T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Budget Estimates 2019–20 (Mental Health)

Melbourne—Thursday, 13 June 2019

Members

Mr Philip Dalidakis—Chair
Mr Richard Riordan—Deputy Chair
Mr Sam Hibbins
Mr Gary Maas
Mr Danny O'Brien
Ms Pauline Richards
Mr Tim Richardson
Ms Ingrid Stitt
Ms Bridget Vallence

WITNESSES

Mr Martin Foley, Minister for Mental Health,

Ms Kym Peake, Secretary,

Mr Terry Symonds, Senior Deputy Secretary, Health and Wellbeing,

Mr Greg Stenton, Deputy Secretary, Corporate Services, and

Mr Ross Broad, Director, Royal Commission Engagement, Department of Health and Human Services.

The CHAIR: All right. Good afternoon to everybody for the second-last session of today. I declare open this hearing of the Public Accounts and Estimates Committee. On behalf of the Parliament, the committee is conducting this inquiry into the 2019–20 Budget Estimates. Its aim is to scrutinise public administration like never before and to improve outcomes for the Victorian community, also like never before, and I believe we are meeting both of those lofty goals with aplomb. The committee will now begin consideration of the portfolio of Mental Health. I welcome the Minister for Mental Health, the Honourable Martin Foley, and officers from the department. Thank you for appearing before our committee today.

All evidence given is protected by the Parliamentary Committees Act. This means that it attracts parliamentary privilege and is protected from judicial review. Witnesses, however, found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty, which could be quite serious, including spending more time with us.

Minister, I invite you to make a very brief opening statement or presentation of no more than 10 minutes. This will be followed by exciting questions from the committee. Over to you, Minister.

Visual presentation.

Mr FOLEY: Thank you, Chair, and can I thank the committee for this opportunity. One in five Victorians experience a mental illness of some degree each year, and almost one in two of us will experience a mental illness in our lifetime. This is approximately, on current population figures, 1.2 million Victorians. We know poor mental health increases the likelihood of not only self-harm but in far too many extreme cases, suicide. In 2017 alone, the most recent figures we have, we lost more than 600 Victorians to suicide. People living with mental illness also are at much greater risk of a whole heap of social and economic disadvantage and poor physical and other outcomes. This includes far too high rates of unemployment, overrepresentation in homelessness, high rates of abuse of alcohol and other drugs, a far too disproportionate contact with the criminal justice system and all too often comorbidities and overrepresentation in poor physical health outcomes.

We know all of us, every street, every suburb and every community, have links into people who need mental health support, and we all through our lived experience understand the devastating impact that mental illness can have when that support, that we rightly as a community seek to demand, is not there. The flow-ons to families, to friends, to workplaces and to the whole community are quite severe at times, and depending on where you are in that one in 5 they can be extremely debilitating in a small number of circumstances—but too many.

So part of the approach that this government is now taking is to, as committed to in the recent election campaign, establish a Royal Commission into Victoria's Mental Health System, and this graph seeks to present in a simple way a very complex set of challenges and problems. The Victorian government, and through our consultation with a whole range of stakeholders, which we will go into, has identified a series of challenges for the independent royal commission into mental health to seek to assist the entire Victorian community and we hope set the pathway for the Australian community to deal with issues around the many gaps in our mental health system. And if I can seek to use this as an opportunity to perhaps focus on what our view is on what at least finding those gaps might be. This is in many ways despite the increasing contributions, financially and organisationally, to seek to address these and other gaps. The truth is that the system continues to struggle at unacceptable levels.

So the Victorian government in its engagement with the royal commission is seeking to focus on five key gaps in what we say is the delivery of mental health challenges in our system. The first of these is an early engagement gap; the second a treatment gap for people with moderate or enduring mental illness, where you fall essentially between being not sick enough for the acute sector but too ill for the primary care sector; then flowing on from that, treatment gaps for people with severe mental illness; and indeed when it comes to particular cohorts, the overrepresentation and really the importance of dealing with the gaps when it comes to children and young people. But then there is a whole system down the bottom of that graph that looks to, if you like, a series of enablers which have perplexed regimes in not just Australia but in comparable jurisdictions right around the world. How do we govern our mental health system? How do we have appropriate funding mechanisms? In this world of big data and opportunities, what data and systems gaps and needs do we need to establish, the many challenges in the workforce, and of course how can we keep our infrastructure investments up to speed in this growing, demanding area?

So in this respect this is why the Victorian government sought to get out of the blocks quickly around the promised royal commission into mental health. Over December and January we looked at an extensive process of consultation with wide-ranging groups across our community. We had more than 8000 contributions over the Christmas-New Year holiday period, which was astonishing in itself for written submissions, as to what they would look like. We led 23 community and sector consultations across 7 locations around the state, and they pointed to, essentially, a set of terms of reference that picked up five areas: how to most effectively prevent mental illness and indeed suicide; how can we deliver the best mental health outcomes and help Victorians navigate what can be at times a complex system; how can we support families and carers and particularly consumers in the sector to deal with their mental health challenges; how can we improve outcomes, particularly at the community level for those priority groups that data shows us are well and truly overrepresented in poor outcomes of mental health; and how can we link this into making sure that we have a recovery model that ensures people are able to contribute successfully to our community whilst at the same time ensuring that problematic alcohol and drug use is addressed in this royal commission.

The royal commission has been out of the blocks—it has its own process now that has been up and running since earlier this year, and they have widely gone around the state. There have been 60 community consultations in 20 locations and 1600 people have attended those informal sessions, and public hearings will commence in early July and continue for some period about that time. And as per the terms of reference and the charter for the commission it will provide an interim report by the end of November, and the final report will be by the end of October next year.

