Western Australian
Auditor General's Report

Treatment Services for People with Methamphetamine Dependence

Report 9: December 2018-19

Office of the Auditor General
Western Australia

7th Floor Albert Facey House
469 Wellington Street, Perth

Mail to:
Perth BC, PO Box 8489
PERTH WA 6849

T: 08 6557 7500

E: info@audit.wa.gov.au

W: www.audit.wa.gov.au

National Relay Service TTY: 13 36 77
(to assist people with hearing and voice impairment)

We can deliver this report in an alternative format for those with visual impairment.

© 2018 Office of the Auditor General Western Australia. All rights reserved. This material may be reproduced in whole or in part provided the source is acknowledged.

ISSN: 2200-1913 (Print)
ISSN: 2200-1921 (Online)

WESTERN AUSTRALIAN AUDITOR GENERAL'S REPORT

Treatment Services for People with Methamphetamine Dependence

Report 9
December 2018-19

THE PRESIDENT
LEGISLATIVE COUNCIL

THE SPEAKER
LEGISLATIVE ASSEMBLY

TREATMENT SERVICES FOR PEOPLE WITH METHAMPHETAMINE DEPENDENCE

This report has been prepared for Parliament under the provisions of section 25 of the *Auditor General Act 2006*.

Performance audits are an integral part of my Office's overall program of audit and assurance for Parliament. They seek to provide Parliament and the people of WA with assessments of the effectiveness and efficiency of public sector programs and activities, and identify opportunities for improved performance.

This audit assessed the availability, accessibility and effectiveness of treatment services for people with meth dependency

I wish to acknowledge the staff at the Mental Health Commission for their cooperation with this report.

CAROLINE SPENCER
AUDITOR GENERAL
18 December 2018

Contents

Auditor General's overview ... 4

Executive Summary ... 5

Introduction ... 5

Background ... 5

Audit conclusion ... 7

Key findings ... 7

Recommendations ... 9

Response from the Mental Health Commission ... 10

Audit focus and scope ... 11

Audit findings ... 12

More services are available and used, but not everyone has access to treatment where and when they need it ... 12

The MHC's limited use of performance data means it cannot be sure it is getting best value for money ... 16

Auditor General's overview

Dependency on drugs, legal or illegal, affects many people and can devastate individuals, families and communities. It can lead to people losing their jobs, homes, health and their lives. Methamphetamine dependency has become widespread, with methamphetamine making up 90% by weight of all illicit drugs used in the state, and often linked with violence and crime.

Since 2016, Western Australia has had a Methamphetamine Strategy and Plan and a Methamphetamine Taskforce to address the problem. The aim has been to limit access to the drug, educate people about the risks involved, and help people overcome the problems that come from its use. The Government recently released the Taskforce's report.

A key part of attempts to reduce methamphetamine dependency and its impacts has been to expand treatment services provided by non-government organisations contracted by the Mental Health Commission. Overall, the Commission has managed this well, resulting in more people accessing treatment and managing their dependency.

The Commission still faces some challenges. There are still gaps in services, and it can be hard to measure how effective treatment programs are. In turn this can make effective contract and performance management difficult. I have made a number of recommendations to help improve these areas, and to provide additional assurance that services are efficiently and effectively delivered. I believe my report will help to inform Parliament and Government as they consider further action to tackle methamphetamine dependency.

Executive Summary

Introduction

Methamphetamine (meth) use can have serious implications for users, their families and the community. A stimulant, meth is often used continuously over several days in what is known as a 'binge', disrupting the patterns of everyday life and work. Continued use can lead to aggressive and violent behaviour, threatening the wellbeing of family, friends and the public and impacting parenting and mental health. It can also lead to police, ambulance and health providers being involved.

This audit assessed the availability, accessibility and effectiveness of treatment services for people with meth dependency by considering if:

- the Mental Health Commission (MHC) ensures the right meth treatment services are in the right places
- all people who require treatments get them, and are they effective.

Background

A 2016 Australian Institute of Health and Welfare (AIHW) national survey found that more than 65,000 Western Australians, 2.7% of the population, had used meth in the last 12 months. This compared with 3.8% in 2013 but was still nearly twice the national rate in 2016 of 1.4%.

