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Accountability for Safe, Quality Care in Bed-Based Addiction Treatment

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Executive Summary

Purpose

This report aims to provide policy makers with an expanded range of regulatory and voluntary approaches to advance an accountable, accessible and inclusive continuum of safe, quality substance use and addiction services and supports across Canada.

Overview

- **Addiction** or substance use disorder is a "medical condition that requires treatment from health care providers" (Health Canada, 2021). Community bed-based addiction treatment is provided by a mix of public and private service operators in non-hospital, bed-based (also called "residential") settings that provide overnight accommodation during treatment.
- **Accountability** is broadly defined as being held answerable to someone to achieve specific objectives. An accountability approach answers the key questions of **who** should be held accountable, **by whom**, for **what,** and with what **consequences** and **force** if requirements are not met.
- People seeking addiction treatment are vulnerable to harms from unsafe, poor-quality clinical practices, and service operators often have little or no accountability if a client experiences harms. Service users and policy makers have expressed **concerns about care safety and quality and lack of accountability** in bed-based addiction treatment.
- Policy makers recognize the importance of improving the safety and quality of bed-based addiction treatment but find few appropriate and sufficient accountability strategies for Canada's mix of public and private service operators and their largely unregulated clinicians.
- The Canadian Centre on Substance Use and Addiction (CCSA) responded to policy makers' concerns with evidence-based resources and tools. The Government of Canada has also launched work to develop national standards for services related to substance use and mental health (Health Canada, 2022). The effectiveness of these and other tools and standards would be increased by robust accountability approaches.
- Policy makers need a greater range of accountability strategies to support improvements in bed-based addiction treatment and recovery services.

A jurisdictional scan of Canadian and international accountability approaches in bed-based addiction treatment found that a limited range of accountability strategies are used to ensure care safety and quality. The main policy goal is clinical accountability for care safety and quality, targeting service operators and clinicians, most often using policy instruments supporting professional stewardship (e.g., clinical standards) and consumer education. The consequences and force used are a mix of regulatory and non-regulatory, or voluntary, strategies in the United States and Canada, and regulatory strategies in Europe and New Zealand. These findings and the limited literature on accountability approaches in addiction treatment highlight a need for more information and resources about robust accountability approaches.

In this report, an accountability conceptual framework drawn from a literature review of best practices is proposed to support developing robust accountability approaches to achieve policy goals. A robust accountability approach consists of suites of complementary regulatory and voluntary

strategies that are tailored to the jurisdiction. It is achieved through mixing and matching policy instruments, targets, forces and consequences. Considerations to balance achieving compliance and minimizing negative market impact are provided. Considerations include risk, compliance, government ideology and evaluation strategies. Tools to support implementing the framework are also provided.

Recommendations

- This report recommends actions for jurisdictions to assess the scope and risks of harm in bed-based addiction treatment services and implement approaches that make service operators more accountable for providing safe, quality care.
- Recommendations are also provided for pan-Canadian collaboration between jurisdictions and CCSA to pilot and evaluate the proposed accountability conceptual framework; develop tools and resources to improve accountability in bed-based addiction treatment; and advance an accountable, accessible and inclusive continuum of safe, quality substance use and addiction services and supports across Canada.

Introduction

This report provides policy makers with an expanded range of regulatory and voluntary accountability strategies for bed-based addiction treatment. These strategies aim to improve care safety and quality and advance an accountable, accessible and inclusive continuum of safe, quality substance use and addiction services and supports across Canada.

People seeking bed-based addiction treatment have expressed concerns about the safety and quality of care. Because there are no consistent clinical standards and few addiction-specific clinician qualification requirements, they have little assurance of safe, quality care. They also find huge variation in treatment cost and access, with the most accessible treatment often being the most expensive and offered by service operators that have the least accountability for providing safe, quality care. Weak accountability systems mean there is little recourse if service users experience harms or have concerns about care safety and quality, and there are few consequences for service operators or clinicians responsible for the harms.

Policy makers have also expressed concerns about inconsistent care safety and quality in bed-based addiction treatment. Although policy makers recognize the importance of improving the safety and quality of care, there is minimal literature on this topic and few accountability strategies, which are often found to be inappropriate or insufficient.

Concerns about accountability for care safety and quality were further heightened during the pandemic. The tragic consequences of poor-quality care for vulnerable populations were vividly illustrated in high rates of illness and deaths in continuing and long-term care facilities, for example, which had limited accountability for care safety and quality. The lack of accountability for unsafe or poor-quality bed-based addiction treatment services poses similar risks to people seeking addiction treatment and recovery.

Background

Addiction or substance use disorder is a "medical condition that requires treatment from health care providers" (Health Canada, 2021). Provincial and territorial governments provide varying levels of public funding for addiction treatment, which unlike many health services, is not required to be funded under the *Canada Health Act*. This funding supports the current system, which consists of a mix of public and private service operators offering addiction treatment in non-hospital, bed-based (also called "residential") settings that provide overnight accommodation for 30 to 90 days of treatment.

Residential (bed-based) treatment refers to programs in which overnight accommodation is provided for the purpose of substance use or gambling addiction treatment. It does not include programs delivered in settings such as youth shelters, shelters for people experiencing homelessness, prison facilities or mental health facilities where the primary purpose of residence is to address needs such as housing, public safety or mental health (McQuaid et al., 2017).

Accountability is broadly defined as being held answerable to someone to achieve a specific objective. It identifies who should be held accountable, by whom, for what, and with what consequences and force if the objective is not met (Deber, 2014a).

Across Canada, there are no consistent clinical standards and few clinician qualification requirements specific to providing addiction treatment services. Also, most bed-based addiction treatment service operators have little or no accountability to provide safe, quality care (McQuaid et al., 2017). Weak accountability contributes to limited implementation of best practices, such as using medication-assisted therapy to treat opioid addictions rather than abstinence-based treatments that increase the likelihood of fatal opioid poisoning during recovery (Frank & Shim, 2022). It also supports inconsistent care safety and quality, and results in service users having little recourse if they experience harms.

Establishing strong accountability is further challenged by the mix of service operator types that may experience different impacts from, and respond differently to, the same accountability strategy. The mix of bed-based addiction treatment service operators includes operators that are publicly operated and publicly funded, operators that are privately operated (for-profit or non-profit) with full or partial public funding (through contracts or grants), and operators that are privately operated (for-profit and non-profit) and privately funded (e.g., client fees, donations).

Publicly operated service operators usually have some accountability for care safety and quality through legislative requirements. For example, treatment programs offered by a health authority are regulated, to some degree, under a health authority act. Publicly operated service operators offer the least expensive programs; however, long wait times often significantly limit access to them.

Some privately operated service operators (for-profit and non-profit) access public funds through contracts. This funding moderates treatment costs, although additional fees may be charged. Government contract requirements may hold contracted service operators accountable for care safety and quality; however, interviewed policy makers report that most contracts require accountability for finances, not care safety and quality. Access to these lower-cost services is often restricted to specific populations or limited by available funding, and there are frequently long wait times for services.

