# The Status of Quality Standards and Quality Improvement Content in Specialty Addiction Studies Programs:
## What our learners are exposed to-

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## Abstract

**Introduction.** Internationally, there is increased interest in enhanced access to quality care (i.e., evidence-based prevention and treatment) for substance use. ICUDDR surveyed its membership to assess the inclusion of quality standards and quality improvement strategies in the substance use treatment curricula provided to students enrolled in certificate, baccalaureate, masters, and post-masters classes and programs.

**Methods.** ICUDDR emailed a questionnaire to 322 members. The 31-item survey was designed to describe membership efforts to train students on quality care standards and quality improvement strategies for treatment services addressing substance use disorders. Participants provided identifying information (e.g., respondent name, institution, country, and the number of students enrolled in certificate, baccalaureate, masters, and post-master's trainings). Items assessed included content on quality improvement, safe care, effective care, patient-centered care, timely care, efficient care, and equitable care (yes, no) (Institute of Medicine, 2001, 2006). If yes, respondents provided a brief description of the content. Additional items examined: methods to understand the patient experience; continuous quality improvement approaches; outcome measurement, tracking and reporting; and system change methods in addiction studies courses and training. Respondents also gave brief examples of plans for new content on quality of care and quality improvement strategies.

**Results.** Respondents (n = 88; 39% of the 224 members who received and opened the survey) were located in Africa (n=31), Asia (n=22), Europe (n=9), North America (n=15), and South America (n=11). Students (total = 42,595) were trained across academic levels with 23% in certificate programs (n=9,856), 68% in baccalaureate (n=28,904; 68%), 7% in masters (n=2,816), and 2% in post-masters (n=1,019) training. Four in ten (n = 37; 43%) of the 88 respondents answered 'yes' when asked if their training courses addressed quality improvement.

The proportion of 'yes' answers indicating they trained students in the dimensions of quality care varied between 37% to 49% of the 59 programs that were actively training students. Among the members reporting training students 70% addressed safe care (e.g., trained supervision, confidentiality of care), 78% had content on effective care (e.g., standardized assessment, use of clinical guidelines, medication), 65% addressed patient-centered care (e.g., personalized treatment plans, Rogerian therapy), 68% discussed timely care (e.g., emergency services, same day treatment), 59% promoted efficient care (e.g., placement criteria; individualized treatment plans), and 65% included training on equitable care (e.g., translation services; adolescent, elder, gender specific services).

Surveys also probed for content on quality improvement methods. Nearly six of ten respondents (59%, n=22) who addressed quality improvement (n=37) provided training on methods to a) understand patient experiences (e.g., active listening) and b) track and report patient outcomes (e.g., use of standardized and validated instruments). Training was less common on a) theories of continuous quality improvement (n = 18, 49%) (e.g., specific quality improvement methods), and b) systems and system change (n=16, 43%) (e.g., family systems). Respondent's plans for new quality of care content included more attention to evaluation, training on quality assurance, a degree in psychiatric nursing, and a course in key quality indicators.

**Discussion.** The survey suggests that about 40% of the respondents were actively providing training on quality standards and quality improvement strategies that address SUD treatment. The international interest (UNODC,WHO,INL) in more access to care and better quality of care gives ICUDDR members the opportunity to enhance their training on quality of care and the methods used to improve and assess

quality of care. Survey results should be used cautiously because of the short period for responses during a season when many universities are less active.

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## Introduction

Treatment for people with drug (and alcohol) use disorders should meet the same standards required for treatments of other health conditions. Treatments for any chronic health condition, 'generally' work. They reduce, stop, or reverse the dysfunctional progress and effects of the health condition. In the case of substance use disorders (SUD), most people with this condition remain undiagnosed and untreated. For those who are treated for SUD, the treatments provided too often fail to meet patient needs (Hepner et al., 2019; McGlynn, 2020; McGlynn et al., 2003).

The reasons for ineffective care reflect the interaction of failures to use evidence based practices, poor workflow within healthcare systems, regulatory and policy processes that inhibit effective care, fragmented systems of care; the persistent stigma of addiction; and social determinants of health including equity, inclusion and discrimination (McGlynn, 2020). In short, the quality of care for SUD is insufficient with little systematic effort toward continuous improvement. Quality of care should be built into the regulation, financing, and delivery of addiction treatment services, and continuing systems of care (Institute of Medicine, 2001, 2006; World Health Organization & United Nations Office on Drugs and Crime, 2020).

The WHO, UNODC and their partners (e.g., including the Bureau of International Narcotics and Law Enforcement [INL}, International Society of Substance Use Professionals [ISSUP], International Consortium on Quality for the Treatment of Substance Use Disorders [ICQ) and ICUDDR) are promoting significant efforts to improve the quality of SUD treatment globally. The work includes sponsorship of professional development training programs focused on evidence-based practices (i.e., use of medications to treat SUDs and clinical behavioral therapies), development, testing and promulgation of standards for SUD treatment, assessment and support of licensing and certification standards, and the Program for International Quality Assurance in Treatment (PIQAT). PIQAT has support from three international organizations (Colombo Plan, OAS/ CICAD and UNODC) working collaboratively to implement quality improvement for substance use disorders (SUDs) in 28 countries over the next two years.

(Morales, 2022).

This ICUDDR exploratory membership survey examines the extent that curriculum content exposes learners to quality standards and quality improvement strategies that seek to reduce harm and stop and reverse dysfunctional consequences of SUDs. The ICUDDR assessment describes current efforts to teach and support quality improvement training and the use of quality improvement strategies in systems treating patients with drug use disorders. Survey questions are based on primary sources that developed, tested and validated standards and improvement strategies that increase quality (i.e., the ability to deliver what was intended for SUD care) (Institute of Medicine, 2001, 2006; World Health Organization & United Nations Office on Drugs and Crime, 2020).