The survey also showed meth had become the drug of greatest public concern, named by 39.8% of respondents in 2016 compared to 16.1% in 2013. To put this in perspective, the survey showed a decline in concern about excessive drinking from 42% to 28%.

There is a suite of WA government activities dealing with substance dependency in general, including meth. They include:

- criminalisation and other legislative approaches
- police and other enforcement and corrective services
- broad public health initiatives
- targeted educational programs
- targeted treatment services.

The Government has had 3 key plans or strategies relating to meth in recent years:

- The 2015 *Better Choices. Better Lives: Western Australian Mental Health, Alcohol and other Drug Services Plan 2015-25 (Better Choices. Better Lives)*. This plan forecasts the alcohol and other drug (AOD) treatment and support services that will be needed in WA to 2025. While this plan provides baseline forecasts of need and capacity for AOD services, its full implementation was not funded.
- The 2016 *WA Methamphetamine Strategy* to address growing concern about the impact of meth dependency. Alongside education and awareness, legal and law enforcement changes, the WA Methamphetamine Strategy aimed 'to expand withdrawal, residential rehabilitation, and community based treatment services' across the state.

- The 2017 *Methamphetamine Action Plan* that updated how the strategy and plan would be implemented, but the key aspects were unchanged.

Our audit focused on the implementation of the Strategy which committed $14.9 million across 2016-17 and 2017-18 to:

- establish a further 52 residential rehabilitation (rehab) and 8 withdrawal beds. This was intended to provide a 9% increase in instances of treatment
- add 13 staff, full-time equivalent, to Community Alcohol and Drug Services (CADS) across the state. Expanding the capacity of these counselling and referral services was expected to provide a 6% increase in episodes of care
- fund a dedicated WA Meth Helpline for 2 years to provide support and advice. In its first 6 months of operation, counsellors and volunteers answered more than 3,000 meth-related calls, mainly from users and their families
- provide 2 years of funding for a specialist outpatient clinic for people with complex methamphetamine withdrawal needs
- fund frontline drug support nurses in hospital emergency departments for 2 years.

The extra beds and CADS staff are an expansion of existing services for people dealing with alcohol and other drug dependencies and are not restricted to clients with meth problems. The 2018-19 State budget funded all these services until 2021-22 except CADS, which is funded until 2020-21.

Residential rehab beds are for services that are all variations of the Therapeutic Community model which is a model for residential drug treatment supported by evidence and accepted by the alcohol and other drug (AOD) sector. This is where the residential community itself, through self-help and mutual support, is the main means of treatment. It is not specific to meth, and is used for treating all drug dependency. There are no pharmacological treatments for meth dependency.

Withdrawal beds are for medically supported detoxification with healthy meals, a clean living space, a supervised environment and daily counselling. Withdrawal usually takes around 7 days. 'Low medical' withdrawal beds offer limited sedative and pain medication to people as they withdraw. 'High medical' withdrawal beds are for people with a higher risk of complications and include additional medical supervision by specialist medical staff.

CADS deliver AOD counselling and referral services. These use variations of Cognitive Behavioural Therapy, often referred to as CBT, one of the most common evidence-based treatments used for drug dependency worldwide.

Although there are many treatment providers, Government funding is primarily through the MHC. The MHC was established in 2010. In 2015 it amalgamated with the Drug and Alcohol Office, which had managed this area since its inception in 1974.

The MHC funds AOD treatment services from 23 non-government providers. It also provides services itself, and contracts some services from the Western Australian Country Health Service (WACHS). While emergency departments deal with many people under the influence of meth and other drugs, the public hospital system is not a key treatment provider.

All services funded by the MHC have to demonstrate that their treatment model is evidence-based and show how it will meet local and individual needs. They must also detail staff qualifications, training and supervision levels.

Audit conclusion

Following a well-run expansion of services in accordance with the WA Methamphetamine Strategy, the Mental Health Commission (MHC) has increased access to treatment in areas of need. This has resulted in a significant increase in the amount and proportion of alcohol and drug treatment undertaken by people with methamphetamine problems.

Despite achieving the increase in services funded under the Strategy, there is still evidence of unmet need for services. There are still fewer residential rehab beds in the north metropolitan area, fewer Community Alcohol and Drug Services staff and fewer withdrawal beds across the state than were estimated to be needed by 2017.