And yet, despite what the next couple of slides show, where we have seen for some time increasing investments in this space, some substantial increasing investments in this space, we continue to get poor outcomes in far too many areas. In terms of at least this particular budget, this budget will deliver a further $173 million worth of investment in mental health, alcohol and other drug services, bringing from over five budgets an investment of some almost $2 billion in an ongoing sense into the budget. That growth in the first term of the Andrews government equates to some 181 per cent, and as this slide shows, that $2 billion investment in mental health and alcohol and drug services in a year-on-year capacity reflects an 8.1 per cent increase in this budget that is before the committee as we speak when you combine both key components of the portfolio's responsibility in mental health and alcohol and other drugs. So you have a bit of a conundrum in that clearly what we are doing is in many respects needing a root-and-branch reconsideration, hence the royal commission.

The royal commission was our main election commitment, but we also committed to not stand still whilst the process was underway and the investment of $51.6 million in this budget is a reflection of new initiatives that deliver a range of support measures that reflects that. There is a $17.1 million package obviously around establishing the royal commission, and given the experience of similar inquiries in other areas around both the state and the country further support for those areas that are likely to see increased demand as a result of the increased community focus that the royal commission brings—that being the mental health complaints commission and the chief psych's office. There is also $14.5 million around delivering better health care for our emergency workers, particularly the centre of excellence for emergency worker mental health, which I share ministerial responsibility for with both the Minister for Police and Emergency Services and the Minister for Workplace Safety—whatever the Attorney-General's other portfolio is called. And then there is a further $20 million to relocate and indeed update the Barwon clinical mental health facilities, which is not unrelated to

them being right next door to the Geelong Performing Arts Centre, which itself was the subject of an election commitment by the government.

At the same time we are also boosting services and programs directly related to what we would expect from talking to stakeholders. The royal commission will look at the sort of services that are about treating people close to home—and increasingly so in an acute setting—but in the community, with the appropriate supports. That is reflected in the $28.7 million for additional mental health services in the community, $6.6 million for a number of prevention recovery units, $23.3 million for more inpatient beds in our acute health services facilities and, as the member for Gippsland South will no doubt be aware, in the neighbouring electorate to his, $10.2 million for the operationalising of the 30-bed residential rehabilitation facility in Gippsland.

Moving on, in the output initiatives part of the budget there is substantial funding set out there for a partnership with the Department of Justice for further expansion and work for the Victorian Fixated Threat Assessment Centre. There is support for our mental health workforce, which we know is a key area. There is funding that has arisen from consultation with Aboriginal-controlled community health and other organisations to prioritise support for severe mental illness in that well and truly overrepresented group of Victorians in mental illness, and there is a further package of support around addressing harm in alcohol and other drug areas—not the least being to expand the hours and range of services for the Medically Supervised Injecting Room but a range of other services as well. And then, as I indicated, there is support for the mental health complaints tribunal and the Mental Health Complaints Commissioner—for her and that organisation to perform their important functions. There is also a $3 million package to address the issues around the gap that has emerged as a result of the commonwealth government abandoning 11 000 residents of this state who are asylum seekers, and some 6000 of those will be facing destitution in the coming weeks and months as a result of withdrawal of commonwealth support to them.

So, in a very whistlestop sense, Chair and committee, that is the very edited highlights of the Victorian government's mental health portfolio contribution in the next 12 months.

The CHAIR: Thank you, Minister. I do not think it is too far-fetched to say that you have the most pressing and important portfolio amongst all of your colleagues, given the royal commission, and if you do not at this stage, you will once the royal commission hands down its findings and recommendations. I hand over to Ms Richards. She has the call until 5.02 p.m.

Ms RICHARDS: Thank you, Minister. Thank you, Secretary and departmental officials, again for being here this afternoon. Minister, seguing on from what the Chair just said, you have an area of great importance, but we are all very conscious of the high number of Victorians losing their lives to drug-related overdoses. I note at budget paper 3, page 50, the provision of $4.2 million over two years to address drug harms, and am conscious that part of this funding is to extend the hours of operation of the medically supervised injecting room in North Richmond. Could you perhaps explain to the committee what the benefit of extending the hours of operation are when the new facility opens?

Mr FOLEY: Thank you, and yes, I can assist the committee in that regard. We know that the ongoing heroin, in particular, scourge that can be seen in stark relief in Richmond—not just in Richmond, but particularly in Richmond and North Richmond—is a major issue of concern. We want to make sure that we do what we can, particularly on the best advice, and in this case three coroners reports plus a bipartisan parliamentary inquiry that called us to do what a number of governments have been called on to do for many decades, and that is to trial a medically supervised injecting facility in the area that had, sadly, the most deaths from heroin overdose, and that is North Richmond.

We began the process of establishing the medically supervised injecting facility in response to those inquiries, which themselves were a response to a 20-year spike in the number of deaths from heroin across the state, but in particular in that community. That number had been progressively increasing since 2012, and whilst this will be an important contribution to responding to that spike, this should not be seen as simply a North Richmond issue; it should be seen as a statewide, indeed nationwide, challenge.