The International Consortium of Universities for Drug Demand Reduction (ICUDDR) is an organization with 322 graduate and postgraduate study programs around the world addressing substance use disorders through empirical research. Through its partnerships, the consortium supports and shares curricula and experiences to improve teaching and trainings addressing substance use disorders. In addition, ICUDDR encourages its member institutions to share their own education and experiences to improve public health. Additional support for the organization comes from the World Health Organization, European Monitoring Centre for Drugs and Drug

Addiction, United Nations Office of Drugs and Drug Addiction, International Narcotics and Law Enforcement Affairs, and the U.S. Department of State.

## Methods

**Survey development.** Seeking more data on current quality and quality improvement training within its membership of universities providing baccalaureate, master's, post-master's degrees, and certificate programs, ICUDDR implemented a rapid assessment of the integration of topics on quality improvement in the programming focused on treatment for substance use disorders in preparation for its 2023 annual meeting. Data collection began with a pilot version distributed to 11 organizations for pre-testing. The survey was revised based on eight responses and emailed to 322 members on 8 May 2023. Three reminders were sent to potential respondents and data collection closed on 5 July 2023. The analytic data set included 88 respondents.

**Survey items.** Participants entered identifying information (e.g., institution, country and the number of students enrolled in certificate, baccalaureate, masters, and post-masters trainings). Items assessed content on quality improvement, safe care, effective care (based on research), patient-centered care, timely care, efficient care, and equitable care (yes, no). If yes, respondents provided a brief description of the content. The items were based on the *Crossing the Quality Chasm* six dimensions of quality care (care should be safe, effective, patient-centered, timely, efficient, and equitable (Institute of Medicine, 2001) and their extension to behavioral health care (Institute of Medicine, 2006). The six dimensions are foundational and incorporated into the international standards for the treatment of drug use disorders (World Health Organization & United Nations Office on Drugs and Crime, 2020). Additional items assessed the use of methods to understand the patient experience, continuous quality improvement, outcome measurement, tracking and reporting, system change and plans for new content on quality of care and quality improvement strategies.

**Response rate.** Survey links were sent to 322 email addresses for member contacts. Ten addresses were invalid, 85 individuals did not open the email, and three declined to participate in the survey leaving 224 potential respondents (72% of the valid email addresses). Completed (or partially completed) surveys (n = 89) included one duplicate submission (from a respondent who partially completed the initial request and completed a follow-up request) leaving 88 valid responses for an overall completion rate of 39.3%% (88/227). The 88 responses included 59 (67%) that reported one or more learners in a training program.

**Data analysis.** Sums were computed for the counts of enrolled students and trainees. The number of "yes" responses were counted for the items assessing the presence of quality content, the six dimensions of quality, and the six questions on specific quality methods and plans for new content. Percent "yes" responses were calculated based on the number of respondents who reported training students or practitioners and the number who reported that their courses and training addressed specific content. Qualitative analysis examined the brief free-response examples describing the dimensions and methods included in the training materials and courses and summarized the data thematically.

## Results

Usable surveys came from 88 universities located in 38 countries. See summary in Table 1. Two of three respondents (67%, n=59) reported providing training in 39 certificate programs (n=9,856 trainees), 28 baccalaureate programs (n-28,904 students), 34 master's programs (n=2,816 enrolled students), and 26 programs provided post-master's training (n=1,019 individuals). See Table 2.

**Table 1 distribution of respondents by continent**

| Continent of Respondent | N |
|---|---|
| Africa | 31 |
| Asia | 22 |
| Europe | 9 |
| North America | 15 |
| South America | 11 |

**Table 2. Respondents (n=59) with training programs**

| Levels of Education | N | Total students |
|---|---|---|
| Certificate (Diploma), Training or Education Program | 39 | 9856 |
| Baccalaureate Level Program | 28 | 28904 |
| Masters Level Program | 34 | 2816 |
| Post-Masters Professional Level Program | 26 | 1019 |

Within the subset of respondents who reported training students or providers, nearly two of three respondents (63%; %= 37/59) reported that their course work and certificate training addressed quality and quality improvement. Across the six dimensions of quality care, the proportion of the training programs discussing quality care ranged from 78% (effective care, n = 29) to 59% (efficient care, n = 22). See Table 3 summary.

**Table 3. Number and percent training in quality improvement and dimensions of quality care**

| Quality of Care Content | N | Percent of total responses (n=88) | Percent of responses with students (n=59) | Percent of programs that address quality (n=37) |
|---|---|---|---|---|
| Do Programs Address Quality Improvement? | 37 | 42% | 63% | 100% |
| Safe care | 26 | 30% | 44% | 70% |
| Effective care | 29 | 33% | 49% | 78% |
| Patient-centered care | 24 | 27% | 41% | 65% |
| Timely care | 25 | 28% | 42% | 68% |
| Efficient care | 22 | 25% | 37% | 59% |
| Equitable care | 24 | 27% | 41% | 65% |

Programs also reported on methods to address quality and quality improvement. Three of five respondents (59%, n=22) noted training content included patient experience methods and measurement, outcome tracking, and reporting. Fewer respondents reported discussion of theories of continuous improvement (n=18, 49%) or system change (n=16, 43%). Respondents also noted that they intended to add new training content to address quality improvement (n = 29) or quality of care (n=19). See Tables 4 and 5.

**Table 4. Number and percent training in methods of quality improvement**

| Quality Improvement Content | N | Percent of total responses (n=88) | Percent of responses with students (n=59) | Percent of programs that address quality (n=37) |
|---|---|---|---|---|
| Do Programs Address Quality Improvement? | 37 | 42% | 63% | 100% |
| Methods to Understand Patient Experience | 22 | 25% | 37% | 59% |
| Theories of Continuous Quality Improvement Methods | 18 | 20% | 31% | 49% |
| Content on Measurement, Outcome Tracking and Reporting | 22 | 25% | 37% | 59% |
| System, System Change, and Organizational Development Theory | 16 | 18% | 27% | 43% |

**Table 5 Plans for new training on quality and quality improvement**

| Future Plans | N | Percent of total responses (n=88) |
|---|---|---|
| Do you plan to add new content to the curriculum on Quality Care? | 19 | 22% |
| Do you plan to add new content to the curriculum on Quality Improvement Strategies? | 25 | 25% |

**Qualitative analysis of quality dimensions**. A qualitative analysis of the free-response examples respondents provided added detail to the yes/no responses on specific training topics. The number of "yes" responses do not agree with the number of examples because some respondents did not provide an example. A thematic analysis illustrated the kinds of content programs taught. Table 6 extracted and summarized the details of the training provided on the six quality dimensions.