Assessing drug treatment effectiveness is difficult because there is no definitive cure. The MHC manages its relationships with individual providers well, but could do better in assessing whether services are meeting client needs. It collects clients' self-assessments before and after each course of treatment and receives information from its service providers on incidents of care and other key performance indicators. However, it does not use this information to understand treatment outcomes or how clients and their families use treatment services, or to predict demand for services. Differences in the way providers report on their performance also makes it hard for the MHC to be sure it is getting the best value from its contracts.

Key findings

More services are available and used, but not everyone has access to treatment where and when they need it

The MHC has effectively managed the expansion of meth treatment services required by the *WA Methamphetamine Strategy* and *Methamphetamine Action Plan*. It ran a successful tender process that added 60 beds and 13 CADS staff to the existing network of drug and alcohol services.

The expansion of services has widened the treatment options available to people with meth problems and their families. Between May 2016 when the Strategy was announced and January 2018, the number of residential rehab beds increased 20% to 439, and the number of withdrawal beds increased 24% to 44. Implementing the Strategy also added a specialist outpatient clinic for people with complex withdrawal needs, a dedicated helpline and funding for frontline drug support nurses in hospital emergency departments.

At the same time, there has been a significant increase in the amount and proportion of AOD treatment undertaken by people with meth issues. Annual total treatments where meth was the main drug of concern increased by 38% from 5,482 in 2014-15 to 7,573 in 2016-17. Residential rehab treatments for people with a major meth problem grew by 74% in the same period.

Reporting from service providers indicates that treatment capacity still cannot meet demand, and the number of residential beds and CADS staff is below the MHC's estimation, in *Better Choices. Better Lives,* of what would be needed. While average wait times for CADS support have improved, in the 3 months to January 2018, 96 people still waited longer for metropolitan CADS support than the MHC standards[1] require.

[1] MHC specifies the maximum wait times for 5 categories of clients based on how urgently they require care. For example, the most urgent category is pregnant women with a maximum wait time of one day.

The MHC's limited use of performance data means it cannot be sure it is getting best value for money

The MHC has strong working relationships with providers, and collects comprehensive information on episodes of treatment. It collects key performance information (KPIs) from providers, but has not ensured key performance indicators are defined in the same way by all providers. However, it does not use this information to assess how people use treatment services, the performance of service providers or to forecast future demand for services.

Assessing drug treatment effectiveness at a specific point in time is difficult because it does not aim to cure but rather to effect long-term behaviour change. Nor does treatment have a defined pathway or end point, and people often use services more than once.

Taken together, these issues make it hard for the MHC to be sure it is getting the best value for money from its providers, or if they are effectively and efficiently meeting clients' needs.

Recommendations

To enable the Mental Health Commission to better evaluate delivery and outcomes as it continues to expand services, it should:

1. Review and finalise its information and reporting requirements for all contracted providers, including waitlist information.

   MHC response: *Agreed. The MHC will undertake a review of reporting requirements for all contracted Non-Government Organisation services upon the procurement/ renewal of all contracts. Consideration will need to be given to current State Government policies, including the Delivering Community Services in Partnership Policy (2018).*

   Implementation timeframe: Ongoing until 30 June 2023

2. Ensure all providers submit all required information in the agreed formats.

   MHC response: *Agreed. The MHC will continue to ensure that all contracted alcohol and other drug services provide information in a consistent format to meet both the MHC contract management requirements and mandatory national reporting requirements in line with the Alcohol and Other Drug Treatment Service National Minimum Dataset. This will be reviewed by the MHC upon the procurement/ renewal of all contracts.*

   Implementation timeframe: Ongoing until 30 June 2023

3. Implement a formal process for comparing service provider performance.

   MHC response: *Agreed. The MHC is a 'purchasing commission' and can consider how to enhance the current level of benchmarking and evaluation of services. However, to undertake a full evaluation to sunset clause program evaluations would require additional resources.*

