T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Budget Estimates 2018–19

Melbourne — 12 June 2018

Members

Mr Danny Pearson — Chair
Mr David Morris — Deputy Chair
Mr Steve Dimopoulos
Mr Danny O'Brien
Ms Fiona Patten
Ms Sue Pennicuik
Ms Harriet Shing
Mr Tim Smith
Ms Vicki Ward

Witnesses

Mr Martin Foley, Minister for Mental Health,

Ms Kym Peake, Secretary,

Mr Robert Fiske, Chief Executive Officer, Victorian Health and Human Services Building Authority, and

Mr Terry Symonds, Deputy Secretary, Health And Wellbeing, Department of Health and Human Services.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2018–19 budget estimates. All mobile telephones should now be turned to silent.

I would like to welcome the Minister for Mental Health, the Honourable Martin Foley, MP; Ms Kym Peake, Secretary of the Department of Health and Human Services; Mr Robert Fiske, Chief Executive Officer, Victorian Health and Human Services Building Authority; and Mr Terry Symonds, Deputy Secretary, Health and Wellbeing; and in the gallery Dr Margaret Grigg, Executive Director, Health Service Policy and Commissioning; Mr Greg Stenton, Chief Finance Officer, Corporate Services; Ms Jodie Geissler, Director, Mental Health; and Mr Ross Broad, Assistant Director, Drug Policy and Reform, Department of Health and Human Services.

Any witness who is called from the gallery during this hearing must clearly state their name, position and relevant department for the record.

All evidence is taken by this committee under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. Any comments made outside the hearing, including on social media, are not afforded such privilege.

The committee does not require witnesses to be sworn, but questions must be answered fully, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty.

All evidence given today is being recorded by Hansard. You will be provided with proof versions of the transcript for verification as soon as available. Verified transcripts, any PowerPoint presentations and handouts will be placed on the committee's website as soon as possible.

Witness advisers may approach the table during the hearing to provide information to the witnesses if requested, by leave of myself. However, written communication to witnesses can only be provided via officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way.

Members of the media must remain focused only on the persons speaking. Any filming and recording must cease immediately at the completion of the hearing.

I invite the witness to make a very brief opening statement of no more than 5 minutes. This will be followed by questions from the committee.

Visual presentation.

Mr FOLEY — To keep to the time frames, I will be quick. The first slide reflects the comparison of this cycle of government with its predecessors in terms of the increase in funding for the mental health and alcohol and other drugs services investments which, in short, reflects a 181 per cent increase, with this most recent budget investing $705 million to bring the total increases in allocation to $1.713 billion over those four years.

Moving on, this year's budget highlights that key increase of $705 million in the mental health portfolio, with 393 million in critical clinical mental health services as its single largest component, with a further 265 million in meeting demand for mental health services and other mental health priorities including those in the community, with 47.3 in alcohol and drug rehabilitation services in rural areas.

The third slide is why we are having this increase in investment. It is, in short, in response to underpinning demand for services. There are many demands on the system, but acute adult admissions, if you like, is the most pointy end of where alcohol and other drugs and mental health services reach a crisis point in our service system. We have seen, obviously, a population growth occur, but we have also seen acute mental health inpatient admissions increasing and the demand therefore on our hospitals increasing. That increased in 2009 from 360 per head of 100 000 population to now 420 in the most recent figures. That is almost a 17 per cent increase over eight years. Whilst we have invested significant extra resources off a particularly low base, nonetheless the particular demand for critical mental health services has increased over that period of time by some 21 per cent. And we are not just seeing an increase in demand — if we can move on to the next slide — we are seeing an increase in the complexity of demand. I do not pretend to be an expert when it comes to mental health diagnosis, but the most accepted measure of these things are these 12 health of the nation outcome scale measures. Over that same period of time we have not just seen an increase in demand, we have seen an increase

the consequence of consumer engagement with the system that has become longer and more intense. As a consequence it is not only more costly, but it also increases the time for recovery and the time needed to transition post-crisis clients back into an appropriate community setting. So with growth we have also seen an increase in complexity of service demand.

