves as being clearly research focused (Lososová et al., 2024), the essence of addiction profession lays in the clinical work, in provision of addiction prevention, harm reduction, counseling, treatment and recovery care, respecting and reflecting changing needs of target groups of the field. Therefore, the main use of the global standards and especially competencies defined aim in the clinically oriented educational addiction programs.

On the other hand, the standards as they are presented cover one hundred percent the content of specialized addiction education programs focused on gaining a clear qualification on substance use. The advantage could be seen in the possibility to discuss what competencies could be used for professionals educated in other, more general disciplines (such as medicine, nursing) who would like to specialize in substance use later.

The standards are dedicated to all levels of higher education study programs and all academic degree programs (see also column no. 2 in *Table 1*; Miovský et al., 2021). The idea of international addiction university-based education standards has become a logical next step but at this stage of development it does not make sense to formulate specific standards for different levels of studies – especially in a moment when different providers (universities) are integrating (a) the same issues/topics for different academic degree levels (comparable learning outcomes), or (b) different setup and extent (but same thematic areas) is used for hierarchic model where addiction studies program is provided on more than only one academic level (continual hierarchic model). A working group of ICUDDR and NADAAC members set a minimum of international standards – we can go further anytime.

At this moment, the proposed document is not used, bringing us to the important reflection if this is the right direction, if the practice and state of the university education really need the internationally valid standards and competencies for the addiction workforce, or if it should be laid to the national level only. We see an extensive wave in attempts to set core competencies, curricula, or educational standards across the addiction field (WHO, 2016; APA, 2021) and this topic deserves space and continual work. More research and evaluation are needed to answer this key question, concurrently with continuing global discussion about the sense and use of global standards and the role of regional specificities in setting the minimal requirements. One potential next step forward is that ICUDDR could begin to develop an accreditation process that could be piloted with a few of its member universities. Nonetheless, the SUD field requires quality documents like these presented and the further discussion could build upon this important step that has been done.

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Attachment A | International Quality Standards for Curriculum Guidelines

Standard 1: Substance Use & Addictive Behavior Disorders Counseling Skills
The curriculum shall include the historical development of the overall field of addiction prevention and treatment.
The history of addictive disorders along with the contexts in which prevention and treatment evolved, provide a foundation for understanding the present conditions in the profession, and a framework for understanding future evolution. This includes the knowledge of how the profession developed from various non-professional experiences, how other disciplines succeeded or failed in dealing with addictive disorders, as well as the social and political forces that impacted upon service delivery.
Standard 2: Substance Use Disorder Counseling Skills
The curriculum will train students to have the knowledge, theory, and skills to provide the core functions of substance related and addictive disorders counseling.
For students being prepared to become substance related and addictive disorders professionals, the curriculum should include, at all levels, the competencies laid out in the International Addiction Studies Accreditation Commission (IASAC).
Graduate and Post-graduate training shall include knowledge, theory and skills to provide administrative and supervisory competency.
Standard 3: Biological Factors of Substance Use Disorders
This curriculum shall provide pharmacology, neuro-physical and biomedical, ecological education.
Students in the field of addiction studies need to have an appropriate level of
understanding of pharmacology as it relates to the physical, emotional, social, and intellectual dynamics of the whole person.
Standard 4: Clinical Evaluation
This curriculum shall include education on screening, intake, assessment and evaluation tools and processes.
Standard 5: Treatment and Service Planning
The curriculum shall provide knowledge, theory and skills related to various substance use disorders evidence-based treatment modalities, discharge planning, and recovery management; the curriculum shall be updated based on new research/evidence.
Document that knowledge of the treatment and service modalities accepted as the current levels of care are identified, described in philosophy and theory, so that appropriate planning and referral can take place.
Standard 6: Information & Documentation Management
This curriculum shall include education on the ethical responsibilities and the formats for documentation.
Standard 7: Continuing Professional Development
Introduction to research, knowledge development, ethical integration, and key sources of information to remain current with the evidence.
Standard 8: Continuum of Care
This curriculum shall include education on other aspects of the continuum of care for substance use disorders including, but not limited to: prevention, intervention, harm reduction, and recovery support.