   Implementation timeframe: December 2019

4. Review provider KPIs to begin a process to ensure like services have like outcome and output measures and targets.

   MHC response: *Agreed. The MHC supports the need to continue to review output and outcome service measures and review targets. Consideration can be given to current national developments around outcome measurement and the need to enhance existing key performance indicators to cover strategic and emerging issues such as co-occurring mental health and alcohol and other drug related issues.*

   Implementation timeframe: June 2020

5. Analyse client outcome data at a provider level to better understand patterns in service use and treatment.

   MHC response: *Agreed. The MHC supports an evaluation of current alcohol and other drug treatment services to compare treatment outcomes and better understand patterns in service utilisation. This analysis would also support the other recommendations in continuing to refine key performance indicators for organisations and support continual improvement in the commissioning of services. Additional resources would be required by the MHC to scope and undertake the evaluation and analysis.*

   Implementation timeframe: June 2020

Response from the Mental Health Commission

The Mental Health Commission acknowledges that methamphetamine use remains a significant concern within the Western Australian community, and remains committed to the development and implementation of efforts to preventing methamphetamine related problems occurring in the first instance, intervening early before problems become entrenched, and providing treatment and support services for those who need it. This includes the continuous enhancement of contracted services output and outcome key performance indicators and ongoing program evaluations which will be informed by the whole of government reform of community services outcomes.

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, released in December 2015, continues to guide investment decisions for the optimal mix and level of mental health, alcohol and other drug services required to meet the needs of Western Australians until the end of 2025. The Mental Health Commission continues to prioritise efforts towards areas of greatest need, subject to regular Government budgetary processes, that includes a requirement to continually grow community based alcohol and other drug treatment services over time.

The MHC supports the need to continue to review output and outcome service measures and review targets to ensure high quality care and value for money for all Western Australians. Further to this, the Mental Health Commission will look to enhance existing key performance indicators to cover strategic and priority issues such as co-occurring mental health and alcohol and other drug related issues.

Audit focus and scope

This audit assessed the availability, accessibility and effectiveness of treatment services for people with meth dependency. It focused on 2 key questions:

1. Does the MHC ensure the right meth treatment services are in the right places?
2. Do all people who require treatments get them, and are they effective?

In conducting the audit, we:

- reviewed policies, procedures, data and key documents
- considered public comment provided to the OAG
- interviewed key MHC staff.

We visited CADS sites in Bunbury and Armadale, and interviewed staff at 6 service providers:

- Abbotsford Hospital Pty Ltd
- Cyrenian House
- Hope Community Services
- Next Step
- Salvation Army
- St John of God Bunbury.

We also spoke with the Western Australia Network of Alcohol and Drug Agencies (WANADA), a key stakeholder in the area.

This was a broad scope performance audit, conducted under section 18 of the *Auditor General Act 2006* and in accordance with Australian Assurance Standard ASAE 3500 Performance Engagements. We complied with the independence and other relevant ethical requirements related to assurance engagements. Performance audits focus primarily on the effective management and operations of agency programs and activities. The approximate cost of undertaking the audit and reporting is $528,000.

Audit findings

More services are available and used, but not everyone has access to treatment where and when they need it

The MHC has added new beds and services, effectively increasing access to treatment

In 2016, the MHC ran an efficient tender process that opened the market to appropriate new providers and expanded the options available. This added 52 residential rehab beds, 8 withdrawal beds and 13 CADS staff[2] to the existing network of drug and alcohol services. A specialist meth clinic was also set up to run high a medical withdrawal service, and funding was provided for frontline drug support nurses in hospital emergency departments. A dedicated meth helpline was also established.

The clinic differed from other AOD outpatient services. It involved intensive patient/client follow up, the trialling of pharmacotherapy to reduce withdrawals, and the offer of a 5 step cognitive behavioural therapy program.

Since the end of the funding, the clinic clients are treated as part of the mainstream outpatient service. The helpline is still active but frontline drug support nurses are no longer employed.[3] All other services are funded through to 2021.

These additions were based on a reasonable assessment of need, and have led to increased use. Between 2012-13 and 2016-17, the number of treatment episodes for all drugs increased 30% from 14,787 to 19,233.