In response to that the quickest way of establishing the facility in response to the I think it was 35 deaths immediately preceding the reporting period was to work with the North Richmond Community Health centre in

responding to their offer to refurbish what was their meeting facility at the North Richmond Community Health centre. That has been done and has been operating for some time since the middle of last year. From the word go we knew that would not be large enough, particularly to meet the wider integrated model of service delivery that the centre provides. It provides a series of pathways and opportunities for many sometimes highly chaotic lifestyle people who may be addicted to heroin in particular to engage with services that they would not otherwise have the opportunity to do. That has, we hope, provided an integrated set of services that can link people to the treatment, rehabilitation and support that ultimately they can engage with to hopefully get out of the chaotic lifestyle addictions that they are a part of. But first and foremost it is a harm minimisation response to try to save lives, and in that regard that continues to be its main goal.

The early days of the operation have been successful, and we hope this particular $4.2 million worth of packages to address drug harms, which were referred to, will further assist that. In regards to the medically supervised injecting facility itself, the money will be part of a package that extends its operations every day of the week by a further 3 hours a day, and once it moves into a larger facility, we will be in a position to expand the range of related services that will be in place. This comes about following not just consultation with the stakeholders in North Richmond and surrounding communities and expert bodies but includes a range of discussions with the likes of the AMA, the Australian College of GPs, Ambulance Victoria, the ambulance employees association, the Victorian Alcohol and Drug Association and a range of advocates including the Penington Institute and the Australian Alcohol and Drug Foundation.

We also want to make sure that as part of this the extended hours and the larger facility will address some of the logjam issues in the facility itself by having a larger facility open for longer with more services. Our hope is that it will address some of the not new but now brought into sharp relief local community amenity issues that we continue to work through with the council, police, local residents and a range of other local NGOs and civic stakeholder groups.

In that regard earlier this year, in April, I announced a series of programs, which are now starting to flow through, in consultation with council, with community and with VicPol that go to things like increasing police activity, which we have seen quite a lot of in addition to 13 extra police that the Yarra policing district now have. I would anecdotally expect that that increased police focus in Richmond more broadly, not just in North Richmond hotspot of heroin use and the medically supervised injecting facility, will probably lead to a spike in police data in this space. I know, and it has been well publicised in the media, there have been a number of significant heroin busts and there have been a significant number of targeted operations looking to disrupt particularly the supply of pushers and mid-level and higher level people who would seek to profit from the distressing situation that so many heroin users find themselves in. This is a difficult space, but confronted with the public policy challenges that had been left unresolved for two decades or more in that community in particular, but bringing it into sharp relief across the state, we think that that is a sensible approach.

There are also measures in there about assertive outreach programs to engage with those users of heroin in that area that have yet to engage with the facility, and we know, again, that that has started to see some benefits. When you combine, hopefully, the carrot of better services and sustainable life with the stick of a greater police enforcement process, with the supporting work around amenity and the opportunities that we are pursuing with the council, with traders and others, we will see the medically supervised injecting facility, as part of a wider response, deliver its necessary objectives. So, in a long way, that is an answer to your question.

Ms RICHARDS: Thank you, Minister. I think you were just about to head down the path I would like to take you now, which is just to give an update to the committee on the results of the trial so far.

Mr FOLEY: In terms of at least the trial within the four walls of the interim facility, it has been a success. Since it opened on 30 June last year, I would agree with the assessment of the medical and professional team that it has contributed to saving lives. There are now over 2850 registered users of the facility, and they have responded to more than 1100 overdoses in that time. No-one will know for sure, but given the history of the 35 deaths in the immediately preceding period and the fact that the facility has had no deaths from overdose or anything else, you would like to think that it has undoubtedly made a contribution to saving lives. That is not to say that there have not been deaths in the surrounding community. Sadly in the immediately adjoining car park a young man lost his life very early on a Sunday morning waiting for the facility perhaps—no-one will ever know—to open. In that regard every death is a tragedy and every heroin-related death in what continues to be

an overrepresentation in the City of Yarra is a tragedy, but in terms of what is happening there we think it has been relatively successful.

Early data also shows that ambulance call-outs in the area for drug-related call-outs have decreased during the medically supervised injecting room's operating hours, and that has reversed the trend of recent times. We also expect that the proportion of overdoses that are reflected in those data during the opening hours of the centre have also decreased. That is promising, but it is still early days in terms of the two-year trial, and we hope that by extending the hours of operation, by providing more capacity and by providing a wider range of services and pathways to engagement and a more sustainable lifestyle that we can build over time on these figures. Yet we know that there are many factors that will contribute to the fluctuations, some of which are beyond our immediate control and require continued cooperation with the commonwealth. They go to importation, the cost and the purity of, sadly, some of the heroin that continues to be such a profitable area for people to trade in.

It is important to note that it is still early days in the two-year trial and that we think the facility has to be given the opportunity to build its capacity, to build its results and at the same time to look towards a wider set of engagements for people whose sadly chaotic lifestyles put them beyond the normal reach of medical and social and civic support. But with this opportunity for engagement we are now starting to see some positive outcomes in that regard as well.

Ms RICHARDS: Thank you, Minister. It seems to me that this model, the medically supervised injecting room model, is quite unique among supervised injecting facilities. I am advised it has allied health services that are co-located there. Are many people taking up the opportunity to access these other treatment services?

Mr FOLEY: That was part of the model that through the consultation processes with a range of experts as well as frontline practitioners in this area, as well as the work of the parliamentary committee that looked in this space—there are many models globally in how to pursue medically supervised injecting facilities. If there is such a thing as best practice, it is to locate such facilities in the heart of where the hotspots of overdose deaths occur and to put around that facility the wider set of health, social and civic engagement services that people addicted to particularly heroin in this case might need. I was interested to see some media comments by the medical director of the facility, who himself is a global expert in this, having previously been at the World Health Organization in this space, talk about that if there was world's best practice it might well look like the North Richmond facility. Whilst I am not a global expert in this space, some of the most recent data that the facility has provided points to that.