Finally, there is a large group of privately operated and privately funded (for-profit and non-profit) bed-based addiction treatment service operators. Although formal data is not available, anecdotal evidence suggests that this may be the largest group of bed-based addiction treatment service

operators in Canada. The accountability of these service operators for safe, quality care is most often voluntary, as meeting government or accreditation body requirements is optional in most Canadian jurisdictions. Their treatment programs are publicly advertised and often the most accessible programs with short or no wait times. These programs also often cost people seeking treatment thousands to tens of thousands of dollars, which may not be fully or even partially reimbursed through employer or private insurance.

In this landscape, people living in Canada who are seeking treatment most often have no way to assess or be assured of care safety and quality. Desperate individuals and families default to accessing treatment that is the most accessible. This care is often the most expensive and from service operators with the least accountability for safe, quality care. Should those receiving care experience harms from these service operators or unregulated clinicians, they have little to no recourse, and there are few consequences for service operators or clinicians responsible for the harms.

Policy Context in Canada

Policy makers have expressed concerns about inconsistent care safety and quality in bed-based addiction treatment. Reported concerns include perceived poor-quality and ineffective treatment, unsafe practices (e.g., unsecured medications or intoxicants, abstinence-based treatment for opioid disorders), and lack of consumer protections (e.g., no service user reimbursement for incomplete or unsatisfactory treatment).

The Canadian Centre on Substance Use and Addiction (CCSA) has responded to policy makers' concerns by providing evidence-based resources and tools to support improvements in safety and quality in community bed-based addiction treatment across Canada, such as the *Finding Quality Addiction Care in Canada: Drug and Alcohol Treatment Guide* (2017; currently being updated). The Government of Canada is also responding with a collaboration of the Standards Council of Canada and other partners to develop national standards for services related to substance use and mental health services to ensure that "Canadians are able to receive high-quality, culturally appropriate care regardless of where they live" (Health Canada, 2022).

Although policy makers are working to establish pan-Canadian clinical standards, there has been only limited discussion about accountability for implementing and adhering to standards, which is critical to improve care safety and quality across service operators.

Policy makers considering accountability for meeting care safety and quality standards most often consider regulatory policy instruments (Hepburn, 2005; Treasury Board of Canada Secretariat, 2007). However, regulatory instruments may not be acceptable to government decision makers who support minimizing regulation. Alternatively, policy makers may consider voluntary compliance, risking minimal participation and no consistent improvement in care safety and quality. The limited literature on accountability approaches (Deber, 2014a; Mark et al., 2020; Byrkjeflot & Vrangbaek, 2016; British Columbia Centre on Substance Use, 2020) demonstrates and exacerbates policy makers' limited tools to address accountability. As a result, policy makers recognize the importance of improving care safety and quality in bed-based addiction treatment but find few accountability strategies. The strategies they do find are often inappropriate or insufficient to support this goal.

Concerns about accountability for care safety and quality were further heightened during the pandemic. The tragic consequences of poor-quality care for vulnerable populations were vividly illustrated by high rates of illness and deaths in continuing and long-term care facilities, for example, which had limited accountability for care safety and quality. Like long-term care, bed-based addiction treatment is offered by a mix of publicly and privately operated and funded service operators caring for a vulnerable population. These operators have limited accountability for harms experienced by their service users. Poor-quality bed-based addiction treatment services that lack accountability for care safety and quality pose similar risks to people seeking addiction treatment and recovery as those posed to residents in long-term care.

This report includes a review and analysis of Canadian and international jurisdictional scans, shares the results of a literature review identifying best practices and findings, proposes an accountability conceptual framework, offers considerations and tools to support implementing the conceptual framework, and makes recommendations for jurisdictions to advance safe, quality care in bed-based addiction treatment.

A jurisdictional scan of Canada's accountability approaches in bed-based addiction treatment was completed through interviews with provincial and territorial policy makers (except Quebec, whose representatives could not be identified for interviews). Policy makers were asked about the types of

service operators in their jurisdiction; their level of concern about bed-based addiction care safety and quality; and accountability approaches they use to improve safe, quality care (see Appendix A for the invitation and questions). Policy makers validated the interview findings by email and in an online meeting. The international jurisdictional review included literature on accountability in bed-based addiction treatment from the United States, New Zealand and Europe. The approaches used by two Canadian municipalities involved in this area were also reviewed. The literature review of best practices in accountability for care safety and quality in addiction treatment was expanded to include accountability for quality care in long-term and continuing care due to the lack of addiction-specific literature. A conceptual framework based on these findings is presented and used to analyze results of the jurisdictional scans. The report findings, conceptual framework and recommendations were also presented and validated by interviewed policy makers by email and in an online meeting.

The literature on accountability approaches in community bed-based addiction treatment is very limited (Mark et al., 2020; Byrkjeflot & Vrangbaek, 2016; British Columbia Centre on Substance Use, 2020), so this report draws heavily from the September 2014 special issue of *Healthcare Policy* (Deber, 2014a) on accountability in Canadian health and social service settings. Because of the limited literature and practice in this area, the proposed conceptual framework and findings in this report warrant further discussion and research.

Accountability Approaches in Canada: Current State

Interviews with provincial and territorial policy makers identified and validated service operator types and the accountability approaches for bed-based addiction treatment used in their jurisdictions. The interview invitation and questions can be found in Appendix A.

The interview findings are summarized in Table 1, which shows service operator types and the accountability strategy by jurisdiction. The service operator types are consistent with those described above (see Background). The label "out-of-jurisdiction," is added as a service operator type to indicate jurisdictions that pay for clients to receive treatment outside of their province or territory. The primary accountability strategies reflect the main strategy used by each jurisdiction and their application to each service operator type.

In summary, British Columbia, Alberta and Quebec have some legislated requirements for care safety and quality for bed-based addiction treatment. British Columbia regulates some bed-based service operators through its *Community Care and Assisted Living Act*; however, British Columbia's policy makers have also identified gaps in the current legislation. Alberta and Quebec are the only jurisdictions with comprehensive addiction treatment regulation that applies across service operator types. Several jurisdictions require publicly operated and funded service operators to be accredited or to meet standards, evaluation requirements or contract terms to receive public funding. Most jurisdictions did not report any regulatory or voluntary accountability strategies applying to privately operated and funded service operators (for-profit and non-profit).

Canadian policy makers need a well-defined accountability approach to improve bed-based addiction care safety and quality as evident in the limited accountability strategies summarized in Table 1.