The MHC's tender process was comprehensive and completed as quickly as could be expected. It asked for expressions of interest on 11 July 2016 for 24 metropolitan and 28 regional residential rehab beds and 4 metropolitan and 4 regional withdrawal beds. It received applications from 10 providers, covering the South West, Midwest, Goldfields, Pilbara and all metropolitan regions. After clear and well-structured assessments and approvals, the process granted new or extended contracts to 6 providers in October 2016 (Table 1).

Contracted Provider	Region	Residential Rehab Beds	Withdrawal Beds
Abbotsford Private Hospital	South West	14	2
Cyrenian House	North Metro	16	–
	Metropolitan	–	4
Goldfields Rehab	Goldfields	4	–
Hope Community Services	Mid-West	10	–
Palmerston Association	South Metro	8	–
Yaandina Family Centre	Pilbara	–	2
Total		52	8

Source: MHC

Table 1: Additional beds for residential rehab and low medical withdrawal services

[2] Full-time equivalent. The number of individuals doing the work will be greater if some are part-time.
[3] St John of God Hospital in Bunbury has continued with this initiative at its own expense.

In January 2018, there were 439 residential rehab beds and 44 withdrawal beds, an increase of 20% and 24% respectively since October 2015. Of these MHC was funding 249 of the residential rehab beds and 42 of the withdrawal beds.

Under the *WA Methamphetamine Strategy*, $3 million was allocated to add the equivalent of 13 full-time staff (FTE) to CADS services (Table 2). An additional $4.5 million was allocated to continue this staffing level from 2018-19 to 2020-21. The positions are for counselling, information and referral for people who need help with meth and their families. These choices were based on a strong assessment of:

- the prevalence and severity of the problems being experienced with meth in each CADS catchment
- the existing community treatment and prevention workforce capacity at each CADS catchment
- the estimated population increases for WA
- high priority areas in *Better Choices. Better Lives.*

Community Alcohol and Drug Service (CADS)	2016 FTE	2018 FTE after Strategy	Operating locations
North Metro	32.2	32.7	Joondalup, Warwick
North East Metro	10.9	12.4	Midland
South Metro	30.1	32.1	Fremantle, Mandurah, Rockingham
South East Metro	13.9	15.4	Thornlie
Drug and Alcohol Youth Service	30.8	31.3	East Perth, Carlisle
Metropolitan total	**117.9**	**123.9**	
Goldfields	12	13	Kalgoorlie, Esperance
Great Southern	6.9	8.4	Albany, Katanning
Kimberley	23	23	Derby, Fitzroy Crossing, Halls Creek, Kununurra
Midwest	11	12	Carnarvon, Geraldton, Meekatharra
South West	17.5	19.5	Bunbury
Pilbara	17	17	Karratha, Newman, Port Hedland
Wheatbelt	10	11.5	Merredin, Narrogin, Northam
Regional total	**97.4**	**104.4**	
CADs total	**215.3**	**228.3**	

Source: MHC

Table 2: Additional CADS FTE funded by *WA Methamphetamine Strategy*

Despite the increases in treatment services, there is evidence that capacity does not yet meet demand

While these additional beds and CADS have increased the amount of service provided, the number of beds does not yet match that forecast in *Better Choices. Better Lives,* and waiting times indicate unmet need for CADS services. Measuring unmet demand is difficult. People who need treatment do not always admit to having a problem in the early period of their

dependency. A range of personal, social and legal issues cause people to avoid treatment and also drop out of treatment, while privacy concerns make data collection challenging.

Despite this uncertainty, *Better Choices. Better Lives* estimated future need for services using national modelling tools applied to the population of WA.[4] This identified an optimal mix and level of mental health, alcohol and other drug services but did not separately identify the specific needs of people dealing with meth dependency.

Despite exceeding the estimated residential rehabilitation bed requirements for 2017 in total, MHC estimates show a shortfall in the north metropolitan area of 101 residential rehab beds (Table 3). MHC modelling also shows there are 18 fewer withdrawal beds across the state than were needed by 2017. It is not clear if these shortfalls accurately reflect current shortfalls in treatment capacity. However, providers report that demand is growing and they have to put people on waitlists for treatment.

The MHC has recognised the need to increase service capacity. It is currently seeking expressions of interest to create 30 new residential rehab beds and 3 low medical withdrawal beds in the South West following a commitment by the Government in the 2017 Methamphetamine Action Plan to target regional areas.