In the first nine months of operation they have provided more than 3300 on-the-spot health and social support interventions to clients of the service; there have been more than 1000 referrals to other service provisions, both within the suite of services operated at North Richmond or to wider health and community support services; mental health support; naloxone training, which itself can save lives; bloodborne virus disease assessments; treatments and information on sexually transmitted infections; and indeed legal support and other health and social supports. From this work, more than 150 people have been tested for hepatitis and 40 people have entered treatment for hepatitis. It has been estimated that hepatitis testing and treatment for around 250 people a year, which they are on track to do, makes a substantial contribution to reducing the hepatitis epidemic in Australia. I know Hepatitis Australia look to strong support for a medically supervised injecting facility as part of their primary health engagement approach to reducing the impact of hepatitis.

More than 250 people from the centre have started opioid replacement treatments or have been referred to other forms of alcohol and other drug treatment services, and 25 per cent of the clients—of over 2000 clients—have requested information on treatment. That is because it is structured deliberately. Yes, it is a clinical setting, but it is also a setting that seeks to engage and hold people in conversation in model care that can lead to other opportunities for engagement. We hope the larger facility, with four times the space when it comes to that wider range of suite of services, will enable that. According to, as I said, the supervising injecting facility's medical director, this co-location of health, social support and the medically supervised injecting facilities makes it one of a very small number globally that operate in such an integrated way. And if it is about providing support to vulnerable people who might in other circumstances struggle to access such services, then perhaps that is not a bad thing if it not just keeps them alive but can improve and gauge their health and wellbeing. Having met a number of those people from my work in dealing with the North Richmond Community Health centre more broadly, when you see families reunited, when you see people go from homelessness and addiction to

employment through things like beating their addiction but getting their teeth fixed, these are measures of success that are hard to quantify but really do change lives.

Ms RICHARDS: That is incredible, extraordinary evidence. Compelling. Minister, I would like to take you away from North Richmond and move you onto what is something we are all very proud of, which is the decision to hold a royal commission into Victoria's mental health system, something that is really important in Cranbourne and I think really important to everyone. I would like to refer you to budget paper 3, page 92, and the $13.6 million for the royal commission. What are some of the key challenges in the mental health system that the government is hoping the royal commission can help address?

Mr FOLEY: As you will recall, the commitment to a royal commission into mental health was a key election commitment in this space in 2018 and is now off and running, which I dealt with at a fairly high level in my presentation, given its centrality to not just the mental health portfolio but through the various social determinants of what contributes to the, frankly, crisis in our mental health services at all levels. I welcome the opportunity to expand on what that might mean and to expand particularly on how is it that since 2014 we can at the same time increase funding for our mental health services and system by some 181 per cent yet in so many areas continue to go backwards in performance measures and social and other outcomes. In that regard, increasing community focus around mental health has been one of the drivers that has emboldened us to go down the path that is funded through, as you say, BP3 commitment, page 92, for the support for the commission's activities.

To touch on what that might mean, at least in terms of how this investment might meet some of the challenges, it is: how can we support the commission in doing its work; assist the wider community to engage as much as possible, but particularly consumers, carers and those with lived experience, to engage with the commission; yet at the same time continue what we think to be the best possible advice about addressing many of the concerns in this space? Whether it is last year's $705 million investment in mental health in the budget that we are just coming to an end of or the more than $150 million in the coming budget's processes, we can point to the quite large increase of 89 new and existing acute inpatient beds being expanded in the acute health system that will see more than 12 800 Victorians gain some of that support. It will be an investment of some $154 million in the community-based mental health area, particularly through the health services network in a community setting, because the truth is that since the de-institutionalisation push a generation ago, far too much of our acute mental health services rely on clinical settings, and the need to get into local community-based but appropriate community-based settings, particularly for acute mental health, remains a priority. And I would be surprised if that is not a major focus of not just the Victorian mental health royal commission but indeed, coincidently, an inquiry by the commonwealth's Productivity Commission that is running at the same time, even though it is looking at slightly different areas.

There is also the continued rollout of the six emergency departments—mental health departments—that will be, and are now, underway in planning, which will seek to divert from a highly inappropriate setting of an acute emergency departments setting, where so many people present in an acute mental health condition, to divert them into a much less stressful dedicated mental health supported area and then to triage them into appropriate care. Far too many hours and difficulties, let alone the services of first responders, particularly police and ambulance services, are being taken up with trying to manage people in sometimes quite a psychotic condition in emergency departments.

There is the establishment of the continued rollout—again across the state, a further six to extend to the 12 locations—of the HOPE program, which is the Hospital Outreach Post-Suicidal Engagement sites, which are all around. Sadly, the greatest indicator of someone who is likely to take their life is someone who has attempted to take their life. And the spaces in which people are engaged in that regard generally are the acute hospital settings, but there has been historically a lack of engagement around post-release—how to support, how does dealing with the drivers of that particular reason as to why people end up in that situation, to be nuanced to a tailored package. So working with what the PHNs and particularly the support that the primary health and commonwealth arrangements can bring to that, we are in the process of doubling that number of HOPE sites around the state, and we think that is a very important initiative that could be built on over time.