*Safe care.* Under safe care respondents listed evidence-based practices, individualized treatment plans, screening for risks, training in supervision, and supervising student learners. While some text described appropriate content related to safe care (e.g., use of audio or video recording for counselor supervision), other examples addressed safety indirectly and better illustrate other dimensions like patient-centered care (e.g., individualized treatment plans). Potential content that was not listed may also be informative – no methods for conflict de-escalation among patients or between patients and staff were provided as examples of safety training.

*Effective care.* Content examples included use of validated assessment tools, patient placement criteria, evidenced-based, pharmacotherapy, and integrated care for co-occurring mental health disorders. Most of the examples were aligned with using treatment protocols based on research. One university, however, noted they followed the country's required treatment protocol and did not provide documentation that the protocol was evidenced based.

*Patient-centered care.* The examples suggest there is a consensus that care should be based on personalized treatment plans with shared decision making. Counselors are trained to use active listening and Rogerian counseling techniques.

*Timely care.* The concept of timely care appeared to have less consensus. While some systems of care stressed access to emergency care and standards for prompt treatment, others addressed the need to track wait times. At least one respondent complained that access to care was restricted because of an insufficient workforce and economic inequality.

*Efficient care.* Few respondents provided good examples of efficient care (e.g., "service delivery that minimizes use of clinical resources"). An underappreciated facet of efficient care is the need to minimize the use of redundancy in intake assessments. Too many treatment programs have unnecessarily complicated admission processes that include asking the same question multiple times and delays between different stages of the admission process. A facet of efficient care is simplifying intake and record keeping processes.

*Equitable care.* Training content included gender perspectives in treatment, inclusiveness, and translation services. Few examples mentioned methods to examine data to assess the presence of inequities in programs or systems of care. If access to care and outcomes from care are not monitored for equity, inequity may be unnoticed and not addressed.

**Table 6: Examples of training for care that is safe, effective, patient-centered, timely, efficient and equitable**

| Quality of care dimension | Example theme |
|---|---|
| | |
| Safe care | Supervise students |
| | Monitor supervision |
| | Screen and assess for elevated risks |
| | Provide confidential care |
| | Use of evidence-based practices |
| | Individualized treatment plans |
| | |
| Effective care | Use of validated and standardized assessment tools |
| | Integrate care for co-occurring mental health and substance use disorders |
| | Adhere to treatment guidelines |
| | Professional counselors follow treatment protocols |
| | ASAM patient placement criteria |
| | Evidence-based behavioral and pharmacological therapies |
| | |
| Patient-centered care | Personalized treatment plans |
| | Gender, adolescent, and race/ethnicity appropriate care |
| | Develop continuums of care |
| | Shared decision making |
| | WHO person-centered practice |
| | |
| Timely care | Emergency services and standards for prompt care |
| | Expedited intake and same day treatment |
| | Track wait times |
| | |
| Efficient care | Individualized lengths of stay |
| | Staff work at the top of their practice |
| | |
| Equitable care | Individualized care |
| | Assess patient satisfaction |
| | Equal access standards |
| | Non-judgmental care |
| | Example variability in access to care |
| | Culturally appropriate care |
| | Translation services |

**Qualitative analysis of quality improvement methods.** The survey also examined training efforts on teaching methods to assess quality improvement. The examples were abstracted and summarized in Table 7. Methods to understand patient experiences included

active listening, role play, and measures of patient satisfaction. Debriefing patients on their clinical experiences and asking clinic leadership to walk through the intake process, however, were not provided as examples of patient experiences and may be underutilized. Methods mentioned for continuous improvement were specific quality improvement protocols and the use of patient surveys. Use of standardized instruments and evaluation methods were listed as examples of outcome tracking. The use of system change techniques as a facet of quality improvement was limited and suggested the value of system change may be under appreciated. Overall, interest in adding training content on quality of care and new courses was limited.

**Table 7: Examples of training content addressing specific quality methods or content and plans for new content**

| Training content | Example theme |
|---|---|
| | |
| Methods to understand patient-centered experience | Active listening and motivational interviewing |
| | Listen to recovering individuals |
| | Role play |
| | Patient satisfaction and feedback |
| | |
| Continuous improvement methods and theory | Specific quality improvement methods |
| | Patient surveys and outcome evaluation |
| | Data analysis |
| | Enhance clinical supervision |
| | |
| Measurement, outcome tracking and reporting | Use standardized and validated instruments |
| | Apply research evaluation and data collection methods in clinical settings |
| | Define outcome measures |
| | |
| System, system change, organizational theories | Six Sigma and other organizational change strategies |
| | Family systems theories |
| | |
| Planned new content on quality of care | Quality assurance and control processes and methods |
| | Clinical supervision strategies |
| | Drug demand reduction |
| | Key quality standards |
| | |
| Planned new content on quality improvement | Practitioner certification |
| | Course on quality in healthcare settings |
| | Use of Six Sigma and other quality improvement methods |
| | Competence in clinical supervision |

See Appendices A through L for the verbatim text respondents wrote as brief examples.

**Discussion**

Two-thirds of the programs responding to the survey noted they were training students to address treatment services for substance use disorders. This exploratory study of how ICUDDR members address quality of care in their training programs generated a modest and varied response and leaves an impression that many of the programs do not have a clear focus on quality of care. About 60% of the respondents who reported training students or providers (62%) replied that their training programs specifically addressed quality of care. Among those who said yes, however, between 60% and 80% of the programs addressed one or more dimensions of care quality.