Region	Additional strategy beds	Total	Estimated bed requirement at		
			2017	2020	2025
North Metro	16	64	165	214	295
South Metro	8	133	128	202	267
Northern & Remote	0	160	106	106	115
Southern Country	28	82	0	36	95
Total	**52**	**439**	**399**	**558**	**772**

Source: MHC

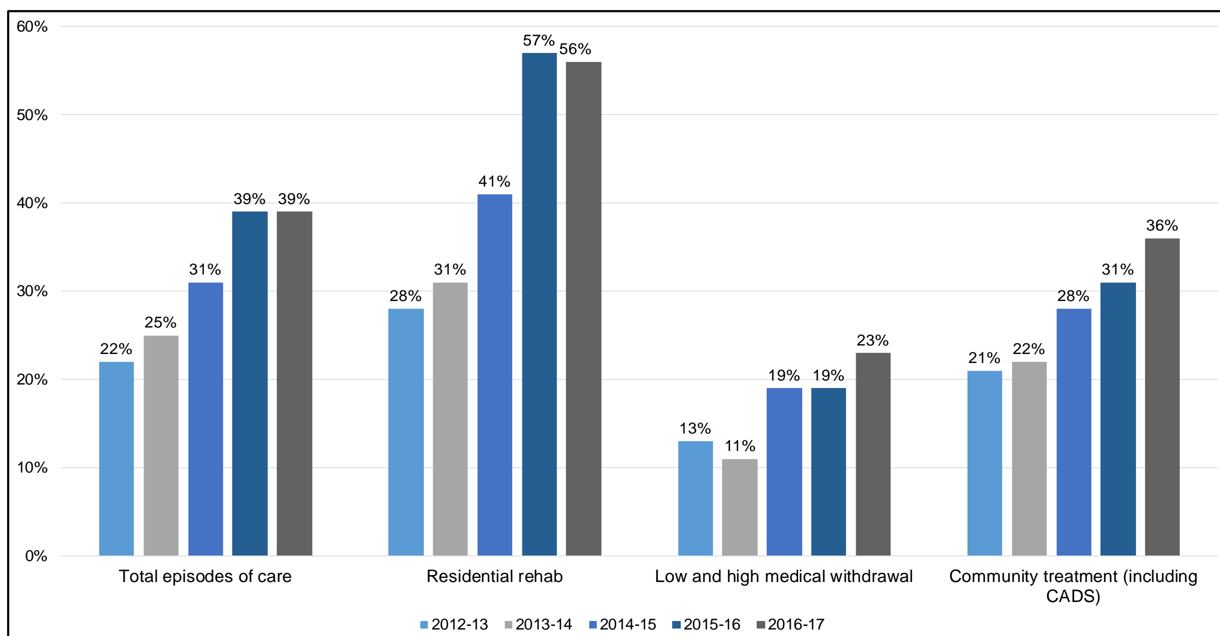
Table 3: Residential rehab beds under the Strategy and MHC's estimate of future bed requirements

A similar situation applies to demand for CADS services. Even after the increase of 13 FTE for CADS counselling services, the total FTE of 228.3 is less than 20% of the 1,178.5 MHC's modelling estimated would be needed by the end of 2025. It is unlikely this will be reached but a more up to date estimate of need could provide a more accurate estimate of any capacity shortfall.

People are using the extra services and average wait times have improved substantially, but some people are still not getting help when they need it

There has been a significant increase in the amount and proportion of AOD treatment undertaken by people with meth issues. Annual total treatments where meth was the main drug of concern increased by 38% from 5,482 in 2014-15 to 7,573 in 2016-17, covering the period when the Strategy was introduced. Residential rehab treatments for people with a major meth problem grew by 74% in the same period and have more than doubled since 2012-13. (Figure 1). The increases in treatment episodes since 2014-15 indicate that the extra services are meeting the intent of expanding the services.

[4] Better Choices. Better Lives p104.