There is investment, as you would expect, in renewing facilities right across the state. There is the multiple health and complex needs assessments, which we run in parallel with a range of other government services for

those really high-needs, high-difficulty cases. And there is further funding in this budget for residential rehabilitation facilities, particularly for alcohol and other drugs, as I indicated, not just in Gippsland but also in the Hume and Barwon areas to construct and operationalise facilities that are rolling out, and there is support for the Grampians-Ballarat facility, which is now up and operational. There are a further 20 beds into that area. And then, in line with trying to deliver in this space of step-up, step-down facilities in a more appropriate community setting, there is further expansion of the prevention and recovery centres to help people both recover from mental illness in the acute setting and in one of those missing middles that we wanted to try to expand the range of services for people who might look to being too ill for primary care assistance but, because of the stresses and strains in the acute health system when it comes to mental health, not sick enough for those settings to get them a more appropriate set of care in prevention and recovery units. And the specialist nature of some of those, particularly when it comes to young people, and particularly in light of the recent Victorian Auditor-General's report into both the mental health acute system and his more recent report on young people trying to address some of those demands, as well as investment as we need to with our mental health workforce to expand its range of skills and growth in what is a very challenging space.

So whilst the system in many respects is full of dedicated and inspirational people doing some of the best work you would want to see, the truth of the matter is that far too often they are unsupported in the institutional and wider set of circumstances, and sometimes in the wider set of social prejudice around stigma and discrimination that tars too many people. Unlike the rest of the health system, where the sicker you are the more likely you are to get service, the sad truth is that the sicker you are and untreated in mental illness, the less likely you are to receive support from the system. So in that regard, together with all the other range of measures, it is an interesting and at times tragic situation where people who need support in the areas that they need are all too frequently unable to receive that support despite the best efforts of record amounts of funding and the unbelievable dedicated support services that many in the professional workforce bring. And whether it is the many measures that are set out in the budget papers, there are challenges in the system, and we hope that this royal commission, based on that, will give us that once-in-a-generation opportunity to not just find out what is good about the system, of which there are some shining examples, but more importantly what needs to be done to not just fix the mental health system itself but address all of those wider social determinant issues and that much wider set of compensations about how it is that we can continue the journey of removing stigma and discrimination from those Victorians who have mental illness challenges. We know that the royal commission can help us address this. We know that from the early reports, particularly from the enthusiasm with which people with lived experience have taken to the commission, and we look forward to their reports and our action on them.

Ms RICHARDS: Thank you, Minister, again for the insights into the complexity of that area—portfolio—you are responsible for. In the minute and 40 seconds—or less now—you have, I would like to take you to budget paper 3, page 51, and the $3.6 million in additional funding to support the royal commission that is laid out there. Can you let the committee know how that will support the work of the royal commission?

Mr FOLEY: I certainly can. Briefly, and in further extension to the material that was in my initial presentation, that funding is to support variously the Mental Health Tribunal, the mental health complaints commission and the Office of the Chief Psychiatrist, which are the key institutional arrangements that flowed from the 2014 Mental Health Act reforms. Given the history of similar inquiries not just in Victoria but elsewhere, we could expect that those are the frontline complaints and services that are going to be particularly hit, which will, from that point of view, build on what we would like to think will be some of the immediate pressures that the royal commission will generate. And that of course is in addition to the last two budgets with over $850 million worth of capital and program investment to seek to address those demands that we are asking the commission to look at. With your permission, Chair, I might end my comments there.

The CHAIR: That is beautifully timed. I will pass on to Mr O'Brien.

Mr D O'BRIEN: Good evening, Minister and secretaries, again. Minister, continuing on the earlier questioning about the medically supervised injecting centre, you gave a figure which you also gave the *Herald Sun* this morning, I think, of 1130 overdoses so far that have been addressed at the centre. Is that correct? Can you tell me how many unique individuals that includes?

Mr FOLEY: When you say I gave the figures, these were figures that were provided to us by the North Richmond Community Health centre.

Mr D O'BRIEN: Yes. When I said you gave the figures I meant to the committee.

Mr FOLEY: Yes, indeed—and I did. They are figures that we well and truly stand by. In terms of whether that represents 1100 unique individuals or whether from the over 2200 registered individuals there are repeat clients who have overdosed, I do not have that data, but instinctively, given that we know that of those 2200 there are a number of people who literally visit the centre on a daily basis—

Mr D O'BRIEN: Sorry, when you said 2200—2200 what?

Mr FOLEY: Registered unique clients to the service.

Mr D O'BRIEN: I thought you said earlier 2850 registered users.

Mr FOLEY: Let me clarify that. In terms of the number of unique clients versus the number of overdoses that were on site, there are 2850—you are quite right, Mr O'Brien—and 1100 overdoses. I am more than happy to take on notice, if in fact that data is available, as to how many of those 1100-plus overdoses—

Mr D O'BRIEN: I wonder whether the secretary or anyone else has that data.

Ms PEAKE: I do not have that specific data, but yes, we are very happy to go back to North Richmond and see what they do have available.

Mr D O'BRIEN: Do we know whether they keep that—

Ms PEAKE: I am not sure; we will need to check with them.

Mr D O'BRIEN: Okay. If we could take that on notice then, please.

Minister, can you advise the committee how many of the users of the facility have successfully completed rehabilitation?

Mr FOLEY: It is early days. Rehabilitation is not a one-stop shop. In many regards I have seen some data that suggests sometimes it takes up to, for a successful rehabilitation program, multiple attempts to get on and fall off the wagon before that successfully happens. But I know anecdotally from material I have seen and conversations that I have had with real-life human beings that there are such successes in terms of people no longer using heroin and re-engaging with family, re-engaging with work and re-engaging with a range of health services. So I suppose in terms of what reflects a successful rehabilitation measure, it is early days, but we remain hopeful that the green shoots that we have seen can be nurtured and, from those large number of people, as you quite rightly pointed out—2850, and growing—who engage with the service, that we can not only keep them alive but keep more and more of them engaged or re-engaged with society.