Table 1. Service operator types and the primary accountability strategies by jurisdiction

Jurisdiction	Publicly Operated	Publicly Contracted	Private Non-profit	Private For-profit	Out of Jurisdiction	Notes
British Columbia	✓	✓	✓	✓		*Community Care and Assisted Living Act* regulates some service providers.
	✓	✓ *Community Care and Assisted Living Act*	✓	✓		
Alberta	✓	✓	✓	✓		*Mental Health Services Protection Act*
Saskatchewan	✓	✓	✓	✓		Developing data system, reviewing facility standards
Manitoba	✓	✓	✓	✓		New standards, considering legislation
Ontario		✓	✓	✓		Center of Excellence developing standards. Some public contracts require accreditation.
Quebec	✓	✓	✓	✓		Information from Literature Review
Nova Scotia	✓	✓	✓	✓		Developing outcomes for contracts
New Brunswick	✓	✓	✓	✓	✓	
Prince Edward Island	✓	✓	✓		✓	Developing standards
Newfoundland and Labrador	✓		✓		✓	Considering standards
Yukon	✓					
Northwest Territories					✓	Developing outcomes/evaluation for out of jurisdiction
Nunavut	2025	✓			✓	Reviewing out of jurisdiction

Legend:
- Service provider type operating in jurisdiction = ✓
- Primary Accountability Strategy = Regulation | Accreditation | Standards | Evaluation | Contract Requirements | None

Note: The information for Quebec is drawn from an unpublished draft report by the British Columbia Centre on Substance Use as Quebec representatives could not be identified for interviews.

See Appendix B for an accessible version of this table.

Conceptual Framework for an Accountability Approach

A robust accountability approach is a suite of complementary policy instruments, targets, forces and consequences that is tailored to the jurisdiction by mixing and matching suitable components to best achieve the policy goal.

Broadly defined, accountability is being held answerable to achieve specific objectives. Developing an accountability approach requires determining **who** will be held accountable (e.g., clinicians or operators), **by whom** (e.g., government, clients), **for what** requirements (e.g., clinical standards), and with what **consequences and force** if the requirements are not met (Deber, 2014a). This is achieved through policy instruments, which are the "means by which policy objectives are pursued" (Treasury Board of Canada Secretariat, 2007).

In a policy context, an accountability approach is designed to achieve one or more specified policy goals (what) by outlining the accountability target or targets (who, e.g., operators or clinicians), policy instruments (what, e.g., pay for performance or clinical standards), consequences if requirements are not met (e.g., no consequences, financial penalty, loss of operating licence) and force (e.g., education, incentives, regulation).

The accountability conceptual framework (Figure 1) aims to expand the range of accountability approaches considered by policy makers as they work to improve care safety and quality in bed-based addiction treatment. The framework is largely based on the studies presented in the September 2014 special issue of *Healthcare Policy*.

The framework outlines policy goals (e.g., quality improvement through performance accountability) that can be achieved through an accountability approach composed of complementary voluntary and regulatory strategies that include policy instruments (Health Canada, 2022; Deber, 2014a; Pals, 2022) and a mix-and-match selection of targets, consequences, and forces.

Accountability strategies may be voluntary, regulatory or market based (Deber, 2014b).

- **Voluntary** approaches do not mandate compliance but may incentivize participation and compliance.
- **Regulatory** approaches encode policy instruments in legislation to achieve the policy goal. Because the approaches are legislated, compliance is mandatory for all targets (e.g., all service operator types).
- **Market-based** approaches use economic, market-driven incentives and disincentives (i.e., grants, taxes) to achieve the policy goal (Hepburn, 2005) and may be regulatory or non-regulatory. Although non-regulatory market-driven approaches aim to create market pressures on the target (i.e., service operators), they do not mandate compliance and are therefore considered voluntary strategies for the purpose of this report.

The accountability conceptual framework includes voluntary (non-regulatory) and regulatory (legislated) policy instruments and strategies. Voluntary strategies become mandatory when they have the force of law. Strategies with the force of law are encoded in legislation and include legislated delegation to a third party (e.g., professional regulatory bodies are delegated to require compliance with professional standards).

Policy instruments are the programs and initiatives used to pursue policy goals with the aim of changing individual behaviour, social norms or processes (Pal, 2022). They are voluntary unless encoded in legislation, making them regulatory and carrying the force of law. There are many schemes categorizing policy instruments (Pal, 2022). The accountability conceptual framework includes the following categories of policy instruments, which are common to many of the schemes discussed by Pal (2022) and Deber (2014a):

- **Financial** (e.g., grants to support operators to become accredited)
- **Professional stewardship** (e.g., clinical standards)
- **Information** (e.g., consumer information on choosing quality services)
- **Organizational structure** (e.g., government operated services)

Although the professional stewardship category is most obviously related to a performance accountability policy goal (such as improving care safety and quality), any of the policy instruments in the framework could be used to achieve this goal.

Policy instruments may be directed to one or more **targets** being held accountable (e.g., service operators, clinicians, service users). Policy instruments are more effective when targets are held accountable for things within their control. For example, clinicians should be effectively held responsible for their clinical practice, which they control, through policy tools such as professional self-regulation. However, service operators, not clinicians, should be held responsible for the organization's financial management practices.

Policy instruments can be implemented with varying **consequences** if requirements are not met. For example, service operators may be subject to financial penalties or may lose incentives or their operating licence if they do not meet requirements. Policy instruments can also be implemented with varying **force.** For example, voluntary education programs to improve clinical practice may be implemented, service operators may lose their accredited status by an accrediting body, or compliance may be legislated and carry the force of law.

Appendix C — Implementation Steps and Tips provides guidance for implementing the framework. Appendix Assessment Tool identifies opportunities to improve accountability approaches by supporting the assessment of harms and determining where further research or information may be needed.

Figure 1. Accountability conceptual framework: Promoting safe, quality care improvement through accountability

POLICY GOALS

Goal	Examples of policy goals
Financial accountability	Cost control, compliance with financial procedures
Performance accountability, including clinical	Safety, quality, performance
Public accountability	Public trust, client satisfaction, access, justice

ACCOUNTABILITY APPROACH

Policy instruments (mix-and-match selection)

Types	Examples of non-regulatory options
Financial	Pay for performance, subsidies, incentives, grants, contracts, activity-based funding
Professional stewardship	Accreditation, clinical guidelines or standards, codes of conduct (Kirsch, 2014), professional certification, professional self-regulation (voluntarily undertaken by professional association), professional learning (Kirsch, 2014), performance measures, patient outcomes, management outputs (Steele Gray et al., 2017)
Information	Consumer education (e.g., guides on choosing "best care"), publicly posting performance measures or quality metrics, report cards
Organizational structure	Privatization of services (Pal, 2022), government operation of services, designation of a third-party operator, government reorganization (e.g., creating a ministry of addiction and mental health, moving addiction from social services to health) (Pal, 2022)
Regulation	**Any of the above non-regulatory strategies can be made to have legal force (be regulated).**

Targets, consequences, and forces (mix-and-match selection)