Attachment B | International Standards for SUD Professional Competencies

A. TRANSDISCIPLINARY FOUNDATIONS FOR SUD PROFESSIONALS
I. UNDERSTANDING SUBSTANCE USE DISORDER
The professional is able to:
1) Understand a variety of models and theories of substance use disorder and other substance-related disorders.
2) Appreciate the social, political, economic, and cultural context within which substance use disorder and substance
use disorders exist, including risk and resiliency factors that characterize individuals and their living environments.
3) Describe the behavioral, psychological, physical health, and social effects of psychoactive drugs, including alcohol and tobacco, on the consumer and significant others.
4) Recognize the potential for substance use disorders to mimic a variety of medical and psychological disorders, and the potential for medical and psychological disorders to co-exist with substance use disorder and substance use disorders.
5) Applying this understanding to clinical practice
II. KNOWLEDGE OF CONTINUUM OF CARE
The professional is able to:
6) Describe the philosophies, practices, policies, and outcomes of the most generally accepted models of harm reduction, early intervention, treatment, recovery, reoccurence prevention and continuing care for substance use disorders.
7) Appreciate the importance of family, social networks, and community systems in the treatment and recovery process.
8) Understand the importance of research, evidence supported practices, outcome data, and their application in clinical practice.
9) Appreciate the value of an interdisciplinary approach to substance use disorder treatment.
10) Understand the contiuum of care and engagement in clinical services and indigenous resources
III. APPLICATION TO PRACTICE
The professional is able to:
11) Understand the established diagnostic criteria for substance use disorders, and describe treatment modalities and placement criteria within the continuum of care.
12) Describe a variety of helping strategies for reducing the negative effects of substance use disorders.
13) Tailor helping strategies and treatment modalities to the client's severity of substance use disorders and recovery.
14) Adapt treatment services to the person's level of cultural and language literacy, acculturation, or assimilation.
15) Appreciate the need to adapt practice to the range of treatment settings and modalities.
16) Be familiar with medical and pharmaceutical resources in the treatment of addictive disease and other substance-related disorders.
17) Understand the variety of insurance and health maintenance options available, and appreciate the importance of helping clients access those benefits.
18) Recognize that crisis may indicate an underlying substance use disorder, and may represent a window of opportunity for change.
19) Enagage indiginous services for recovery across the contiuum of care
17) Apply the importance of research, evidence supported practices, outcome data, and their application in clinical practice.
20) Understand the need for, and the use of, methods for measuring treatment outcomes.
IV. PROFESSIONAL READINESS
The professional is able to:
21) Understand diverse racial and ethnic cultures, including their distinct patterns of interpreting reality, world view, adaptation, and communication, and incorporation of the special needs of minority groups and the differently abled into clinical practice.
22) Understand the importance of self-awareness in one's personal, professional, and cultural life.
23) Understand the substance use disorder professional's obligation to adhere to generally accepted ethical and behavioral standards of conduct in the helping relationship.
24) Understand the importance of ongoing supervision and continuing education in the delivery of client services.
25) Understand the obligation of the substance use disorder professional to have knowledge of prevention, harm reduction, recovery paths and support, as well as treatment.
26) Understand and appropriately apply agency-specific policies and procedures for handling crises or dangerous situations, including safety measures for clients and staff.
B. SUBSTANCE USE DISORDER PROFESSIONALS' COMPETENCIES
The knowledge, skills, and attitudes within each function that are essential to the competent practice of substance use disorder treatment and substance use disorder counseling.
I. CLINICAL EVALUATION
The systematic approach to screening and assessment.