Mr D O'BRIEN: You mentioned, Minister, I think 250 people have been referred to or have begun opioid replacement therapies. Again, presumably that is a longer term process. Is there an end date to those therapies?

Mr FOLEY: I am not a clinician, but as I understand the process, these again are processes that endure and, depending on where people are for their particular journey into addiction, which can be complex. Whilst there might be indicative trends, every journey into addiction is unique, and in that regard every journey out of addiction is equally unique, so—

Mr D O'BRIEN: You have indicated 3300 health and social support assessments had been undertaken.

Mr FOLEY: That is right—health and other social supports.

Mr D O'BRIEN: Can you tell us, though, how many people have actually undertaken a drug rehabilitation program as a result of their attendance at the facility?

Mr FOLEY: From the data that North Richmond have provided, those on-the-spot health and social support interventions have seen some of the services that are referred to include things like mental health and wellbeing, family violence and housing, including drug and alcohol rehabilitation.

Mr D O'BRIEN: Do you have a number for the number of people who have actually started drug and alcohol rehab?

Mr FOLEY: Not in the material provided to me in recent times by North Richmond. Sometimes it is multiple services all at once.

Mr D O'BRIEN: Of course.

Mr FOLEY: Regularly it is multiple services all at once.

Mr D O'BRIEN: Could I ask perhaps, Secretary, maybe if/when going back to North Richmond if we could ask that question as well.

Minister, can you tell me how many people are currently on the public drug rehab waiting list?

Mr FOLEY: Far too many is the short answer, but this is a government that prides itself on having more than doubled—or being in the process of more than doubling—the residential rehabilitation beds for drug and alcohol services and there are now hundreds more Victorians accessing those services right around the state than there were when we came to government.

Mr D O'BRIEN: Which is certainly welcomed. Can you actually give me a figure of the waiting list at the moment?

Mr FOLEY: I have not got that figure at my fingertips, but I might ask the secretary.

Mr D O'BRIEN: Secretary, do you have a figure?

Ms PEAKE: No.

Mr D O'BRIEN: Is that figure kept?

Ms PEAKE: I am very happy to go back and check what we can provide. I do not know.

Mr D O'BRIEN: Okay. If we can have that on notice please, that would be appreciated.

Mr FOLEY: We are happy to undertake that, but clearly in the context of an increasing set of demands and a more than doubling of the residential rehabilitation beds from just over 200 to over 400, plus by the end of this current rollout, of which we are well and truly into the mid-300s at the moment, most pleasing—if there is such a thing as pleasing in this space—has been the fact that over half of those new beds have been in regional and rural Victoria.

Mr D O'BRIEN: Which leads me to a question I was going to come to later. Certainly, Minister, I welcome the reference you made to the Hope Restart Centre and the funding going into that. That is very welcome in Gippsland, but you also made a commitment for a facility in the Latrobe Valley. In fact you have gone to a site and chosen where it is going to be, and also Mildura and Warrnambool, but when I look at page 64 of BP3 with respect to asset initiatives for the department, I cannot see funding for any of those projects. Can you point me to where it is? Rehab for the Latrobe Valley, Mildura and Warrnambool.

Mr FOLEY: The Latrobe Valley facility was funded in the last budget. Ms Shing was out of the last budget, and the member for East Gippsland went down—

Mr D O'BRIEN: So it was a line item last year?

Mr FOLEY: In the current one we are in, 18–19.

Mr D O'BRIEN: Yes, sorry, the line item in last year's budget.

Mr FOLEY: It was not a line item but it came out from that budget, and you will find in this budget there is operational funding for that facility, which will be a 20-bed youth operational area, and that will be delivered.

In terms of the Hume, Barwon, Gippsland packages—of which you are quite right, the Gippsland facility is one—the 17–18 budget provided $9.7 million for the purchase of land in those areas. The Barwon facility has been located, the site is underway and there is funding to take that to the next stage in Lara. In the Hume region it is in Wangaratta. These sites have been announced with strong support from social partners, civic partners in the delivery of those services, which cannot come online soon enough.

Mr D O'BRIEN: So Warrnambool and Mildura were the other ones I asked about. Is there funding for those? Have they been announced?

Mr FOLEY: I am not sure where the Warrnambool and Mildura facility line that you are talking about might be.

Mr D O'BRIEN: Well, has there been a government commitment to either of those cities for rehab beds?

Mr FOLEY: These of course are statewide services, and whilst it is always desirable to have facilities located as close as possible to where people live, as beds become available, no matter where you are in the state, these are offered. Unless I am mistaken, which I am happy to take advice on, I am not aware of a commitment that this budget has made along the lines that you are talking about. We do know that there are consortiums currently operating in both the Mallee and in the south-west in this area. The member for Polwarth would be well aware of that.

Mr D O'BRIEN: Minister, that is fine, I have got the answer I was after.

Can I just go back to the injecting room? I notice when you said that there are a number of organisations and groups that you were consulting with that you did not mention the Police Association Victoria. I do not know whether that was an oversight or not, but you will be aware, I am sure, that the TPA did a survey of its front-line general duties members recently which found that 80 per cent of those surveyed believed that crime had increased around the precinct in which the facility is located; that members perceive that crimes against the person, property crime, drug-related crime and antisocial behaviour have all increased; and that there has been an increase in complaints from local residents. Recently we saw evidence—video footage—of people shooting up in the street, drug deals happening in the street and in the laneway just near to the facility, a couple having sex apparently, allegedly drug affected, and other antisocial behaviour and crime. How is it, therefore, that the facility is meeting object (e) of the act, to improve the amenity of the neighbourhood for residents and businesses?