Accountability element	Examples of non-regulatory options
Target (who)	Service operators (e.g., for-profit owner, non-profit operator, public operator) Care operators (e.g., addiction counsellors, nurses, social workers, physicians) Public, service users (e.g., people seeking treatment and their families)
Consequence	None Information or education (e.g., non-compliant operator educated on required reporting) Fiscal penalties (e.g., fines, taxation) Sanctions (e.g., investigation, professional regulatory response, consumer complaint process)
Force (lot to high)	No action Symbolic action (e.g., association listing on a government website) Information or education Incentives (e.g., tax breaks, endorsement, preferential access to funding, contracts, grants) Disincentives (e.g., loss of incentives, fines, monitoring for compliance)
Regulating	**Examples:** • **Regulating targets: Licensure, certification, registration, professional self-regulation** • **Regulating consequences: investigation, ombudsman** • **Regulating force: financial penalties, legal sanctions** **Any of the above non-regulatory options can be made to have legal force (be regulated).**

Improving Safe, Quality Care in Bed-Based Addiction Treatment

Analysis of Accountability Approaches in Canada

Interviews with provincial and territorial policy makers identified and validated service operator types and the accountability approaches for bed-based addiction treatment in their jurisdiction. As summarized in Table 1, only Alberta and Quebec have comprehensive addiction treatment legislation that applies across service operator types. As previously noted, British Columbia has regulation, but it is less comprehensive). Several jurisdictions also require publicly operated and funded service operators to be accredited, or meet standards and evaluation requirements, or have contract terms to receive public funding. Jurisdictions providing public funding to private operators usually require financial accountability, although some also have care safety and quality requirements (e.g., service operator must be accredited to be funded). Finally, most jurisdictions reported use of a minimal range of accountability strategies and, in most jurisdictions, privately operated and funded service operators (for-profit and non-profit) have no formal accountability to government.

Policy makers from jurisdictions with smaller populations and fewer service operators reported that existing accountability approaches are largely meeting the jurisdiction's care safety and quality policy goals. However, these policy makers also expressed concerns about lack of assurance of consistent care safety and quality for service users they fund to access treatment out of their jurisdiction. These concerns stem from inconsistent accountability requirements across jurisdictions. In contrast, larger jurisdictions expressed more concerns about care safety and quality and accountability within their own jurisdictions, and more often expressed interest in regulatory accountability approaches.

The conceptual framework was used to analyze information provided by interviewed policy makers (see Appendix A for interview invitation and questions). The predominant policy goals, policy instruments, target, consequences and force are as described in the following subsections.

Policy Goal

The main policy goal across Canadian jurisdictions is clinical accountability to improve system-level care safety and quality. The primary challenges identified by policy makers include:

- Patient access to timely, appropriate treatment (i.e., gender-flexible, culturally appropriate, specialized services; accommodation of harm reduction approaches; evidence-based treatment) for both within and out-of-jurisdiction services, regardless of the service operator type;
- Continuity of care (e.g., information sharing, client transitions between government and contracted operators and out-of-jurisdiction operators);
- Assessment and monitoring of service quality and compliance with highly variable local requirements of out-of-jurisdiction contracted service operators;
- Variable staff qualification requirements and staff-to-client ratios in contracted agencies and private operators, which may be misaligned with services provided; and
- Availability of culturally competent and representative staff, and the need to balance staff qualification requirements with cultural considerations.

Policy Instruments

Aligned with the main policy goal, jurisdictions most often use professional stewardship policy instruments and apply a variety of strategies such as standards or accreditation.

A few jurisdictions also use financial policy instruments, most frequently by contracting services from private service operators. These operators are most often required to meet financial rather than care safety and quality accountability requirements.

- A few jurisdictions use, or are planning to use, consumer education instruments. For example, Alberta and British Columbia publicly post the licensure status of service operators.

Target

- Jurisdictions largely target service operators. Alberta's legislation includes a provision to target clinicians through self-regulation; however, this has not yet come into effect.

Consequences and Force

In most jurisdictions, the force of policy instruments varies by service operator type.

- Publicly operated services are usually subject to regulation (e.g., a health authority act when the services are operated by a provincial or territorial health ministry).
- Alberta and Quebec have addiction treatment regulation that applies across service operator types. Alberta's regulation requires that service operators meet clinical and administrative requirements to be licensed to operate. Quebec's regulation requires that service operators be accredited to access provincial funds.
- Publicly funded (e.g., contracted) service operators are subject to loss of funding if they do not meet financial conditions, clinical standards or accreditation requirements as outlined in contract, grant or other funding agreements.
- In most jurisdictions, private for-profit and non-profit service operators are not subject to regulatory consequences for care safety and quality, although they may experience market impacts. For example, a service operator may lose clients if the clients were concerned about high costs or poor service.

Interviews with provincial and territorial policy makers also identified the following challenges in advancing accountability approaches:

- Understanding the scope of the issue and the risks resulting from the lack of data on private (for-profit and non-profit) and contracted services (see Recommendations).
- Addressing tensions such as how much to regulate private health-related businesses (see considerations in Developing an Accountability Approach).
- Implementation challenges (see Recommendations):
    - Managing change, designing to accommodate local contexts (e.g., existing legislation, cross-sector involvement), addressing resource capacity issues (e.g., funding, staff) and achieving compliance through enforcement and incentives.
    - Establishing consistent governance supporting the integration of health and social service care.

- Addressing ideological tensions (e.g., support for regulation; harm reduction, recovery and abstinence philosophies; social services and healthcare approaches).

Policy makers also expressed interest in supporting Indigenous-serving operators to improve care safety and quality; however, this was not pursued as it is out of scope for this report.

Accountability Approaches in Other Jurisdictions

Accountability approaches in the United States, Europe and New Zealand were examined through a literature review to identify novel or best practices. The findings are summarized in Table 2. The findings were also analyzed using the accountability conceptual framework.

In the **United States**. in 2021, 39 states had some regulation of bed-based addiction treatment; however, it varied significantly across states and there was no federal regulation (O'Brien et al., 2021). The National Alliance of Recovery Residences (NAAR) supports care safety and quality across the U.S. through a voluntary accountability approach. NAAR works with affiliates in over 30 states that inspect, assess and grant NAAR certification to facilities (NARR, 2022). Although this is a voluntary program, some state governments, such as those in Florida, Ohio and Connecticut, incent involvement by providing endorsements and preferential market access (e.g., only allowing medical referrals to NARR-certified agencies).

In most **European countries**, governments fund bed-based addiction treatment, and almost all regulate these services in some way. The main policy goal is clinical accountability, which is often supported by evidence-based clinical guidelines, service standards and accreditation strategies targeting service operators and clinicians (European Monitoring Centre for Drugs and Drug Addiction, 2014).

New Zealand has legislation enabling involuntary treatment as a last resort for people with severe addictions. To ensure care safety and quality, service operators, clinicians and service standards are legislated nationally, although monitoring occurs at a district level. However, New Zealand is currently establishing Indigenous governance and stewardship for addiction and mental health services. This work is ongoing and was not sufficiently advanced to report, but it may provide a model for future consideration.

In summary, the analysis found that the main policy goal is clinical accountability to improve system-level care safety and quality. Also, government policy instruments largely support professional stewardship and consumer education and target clinicians and service operators. Finally, the consequences and force are largely mixed in the United States and regulatory in Europe and New Zealand.