Moving on to, if you like, the wagon wheel there of how in that context do we reform clinical mental health services, it is essentially through a six-prong approach, six key areas where we seek to reform clinical mental health as the most logical entry point for a system-wide reform when it comes to mental health and alcohol and drug services. The first of those is how do we redesign community-based care, because of course early intervention as well as step-down responses from acute settings is a critical factor here. So redesigning adult community mental health care has been a component, together with increased focused on responding to people when they are in that crisis situation.

There are clearly public sector safety issues there, not just workforce but broader community engagement when it comes to these clinical services, so there is a funding stream there. All of which means demands on not just the number of workers in the system, specialist workers in the system as well as the generalist workers, but the need for these workers to deal with an increasing number of difficult clients — a higher number with comorbidity issues rises year on year — and a process to tackle that. Equally, the step-up, step-down process to make sure that we have got both subacute as a step up from community but as a step down from acute clinical services has, at a broad level, been the underpinning approach to our response here.

Moving on to the next slide about community-based mental health services, only by improving the mental health at the community service provision level are we able to try to take one of those slices of that wagon wheel to not just improve outcomes for consumers but to make sure that that service system, where its greatest demand is, is in the service location that is most suitable to grounding people back in their community. At the same time, making sure that the engagement of management of mental health services with the wider social welfare support networks is also a key part of the community-based arrangements together with the overlay with clinical engagement and the relationship between that continuum of mental health challenges.

Moving on to the emergency department crisis hubs, a key part of dealing with the acute end of the mental health challenges the community faces is how to deal with people at the most critical point of their engagement with the system. Invariably that is in the emergency departments. The $100.5 million response, driven by data arrangements as to where the need is, is to have a two-track approach, both an ambulatory and then a wider short-stay recovery process whereby there is a dedicated pathway in the six major emergency departments listed there as we would hope the first tranche of making sure that those people at crisis with mental health and alcohol and drug situations are for their own wellbeing — let alone the workforce, the first responder workforce or the health workforce — is dealt with in a dedicated pathway in the emergency units as well as providing a better outcome not just for them but the rest of the emergency department areas where people come into contact at the moment with some of those very challenging behaviours as well as the health workforce. Those locations will be rolled out starting — indeed some of them coincidentally with major redevelopments of their own emergency departments which will now incorporate a dedicated mental health pathway.

Moving on, in terms of meeting demand just as the system grows, there are a number of additional provisions. We think that community mental health and acute and subacute areas need particular attention. We think that this funding that is provided, an extra 232 million, will see almost 13 000 community-based services for Victorians being delivered, particularly through a further 89 acute inpatient beds. We see almost $12 million delivered in other arrangements, and for the sake of the committee I would move on to alcohol and drug services and the $47.3 million invested there, which is really about how we support services across the community and across health services and alcohol and drug services that deliver life-saving treatment and rehabilitation. The wider package, which we launched in October, is part of a 57 per cent increase in funding for alcohol and other drug treatment services through our state budgets over those last four years as part of this arrangement.

A key part of that has been for three new 30-bed facilities in regional Victoria, one of which we announced last week. The one we announced is in Bairnsdale and there are others in the Barwon and Hume regions, on which will be making further statements shortly. They in turn build upon our 100 extra rehabilitation beds that we have already delivered as part of the Drug Rehabilitation Plan. They in turn come on top of previous investments around expansion of the Grampians facilities and expansion of a range of community-based and bed-based

systems where we will have seen over the course of this government bed-based resi rehab grow from 208 beds that we inherited in 2014 to over 450 beds when all those facilities are operational over the life of this budget cycle. So once all these beds are operational we think that will deliver 700 more Victorians each year the access to supported residential services in resi rehab they need, and that is in addition to the community-based service delivery.