Ia. SCREENING
The process through which the professional, client, and available significant others determine the most appropriate initial course of action, given the client's needs, characteristics, and available resources within the community.
The professional is able to:
27) Establish rapport, including management of crisis situations and determination of need for additional professional assistance.
28) Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, culture and gender. At a minimum, data should include: current and historic substance use; health, mental health, and substance-related treatment history; mental status; and current social, environmental, and/or economic constraints on the client's ability to follow-through successfully with an action plan.
29) Screen for toxicity, withdrawal symptoms, aggression or danger to others, and potential for self-inflicted harm or suicide.
30) Help the client identify the role of substance use in their current life.
31) Determine the client's readiness for treatment/change and the needs of others involved in the current situation.
32) Review the available treatment options relevant to the client's needs, characteristics, and goals.
33) Apply accepted criteria for diagnosis, and the use of modalities on the continuum of care, in making treatment recommendations.
34) Construct with the client and others, as appropriate, an initial action plan based on needs, preferences, and available resources.
35) Be able to interpret and utilize objective assessment tools, including laboratory data.
36) Based on an initial action plan, take specific steps to initiate an admission or referral, and ensure follow-through.
Ib. ASSESSMENT
An ongoing process through which the professional collaborates with the client, and others, to gather and interpret information necessary for planning treatment and evaluating client progress.
The professional is able to:
37) Select and use comprehensive assessment instruments that are sensitive to and address, and understand behavioral indictors:
– Age, gender, and culture
– History of alcohol and other drug use
– Neurodiversity and developmental conditions
– Health, mental health, and substance-related treatment history
– History of sexual or other physical, emotional, nutritional, and verbal abuse, and/or other significant events
– Family issues
– Work history and career issues
– Psychological, emotional, and world-view concerns
– Physical and mental health status
– Acculturation, assimilation, and cultural identification(s)
– Education and basic life skills
– Socio-economic characteristics, lifestyle, and current legal status
– Use of community resources
– The impact of criminal justice status on the client
38) Analyze and interpret the data to determine treatment recommendations.
39) Seek appropriate supervision and consultation.
40) Document assessment findings and treatment recommendations.
41) Effectively communicate the assessment results to client and the impact of these factors on the action plan.
II. TREATMENT AND SERVICE PLANNING
A collaborative process through which the professional and client develop desired treatment outcomes, and identify the strategies to achieve them.
At a minimum, the treatment plan addresses the identified substance related disorder(s), as well as issues related to treatment progress, including relationships with family/friends, employment, education, spirituality, holistic and alternative interventions, health concerns, and legal needs.
The professional is able to:
41) Understand best practice clinical guidelines of care
42) Obtain and interpret all relevant assessment information.
43) Explain assessment findings to the client and others potentially involved in treatment.
44) Provide the client and significant others with clarification and further information, as needed.

45) Examine treatment implications in collaboration with the client and significant others.

46) Confirm the readiness of the client and significant others to participate in treatment.

47) Prioritize client needs in the order they will be addressed.

48) Formulate mutually agreed-upon treatment outcomes for each need.

49) Identify appropriate strategies for each outcome.

50) Match treatment activities and community resources with prioritized client needs, in a manner consistent with the client's diagnosis and existing placement criteria.

51) Develop, with the client, a mutually acceptable plan of action, as well as methods for monitoring and evaluating progress.

52) Inform the client of their confidentiality rights, program procedures that safeguard them, and the exceptions imposed by local regulations and/or laws.

53) Reassess the treatment plan at regular intervals, and/or when indicated by changing circumstances.

54) Integrate other community based services as necessary into the treatment plan

55) Integrate crisis prevention and management services into the plan.

56) Integrate reoccurence prevention, treatment re-entry, and recovery support into the plan

III.REFERRAL AND INTERDISCIPLINARY COLLABORATION

The process of facilitating the clients' and their involved significant others/families utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning.

The professional is able to:

57) Establish and maintain professional relations with civic groups, agencies, other professionals, governmental entities, and the community-at-large in order to ensure appropriate referrals, identify service gaps, expand community resources, and help address unmet needs.

58) Continuously assess and evaluate referral resources to determine their appropriateness.