Two **Canadian municipalities** that regulate addiction treatment service operators were also reviewed and are included in Table 2. Municipal responsibilities vary based on what the provincial or territorial government has delegated to municipalities, but generally, municipal governments are responsible for local governance issues not addressed by federal or provincial governments. Municipal bylaws may regulate issues such as where a business may operate in the municipality, where and how much parking a business has, or how much traffic is reasonable in a neighbourhood. The cities of Surrey, British Columbia, and London, Ontario, have implemented accountability approaches for bed-based addiction treatment. Within their authority for public safety (a public accountability policy goal) these two municipalities have implemented professional stewardship policy instruments (i.e., licences) targeting service operators to meet public safety requirements.

Table 2. Summary of accountability approaches in other jurisdictions

Jurisdiction	Force	Oversight and monitoring	Consequences
Florida, Ohio and Connecticut (O'Brien et al., 2021)	Voluntary incentives (e.g., endorsement, preferred status for medical referrals) provided by the state government States formally affiliated with NAAR register and certify operators meeting standards	NAAR state affiliates assess for continued certification; response process for consumer complaints is not clear	Loss of certification, loss of state incentives (such as preferred status for medical referrals)
England (European Monitoring Centre for Drugs and Drug Addiction, 2014)	Regulated: Legislation requires service operator registration with the Care Quality Commission (independent of government), incentives and consumer education through public posting of quality assessments Clinicians are regulated under the National Counsellor Accreditation Certificate scheme	Care Quality Commission inspections, quality assessments and complaint investigations	Warnings, fines, de-registration
New Zealand (Manatū Hauora Ministry of Health [New Zealand], 2022)	Regulated: Legislation of service operators (licensing, certification), health practitioners and service standards	Districts monitor and enforce legislation	Inspection, audit, loss of licence or certification
Surrey, British Columbia (City of Surrey, 2022)	Regulated: Municipal bylaw for each facility; licensing; requirements outlining physical expectations of space, tenant restrictions, required tenant data	Inspection, response to complaints, data on tenants	Inspection, loss of licence, fines
London, Ontario (City of London, 2021)	Regulated: Municipal bylaws; licensing; requirements outlining physical expectations of space, business administration	Inspection, response to complaints, data on tenants	Inspection, loss of licence, fines

Developing an Accountability Approach

Considerations for Regulatory and Voluntary Strategies

A key policy question posed by interviewed policy makers interested in establishing accountability approaches to improve care safety and quality in bed-based addiction treatment was how to determine when to recommend regulatory or voluntary strategies, and for what.

Improving performance accountability in bed-based addiction treatment is a complex issue. It can be most effectively addressed with an accountability approach that consists of a complementary mix of regulatory and voluntary strategies (Pals, 2022; Treasury Board of Canada Secretariat, 2007).

Different issues will be most effectively addressed by different policy instruments. For example, regulation should be given greater consideration as the risks of harm increase (Lewis, 2013). Therefore, a jurisdiction may wish to regulate how medications are secured but use voluntary strategies to encourage service operators to improve clinical documentation.

A method to support selecting voluntary or regulatory strategies for specific issues related to improving care safety and quality (e.g., staff qualifications, clinical practice standards, clinical documentation) is to complete a cost–benefit analysis assessing the costs and social benefits of regulation (Beales et al., 2017).

Policy makers must also consider the ideology of government decision makers who may be more or less supportive of regulation (Walker, 2002). Decision makers who support limited regulation may be more supportive of voluntary strategies.

Regardless of government ideology, there is an opportunity for jurisdictions to implement a wider range of voluntary strategies. Voluntary strategies, which may be implemented alone or in concert with regulatory strategies, can minimize regulation and promote compliance while reducing negative impact on the market. Below are additional factors to bear in mind when considering the suite of regulatory and voluntary strategies to include in a comprehensive accountability approach.

Considerations for Regulatory Strategies

- Regulation should be considered when the risks of unsafe practice are high and when consumers cannot reasonably assess service quality (Lewis, 2013).
- Regulation (i.e., legislation) is comprehensive and mandatory (unless otherwise specified in regulation), applying equally across service operator types. Therefore, it provides equal protection of clients across service operator types and locations.
- Improved care quality, resource efficiency and outcomes have been found in non-government organizations subject to regulation (Kirsch, 2014). However, in Quebec's experience with long-term care, regulation resulted in smaller private service operators closing, and clients with complex and severe symptoms shifting into the public system. Regulation provided little or no real system-wide improvement in care quality (Bravo et al., 2014).
- Regulation enables data collection across service operators, which can improve government data analysis and better inform policy.

- Regulation may incur greater government costs for monitoring and enforcement. These costs may be mitigated by minimizing regulatory requirements or delegating this responsibility to a third party (e.g., accreditation body, professional regulatory body).
- Requiring accreditation in regulation may limit government monitoring and enforcement costs, as regular assessment and monitoring is provided by the accrediting body and may be paid for by the service operator. Further considerations regarding accreditation and standards include the following:
    - Unless regulated (as in Quebec), accreditation and standards are voluntary and may not result in a comprehensive accountability approach.
    - Documenting the accreditation process or standards outside of regulation (e.g., in policies and procedures) facilitates timely updating of requirements as compared to amending regulation. However, standards from reputable accrediting bodies or standards organizations are regularly updated with evidence-informed best practices, supporting continuous improvement in enrolled service operators.
    - The literature finds mixed effectiveness of accreditation improving care safety and quality (Mark et al., 2020; Accreditation Stakeholders Working Group, 2015). The literature also finds limited participation in accreditation when it is used as a voluntary strategy as operators perceive the required financial and staff time investments as outweighing potential benefits (Accreditation Stakeholders Working Group, 2015).
- Interviewed policy makers from Alberta and British Columbia reported their experience that regulation can enable operators to collaborate and coordinate by creating sector-wide communication and meeting opportunities that may not have otherwise developed. Collaboration increases opportunities among operators for system-wide learning and improvement and for system-wide coordination, which could increase pressure on governments for funding or other measures.
- Policy makers developing regulatory approaches should consider which elements should be in an act (most difficult to change, likely once in five to 10 years), regulations (likely to change once in three to five years), or standards (easiest to change).
- The amount of regulation can be reduced by co-ordinating regulation and robust voluntary accountability approaches. For example, medication management (e.g., safe storage of medications) may be regulated, but administrative and management requirements (e.g., operational policies and procedures, human resources practices) may be incentivized and encouraged with a robust suite of voluntary strategies, such as operator education, grants to improve operations, and public posting of administrative efficiency ratings.
- The Organisation for Economic Co-operation and Development (Hepburn, 2005) provides the following considerations for selecting regulatory policy instruments. The policy instrument should:
    - Address defined policy goals;
    - Not conflict with existing regulations;
    - Include effective monitoring and mechanisms to support compliance (e.g., consequences and force);
    - Maximize benefits;
    - Minimize compliance costs for targets (e.g., support flexible means to achieving compliance);

- Minimize government implementation costs;
- Be transparent in their operation and impacts; and
- Include appeals mechanisms.