The CHAIR — Minister, the budget paper reference is budget paper 4, page 62, and it talks about the capital costs for the trial of a medically supervised injecting centre. Can you outline to the committee what were some of the factors that the government took into consideration when the decision was made to hold this trial, please?

Mr FOLEY — Certainly. In short, we have seen the rate of heroin-related deaths now at its highest in over 20 years, and this has been a consistently increasing pattern since 2012. I was therefore pleased to see Parliament pass the Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017, which is all about how we can facilitate a trial of a medically supervised injecting facility in the North Richmond Community Health centre from the middle of this year.

Every single death to drugs is a tragedy. It is a tragedy for the families, friends and those affected, as well as a wider community. Whilst drug addiction is necessarily a complex health issue, we know that there is not one single solution to that, particularly the debilitating impact that drugs have. Working on the basis that this is a necessarily complex problem, we investigated the relative benefits of a medically supervised injecting centre against a substantial amount of work that had been done in the space: a number of coroners inquiries, a parliamentary inquiry, submissions from the likes of the AMA, the Royal Australian College of General Practitioners, the Victorian Ambulance Employees Association, the Pennington Institute and the Victorian Alcohol and Drug Foundation. But particularly persuasive were the views of the State Coroner about the lives lost to addiction. Most importantly, the stories that were shared with us, the stories that we hear time after time of families devastated by drugs. On the basis of that, we took the view that if the evidence changes, we need to change our position. Based on that we have introduced, through the legislation, the medically supervised injecting facility at the North Richmond Community Health centre as a trial.

The CHAIR — Minister, why was North Richmond chosen as the location?

Mr FOLEY — North Richmond in particular was chosen because the City of Yarra is the local government area with the highest frequency of heroin-related deaths over the period from 2012 onwards. In terms of specific ambulance call-outs, the North Richmond Community Health centre and its immediate surrounds of North Richmond facilities, whether it be the office of housing, the nearby private residences, the nearby car park or indeed the nearby school, were overrepresented as the hottest of hotspots when it came to those ambulance call-outs. That was one reason.

The other reason being that, in addition to the ambulance call-outs, the North Richmond Community Health centre already delivers a needle syringe program, it delivers a naloxone education program, it has blood-borne virus education, health promotion and outreach in terms of overdose and addiction response services and its staff have been particularly trained in both health care and support services for the injecting drug use community, meaning that that centre could offer the best possible care pathways out of addiction in a community that was being disproportionately disrupted, from an amenity sense, around the flow-on impacts that public injecting was delivering.

Mr T. SMITH — Minister, following on from the Chair's questions with regard to the North Richmond injecting room. In October last year when you announced the injecting room you completely ruled out having ice or methamphetamine being injected in the facility. What was the piece of evidence that changed your initial brief to now where ice is now permitted to be injected?

Mr FOLEY — As I indicated in answer to the questions from the Chair, it was the evidence that was presented to us. We established an expert-based advisory committee which had a variety of stakeholders on it, not the least being Victoria Police, as well as addiction specialists, community health specialists and others, and all the way along that group was the most influential in reshaping our expectations.

Mr T. SMITH — But Minister, you started off by saying —

Ms SHING — He is answering the question.

Mr T. SMITH — Please, Ms Shing. You said ice would not be permitted and then it became permissible. What was the piece of evidence that changed the government's policy with regard to ice at this facility next door to a primary school?

Mr FOLEY — On the basis that the medically supervised injecting centre expert advisory committee pointed to experiences globally as well as the centre that we are most keen to model the North Richmond centre on, that being the Kings Cross centre. Globally there are an increasing number of these facilities. There is one in Oslo that has ruled out the use of methamphetamines and others, and simply restricts the use. In terms of its performance measures, it is running at somewhere between 20 per cent to 25 per cent of what it had expected and its comparable other centres are using in terms of the number of clients that it would have expected to gain. Based on the examples that we had seen, most particularly in Kings Cross as the most directly comparable centre, the advice from the medically supervised injecting facility advisory group was —

Mr T. SMITH — But Minister, you made comments at the outset ruling out ice, then you changed.