Overall, ICUDDR and its members have opportunities to take additional steps to develop and strengthen curriculum that focuses on quality of care standards and quality improvement strategies. The opportunity for further focus on curriculum and other learning about quality standards and improvement strategies raises the question about faculty capacity to develop this content. Little is known at this point about the expertise with quality standards and improvement strategies of faculty in SUD specialty learning programs. Is there need for peer learning and other faculty development activity in this domain?

Finally, the international effort to work with member countries to adopt quality standards and employ strategies to improve quality is dependent on a workforce that is knowledgeable about these topics. Strengthening the understanding of quality standards and improvement strategies in the pipeline of future SUD workforce is critical to the international effort success.

Discussion following the meeting touched on additional facets of quality care. The concept of quality assurance is perhaps better developed and understood as meeting specific accreditation or certification requirements. But it is a distinct and different process than quality improvement. Quality improvement requires systematic measurement of specific outcomes and dimensions of care processes and involves intentional efforts to make incremental gains in the outcome metrics. Questions and comments also addressed the use of name brand quality improvement strategies that have widespread adoption in manufacturing and large hospital settings (e.g., Six Sigma, LEAN). These strategies often require resources and skills that are usually not available in underfinanced drug treatment services. Rather than trying to implement these ambitious methods of quality analysis and improvement, ICUDDR members should focus on simple affordable approaches to the development and monitoring of program performance and outcomes.

**Limitations**. The membership survey was implemented rapidly and suffers from a weak response rate. It was also initiated and completed during Summer in the Northern Hemisphere – a period when many universities have limited operations. Survey development was expedited and not tested in languages other than English (although a Spanish language version was distributed following the initial emailing). Results may have limited generalizability. A more comprehensive preparation and implementation process may improve response rates and permit stronger inferences. Assessment of the quality of prevention services was not addressed in the survey.

**Next Steps.** ICUDDR is well positioned to work with its membership and help broaden the understanding of how to address quality and quality improvement in academic and clinical settings. A number of respondents specifically asked ICUDDR to provide curricula and training to help them sharpen their focus on quality of care. Before recommending a curriculum outline, however, training programs should ask, “What do learners need to know about quality standards and quality improvement strategies?” to guide curricular development.

Six learning objectives may serve as a starting point for the discussion.

- Understand the patient’s experience with seeking, engaging in and sustaining treatment and recovery.

- Know the basic evidence based clinical, pharmacological, social support, and environmental interventions to reduce harm, prevent, treat, and sustain recovery from, SUD.
- Understand the impact of difference (e.g., racial, cultural, ability, gender, sexual orientation, economic status) in system response to patient SUD needs.
- Understand the impact that intervention system design and accompanying policies, practices, and regulations have on quality of care delivered.
- Understand the role of measuring, tracking and reporting results of Interventions.
- Understand the methods and capacity to continuously make and evaluate system changes aimed at improving intervention results.

To support members, ICUDDR should assess the disappointing survey response rate (i.e. programs had no content to report? Study timing? Insufficient time for preparation and response?) The reasons may be central to the strategy that ICUDDR shapes for follow up. ICUDDR also needs to identify and understand the needs of International Stakeholders involved in promulgating quality standards and quality improvement strategies to engage member organizations in development of content focused on quality standards and improvement strategies. With that understanding, it is possible to form a member quality Content Curriculum work group charged to:

- *Scan academic environment for model curricula*
- *Develop, define, refine appropriate learning objectives*
- *Identify needs for faculty development.*

Finally, after 2-3 years of focused work this study might be replicated to identify progress among member organizations.

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**Appendices listing verbatim examples**

**ICUDDR Quality of care survey**
**Appendices for Qualitative responses**

**Appendix A: Examples of safety of care from training curriculum**

| | |
|---|---|
| 12 | DetecciÃ³n temprana de casos en poblaciÃ³n universitaria Early detection of cases in the university population |
| 21 | UTC protocols |
| 24 | Proper screening and assessment prior to referral crisis management: client's suicide and counselor's well being. |
| 27 | We have systematic of quality care. We have principle of the program, quality assessors team and head of the program. |
| 28 | It may be included in many lessons, as in the example provided about double checking med admin., but is not specifically mentioned in the curriculum |
| 29 | SUPERVISOR IS AVAILABLE AND COORDINATOR IS ALSO SUPERVISING AND MONITORING |
| 32 | Medical curriculum contains chapters on the care quality management including topics such as patients' and careers' safety. |
| 37 | Care is given in the environment by professionals in accordance with health standards |
| 38 | We plan intervention gap reduction in addictions. We have a monitor technological system to address this goal. |
| 39 | Physical, emotional safety Confidentiality |
| 42 | Assignment: Practice Dimension IV: Service Coordination in TAP 21 on pages 80 - 85. For this assignment create a document for your client and the clientâ€™s significant other that provides information listed below: Establish accurate treatment and recovery expectations with the client and involved significant others, including but not limited to: The nature of services Program goals Program procedures Rules regarding client conduct The schedule of treatment activities Costs of treatment Factors affecting duration of care Clientsâ€™ rights and responsibilities The effect of treatment and recovery on significant others Also, summarize the client's personal and cultural background, treatment plan, current and or past recovery progress, and any problems that may have or may in the future inhibit progress to recovery. |
| 55 | We are updating the curriculum time by time |
| 56 | Using the five rights in medicine administration |
| 57 | Informed consent, evidence based practice using guidelines by ministry of health |
| 66 | Screening, diagnose and best practice for different health necessities |
| 68 | Not introducing methods of using drugs or introducing new drugs in prevention activities. |
| 73 | Case management |
| 75 | The program includes evidence-based Prevention and Treatment Courses, where students are also trained in their evaluation. They also do practices, where they apply the evidence-based programs and are supervised |

| | |
|---|---|
| 77 | Psychiatry and substance sheet are took 3 times by psychiatrist, psychologist and social worker, HCV and HOV treatment is provided In the same setting |
| 79 | Evidence-based practices, treatment quality management |
| 86 | How to report patient safety events and morbidity & mortality conferences |
| 90 | Our prevention programs are socially and culturally adapted and have evidence of efficacy. |
| 91 | Pragmatics of medication assisted therapies |