Considerations for Voluntary Strategies

- Voluntary strategies may incur less government cost by eliminating regulatory obligations to monitor or enforce requirements. However, other government costs may be incurred in implementing and assessing the impact of voluntary accountability strategies (Neyland et al., 2019).
- Some voluntary strategies improve public transparency of service operator requirements and performance (e.g., public posting of quality assessments). As these strategies are not mandatory, a segment of the sector may opt out of participating and remain invisible (Steele Gray et al., 2017).
- Voluntary strategies allow the marketplace to operate unimpeded without favouring operators, which could reduce innovation, sector growth, or job creation (Beales et al., 2017). Voluntary strategies also minimize service operator red tape (Neyland et al., 2019). As such, voluntary strategies may better align with governments that support minimal market regulation.

In Summary

Table 3 summarizes considerations in selecting accountability strategies to improve care safety and quality.

Table 3. Summary of considerations in selecting accountability strategies

Consideration	Voluntary strategies	Regulated strategies
Protection from risk of harms	Lower	High
Rate of compliance	Lower (use more strategies to increase)	High
Ease of data collection	Lower	High
Cost to government	Lower	Higher (if government monitoring needed)
Public transparency	Varies with strategy	Higher
Market impact	Lower	Higher

Considering the Effectiveness of Accountability Approaches

There is limited documentation and research available on healthcare accountability and the effectiveness of accountability approaches (Mark et al., 2020; Byrkjeflot & Vrangbaek, 2016; British Columbia Centre on Substance Use, 2020). However, literature from the long-term care sector and the work in the September 2014 special issue of *Healthcare Policy* (see Deber, 2014a, 2014 and other articles in that issue) provides the following considerations to improve the effectiveness of accountability approaches:

- Policy goals should be well-defined and supported by aligned policy instruments.
- Policy goals should be selected to limit conflicting goals impacting service operators.
    - Accountability approaches should be aligned to support continuity of care (e.g., ensure safety and quality standards are consistent across public and private service operators).
    - The impact of the accountability approaches intersecting with other legislation should be considered (e.g., health privacy legislation).
- The target of the accountability approach must have control over the policy goal they are being held accountable for achieving. For example, clinicians control their use of clinical best practices, but not organization financial management. Therefore, it will be more effective to target clinicians for performance accountability and service operators for financial accountability policy goals.
- For regulated accountability approaches, legislation should:
    - Clearly define "bed-based addiction treatment services" (3Sixty Public Affairs, 2017); and
    - Align with quality indicators to ensure care safety and quality are impacted as intended (Office of the Privy Council, 2017; Deber, 2014b).
- Measuring the effectiveness of accountability approaches is challenging (Deber, 2014b) but critical. Measurement can be supported by:
    - Establishing clear, measurable policy objectives and evaluation approaches (Office of the Privy Council, 2017); and
    - Using evaluation approaches designed to assess dynamic, complex processes and "soft" outcomes, such as Michael Quinn Patton's *Principles-Focused Evaluation* method.
- Professional stewardship policy instruments (e.g., professional self-regulation) were found to be particularly impactful strategies for non-government organizations (Kirsch, 2014). These strategies may be equally effective for private non-profit and publicly funded operators of bed-based addiction treatment services.
- Steele Gray et al. (2017) studied the organizational compliance of Ontario's long-term care sector with accountability requirements in contracts for public funding. They found that:
    - Half or more of service operators (particularly small- and medium-sized operators) did not enter into public funding contracts, thereby remaining invisible and did not participate in non-regulatory accountability strategies. It is anticipated that results would be similar in bed-based addiction treatment.
    - Compliance with voluntary accountability approaches may be improved by:
        - Tailoring accountability requirements to the needs of service operators;
        - Providing funding and other supports to incentivize and enable operators to make internal changes (e.g., administrative or clinical practice changes), adopt novel practices (e.g., partnerships or subcontracting) and support compliance with the accountability requirements; and
        - Implementing a comprehensive, cohesive suite of voluntary strategies (e.g., funding, supports, public transparency and preferred market access) to incentivize adoption and compliance with accountability requirements.

Recommendations

The following recommendations aim to increase the impact of care safety and quality improvement efforts (i.e., standards, accreditation) by strengthening accountability for them.

These recommendations also respond to provincial and territorial questions and requests, draw on the jurisdictional scan of accountability approaches and further the proposed accountability conceptual framework.

Recommendations for Jurisdictions

1. Determine the scope of the issue by establishing the number and distribution of people affected (e.g., client volume and service catchment areas) for publicly operated, publicly funded, private for-profit and private non-profit service operators.
2. Determine the risk of harm (e.g., severity and frequency) by assessing the service quality of publicly operated, publicly funded, private for-profit and private non-profit service operators. In addition to risks to service users, the public and others, there are potential risks to government; these include client harms related to receiving government-funded services (e.g., opioid overdose after abstinence-based treatment), as well as potential government liability related to harms resulting from lack of service access (e.g., unmet service needs).
3. Develop an accountability approach that answers the key questions of who should be held accountable (e.g., clinicians, service operators), by whom (service users, the public or the government), for what (e.g., care safety and quality standards), and with what consequences and force. See appendices A and B for guidance.

Recommendations for CCSA and Pan-Canadian Collaboration (Validated by Jurisdictions)

4. Pilot and evaluate the accountability conceptual framework. Support jurisdictions to establish comprehensive accountability approaches composed of regulatory and voluntary strategies when implementing new standards or accreditation programs to maximize compliance and program effectiveness.
5. Publish a common definition of bed-based addiction treatment services to support provincial and territorial legislation and standards development. A common definition will help to define the requirements to be met in an accountability approach.
6. To support assessing the effectiveness of accountability approaches and add to the published knowledge base, develop and publish pan-Canadian guiding principles linked to outcomes for facility and service standards aligned with clinical best practices.
7. Continue to support provinces and territories with tools and resources for service quality improvement and accountability, including pan-Canadian guiding principles and best practices on care continuity within and between addiction treatment sectors. These tools and resources will further expand the range of accountability policy instruments available to policy makers.
8. Support establishing a pan-Canadian association of community bed-based addiction treatment service operators (public and private service operators). Such an association will enhance the data available on service quality and quantity and increase opportunities to promote care safety

and quality in the private market. It will also support assessing the scope of the accountability concerns and implementing voluntary professional accountability strategies with private operators.

9. Facilitate regular opportunities (e. g., at CCSA's Issues of Substance conference) for provincial and territorial representatives to engage in structured discussions about accountability approaches and issues to support continued development of this work and learning.
10. To further develop this work, support provinces and territories in addressing the implementation issues they have identified, including the following challenges:
    - Managing change, designing to accommodate local contexts (e.g., existing legislation, cross-sector involvement), addressing resource capacity issues (e.g., funding, staff) and achieving compliance through enforcement and incentives;
    - Establishing consistent governance that supports greater collaboration and integration across health and social service care operators; and
    - Addressing tensions (harm reduction, recovery, and abstinence philosophies; social services and healthcare approaches).