Mr FOLEY — Because the evidence and the advice that came back post the October announcement from the expert advisory committee, which reported this year, was that if you wanted to meet the policy objectives of saving lives and engaging people with services, you had to provide the reality of how people engage with services given where they are at. In that regard I was persuaded particularly by some contributions in the debate that pointed to the fact that many people had called for medically supervised injecting centres early in their contributions. In particular I was persuaded by one contribution that said:

> If this is just a heroin injecting room, we are going to miss out on many, many opportunities where these people would be using other drugs and even alcohol.

That contribution came from the second-reading debate from the shadow mental health spokesperson, Ms Kealy. So I was particularly persuaded in retrospect by that argument, but I was really persuaded —

Mr T. SMITH — Minister, if I could move on, Minister, to your comments on 3AW on 11 April with regard to Samoan security guards. How many Samoan security guards will be hired at the facility?

Mr FOLEY — Clearly I injudiciously raised those comments, and if they caused offence to any members of the community — Samoan or otherwise — I withdraw them, and I apologise for them. In terms of security, there will be security available the entire time that the facility is open, and given the two stages in which the facility will be rolled out on both an interim basis and then a dedicated facility during the period of the trial, those specifics around the numbers of security guards will be determined by the North Richmond Community Health centre — whose facility it will be — in consultation with experts in this space, particularly Victoria Police and others.

Mr T. SMITH — So do you accept, Minister, that your comments on radio were racist?

Mr FOLEY — No, I do not accept they were racist. I just indicated that they were injudicious, and I apologise for them.

Mr T. SMITH — Why did you pick out the Samoans?

Mr FOLEY — I injudiciously made that comment, and I withdraw it.

Mr T. SMITH — Minister, it was a racist comment, wasn't it?

Mr FOLEY — No, it was not a racist comment, indeed as the Leader of the Opposition conceded — he withdrew that comment when he made that accusation. So I agree with the Leader of the Opposition that that was not a racist comment.

Mr T. SMITH — What is the expected expenditure for security at the ice injecting facility?

Mr FOLEY — Well, I do not know of any ice injecting facility. What I know is that there is a medically supervised injecting centre. Based on the expert advice, if we assume that the multidrug-use community, as we have seen in Sydney, runs at around about the 20 per cent mark of users of that facility — that would be the

kind of level which we are looking at — that wider security issue we will see addressed through the $3.5 million allocation that is made as part of this budget allocation to the North Richmond Community Health centre.

Mr T. SMITH — $3.5 million for a security upgrade to the North Richmond —

Mr FOLEY — No, the operating costs of the facility will take into account security, and we will see a $3.5 million operating cost, of which a component will be —

Mr T. SMITH — Which is what, Minister?

Mr FOLEY — That will be determined by the North Richmond Community Health centre based on the experience of the facility.

Mr T. SMITH — Hang on, this thing opens in two weeks and you cannot tell me how much you are spending on security?

Mr FOLEY — No, I can tell you that there is $3.5 million in operating costs. The arrangements with staff to deliver the medical services, the response services, the pathway services for wraparound pathways out of addiction and the security — all will fall within that $3.5 million operating costs.

Mr T. SMITH — So you cannot tell me what the breakdown of costs are?

Mr FOLEY — I can tell you that there will be a $3.5 million operating —

Mr T. SMITH — I have asked that three times now, Minister. What is the cost breakdown, Minister, for the security for this centre that is right next door to a primary school? Let the record reflect there are notes being passed around by the secretary to the minister. He does not know the answer.