59) Differentiate between situations in which it is most appropriate for the client to self-refer to a resource, and instances requiring professional referral.

60) Maintain relationships with indiginous healing and recovery systems

61) Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs.

62) Explain in clear and specific language the necessity for, and process of, referral to increase the likelihood of client understanding and follow-through.

63) Exchange relevant information with the agency/professional to whom the referral is being made, in a manner consistent with confidentiality regulations and generally accepted professional standards of care.

64) Assist community partners in developing assessment and early intervention strategies

65) Evaluate the outcome of the referral.

66) Initiate collaboration with referral sources.

67) Obtain and interpret all relevant screening, assessment, and initial treatment planning information.

68) Confirm the clients' eligibility for admission and continued readiness for treatment/change.

69) Complete necessary administrative procedures for admission to treatment.

70) Establish accurate treatment expectations for the client and involved significant others/families, including:

– Nature of services

– Program goals

– Program procedures

– Rules regarding client conduct

– Schedule of treatment activities

– Costs of treatment

– Factors affecting duration of care

– Client rights and responsibilities

71) Coordinate all treatment activities with services provided to the client by other resources.

72) Summarize the client's background, treatment plan, recovery progress, and problems inhibiting progress for the purpose of assuring quality of care, gaining feedback, and planning changes in the course of treatment.

73) Understand terminology, procedures, and the roles of other disciplines related to the treatment of substance use disorder.

74) Contribute as a member of a multi-disciplinary treatment team.

75) Demonstrate respect and nonjudgmental attitudes toward the client in all contacts with other professionals or agencies.

76) Maintain ongoing contact with the client, and involved significant others/families, to ensure adherence to the treatment plan.

77) Understand and recognize culturally appropriate stages of change and other signs of treatment progress.

78) Assess treatment/recovery progress and, in consultation with the client and significant others/families, make appropriate changes to the treatment plan to ensure progress toward treatment objectives.

79) Describe and document treatment process, progress, and outcome.

80) Apply generally accepted measures of treatment outcome.

81) Utilize referral skills, as described in Section 3 (above).

82) Conduct continuing care, reoccurence prevention, and discharge planning with the client and involved significant others/families.

83) Assure the accurate documentation of case management activities throughout the course of treatment.

84) Apply placement, continued stay, and discharge criteria for each modality on the continuum of care.

IV. COUNSELING

A collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives. Counseling includes individual, couple, family, and group methods that are sensitive to individual client characteristics and the influence of significant others/families, as well as the client's cultural and social context. Competence in counseling is built upon an understanding and appreciation of, and the ability to use appropriately, the contributions of various substance use disorder counseling evidence informed models and methods as they apply to modalities of care for individuals, groups, families, couples, and significant others.

IVa. INDIVIDUAL COUNSELING

The professional is able to:

85) Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy.

86) Facilitate the client's engagement in the treatment/recovery process.

87) Work with the client to establish realistic, achievable goals consistent with achieving and maintaining recovery.

88) Encourage and reinforce all client actions that are determined to be beneficial in progressing toward treatment and recovery goals.

89) Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment and recovery goals.

90) Recognize how, when, and why to use the client's significant others/families to enhance or support the treatment plan.

91) Promote client knowledge, skills, and attitudes that contribute to a positive change in substance use behaviors.

92) Promote client knowledge, skills, and attitudes consistent with the maintenance of good health (as defined by both the client culture and the treatment culture) and the prevention of communicable diseases.

93) Facilitate the development of basic and life skills associated with recovery.

94) Adapt counseling strategies to the individual characteristics of the client, including (but not limited to): disability, gender, sexual orientation, developmental level, acculturation, ethnicity, age, health status, and neurodiversity

95) Apply crisis management skills.

96) Mentor the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment and recovery progress, reoccurence, and continuing care.

IVb. GROUP COUNSELING

The professional is able to:

97) Describe, select, and appropriately use strategies from accepted, culturally appropriate, and evidence informed models and methods for group counseling for clients with substance use disorders.