**Appendix B: Examples of effective care from training curriculum**

| Line # | Effective care example |
|---|---|
| 6 | Rehabilitation |
| 16 | EvaluaciÃ³n de las intervenciones para la atenciÃ³n del consumo de sustancias Evaluation of interventions for the care of substance use |
| 21 | Assessment through standard test |
| 24 | We follow the Dangerous Drugs Board client flow guidelines. |
| 25 | Recognizing the importance of cultural competence and strategies to meet the needs of diverse populations in assessment and treatment planning |
| 27 | Comprehensive care for SUD and behavioral addiction |
| 28 | All teachers are required to provide guidelines of care based on evidence-based research, efficacy and effectiveness |
| 32 | Curriculum contains brief lessons on evidence-based medicine, including the process of development, implementation of clinical care protocols and it's monitoring. |
| 37 | Drug abuse prevention program. Drug user treatment program. |
| 38 | Care is provided by applied research protocols and trained professionals from the Masters program. |
| 39 | Outcome and improvement, evidence-based practice |
| 42 | ASAM Criteria is used in Case Management. We use the newest ASAM Criteria Assessment Interview Guide that is Fillable |
| 55 | We encourage the teachers to be specific and to make a consultation for the effectiveness |
| 56 | Psychopharmacology |
| 57 | We try to apply evidence based treatment |
| 66 | Screening and brief intervention, CBT, harm reduction |
| 68 | in our prevention activities we only teach evidence based practices and approaches. |
| 73 | CBT, MI, 12steps, etc. |
| 75 | Students are trained to design, plan, and implement evidence-based programs. They are educated and trained to adopt and adapt evidence-based programs and carry out pilot tests to evaluate them and see if they have been correctly adapted and if they work in their contexts |
| 77 | Characteristics of effective treatment Evidence based practice in addiction Pharmacology of SUD |
| 79 | Professionals trained in evidence-based practices, protocols for administration of assessment instruments, medication delivery, etc. |
| 86 | Evidence based treatments for OUD, MUD, nicotine use disorder, etc. |
| 90 | Our prevention interventions are closely follow-up by a monitoring team composed of trained professionals and experts in the field. |
| 91 | treatment of patients with co-occurring mental health and SUDs, treatment in criminal justice environment |

**Appendix C: Examples of patient-centered care from training curriculum**

| Line # | Patient-centered care example |
|---|---|
| 6 | personalized care |
| 12 | Reciben atenciÃ³n psicolÃ³gica profesional en casos detectados. I receive professional psychological attention in detected cases. |
| 16 | |
| 21 | Special groups for specific populations |
| 24 | Recognition of various treatment setting in accordance to the client's needs. |
| 25 | Involve patients in treatment decisions and collaborate on their personalized treatment plans and identify strategies to enhance patient engagement, empowerment, and autonomy in the treatment process |
| 27 | We have clinical practice guideline |
| 28 | The intervention protocols suggested for all dependences include Individual Treatment Plans patient-centered, whose goals and methods must be specified, accepted, and signed by the patient, the caring team, and sometimes also the family when existing and cooperating. |
| 32 | Students are educated on provision of care on four levels from primary (mainly outpatient) to fourthiary (advanced specialized). |
| 37 | The continuum of care for addiction patients. |
| 38 | We give care centered on patients in the community, primary, and secondary levels. |
| 39 | Based patient preference, respect for patients need demand and dignity |
| 42 | Assignment - Create a Relapse Prevention Plan As those in recovery know, a relapse is never out of the realm of possibilityâ€“no matter how long youâ€™ve been sober. Because of that, it is vital to have a plan for how to avoid relapse and what to do if it does happen to you. I have seen those in recovery for 6-10 years end up in use again due to some of the circumstances we are hoping to plan for now. This plan is often referred to as a relapse prevention plan and I like to think of it more as a recovery plan. Planning for our life long recovery from whatever it is we need to recover from. Learning how to make a relapse prevention plan and going through the process of creating a relapse prevention plan (recovery plan) could be the difference between longer periods of sobriety and repeated relapse. What Is a Relapse Prevention Plan? A relapse prevention plan is a vital tool for anyone in recovery or for anyone who is wanting to make changes in current life habits. Having a plan helps you recognize your own personal behaviors that may point to relapse in the future. It also outlines ways to combat those behaviors and get back on track. When we fail to plan, we plan to fail! Most often, a relapse prevention plan is a written document a person creates with their treatment team or support system and shares with their support group. The plan offers a course of action for responding to triggers and cravings. During the weeks of this quarter we have been working on specific assignments at the end of each chapter. Their was a method to this madness, now we have some information that can be used to create a relapse plan. It can sometimes to take weeks to think of what we really feel, what we need, and how we might get there. When working with clients be patient as they work to figure out where they are, who they were and who they now want to become. Instructions: Fillable PDF for class 2023.pdf This form is a fillable PDF. You can click the link, then download the file and open with Adobe Acrobat Reader DC. If |