Mr FOLEY — The $3.5 million in operating costs per annum for the centre will cover all of the operating arrangements. As we have indicated, we are seeking to model this as closely as possible on the very successful Kings Cross centre, and that is where the model of the costs has come from, whether it be security, whether it be medical support, whether it be pathways —

Mr T. SMITH — What are the operating hours of this injecting facility?

Mr FOLEY — I do not know of the finally determined operating hours, but what we do understand is that the centre will be operating approximately 11 hours per day and that in terms of what that will affect, we understand that the centre will open in terms of standard operating hours from 9.00 a.m. to 5.00 p.m. every day of the week, but that of course given —

Mr T. SMITH — Mr Fiske's phone has just been passed in your direction, Minister. You might want to read it.

Mr FOLEY — But we also understand —

Members interjecting.

Mr FOLEY — In terms of the facility —

The CHAIR — Order! Ms Pennicuik until 3.55 p.m.

Ms PENNICUIK — Good afternoon, Minister, Secretary and everyone else. Thank you for coming. Could I ask a question about budget paper 3, page 242, which is the mental health community support services, with some $98.9 million. I am just wondering, of that $98.9 million, whether Victoria has included its share of the commonwealth government's commitment of $80 million nationally over three years for the national psychosocial support measure, which aims to address the gap within mental health community support services to people with episodic mental illness?

Mr FOLEY — Particularly in regard to the issue of the gap between NDIS and community mental health?

Ms PENNICUIK — That is right.

Mr FOLEY — Yes. The commonwealth's $80 million is a national figure. We are yet to establish what their proportion is, but Victoria is more than in a position —

Ms PENNICUIK — Based on population it would be about 20 million.

Mr FOLEY — You would imagine, but you know, we will wait and see. But in terms of at least what the Victorian government's mental health community support system NDIS package would be, we well and truly will be easily matching that figure in our contribution.

Ms PENNICUIK — You said you would wait and see. How long will that take for you to know what the Victorian contribution will be? As I understand, that —

Mr FOLEY — In terms of the commonwealth's contribution, this is arguing as to —

Ms PENNICUIK — It is based on the states matching that share of funding.

Mr FOLEY — Not that I am the commonwealth minister. But we are more than matching that contribution.

Ms PENNICUIK — Well, how?

Mr FOLEY — By direct budget allocation under this process.

Ms PENNICUIK — Which particular program can you point to in that regard that specifically relates to the psychosocial support measures?

Mr FOLEY — I think the reference that you are making in the budget paper you referred to is all state contributions, not the commonwealth's contribution.

Ms PENNICUIK — I am asking you about that though.

Mr FOLEY — Yes. But we are more than matching whatever the proportion of the commonwealth's gap is. So go back a step: the NDIS sadly, through arrangements I would say that lie at the hands of the commonwealth not resourcing the NDIA appropriately, has created a gap in the delivery of psychosocial services.

Ms PENNICUIK — That is right. That is why I am asking a question about it.

Mr FOLEY — So their proposal to address perhaps a quarter of that, perhaps $20 million, is their contribution, in their view, to meeting that gap. That is nowhere near —

Ms PENNICUIK — So have you received, or are you expecting to receive, that approximately $20 million contribution based on what you are saying?

Mr FOLEY — It is not clear to me. I am happy to, should we be able to establish that from our friends at the commonwealth because it is their budget allocation, not ours, but we will easily be outstripping that contribution in terms of our contribution to community mental health services — not just those that transmit into the NDIS from the 2013 bilateral agreement, but from our own ongoing contributions.

Ms PENNICUIK — Similarly in a report that was released by the University of Sydney on psychosocial disability —

Mr FOLEY — *Mind the Gap* report?

Ms PENNICUIK — Yes, that one. It puts the figure at around 18 000 Victorians who will be caught up in that gap. Could you tell the committee how or which programs you have to catch those 18 000 people? You may need to provide some of that on notice.