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Appendix A: Jurisdiction Interview Invitation and Questions

Dear Colleague,

During our work together over the last number of years, many of you have expressed concerns about community bed-based services, whether it be about the need for data, or inconsistent service safety, quality and consumer protections across the private and public landscape of community bed-based addiction treatment services. Many of you have also shared that the pandemic, ongoing opioid crisis, and increasing numbers of people seeking services have shone a spotlight on this issue.

To continue advancing evidence-based solutions supporting an accessible, inclusive continuum of quality substance use and addiction services and supports across Canada, I am writing to invite you to participate in **two** online discussions to support CCSA in the development of a policy paper on approaches to the provision of jurisdictional oversight of community bed-based addiction treatment services to ensure overall quality and safety of services.

As we have seen in some jurisdictions, improving community bed-based addiction treatment safety, quality and consumer protections can be achieved through legislation and regulation, accreditation, service standards, or financial incentives and every jurisdiction will need a unique solution that works for them. Our goal is to develop a policy paper that you can use to help address this issue in your jurisdiction. The policy paper will provide a literature review, summary of input from across Canada, summary of 'wise practices', and will suggest possible regulatory approaches and models.

We have contracted Michelle Craig, formerly the Executive Director of the Addiction and Mental Health Branch in the Government of Alberta to support this work. Amongst many other projects, Michelle led the development and implementation of Alberta's legislation regulating community bed-based addiction treatment and brings a unique understanding and experience to this work. Having recently retired from an Assistant Deputy Minister position with the Government of Alberta, I'm pleased to have her working with us. Michelle will contact you shortly to invite you to participate in **two meetings**:

- An *individual* **45-minute** Zoom conversation, between **February 28 and March 11, 2022**, to gain an understanding of bed-based addiction treatment regulation and quality in your jurisdiction, (I will call to arrange these meetings with you); and
- A **two hour** Zoom meeting **March 29, 2022, from 12:00pm to 2:00pm** Eastern, for a *group discussion* of the themes identified through the interviews and literature review and possible recommendations. You will receive a meeting invitation to hold this date and time in your calendar in the coming days.

We have also attached in advance some questions that will help guide the discussions.

Thank you,

Regulating Community Bed-Based Addiction Treatment — Interview Questions

Improving community bed-based addiction treatment safety, quality and consumer protections can be achieved in many ways including legislation and regulation, requiring service standards be met, and/or financial incentives. With your input, CCSA is developing a policy paper to support decision makers' consideration of various approaches that include legislative and regulatory and provide consumer protections, protect the health and safety of people seeking bed-based addiction treatment and promote quality care.

1. How can CCSA and this policy paper help you support advancing regulation or other measures that aim to improve service safety, quality, and consumer protections for publicly and privately funded community bed-based services?
2. Is, or has, your jurisdiction considered regulating community bed-based addiction treatment services or facilities?
    a. If yes, what are/were the short- and long-term goals (e.g., consumer protections or service quality, data gathering, clarity on the various types of bed-based homes and treatment operators)?
    b. What regulatory approaches are/were being considered (i.e., as a health or social service, stand-alone legislation or as part of existing legislation)?
3. Are there other approaches that your jurisdiction is considering for publicly and privately funded community bed-based services to improve service safety, quality, and consumer protections (e.g., regulation, accreditation, service standards implementation and compliance oversight)?
4. As you consider the public and privately funded landscape, what do you see as the challenges in developing and implementing regulations or other measures that aim to improve service safety, quality, and consumer protections?
5. What measures do you currently have in place to support safe, quality care and consumer protections and ensure overall compliance? What further measures, if any, are planned?
6. What is the readiness of government and of service operators for regulation or other quality improvement measures such as accreditation, service standards that aim to improve service safety, quality, and consumer protections?

Appendix B: Accessible version of Table 1

Jurisdiction	Publicly funded and operated	Publicly contracted, privately operated	Privately funded and operated non-profit	Privately funded and operated for-profit	Out-of-jurisdiction	Notes
British Columbia	Yes Some Accreditation Some regulated	Yes Some contract requirements Some regulated	Yes Some regulated	Yes Some regulated	None —	Regulation in *Community Care and Assisted Living Act* applies to some, not all, operators; considering other approaches.
Alberta	Yes Regulated	Yes Regulated	Yes Regulated	Yes Regulated	None —	*Mental Health Services Protection Act.*
Saskatchewan	Yes Standards	Yes Contract requirements	Yes None	Yes None	None —	Developing data system, considering other approaches.
Manitoba	Yes Accreditation	Yes Accreditation	Yes None	Yes None	None —	New standards, considering other approaches.
Ontario	None —	Yes Contract requirements	Yes None	Yes None	None —	Some contracts require accreditation. Centre of Excellence developing standards, considering other approaches.
Quebec	Yes Regulated	Yes Regulated	Yes Regulated	Yes Regulated	None —	Information from literature review
New Brunswick	Yes Accreditation	Yes Accreditation	Yes None	Yes None	Yes None	No additional information provided.
Nova Scotia	Yes Accreditation	Yes Accreditation	Yes None	Yes None	None —	Developing key performance indicators and outcomes for contracts.
Prince Edward Island	Yes Accreditation	Yes Contract requirements	Yes None	None —	Yes None	Developing standards.
Newfoundland and Labrador	Yes Accredited	None —	Yes None	None —	Yes Contract requirements	Considering standards.
Yukon	Yes Evaluation	None —	None —	None —	None —	No additional information provided.
Northwest Territories	None —	None —	None —	None —	Yes Accreditation	Considering other approaches.
Nunavut	2025 TBD	Yes Contract requirements	None —	None —	Yes Accreditation	Reviewing out-of-jurisdiction operators.

Note: The information for Quebec is drawn from an unpublished draft report by the British Columbia Centre on Substance Use as Quebec representatives could not be identified for interviews.