| | |
|---|---|
| | you do not have Reader then you can go to the link below and then submit the document to open it as a Fillable PDF. Adobe Open a PDF Or, you can use the free download for Adobe Acrobat Reader Adobe PDF ReaderLinks to an external site. Part 1: I found a really good relapse prevention plan document from Addiction Outreach Clinic and have provided it in the above link. If you can download the PDF and fill it in then go ahead, if you cannot then use the headings to create your relapse prevention plan. Part 2: Once you have created the plan then please write a 2-page paper about the process of relapse and recovery you experienced while taking this class and writing this plan. If you are working on a plan for your client then discuss how this might feel for a client as you work with a client through these steps. Submission Instructions: This is a two part assignment. 50 points for the relapse prevention plan and 50 points for the 2 page write up. Total points for this assignment is 100. |
| 55 | We refer to the authority concerned |
| 56 | Our counselling practicum is centred on Carl Rogers' client centred approach; which informs the patient centred care approach |
| 57 | We identify the problems of patients and explain it to patients and working together with patients to prioritize and overcome the problems |
| 66 | Use patterns and different interventions |
| 68 | |
| 73 | Rogers' person-centered therapy Patient Placement Criteria |
| 75 | As the training program is monitored by the Ministries of Health and Education, there are trainings for the authorization of services and the standard includes patient-centered care to ensure the quality of care and prevent iatrogenic and violation of human rights. |
| 77 | Relapse prevention programs Matrix outpatients program |
| 79 | The person-centered practice from the world health organization is established in the graduate profile. |
| 86 | shared decision making |
| 90 | |
| 91 | Multiple motivational interviewing parts of different curricula |

**Appendix D: Examples of timely care from training curriculum**

| Line # | Timely care example |
|---|---|
| 6 | referral |
| 12 | Se brinda a los alumnos informaciÃ³n sobre un convenio que se tiene con una organizaciÃ³n de desintoxicaciÃ³n y rehabilitaciÃ³n para alumnos universitarios y familiars. Students are provided with information about an agreement that they have with a detoxification and rehabilitation organization for university students and their families. |
| 16 | Que el usuario tenga nivel de riesgo bajo o moderado para recibir atenciÃ³n That the user has a low or moderate level of risk to receive care |
| 21 | Follow up programs upon egress. |
| 24 | |
| 25 | strategies to streamline the intake and admission process for expedited care and ethical considerations and potential barriers associated with providing timely care |
| 27 | We have emergency and reguler care. And it is continuum |
| 28 | Timely care is actively promoted, far from ancient practices of having patients on waiting lists for a long time to "test their motivation". Unfortunately, waiting lists still exist because of insufficient care available, except for emergencies. |
| 32 | Clinical care standards specify timing for care provison based on patient's needs |
| 37 | The care of drug-using patients is done on an outpatient basis at the addiction care and support center (Luigi variara), and also in internal hospitalization |
| 38 | We technologically monitor timely care. |
| 39 | Patient needs prompt care |
| 42 | We address that timely care is not available at most agencies due to the limited number of treatment counselors. Also, due to insurance, private pay as opposed to insurance pay, or state pay. Level of how persons are cared for and how they manage their recovery is sadly based on income and insurance levels. |
| 55 | We make it to be students centered |
| 56 | |
| 57 | Assessment followed by treatment on the same day |
| 66 | |
| 68 | |
| 73 | need-focused therapy |
| 75 | This is part of the training in the standards that treatment programs must have |
| 77 | Emergency phone calls with the team Service availability 24 hours Detoxification 24 hours Emergency in addiction |
| 79 | Timely care according to the levels of risk and need in drug prevention and treatment. |
| 86 | on-demand access to treatment |
| 90 | Our prevention programs are adequate for the age of the intervention population. |
| 91 | Brief Interventions in Primary Health care settings |

**Appendix E: Examples of efficient care from training curriculum**

| Line # | Efficient care example |
|---|---|
| 6 | Consultation length |
| 12 | |
| 16 | |
| 21 | levels of care from OIP and up |
| 24 | Need for multidisciplinary approach and utilization of case managers. |
| 25 | Determining Appropriate Lengths of Stay Strategies for Treatment Efficiency Ongoing Monitoring and Aftercare Planning |
| 27 | We have indicators to assess the quality and effectiveness of care |
| 28 | As an example, research shows that the variable more clearly associated with Therapeutic Communities' efficacy is a more extended stay. In this case, conversely to others, longer stays may be more effective because shorter ones don't work |
| 29 | BASED ON CLIENTS NEED AND LEVEL OF CARE NEEDED AND IT IS INDIVIDUALIED |
| 32 | |
| 37 | The stay for psychological and medical care varies depending on whether the treatment is intensive or short. The duration varies between 2 weeks and 6 months. according to withdrawal or substitution treatment |
| 38 | We address the screening of risk levels. |
| 39 | Service delivery in a manner where resources utilisation is at max |
| 42 | Medication Assisted Treatment (MAT) has assignments related to this. I don't have access to all course materials as the instructors teach and retain that information. I do have access to all syllabi to review. |
| 55 | We utilized it for the sake of our success in the area of achievement |
| 56 | |
| 57 | |
| 66 | |
| 68 | We always talk about improving our programs using evidence--monitoring and evaluation techniques are taught. |
| 73 | Patient Placement Criteria case management |
| 75 | Not only efficient, but safe, following the guidelines for the care of patients with SUD of the Ministry of Health |
| 77 | Yes the curriculum teaches the various treatment programs according to PPP ( 1 month till 1 year ) |
| 79 | Evidence-based practice and implementation science is within the training of professionals. |
| 86 | |
| 90 | |
| 91 | Treatment matching |