Mr FOLEY — Hopefully not. In 2014 the then government signed an agreement with the commonwealth about how community mental health services would transmit into the NDIS, nominating what all those services would be. It sought to reorganise the mental health community support services schemes accordingly. Those processes form part of the $2.5 billion state contribution to the NDIS, running at around about a 13 per cent

component of that $2.5 billion. On reflecting the kind of figure of which you would expect people of that group with what are now called psychosocial disabilities that are caught up within the mental health community —

The CHAIR — Order! Ms Ward until 4.00 p.m.

Mr FOLEY — And I will take the rest on notice.

Ms PENNICUIK — Just on notice, thank you, Minister.

Ms WARD — Minister, can I get you to come back to your presentation, please? The last slide talks about $40.6 million to fund the construction of three new 30-bed residential treatment facilities in Barwon, Gippsland and Hume. Can you talk us through how they are going to advantage the regional communities?

Mr FOLEY — I can. The truth is the further away you get from Melbourne, proportionately the less access you have to drug and alcohol services more broadly and residential rehabilitation services in particular. That is why this $40.6 million to construct three new residential services was in this most recent budget allocation, nominating Barwon, Gippsland and Hume. That comes on top of last year's contribution towards this program of $9.7 million.

The truth is that some of these regions have currently no access to state-funded residential rehabilitation facilities at all, opening up not just a market problem but sometimes, sadly, communities that are preyed upon by shonks in this process that prey on desperate families' needs to get services into this area. With extra new beds, each of these 30-bed new facilities — the most recent of which builds on the Ballarat facility which will come online in October and be fully operational in a year — we would expect to see approximately 700 more Victorians able to access rehabilitation services every year through these extra beds, and with them the new facilities that go with them. Fifty per cent of the increase that I referred to, which is a more than doubling the number of beds, from 208 to over 400, will be in rural and regional Victoria, and that is part of the reflection that rural and regional Victoria continues to be disproportionately worse off in outcomes when it comes to both the levels of need for such services and the access to such services.

Ms WARD — Minister, there are 100 new residential rehab beds as well that are now in operation. I believe some of those are at Odyssey House, which is in my electorate. How many people will benefit from these additional beds each year?

Mr FOLEY — When we announced our broader drug rehabilitation plans in October, which included getting tougher legislation on those who might push drugs, particularly ice and others, and the medically supervised injecting centre, it was also to have 100 new beds in the system. Those 100 new beds have been in the system since March and based on their level of uptake, in addition to the new beds in the regions we would expect a further 400 people every year to take access of those 100 beds.

Ms SHING — I might just leap in with the time that we have remaining, Minister. I would really like to talk about suicide prevention and the work that needs to go on now and into the future to prevent suicide from taking place in the first place and to assist those who have attempted suicide. We know that the number of lives lost to suicide in 2016 was more than double the road toll, we know that suicide is something which touches every family and every person in the state, and we know that we have to do more to reduce the number of suicides. Budget paper 3, page 84, talks about increased funding for the hospital outreach post-suicidal engagement, or HOPE trials. What are the suicide prevention initiatives being funded that are based around this, and how do we do more to continue to have this conversation that is so sorely needed around this particular issue?

Mr FOLEY — In the time available, the HOPE program, which was rolled out in six health networks last year, will be extended to a further six through this process. That will now pick up St Vincent's, the Alfred, Peninsula Health, Frankston, Barwon, Geelong, Maroondah, Albury-Wodonga, Wangaratta, and a six further sites which we are currently modelling will be announced very shortly, but again based on the demands that are screaming out to be addressed in this space.

Mr T. SMITH — If I could continue my previous line of questioning about opening hours for this facility. Minister, you said before that it was going to be open for 11 hours a day, but you also said that it was going to be open between 9 and 5.

Ms WARD — And then you cut him off before he finished.

Mr T. SMITH — Which is it?