Source: MHC

Figure 1: AOD episodes of care where meth was the main drug of concern 2012-13 to 2016-17

Meth has replaced alcohol as the major source of demand for treatment, increasing demand for residential rehab services:

- In 2012-13 alcohol was the major cause of treatment, with 44% of all cases. By 2016-17 it was meth, making up 39% of cases.
- Treatment episodes where meth was the main drug of concern increased by 121%, from 3,421 to 7,573.
- In 2012-13, 162 people with a major meth problem received residential rehab treatment. In 2016-17 the number was 582, an increase of 259%.

While treatment numbers are increasing, there are still shortfalls across all service types. In the 3 months to January 2018, 5% of those on waitlists waited longer for metro CADS support than priority standards require. Another 9% left the system without getting treatment. This suggests that 1 in every 7 people seeking treatment are either not being seen in time or are dropping off the waitlist. It is not clear if this is acceptable to the MHC or should be improved. There was no information on non-metropolitan CADS. Average wait times for CADS appointments have improved substantially. Median times have also dropped, showing more people are being seen more quickly (Table 4).

CADS wait times	November 2016	January 2018
Average wait time (days)	15.3	10.2
Median wait time (days)	8	7

Source: MHC

Table 4: Wait times for CADS appointments have improved since 2016

At January 2018, 33 residential rehab beds were unoccupied, all but 2 of them in Geraldton. The vacancies in Geraldton were due to a change in service delivery which required all clients to do farm work. The provider has also introduced a strict no smoking policy which appears to have discouraged some people from using that service. The MHC is monitoring this situation.

A decrease in the Meth Helpline budget potentially reduces accessibility to counselling services. There were 1,447 calls to the Meth Helpline in the 12 months to 18 May 2018. In July 2018, the MHC confirmed the helpline's budget had dropped by $154,000 for 2018-19, due to the end of funding from the Strategy. The Meth Helpline is staffed by the Alcohol and Drug Support Service (ADSS) and, though the Meth Helpline is still active, there are now 10 fewer ADSS shifts per fortnight, decreasing from 75 to 65.

The MHC's limited use of performance data means it cannot be sure it is getting best value for money

The MHC's funding of AOD services is significant. It contracts 41 providers engaged through 115 contracts to deliver services to those seeking alcohol or drug treatment. The total cost of these contracts was $57.7 million in 2017-18. Around half the total expenditure goes to 11 providers for 19 contracts. It is important for the MHC to know that it is getting value for money.

Assessing the effectiveness of drug treatment is difficult at an individual or organisational level. At an individual level, this is because treatments do not aim at a cure but at long-term behaviour change. The 2 key accepted ways to assess whether treatments have been effective are to measure completion of treatments and to collect client self-assessments. At an organisational level, it is difficult because treatment does not have a defined pathway or end point. It is also expected that people will use services more than once over varying periods of time.

The MHC manages its relationship with individual providers well

As outcomes are difficult to measure, contract managers need to maintain good current knowledge of, and close relationships with, their contractors. The MHC has long familiarity with its service providers and understands the field well. This is helped by professional expertise and relatively high levels of staff continuity. As a result, they manage individual providers well.

The MHC's contract managers:

- conduct regular reviews of each contract in line with Key Performance Indicators (KPIs)
- ensure providers comply with major requirements of their contracts such as maintaining accreditation, maintaining appropriate insurance and continuing to offer the service defined by their contract
- manage any critical incidents with providers
- respond to any queries that the provider may have about their contract or to discuss any other isues
- understand the providers' businesses.

The MHC collects a lot of information but does not analyse it to ensure service effectiveness and value for money

The MHC collects comprehensive information, by provider, on every episode of treatment, including completions and self-assessments. Most providers input this information directly to the MHC's data system, known as SIMS. One provider does not share data at this level.

The MHC monitors and reports this information in aggregate terms. However, it does not use this information to assess how people use treatment services, the performance of service providers or to predict future demand for services.

The MHC collects data from service providers and works with service providers to address issues when data collection requirements are not met. However, not all providers share their data and the MHC does not analyse all the data it collects to the extent possible. It has not conducted a comparative assessment of treatment service providers to understand what services are most effective and give value for money.

Specifically, the MHC collects and reviews:

- client outcome and output information from every provider
- client satisfaction information from every provider
- contract KPI information from providers
- waiting list information for CADS and, since January 2018, residential rehab.

