Accountability in Bed-Based Addiction Treatment

Purpose

In response to policy makers' requests for strategies to improve accountability for safe quality care in bed-based addiction treatment, this report discusses voluntary and regulatory accountability approaches to advance an accountable, accessible and inclusive continuum of safe, quality substance use and addiction services and supports across Canada.

People seeking addiction treatment are vulnerable to harms from unsafe, poor-quality practices, and 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 the lack of accountability in bed-based addiction treatment. However, a greater range of accountability strategies is needed to improve bed-based addiction treatment and recovery services.

Background

Addiction, or a substance use disorder, is a medical condition that can be treated by healthcare providers. 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 a specific objective, It answers the questions: who should be held accountable, by whom, for what, and with what consequences and force if requirements are not met.

Policy makers recognize the importance of improving the safety and quality of bed-based addiction treatment care but find few accountability strategies that are sufficient and appropriate for Canada's mix of public and private service operators and their largely unregulated clinicians.

The Canadian Centre on Substance Use and Addiction has responded to policy makers' concerns with evidence-based resources and tools. The Government of Canada has also launched work to develop national Substance Use Health and Mental Health standards. The effectiveness of these and other tools and standards would be increased if used with robust accountability approaches.

Results

A jurisdictional scan of Canadian (Table 1) and international (Table 3) accountability approaches in bed-based addiction treatment found that a limited range of accountability strategies are used to ensure care safety and quality. The predominant policy goal is clinical accountability for care safety and quality, targeting operators and clinicians, most often employing policy instruments supporting professional stewardship (e.g., clinical standards) and consumer education. The consequences and force employed are largely 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 about accountability approaches in addiction treatment highlight a need for more information and resources about robust accountability approaches.

Drawn from a literature review of best practices, a proposed accountability conceptual framework (Figure 1) supports developing robust accountability approaches to achieve policy goals. A robust accountability approach includes a suite of complementary regulatory and voluntary strategies that are tailored to the jurisdiction and is achieved through mixing and matching policy instruments, targets, forces and consequences.

Considerations to balance achieving compliance and minimizing negative market impact are provided (Table 4). Considerations include risk, compliance, government ideology and evaluation strategies.

Tools to support implementing the framework are also provided (appendices 1 and 2).

Recommendations for Jurisdictions

1. Determine the issue scope by establishing the number and distribution of people affected (e.g., client volume and service catchment areas) for publicly operated, publicly funded, private non-profit, and private for-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 non-profit, and private for-profit service operators. In addition to risks to service users, the public and others, there are potential risks to the 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.

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

4. Pilot and evaluate the Accountability Conceptual Framework and support jurisdictions to establish comprehensive accountability approaches comprised 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 service basket to support provincial and territorial legislation and standards development. This will support better defining what, or the requirements to be met in an accountability approach.
6. To support assessing accountability approach effectiveness 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 service quality improvement and accountability tools and resources, including pan-Canadian guiding principles and best practices on care

continuity within and between addiction treatment sectors. This will further expand the range of accountability policy instruments available to policy makers.

8. Enable the establishment of a pan-Canadian association of community bed-based addiction treatment service operators (public and private service operators) to enhance data available on service quality and quantity and increase opportunities to promote care safety and quality in the private market. This will support assessing the scope of the accountability concerns and implementing voluntary professional accountability strategies with private providers.
9. Facilitate regular opportunities (i.e., at the Issues of Substance conference) for provincial and territorial representatives to engage in structured discussions about accountability approaches and issues to support the continued development of this work and learning.
10. To further develop this work, support provinces and territories to address implementation challenges they have identified, including:
    - Change management; designing to accommodate local contexts (e.g., existing legislation, cross-sector involvement); resource capacity (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.
    - Addressing tensions (harm reduction, recovery, and abstinence philosophies; social services and healthcare approaches).

Tables and Figure

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

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 Accreditation	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

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 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.**

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

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

Appendices

Appendix 1: Implementation Steps & Tips

Accountability Conceptual Framework — Promoting Safe, Quality Care Improvement

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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 2: Assessment Tool

Assessment Tool for Bed-Based Addiction Treatment Accountability Approaches

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.

6. **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			

7. **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			

8. **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			

9. 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			