Ms SHING — Oh, my God. Let the record reflect that Mr Smith is having to add up the numbers now.

The CHAIR — Order, Ms Shing!

Mr FOLEY — The facility will be rolled out in two stages. The interim arrangements, which will be on a temporary basis until a dedicated facility is in place, will be provided next year. In terms of what we expect to be the hours, these will be determined based on the experience of the facility. We would expect there to be once operational — and there will be transitional arrangements based on that — about 11 hours a day. But the specific hours will be —

Mr T. SMITH — During school hours?

Mr FOLEY — Quite possibly, yes.

Mr T. SMITH — Weekends?

Mr FOLEY — Quite possibly, yes.

Mr T. SMITH — This is opening in two weeks, yes?

Mr FOLEY — It will be open when it is ready. We have indicated midyear, and when the facility is ready to open, it will be open.

Mr T. SMITH — And you cannot tell us specifically its opening hours.

Mr FOLEY — Those issues will be determined by the North Richmond Community Health centre when the facility passes all of its occupancy and planning and building obligations. We have indicated that to be midyear. We remain confident that that will be midyear. In terms of operating hours we would expect that would be based on the need that the North Richmond Community Health centre perceives, and that will vary from different arrangements. But we would expect, again based on the successful Kings Cross arrangements, about an 11-hour day once that facility —

Mr T. SMITH — Can you give me any indication of its closing time?

Ms SHING — You have not heard the answer, Mr Smith.

Mr FOLEY — In terms of its operating hours, those —

Ms WARD — You might have to try again, Minister. He is not understanding the answer.

The CHAIR — Order!

Mr FOLEY — In terms of its operating hours, they will be determined by the North Richmond Community Health centre once the facility passes all of its obligatory standards. We would think that the North Richmond Community Health centre will make that available through its community reference group which is established when those issues are resolved.

Mr T. SMITH — The member for Geelong has suggested that an ice injecting room might be a good idea in that city. Will you categorically rule out an ice injecting room for Geelong?

Ms WARD — Give me a break.

Ms SHING — Who's talking about an ice injecting room, Mr Smith? Seriously.

Ms WARD — No-one is talking about an ice injecting room.

The CHAIR — Order!

Mr T. SMITH — Or a heroin injecting room, or any other injecting room for Geelong, Minister.

Ms SHING — You can't even get the terminology right, Mr Smith.

The CHAIR — Order, Ms Shing!

Mr FOLEY — A medically supervised injecting centre, under the legislation that the Victorian Parliament passed, can only be trialled in the North Richmond Community Health centre portfolio's nominated piece of real estate —

Mr T. SMITH — I am aware of that.

Mr FOLEY — and that is in North Richmond, and so I can categorically rule out that there will be a medically supervised injecting facility in Geelong or anywhere else whilst that piece of legislation continues.

Mr T. SMITH — Frankston?

Ms SHING — Did you not read the legislation or listen to the answer?

Mr T. SMITH — No more injecting centres?

Mr D. O'BRIEN — We also read the Premier's words.

Members interjecting.

The CHAIR — Order!

Mr T. SMITH — Apparently this was only going to happen —

The CHAIR — Order!

Mr FOLEY — Again, I would answer that by pointing to the legislation that the Parliament passed, which nominates a trial process of an initial two years with the prospect of, subject to meeting performance standards to be established during a period of time, a further three years at the North Richmond Community Health centre as the standalone, single and only medically supervised injecting centre in Victoria.

Ms WARD — You cannot be much clearer than that.

Mr T. SMITH — That is until you change the law, Minister. You have not ruled out changing the law.

Ms WARD — Mr Smith, this is ridiculous.

Ms SHING — Can the record reflect Mr Smith did not read the legislation and has asked the same question six times now.

The CHAIR — Order, Ms Shing!

Mr FOLEY — The legislation only enables one facility, and that facility is at North Richmond.