98) Perform the actions necessary to start a group, including: determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods for termination or graduation from the group.

99) Facilitate the entry of new members and the transition of exiting members.

100) Facilitate group growth within the established ground rules, and precipitate movement toward group and individual goals by using methods consistent with group type.

101) Understand the concepts of "process" and "content," and shift the focus of the group when such an intervention will help the group move toward its goals.

102) Describe and summarize client behavior within the group for the purpose of documenting the client's progress and identifying needs/issues that may require modification of the treatment plan.

IVc. COUNSELING FOR FAMILIES AND SIGNIFICANT OTHERS

The professional is able to:

103) Understand the characteristics and dynamics of families and significant others affected by substance use disorders.

104) Be familiar with and appropriately use models of diagnosis and intervention for families and significant others, including extended, kinship, or tribal family structures.

105) Facilitate the engagement of selected members of the family and significant others in the treatment and recovery process.

106) Help members of the family and significant others understand the interaction between their system and substance use disorders.

107) Help families and significant others adopt strategies and behaviors that sustain recovery and maintain healthy relationships.

V. CLIENT, FAMILY, AND COMMUNITY EDUCATION
The process of providing clients, families, significant others, and community groups with information on risks related to substance use, as well as available prevention, treatment, and recovery resources.
The professional is able to:
108) Provide evidence informed, culturally relevant formal and informal education programs that raise awareness and support substance use prevention and/or the recovery process.
109) Describe factors that increase the likelihood that an individual, community, or group will be at-risk for substance use.
110) Sensitize others to issues of cultural identity, ethnic background, age, and gender role or identity in prevention, treatment, and recovery.
111) Describe warning signs, symptoms, and the progression of substance use.
112) Describe how substance use affects families and significant others.
113) Describe continuum of care resources that are available to significant others.
114) Describe principles and philosophies of prevention, treatment, reoccurrence, and recovery.
115) Understand the health and behavioral problems related to the treatment of substance use, including transmission and prevention of communicable diseases.
116) Teach basic life skills such as stress management, relaxation, communication, assertiveness, and refusal strategies.
VI. DOCUMENTATION
The recording of the screening and intake process, assessment, and treatment plan, as well as the preparation of written reports, clinical progress notes, continiuing care plans, discharge summaries, and other client-related data.
The professional is able to:
117) Demonstrate knowledge of accepted principles of client record management.
118) Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.
119) Prepare accurate and concise screening, intake, and assessment reports.
120) Prepare and record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.
121) Record progress of the client in relation to treatment goals and objectives.
122) Prepare an accurate, concise, informative, and current discharge summary.
123) Document the treatment outcome, using accepted methods and instruments.
124) Understand and comply with local, applicable confidentiality and data protection laws and regulations.
VII. PROFESSIONAL AND ETHICAL RESPONSIBILITIES
The obligations of a substance use professional to adhere to generally accepted ethical and behavioral standards of conduct and continuing professional development.
The professional shall:
125) Demonstrate ethical behaviors by adhering to established professional codes of ethics that define the professional context within which the professional works, in order to maintain professional standards and safeguard the client.
126) Interpret and apply information from current counseling and substance use research literature in order to improve client care and enhance professional growth.
127) Adhere to local laws, and agency regulations, regarding substance use treatment.
128) Recognize the importance of individual differences by gaining knowledge of all factors influencing client behavior, and applying this knowledge to practice.
129) Utilize a range of supervisory options to process personal feelings and concerns about clients.
130) Conduct culturally appropriate self-evaluations of professional performance, applying ethical, legal, and professional standards to enhance self-awareness and performance.
131) Obtain appropriate continuing professional education.
132) Research and join organizations which enhance professional development.
133) Assess and participate in regular supervision and consultation sessions.
134) Continually assess personal physical, spiritual, and mental health.
135) Develop and utilize strategies to maintain personal physical, spiritual, and mental health.

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