VERIFIED TRANSCRIPT

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2010–11

Melbourne — 19 May 2010

Members

Mr R. Dalla-Riva	Mr G. Rich-Phillips
Ms J. Graley	Mr R. Scott
Ms J. Huppert	Mr B. Stensholt
Mr W. Noonan	Dr W. Sykes
Ms S. Pennicuik	Mr K. Wells

Chair: Mr B. Stensholt
Deputy Chair: Mr K. Wells

Staff

Executive Officer: Ms V. Cheong

Witnesses

Ms L. Neville, Minister for Mental Health,

Ms F. Thorn, Secretary,

Dr K. Edwards, Executive Director, Mental Health and Drugs Division, and

Mr P. Fitzgerald, Executive Director, Strategy, Policy and Finance Division, Department of Health.

The CHAIR — I now call on the minister to give a brief presentation of no more than 5 minutes on the more complex financial performance information relating to the budget estimates for the mental health portfolio.

Overheads shown.

Ms NEVILLE — Thank you, Chair. I will be touching on both the mental health area and also the drug and alcohol area. As I mentioned in my overview to the question that you asked earlier, a year ago we released the government's mental health strategy, a 10-year strategy, Because Mental Health Matters. It sets out a very wide-ranging agenda on development and change across mental health and, as I indicated, we have also got the first of the strategy implementation plan signed off and that being implemented.

Building system capacity early in life is a key part of the reform agenda and through this particular budget more rural young people will receive early and effective help for a broader range of mental health problems. This investment brings the total number of youth early invention teams to six; four were previously funded in the previous budget. Importantly we will also build new capacity early in the reform implementation process in order to better support teenagers and young people who are highly distressed or at risk of suicide. We have also continued to consolidate and enhance psychiatric triage services to build a more accessible front door to mental health treatment and care, and the new investment brings us to close to statewide coverage of this reform initiative. We have also focused on the needs of senior Victorians with severe mental illness.

In the 2010–11 budget, excluding capital, our total output will now be over $1 billion, which is a 122 per cent increase from more than 10 years ago. Our capital investment in this budget also continues with $70 million provided. This builds on the $74 million capital investment allocated in the 2009–10 state budget. The key challenge for the coming year is to give momentum to the critical elements of the reform agenda, and this slide outlines the priority areas for reform in 2010-11.

As I indicated, one of our priority areas within the mental health reform strategy is how do we build greater capacity to prevent and intervene earlier, particularly early in life with children and young people? This budget has significant investment in this area around early intervention for rural young people, youth suicide prevention and youth crisis response teams as well in rural and metropolitan areas, so a total budget all up for mental health of almost $175 million, which builds on the over $300 million that has been delivered in the last two budgets to implement the mental reform strategy.

As I indicated, there is increased capacity with the new mental health wing at the Bendigo hospital, amounting to $56 million, which will see a new inpatient facility, 75 mental health beds up from 42, and also the building of a 22-bed community care unit on the Austin Heidelberg site, which will see for the first time all metropolitan mental health areas having access to their own community care unit. There is also funding to operationalise beds that we have been building, which include the PARC beds at Bendigo and Frankston, Geelong acute beds and the additional 25 beds at the Northern Hospital.

Just briefly, in alcohol and other drugs, as I mentioned earlier in my other presentation, we have three strategic policy documents that underpin our work in this area: the blueprint which maps out a client-centred and service-focused reform agenda with a very strong focus on prevention and early intervention; an amphetamine-type stimulant strategy about what work we need to do to prevent and reduce the supply, use and demand for amphetamine-type stimulants; and also our Victorian alcohol action plan which had an investment of $37 million over four years last year. We have made significant and solid progress in implementing the range of programs, which I will not go through unless the committee has a particular question.

The CHAIR — We can follow that up later.

Ms NEVILLE — In this budget we have invested $20.8 million over four years to provide additional drug and alcohol treatment services in Melbourne's growth areas. That map shows you where those additional services will be provided. Of course that is on top of the over $510 million we have committed since 1999 to address alcohol and drug-related harms in Victoria.