Mr FOLEY: There are a couple of elements to your question there, Mr O'Brien, so if I could deal with them in the way in which you have bowled them up. Firstly, our discussions with Victoria Police are primarily with Victoria Police, as you would expect, particularly at a command and indeed a local level. These are regularly scheduled, and as recently as the last few weeks Victoria Police indicated that both their operation in January and February and the more recent operations post-April have seen substantial activity by them in response to their increased policing presence. I am not sure when the next police data in this space is due out, but I would expect to see a spike in police reports in this space.

Mr D O'BRIEN: Minister, that is getting away from the question, which is: how is this addressing the amenity of the neighbourhood given that is one of the objectives of the act?

Mr FOLEY: Yes, but your question also dealt with police, and I will generally, within the time, given the—

Mr D O'BRIEN: Yes, and that information you gave in the answer to Ms Richards before, so I am happy to move on.

Mr FOLEY: Yes, but you raised the police association. I have for a number of times, both in the preparation of the rollout of the facility and subsequent to, both myself and the Minister for Police and Emergency Services, engaged with the association, and—

Mr D O'BRIEN: Yes. And do you acknowledge their concerns then—of the frontline members?

Mr FOLEY: I definitely acknowledge the concerns of all the stakeholder groups around, and particularly the residents. Indeed I have met in recent times with different residents groups both on the North Richmond housing estate and the surrounding private community around those issues.

Mr D O'BRIEN: In which case you would be aware both TPA and some residents would like the facility to be moved out of a residential area. Will you consider that at all?

Mr FOLEY: Well, it is not up to me to reconsider that, because as you would be aware—

Mr D O'BRIEN: But you are the minister, aren't you? Aren't you responsible for it?

Mr FOLEY: I am responsible for implementing the public policy and the legislation of the state. And, as you will be aware, there is an independent—

Mr D O'BRIEN: Yes. We passed legislation in this Parliament that enabled it.

Mr FOLEY: And that same piece of legislation specifies where, to the location-specific address, the trial needs to be conducted, and that specifies to the address allotment the North Richmond Community Health facility in North Richmond.

Mr D O'BRIEN: The question still stands though, Minister. Will you consider—

Mr FOLEY: It does, so of course part of the charter for the independent oversight—expert oversight—group chaired by Professor Margaret Hamilton and assisted by John Ryan from Penington Institute and former Chief Commissioner of Police Ken Lay is that they are charged with providing, independently of the executive side of government, the advice as to how this centre is progressing in regard to the legislative obligations. So we will look to Professor Hamilton's group to provide us with that kind of suggestion and advice—whether it be the TPA, whether it be the medical profession, whether it be the North Richmond community—to provide that answer.

Mr D O'BRIEN: Minister, I am conscious my time is running out. The needle vending machine at the community health centre has been closed or shut down on a trial basis. Will it remain closed?

Mr FOLEY: Again, this is not a decision for me. I am not a clinician on the ground, but, as I understand it from both media reports and communication from the North Richmond Community Health centre, they have taken the decision to temporarily close that machine in the—

Mr D O'BRIEN: That was based on the notion that it exacerbated the honey-pot effect, I believe. Can I ask, do you accept that the centre itself has created a honey-pot effect for North Richmond?

Mr FOLEY: I accept what is independent expert advice, and particularly the medical advice from the North Richmond Community Health centre tells me that what they are looking for is an opportunity to directly engage with the drug-using community, and that is why their advice is that by closing that machine temporarily and seeking to engage more directly with the drug-user community, that gives them the opportunity, through the syringe exchange program, which I need to point out is separate from the medically supervised injecting facility—

Mr D O'BRIEN: Yes, I understand that.

Mr FOLEY: That gives them the opportunity to engage more directly, and if in their view that has a consequential spin-off effect of less drug paraphernalia and less public drug use, then I am prepared to back their judgement that that is a worthy outcome.

Mr D O'BRIEN: Minister, you mentioned drug-related ambulance call-outs had been reduced, but you did not give a figure or a number or a comparison. Do you have a number as to a percentage or the actual number that has been reduced?

Mr FOLEY: I was relying on material put into the public realm by Ambulance Victoria, and I do not readily have that figure on hand.

Ms PEAKE: My understanding is there has been a 9 per cent reduction.

Mr D O'BRIEN: Nine per cent? Okay. Thank you. Just finally on this issue, you mentioned of the 2850 registered users you expect that to grow. I do not know whether that was just your own expectation. Is there a target—not a target—an expectation of what the final figure might be once the new facility is open?

Mr FOLEY: All we have seen is an increasing number of people engage with the service, and I would expect, based on the past nine months, on advice given to me by the centre, that we would see, with the larger facility with a wider range of support services, that the current month-on-month growth will continue. For how long, to what point, I am not in a position to say.

Mr D O'BRIEN: Do you know, Secretary, what the current month-on-month growth is?

Ms PEAKE: I do not, but again I am happy to come back to you.

Mr D O'BRIEN: Could I get that on notice as well, when you ask, just to give us that projection for the future?

Can I very briefly in the time left go to mental health more broadly and the royal commission, which you have touched on. Minister, can you confirm that work is underway to introduce a mental health levy to pay for the recommendations of the mental health royal commission?