Legend: — = Not Applicable

Return to Table 1

Appendix C: Implementation Steps and Tips

Accountability conceptual framework: Promoting safe, quality care improvement through accountability

POLICY GOALS

Goal	Examples of policy goals
Financial accountability	Cost control, compliance with financial procedures
Performance accountability, including clinical	Safety, quality, performance
Public accountability	Public trust, client satisfaction, access, justice

ACCOUNTABILITY APPROACH

Policy instruments (mix-and-match selection)

Types	Examples of non-regulatory options
Financial	Pay for performance, subsidies, incentives, grants, contracts, activity-based funding
Professional stewardship	Accreditation, clinical guidelines or standards, codes of conduct (Kirsch, 2014), professional certification, professional self-regulation (voluntarily undertaken by professional association), professional learning (Kirsch, 2014), performance measures, patient outcomes, management outputs (Steele Gray et al., 2017)
Information	Consumer education (e.g., guides on choosing "best care"), publicly posting performance measures or quality metrics, report cards
Organizational structure	Privatization of services (Pal, 2022), government operation of services, designation of a third-party operator, government reorganization (e.g., creating a ministry of addiction and mental health, moving addiction from social services to health) (Pal, 2022)
Regulation	**Any of the above non-regulatory strategies can have legal force (be regulated).**

Targets, consequences, and forces (mix-and-match selection)

Accountability element	Examples of non-regulatory options
Target (who)	Service operators (e.g., for-profit owner, non-profit operator, public operator) Care operators (e.g., addiction counsellors, nurses, social workers, physicians) Public, service users (e.g., people seeking treatment and their families)
Consequence	None Information or education (e.g., non-compliant operator educated on required reporting) Fiscal penalties (e.g., fines, taxation) Sanctions (e.g., investigation, professional regulatory response, consumer complaint process)
Force (lot to high)	No action Symbolic action (e.g., association listing on a government website) Information or education Incentives (e.g., tax breaks, endorsement, preferential access to funding, contracts, grants) Disincentives (e.g., loss of incentives, fines, monitoring for compliance)
Regulating	**Examples:** • **Regulating targets: Licensure, certification, registration, professional self-regulation** • **Regulating consequences: investigation, ombudsman** • **Regulating force: financial penalties, legal sanctions** **Any of the above non-regulatory options can be regulated.**

Implementation Steps and Tips

Implementing an Accountability Approach in Bed-Based Addiction Treatment to Promote Safe, Quality Care

An **accountability approach** outlines **who** is held accountable, **by whom, for what,** and with **what consequences** if requirements are not met.

1. **Assess the risk of harm.** This step determines whether and with what force action may be warranted to improve accountability for bed-based care safety and quality. It also informs the policy goal. For example, if physical or mental harms are found to be a significant risk, a performance accountability policy goal is suggested. The policy goal will be further defined in Step 2.
    a. Use the accountability assessment tool to assess the comprehensiveness of the accountability approach, compliance rate and identify accountability gaps.
    b. Consider the scope of potential harms by assessing the number of clients potentially affected, the severity of potential harms (e.g., from inconvenience to physical or mental harm requiring treatment to death) and the duration (e.g., short to long term or permanent) of potential harms.
    c. Consider regulation when the risks (or costs) of unsafe practices are high (as defined in Step 1b) and when consumers cannot reasonably assess service quality (e.g., there is no standardized or public reporting of quality).
    d. For additional support in making this decision, complete a cost–benefit analysis to assess the costs and social benefits of regulation.
2. **Define the policy goals and key success metrics**. The primary policy goal to improve care safety and quality is clinical accountability. Additional or secondary policy goals may be articulated in government strategic directions. The policy goals and key success metrics inform the policy instrument, target and evaluation.
    a. Consider government decision makers' ideology and preference for voluntary or regulatory approaches.
    b. Compliance with voluntary approaches is usually lower than with regulatory approaches, which carry legal force and consequences. Compliance with voluntary approaches can be increased by implementing a suite of voluntary strategies that allow targets to choose the approach that is best for them. Consulting or collaborating with targets to select voluntary approaches will further support increased compliance.
    c. Clearly define and establish measurability of policy goals to guide the selection of aligned policy instruments and support evaluation of the effectiveness of accountability approaches. To enable effective evaluation of this complex issue, consider using a principles-based measurement and evaluation approach.
    d. Identify key success metrics. For example, compliance rate is a key metric to determine the effectiveness of voluntary approaches. Other key metrics may be pre- and post-implementation assessments of care safety and quality (such as adherence to standards or accreditation).

3. **Select the policy instrument type and target.**
    a. Analyze and select from among the policy instrument options.
    b. Consider implementing a suite of voluntary instruments alone, or in combination with regulation, to increase compliance rates.
    c. Consider targeting care operators through professional stewardship policy instruments (see the accountability conceptual framework for examples), as this was found to be effective in some settings.
    d. Consider that voluntary approaches may be more cost-effective as government monitoring of compliance may not be required.
4. **Determine the consequences and force of selected policy instruments.**
    a. Select consequences that align with the policy goal, instrument and force.
    b. Determine the appropriate force for the selected policy instruments. Force may be voluntary, regulatory or a mix. Compliance will be highest under a regulatory approach as it is mandatory for all operators. However, using a mix of regulatory and voluntary strategies can help streamline regulation and maintain strong compliance. For example, aftercare for opioid addiction can prevent overdose deaths and may be regulated (e.g., in care standards enforced through legislation), but nutritional value of meals may be encouraged through optional (voluntary) education.
    c. Consider the results of the risk assessment, the scope of the potential harms and the cost–benefit analysis (determined in Step 1) in choosing an appropriate consequence and force.
5. **Evaluate the comprehensiveness of the accountability approach and, if possible, its effectiveness.** The results will inform changes required in the accountability approach to achieve the policy goals and reduce risks of harm.
    a. Use the accountability assessment tool (see Appendix D) to assess the comprehensiveness of the accountability approach and identify gaps.
    b. Consider evaluating the impact of the accountability approach on care safety and quality (e.g., change in care quality pre- and post-implementation of the accountability approach). To enable effective evaluation of this complex issue, consider using a principles-based measurement and evaluation approach.

Appendix D: Accountability Assessment Tool

This assessment tool identifies opportunities to further develop the accountability approach. Indicate the target, requirements, agent, consequence and force applicable to each service operator type. The greater the proportion of "unknowns," the greater the potential risk of harm and need for more information.

1. **Who** is held accountable for safe, quality services?

Target	Publicly operated and funded operator	Privately operated (for-profit or non-profit) and publicly funded operator	Privately operated (for-profit and non-profit) and privately funded operator
Service operator			
Caregivers			
Other			
Unknown			

2. **What** safety and quality requirements are the targets accountable for?

Safety and quality requirements	Publicly operated and funded operator	Privately operated (for-profit or non-profit) and publicly funded operator	Privately operated (for-profit and non-profit) and privately funded operator
Government standards (regulated or unregulated)			
Third party (e.g., accreditation or professional body) requirements			
Service operator policies or standards			
Other			
Unknown			

3. **By whom** are the targets (from Step 1) being held accountable?

Agent	Publicly operated and funded operator	Privately operated (for-profit or non-profit) and publicly funded operator	Privately operated (for-profit and non-profit) and privately funded operator
Government			
Third party (e.g., accreditation or professional body)			
Clients or service users			
Other			
Unknown			

4. What are the **consequences** and **force** if the targets do not meet requirements?

Consequence and force	Publicly operated and funded operator	Privately operated (for-profit or non-profit) and publicly funded operator	Privately operated (for-profit and non-profit) and privately funded operator
Regulatory (e.g., legislated consequences such as fines, loss of licence, criminal charges)			
Voluntary (e.g., education, incentives, disincentives)			
No or symbolic action			
Unknown			