The CHAIR — Obviously alcohol and also drugs have a big impact in relation to mental health, particularly for young people. This tends to change, sort of, almost every few years in terms of the emphasis and sometimes unfortunately in terms of the drug of choice. Ecstasy is certainly an issue. I am just wondering what initiatives

you have in regard to treatment and preventing the use of it. Obviously as minister I understand you are responsible for these issues.

Ms NEVILLE — As I indicated in the presentation, our amphetamine-type strategy is our overarching framework about the work we want to do in reducing and preventing the use of amphetamines given the dangerous nature of those drugs. It is interesting that you mentioned the issue of alcohol.

The CHAIR — It is usually a mixture.

Ms NEVILLE — That is right; it is often a mixture. We are actually starting to see some decline in alcohol use amongst young people, although we still have high levels of risky drinking. But one of the areas in which we are seeing some increase in the use of illicit drugs is in the area of ecstasy. Today I was pleased to announce a $500 000 education campaign which will focus on the dangerous short and long-term consequences of ecstasy such as mental health impacts, come downs, irritability and potential death. As I was referring to some of those figures, according to the latest Australian secondary schools alcohol and drug survey there has been an increase in ecstasy use by young people, unlike other illicit drugs where you are seeing they are either stabilised or are declining. Changes over time are seeing an increase particularly amongst 16 and 17-year olds. We also know that ecstasy use is one of those amphetamines where young people tend to use this form of amphetamine when they are younger than with other form of amphetamines.

We have also seen a bit of a change through a survey this time of the number of young people who are indicating that they see occasional use of ecstasy as less dangerous than they saw it in the last survey. For those reasons we felt it was important that we had a targeted approach to this particular drug use. Our campaign will focus on Victorians aged between 14 and 17, about intervening earlier and indicating to young people the serious harms and risks that are associated with experimenting with ecstasy.

The campaign will commence at the start of the party season to achieve the most targeted approach on young people and will comprise paid advertising at venues with oriented media, social networking sites on the internet, radio and outdoor signage. We know the effects of any drug can vary from person to person. Because ecstasy is commonly used prior to or during dance or rave parties, the stimulant effects are likely to increase. The irony about this drug is that when it is most likely to be used is when it is at its most dangerous because of the risk of overheating that occurs as a result of those dance parties. We know there are real dangers in the use of ecstasy use. We want to get that message out to young Victorians. It will also be backed up by raising awareness with young people and families using schools, raising information and providing information to parents about what they can do, and how they talk to their children about the issue of ecstasy. This is an important early measure so we can ensure that we do not see any alarming increasing trends in relation to ecstasy use.

The CHAIR — It is an important issue.

Mr DALLA-RIVA — Can I see slide 3, 'Investing in mental health'.

The CHAIR — It is the graph.

Mr DALLA-RIVA — It is also referenced in budget paper 3, page 77. That is the output summary within the Department of Health of which mental health is a component. I note the minister was very pleased to make a comparison and show the growth there, but a comparison of the state budgets over your term as Minister for Mental Health shows in actual fact a 5.4 per cent drop in mental health's share of the overall health budget since the 2006–07 budget compared with a 1.5 per cent increase in acute health. I am happy to table the spreadsheet we have. One of my questions is: is this not exactly what the Australian of the year, Professor Patrick McGorry, meant when he was quoted in the *Age* after the budget as saying the state budget confirms:

> growing community concern that despite a major splurge on health care, people with mental ill health are being left even further behind —

and that —

> despite acknowledgement that the —

mental health—

> system is in a mess, by both the state and federal governments, neither seems to be committed to solving it or investing in it …

I also refer to your glowing accolades of Professor McGorry in Parliament in February where you described him as a 'renowned leader' doing 'pioneering work' and making an 'extraordinary contribution'. So, Minister, I ask how can you sit here today claiming that you and your government are helping vulnerable Victorians when you have presided over the largest ever decline in the proportion of health budget going to mental health, and will you now admit that vulnerable Victorians with a mental illness are being left even further behind by you?