However, we would also have expected the MHC to:

- use benchmarks to enable cross-service comparisons
- analyse outcome data to assess the relative effectiveness of services it funds
- verify that clients are receiving the services that they need
- analyse data about individual treatment pathways
- compare client post-treatment self-assessment data from different providers.

Also, it does not collect data on:

- how many times individuals return for treatments over what periods of time or if they attend more than 1 facility
- treatments per individual per provider
- comparative completion rates of providers
- waitlist differences between providers in different locations
- how long people are on residential rehab waitlists.

This makes it difficult for the MHC to assess if providers are meeting clients' needs effectively and efficiently. In turn, this limits its ability to improve the mix of services offered by providers.

The MHC is not using service KPI information as effectively as it could to improve the planning and management of treatment services

The MHC relies heavily on contract KPIs and targets to assess provider performance. However, the targets vary between providers and the MHC does not always enforce contract requirements for reporting. This indicates that there is no clear benchmark for performance. In turn, this limits the assurance the MHC can have that the system is performing well.

Each contract the MHC has established with providers includes a consistent set of activity based measures. Many of them mirror the factors in the client assessments on SIMS, but measured as percentages of treatment episodes, for example, percentage of clients reporting improved physical health.

While the measures are consistent, the targets are not, limiting the MHC's ability to use them to compare performance. For example, the target for improved mental health of clients of non-residential counselling ranges from 40% to 80%. It is not clear if this is based on any

unique quality of the service or client base, and suggests that providers might be interpreting the same measure differently. Further, the MHC has not required all providers to report against all the measures.

While the MHC generally manages providers well, its current contract templates have no penalty terms that it can use to drive improvements. The MHC also has no guidance or policy for contract managers to deal with providers who may not meet performance requirements. This means it could do little if providers did not meet contract expectations.

The MHC relies on its experience and understanding of treatment models, how long-established providers work, and academic research to inform its contracting. It also requires external accreditation of providers to assure service quality. While this has been accepted by MHC to date, we saw no evidence that the MHC evaluates the suitability of accreditations or that providers consistently meet the standards within them. Given other information weaknesses, this limits its assurance that services are meeting client needs.

While the MHC has collected CADS data for a number of years, it only started systematically collecting rehab waitlist information from January 2018 and not all providers are reporting it. Our analysis of CADS wait times showed much longer waiting times for some services than others. We did not see any evidence that the MHC has addressed these differences.

Auditor General's Reports

Report number	2018-19 reports	Date tabled
8	Opinions on Ministerial Notifications	10 December 2018
7	Audit Results Report – Annual 2017-18 Financial Audits of State Government Entities	8 November 2018
6	Opinion on Ministerial Notification	31 October 2018
5	Local Government Procurement	11 October 2018
4	Opinions on Ministerial Notifications	30 August 2018
3	Implementation of the GovNext-ICT Program	30 August 2018
2	Young People Leaving Care	22 August 2018
1	Information Systems Audit Report 2018	21 August 2018
Report number	**2018 reports**	**Date tabled**
13	Management of Crown Land Site Contamination	27 June 2018
12	Timely Payment of Suppliers	13 June 2018
11	WA Schools Public Private Partnership Project	13 June 2018
10	Opinions on Ministerial Notifications	24 May 2018
9	Management of the State Art Collection	17 May 2018
8	Management of Salinity	16 May 2018
7	Controls Over Corporate Credit Cards	8 May 2018
6	Audit Results Report – Annual 2017 Financial Audits and Management of Contract Extensions and Variations	8 May 2018
5	Confiscation of the Proceeds of Crime	3 May 2018
4	Opinions on Ministerial Notifications	11 April 2018
3	Opinion on Ministerial Notification	21 March 2018
2	Agency Gift Registers	15 March 2018
1	Opinions on Ministerial Notifications	22 February 2018

OAG
Office of the Auditor General
Serving the Public Interest

Office of the Auditor General
Western Australia

7th Floor Albert Facey House
469 Wellington Street, Perth

Mail to:
Perth BC, PO Box 8489
PERTH WA 6849

T: 08 6557 7500

E: info@audit.wa.gov.au

W: www.audit.wa.gov.au

Follow us on Twitter @OAG_WA

Download QR Code Scanner app and scan code to access more information about our Office