Mr DIMOPOULOS — The rest of us understand that, Minister.

Mr D. O'BRIEN — Just quickly, can I place on notice now, given the time, you mentioned in response to Ms Shing's question before about suicide prevention, there is $6.5 million in budget paper 3, page 72, for assisted suicide. Could you provide on notice how much money is available from your portfolio towards suicide prevention, including for terminally ill Victorians?

Mr FOLEY — Voluntary assisted dying is the responsibility of the Minister for Health.

Ms SHING — Not assisted suicide?

The CHAIR — Order!

Mr D. O'BRIEN — And I am asking about suicide prevention.

Ms PATTEN — As Ms Shing said, not assisted. I have to probably comment on some disappointment that we will not see facilities opening in areas where people are dying.

Mr D. O'BRIEN — Suicide.

The CHAIR — Order! Ms Patten is trying to ask a question. Order, across the table, please.

Ms PATTEN — For the benefit of some of my colleagues, we see different opening hours at supervised injecting centres dependent upon the needs of the clients. In Sydney they open at 7.00 a.m.; in Zurich they open at 11. So it will vary, and Richmond will find the sweet spot for providing the most good to them.

I guess the other thing that some of our colleagues fail to understand is that nobody knows what substance people will be using in these injecting centres, and this is where I am most concerned with the introduction of fentanyl and carfentanil into our communities and the fact that I am very concerned that that is actually going to increase once the prescription monitoring scheme is up and running and some people are actually knocked out of the regulated opioid market and will be forced into the unregulated opioid market that we see in North Richmond. So I am wondering, Minister, if you have considered how you are going to cope with the rollout of the prescription monitoring scheme in light of the fact that it almost inevitably will lead to greater deaths related to the introduction of fentanyl into our market?

Mr FOLEY — The prescription monitoring scheme more widely will undoubtedly help rehabilitation and drug monitoring services and help save lives. That is being managed by the Minister for Health. What we have tried to do is to make sure that we avoid perverse outcomes from that. One of the perverse outcomes might well be the issue about driving synthetic opioid use underground. There is no bigger threat globally than, as you have indicated, fentanyl. Fentanyl is a perfectly legal derivative when used properly in the medical and first responder system, but it is a very, very powerful drug, somewhere between 25 and 50 times stronger than heroin and up to 100 times stronger than morphine. Interestingly enough, in North America, starting on the west coast and moving across over recent times, since 2016 we have seen a wave of fentanyl, a lot of it from China and north Asia, from illegal prescribers start to really devastate those drug-using communities, invariably inadvertently but not totally. People sometimes do material that is not clean in terms of how it has been prepared. It can have a tiny amount of fentanyl in it and inadvertently lead to deaths given the strength of fentanyl.

Ms PATTEN — We have even seen it in methamphetamine.

Mr FOLEY — The mix is lethal in every sense of the word. Whilst we have seen limited episodes of fentanyl abuse in Australia, it has largely been through it being illegally transferred from our health or first responder system. So far we have been successful, working with the commonwealth and other jurisdictions, to keep it out of our borders, but it would not take much. Police are getting ready and services are getting ready for the reality that we may well follow, as sadly we have on many other fronts, that North American global trend. To be brutal about it, if fentanyl gets into the illicit drug market, then the devastating consequences and the need to have the opportunities for multi-use drugs facilities like the medically supervised injecting centre grows.

Ms PATTEN — Absolutely. So, Minister, if you could possibly take this on notice. We have had a lot of conversations about dual-diagnosis facilities and we know the link between mental health and drug use. If you could maybe provide information on notice about some of the facilities where there is that dual-diagnosis treatment, so where people can be treated under the same roof. Thank you.

Mr FOLEY — Certainly.

The CHAIR — Order! I would like to thank the witnesses for their attendance. The committee will follow up on any questions taken on notice in writing. A written response should be provided within 10 business days of that request.

Witnesses withdrew.