Mr FOLEY: I am not aware of anything along those lines. What I am aware of is that the mental health royal commission has been charged, as per its terms of reference, to come up with a comprehensive road map to seek to address particularly those five key gaps from our point of view.

Mr D O'BRIEN: Obviously it is going to cost money—there is no question about that—to implement the recommendations. You say you are not aware of it. Will you rule out a mental health levy to pay for the implementation?

Mr FOLEY: We are holding a royal commission with wideranging terms of reference and a charter—so independent experts engaging with consumers, people with lived experience, experts in the field and the wider Victorian community—and at the same time liaising with the commonwealth who, through the Productivity Commission, are addressing this coincidentally not unrelated issue, particularly when it comes to how to both account for and respond—

Mr D O'BRIEN: Minister, I was asking—

Mr FOLEY: I will take their advice first.

Mr D O'BRIEN: So you are not ruling out a levy to pay for the implementation?

Mr FOLEY: I do not want to contradict you, nor do I wish to put words into—

Mr D O'BRIEN: Feel free, Minister.

The CHAIR: Yes, we do it all the time, Minister.

Mr FOLEY: Nor do I wish to put words into the space for the royal commission. It would not be appropriate for the responsible line minister to publicly put on the record, particularly in the Parliament, the context of what the commission can and cannot resolve.

Mr D O'BRIEN: Fair enough. So can I ask the secretary—

The CHAIR: Minister, sorry to interrupt you, but Mr O'Brien's time has expired. We move on to Mr Hibbins.

Mr HIBBINS: Thank you, Minister, and your team, for appearing this evening. Can I first ask about the recommendation from the mental health complaints commissioner in terms of developing a sexual safety strategy for Victorian acute mental health inpatient units? Obviously there are some pretty alarming rates of vulnerable women facing sexual assault in state care. Can I ask: can I get an update on the development of that strategy, whether that is being done and whether there is any funding towards that strategy?

Mr FOLEY: Indeed. So the work that was done by the mental health complaints commissioner in 2018 was her largest report since that office was created, and quite rightly so because it was a confronting report, as I am sure that anyone that has had a look at it would attest. Making sure that consumers, staff and visitors to our public mental health services are safe, particularly women, from sexual violence, was quite rightly the priority of that report and something that the government has endorsed and that we have shared with the providers of services. Some of the rollouts since that work last year has included both, as recommended, expert advisory oversight when it comes to advice around the mental health services consumer and care organisations and the number of government agencies that deal with bringing all consumers but particularly women into those areas. It also has dealt with action arising from governments in this space through both the mental health complaints commissioner and the Office of the Chief Psychiatrist, who is charged with government policy and leadership and oversight in this space.

But in terms of the specifics that you raised, the Victorian Health and Human Services Building Authority has started to action a sexual safety audit of all Victoria's adult mental health inpatient units. This audit is identifying how, sometimes, inappropriate built environments can lead to sexual safety risks, as the commissioner has found, and we are already seeing some work being done by both the Office of the Chief Psychiatrist and the mental health complaints commissioner around that. We have seen in terms of investments the government has made some recent investment announcements in female-friendly mental health inpatient units, particularly given some $6.3 million to Eastern Health, which have dedicated their specialist facilities, which I think are in Box Hill, to be completed by the end of this year. I was recently—

Mr HIBBINS: When you say 'female friendly', sorry, are you referring to—

Ms PEAKE: Sorry, female only.

Mr HIBBINS: Yes—so you said female friendly, are you referring to female only?

Mr FOLEY: Yes.

Mr HIBBINS: Yes, okay.

Mr FOLEY: I have not been to that facility, but I have been to the Werribee facility, which is somewhat larger, which is a new 54-bed inpatient unit at Werribee Mercy, which has a 15-bed women-only ward, which the member for western metro joined me at on an inspection. That has dedicated gender-specific wards which are increasingly—rightly—the norm. It is not the only response to what the commissioner recommended but it is part of the response. There is a series of programs and audits flowing from the work being done by the building authority and the Office of the Chief Psychiatrist to prioritise and bring those on, and the opportunities for further investment in this area are actively before government as we speak.

Mr HIBBINS: Thank you. Can I now move to some of the issues that were raised in the Auditor-General's report in March into mental health services. One goes to the gap between service costs for area mental health services and what DHHS actually pays for services. Can you guarantee or ensure that from the budget, from these new initiatives in terms of meeting critical mental health service demand, that all that money will actually flow to the services, the new services, that you are promising and not go towards covering the gap that currently exists?

Mr FOLEY: I can guarantee that the money will go to the area mental health services and the health providers of those services. As that report correctly pointed out, there has been a multiple decades-long gap between the unit price of beds and the actual price to the units themselves in delivering those beds. Particularly in the acute settings that becomes quite a pressing issue, and we see in some of the performance measures the really unacceptable situation of beds being used for shorter and shorter periods, sometimes—I am not a

clinician—arguably against clinical advice as people get punted out and, unsurprisingly, as the budget paper measures show, people are coming back into services quicker, and that is a bad outcome.

The CHAIR: Minister, I do apologise for interrupting you and Mr Hibbins. I do apologise for being the party pooper, but the minister's time has expired. Thank you very much, Minister, for appearing before our committee today, but do not go anywhere, because we still want you for a couple more portfolios. The committee will follow up on any questions taken on notice in writing, and responses will be required within 10 working days of the committee's request. I declare this hearing adjourned.

Witnesses withdrew.