**Appendix F: Examples of equitable care from training curriculum**

| Line # | Equitable care example |
|---|---|
| 6 | inclusivity |
| 12 | |
| 16 | todos los usuarios tienen la facilidad de accesar a la intervenciÃ³n all users have easy access to the intervention |
| 21 | Gender perspectives in treatment |
| 24 | |
| 25 | Language Access Barriers  Strategies for Enhancing Language Access  Working with Interpreters  Cultural Sensitivity and Competence |
| 27 | |
| 28 | Translation services for migrants are mentioned. Lowering barriers for gender-related questions, as well as for sexual orientation or age reasons (promoting better treatment for the elderly) receive specific sessions. |
| 29 | each client comes to us have free access to care and we provide menu of options and if client wants to get services then they are welcome, out clinical and administrative staff facilitate them. |
| 32 | This is briefly mentioned in the addictions field as equitable care is an overarching princliple of the public health care system and everyone is guarnateed qual access to health care. |
| 37 | All drug-using patients benefit from the same care, but the care is very expensive and sometimes not available to everyone. |
| 38 | |
| 39 | Implementing quality health and removing biasis. |
| 42 | As noted before we address that all men are not created equal and that justice is not blind. Money is a huge factor in equitable care. However, we are working on that. |
| 55 | We preserve our communityâ€™s documents |
| 56 | Principles of counselling;concepts like empathy, warmth, unconditional positive regard, non-judgemental attitude help in promoting equitable care |
| 57 | |
| 66 | Race, gender and territory oriented |
| 68 | |
| 73 | Non-discrimination |
| 75 | Techniques for users with disabilities are reviewed with students |
| 77 | |
| 79 | Understanding equitable care on the foundation of evidence-based practice, thus care for all on the basis of evidence-based practice and not just guaranteeing access without quality criteria. |
| 86 | Translation services, epidemiology and treatment outcomes in different patient populations |
| 90 | All persons in the target population receive the universal interventions without regard for their risk level. |
| 91 | LGBT treatment issues |

**Appendix G: Methods to understand patient experiences**

| | |
|---|---|
| 6 | applies sick role model |
| 21 | Motivational interviewing |
| 24 | Various counseling skills, involving active listening, recognition of the reasons for drug use, etc. |
| 25 | Methods to Gain Insights into the Patient Perspective  Assuming the Patient Role in Simulated Scenarios  Incorporating Patient Feedback into Treatment Planning Effective Communication and Collaboration |
| 27 | We include the topic in addiction psychiatric interview model |
| 29 | they are provided different sessions, interactive session, presentation, activities and discussions |
| 32 | Patient satisfaction survey is one of the topics in the care quality management course. |
| 37 | We have training in psychological care, in basic skills in counselling, the helping relationship, psychoeducation, group therapy, which allows us to understand the patient |
| 39 | Perception, interaction and satisfaction |
| 42 | Students are asked to review their own biases to understand how their attitudes and behaviors may impact the clients.  Our courses are required to be Accessible to all students and we teach about multiple cultural |
| 61 | ESCUCHA ACTIVA (Active Listening) |
| 66 | Patient centered care, participatory approach |
| 73 | Listening to the experience of recovery  Qualitative research methods |
| 75 | Therapy training includes active listening and motivational style, among others |
| 77 | Working groups, role plays, case studies |
| 79 | Specifically user satisfaction surveys in prevention and treatment programs. |
| 91 | Client treatment satisfaction assessment |

**Appendix H: Continuous Improvement Methods**

| | |
|---|---|
| 6 | Six sigma |
| 12 | Seminarios en lÃ-nea relacionados con diferentes aspectos de las adicciones y los Ã¡mbitos en los que se presentan. Individual, familiar, escolar. Online seminars related to different aspects of addictions and the fields in which they are presented. Individual, family, school. |
| 25 | Introduction to the Toyota Performance System (TPS)  Identifying Improvement Opportunities  Implementing CQI Initiatives  Creating a Culture of Continuous Improvement |
| 27 | We develop method improvement with using questionnaires |
| 29 | we are using theory of change for the process and outcome evaluation |
| 32 | The medical curriculum contains this topic but it is not specific to the addiction medicine. |
| 37 | The motivational method, acceptance and commitment, evidence-based practice, cognitive behavioral methods. |
| 39 | Chronic care model and patient care model |
| 42 | In Clinical Supervision we discuss the issues of how the counselor can improve, how to monitor the quality of an intervention and what is needed to make changes. |
| 55 | By counseling |
| 68 | We teach about monitoring and evaluation using quantitative and qualitative measures, pre-and post testing, and using focus groups to test our messages before putting into audience. |
| 79 | It has a complete course on the subject |
| 90 | We include methods for close monitoring and subsequent technical assistance. |

**Appendix I: Content on measurement, outcome tracking, and reporting**

| | |
|---|---|
| 6 | validation and feedback method |
| 9 | Used service quality assessment tools |
| 21 | Motivational interviewing |
| 16 | MetodologÃ-a de la investigaciÃ³n (Research methods) |
| 21 | Follow up protocols and continuation of care instruction |
| 25 | Develop knowledge and skills in establishing operational definitions for key treatment outcomes. Learn techniques for validating and ensuring the reliability of measurement tools. Explore strategies for tracking and reporting treatment outcomes effectively. Understand the ethical considerations and challenges in measurement and reporting. |
| 27 | Using instruments to assess the the outcome |
| 28 | Sessions on epidemiological reporting, process and outcome evaluation through indexes and questionnaires (e.g., ASI, Maudsley Inventory), are included |
| 32 | Addiction Severity Index |
| 37 | The research is carried out by students from the University of XYZ and the writing of the articles is published. The data is kept at the national committee for the fight against drugs. |
| 39 | That can be translated into health that is basically measure ment of an outcome |
| 55 | By assignment |
| 66 | Measures and instruments |
| 68 | We teach about monitoring and evaluation using quantitative and qualitative measures, pre-and post testing, and using focus groups to test our messages |
| 73 | Quantitative and qualitative research |
| 75 | The importance of systematization and evaluation is reviewed with the students, as well as that each user has their own Clinical History. |
| 77 | How to document behaviors , patient file content , how to make a client plan, vacations reports , sessions reports, multi disciplinary team assessment Od patients performance |
| 79 | We have subjects on measuring and reporting results, in report writing only in the final project, no clinical reporting structure. |
| 90 | We use sequential evaluation of short, mid, and long-term evaluations. |
| 91 | PhD program on outcome evaluation studies |

**Appendix J: Content on system change and organizational development**

| | |
|---|---|
| 6 | Theory of change |
| 25 | Theories and Models of System Change and Organizational Development Factors Influencing Successful System Change  Collaboration and Leadership in System Change |
| 37 | Etiological theories, cognitive theories, social theories, theories of reasoned action, |
| 55 | Theory of uncertainty |
| 68 | We teach prevention campaign development, evaluation, and quality improvement using evaluative strategies and program re-development. |
| 73 | Community welfare theory |
| 77 | Family systems, wheel of change, psychological theories explaining addiction and change |
| 79 | Yes, we have it in the subject as leadership. |
| 90 | For the training of prevention teams, they are given content on the theories of change in the organization. |
| 91 | Organizational change theory and practice |

**Appendix K: Plan for new content on quality of care**

| | |
|---|---|
| 6 | Evaluation studies |
| 16 | Evaluar aceptabilidad, factibilidad Assess acceptability, feasibility |
| 21 | Quality assurance |
| 27 | The objective and subjective measurement of quality care |
| 29 | so far we don't have any curriculum on quality of care, but we would request ICUDDR to facilitate us in this area. |
| 34 | Rehabilitation and taking care of addiction and substance use disorder. |
| 37 | We must take into account our social environment. We must add the local treatment, |
| 43 | Module: Ensuring Quality Care in Healthcare Settings Objective: To educate students on the principles and practices of providing high-quality care in healthcare settings. Topics Covered: Introduction to Quality Care Definition of quality care Importance of quality care in improving patient outcomes Key Elements of Quality Care Patient safety and error prevention Effective communication and teamwork Evidence-based practice Patient-centered care Quality Improvement Methods Overview of quality improvement frameworks (e.g., Plan-Do-Study-Act cycle) Data collection and analysis techniques Implementing and monitoring quality improvement initiatives Patient Satisfaction and Experience Understanding patient satisfaction and its impact on quality care Strategies for improving patient experience Engaging patients in their care and decision-making process Ethical Considerations in Quality Care Ethical principles in healthcare Balancing patient autonomy and quality care Addressing ethical challenges in quality improvement efforts Regulatory and Accreditation Standards Overview of healthcare regulatory bodies and accreditation organizations Compliance with standards and regulations for quality care Continuous quality monitoring and audits Leadership and Culture of Quality Care Role of leadership in fostering a culture of quality care Building a culture of safety and accountability Empowering healthcare professionals for quality improvement |
| 56 | Plans are advanced to develop a new degree program for psychiatric mental health nursing; a new course on introduction to addiction disorders is proposed and will integrate this component. in addition, the component can still be included under the Psychiatric Nursing Leadership course. |
| 59 | Quality assurance content that will ensure uniformity and adherence to standards and guidelines. |
| 65 | Quality control guidelines for treatment and prevention of substance use disorders |
| 75 | In the Public Health and Drug Dependency module, issues related to policies will be included and the importance that these are based on evidence and that professionals, once graduated, influence them. |
| 77 | Measures to improve and assure the continuous development of the teams especially recovering Counselors |
| 79 | Have the content of quality assurance in prevention, treatment and recovery. |
| 80 | We are planning to introduce new BS program in psychology and trainings on drug demand reduction |
| 88 | We plan to develop a course on the Key Quality Standards, its measurement and how to design Plans for Improvement |

•

**Appendix L: Plans for new content on quality improvement strategies**

| | |
|---|---|
| 6 | Student tests |
| 12 | cursos de actualizaciÃ³n de los terapeutas que llevan a cabo el tratamiento de los alumnos universitarios refresher courses for therapists who treat university students |
| 16 | EvaluaciÃ³n de la calidad quality assessment |
| 21 | competence in clinical supervision |
| 25 | Lean Six Sigma: Students learn Lean Six Sigma methodologies to streamline processes, reduce waste, and improve efficiency in addiction treatment programs. They utilize tools such as value stream mapping, process flow analysis, and waste reduction techniques to identify areas for improvement and implement data-driven solutions. Patient Feedback and Surveys: Students understand the importance of gathering patient feedback to drive quality improvement efforts. They learn techniques for collecting and analyzing patient satisfaction data through surveys, focus groups, or interviews. This information is used to identify areas of improvement and make patient-centered changes in addiction treatment practices. |
| 27 | the assessment of quality improvement |
| 29 | we need guidance from ICUDDR on this |
| 34 | Improvements of steps for addiction control |
| 37 | We need support to reduce the cost of care and make it accessible to all. |
| 43 | Module: Ensuring Quality Care in Healthcare Settings Objective: To educate students on the principles and practices of providing high-quality care in healthcare settings. Topics Covered: Introduction to Quality Care Definition of quality care Importance of quality care in improving patient outcomes Key Elements of Quality Care Patient safety and error prevention Effective communication and teamwork Evidence-based practice Patient-centered care Quality Improvement Methods Overview of quality improvement frameworks (e.g., Plan-Do-Study-Act cycle) Data collection and analysis techniques Implementing and monitoring quality improvement initiatives Patient Satisfaction and Experience Understanding patient satisfaction and its impact on quality care Strategies for improving patient experience Engaging patients in their care and decision-making process Ethical Considerations in Quality Care Ethical principles in healthcare Balancing patient autonomy and quality care Addressing ethical challenges in quality improvement efforts Regulatory and Accreditation Standards Overview of healthcare regulatory bodies and accreditation organizations Compliance with standards and regulations for quality care Continuous quality monitoring and audits Leadership and Culture of Quality Care Role of leadership in fostering a culture of quality care Building a culture of safety and accountability Empowering healthcare professionals for quality improvement |
| 47 | QI Implementation Science |
| 55 | The one that will suit the current situation |
| 59 | Drug treatment program |
| 65 | Training program |
| 75 | With this questionnaire they have aroused our interest in making adjustments to the program and more explicitly including the issue of quality assurance. |

| | |
|---|---|
| 79 | Have the content of quality assurance in prevention, treatment and recovery. |
| 80 | We are planning to introduce quality Improvement diploma |
| 87 | Not elaborated yet |
| 88 | How to establish priorities, process of change, culture of quality, who should be involve, network building for sustainability between academia and and public sector |
| 90 | Certification of practitioners (individual). Program quality accreditation (institutional) |
| 91 | Quality Improvement on Criminal Justice environments |