Ms NEVILLE — Can I just start off by acknowledging Pat McGorry. He is absolutely a world leader in youth mental health. He has been an advocate on early intervention. He absolutely was a driver with us in the reform strategy and the priorities of that reform strategy in relation to needing to redesign our youth mental health services and in the type of investment we needed to make in relation to youth mental health. He is also a member of the Victorian Mental Health Reform Council that is driving both the overall reform agenda and also the implementation strategy. He is absolutely central to that. He is a well-deserving Australian of the Year.

As I indicated, the investment that we have made in this budget is $175 million. Over $300 million has been invested in mental health in the previous two budgets. It has been invested very strategically based around the mental health reform agenda. In fact there is absolutely no question that since this government came to office our investment in mental health has gone up significantly. If you have a look at the average rate at which the previous government had been investing in mental health — —

Mr WELLS — Hang on. We have been told all morning — —

Mr DALLA-RIVA — No, this is about the proportion — —

Ms NEVILLE — And since that time — —

Mr WELLS — Why have you not ruled her out of order in regard to that? You have two set of rules.

The CHAIR — No, I do not have two sets of rules.

Mr WELLS — You do have two sets of rules.

The CHAIR — Mr Dalla–Riva talked about long-term trends and more recent trends as well, but we are trying to focus on the estimates and going forward in the next year and the three subsequent out years, Minister.

Ms NEVILLE — In the last three budgets — I have not got the slide here, but I am happy to provide that information to the committee — since we have had a Minister for Mental Health and a separate division within the department there has never been such a significant investment in mental health. So I am very happy to provide that additional information.

Mr DALLA-RIVA — But the proportion of it against the — —

Ms NEVILLE — People also need to remember that everything that we do in mental health does not sit within the mental health division. For example, funding of emergency departments is pretty critical to supporting and assisting people with a mental illness who require crisis intervention. All our primary care counsellors, who all sit within the health outputs, do not sit within the mental health division but play a critical role in early intervention and community support services in our community. We know that mental health clients absolutely need better access to dental care and all of those very important health services that can impact on someone's mental health and their capacity.

One of the programs that Daniel Andrews recently announced with me was exactly that sort of program through the health output to provide priority access to people with a mental illness to certain primary care services. Right across the health budget there is a range of initiatives that support people with a mental illness. I would not want to see everything just sitting within one division. It is a whole-of-government approach. Whether it is in our schools — and this budget actually invests further money and capacity building. If you have a look at the strategy, that is exactly what it says. Whether it is in education, in skills or training, in research areas, innovation, health, child protection, wherever it is, there is a role for all of us to play in enhancing the way that we respond to the needs of people with a mental illness. That is what you see with the mental health reform strategy.

The CHAIR — Mr Dalla–Riva asked for some information in regard to trends against certain benchmarks. You promised to provide information in relation to that in terms of trends over the previous three years and obviously going forward as well. I would appreciate it if you provided that in terms of what Mr Dalla–Riva was asking.

Mr SCOTT — Minister, I refer you to pages 98 and 306 of budget paper 3. Minister, alcohol and other drugs are a major concern for the community. Can you please describe to the committee what this government is doing through the forward estimates in terms of prevention and treatment?

Ms NEVILLE — As I indicated very briefly in my overview of the drug and alcohol area, since 1999 we have committed over $510 million for a range of initiatives across government to address drug and alcohol issues here in Victoria. In this financial year, 2010–11, the Department of Health will provide $135.7 million for drug prevention and treatment programs to over 105 alcohol and other drug services across the state. As I indicated, this includes $20 million over four years for new drug and alcohol services in our growth corridors. It also includes nursing support in Aboriginal alcohol and drug addiction services and also a continuation of existing drug treatment and harm reduction services in St Kilda.

In the breakdown of that $20 million, $14 million is going into the new services that will provide additional counselling, consultancy and continuing care services, which will have multidisciplinary teams delivering a range of therapeutic alcohol and drug treatment to adults in areas, as I said, Casey, Hume, Whittlesea, Melton and Wyndham.

The $4.4 million over four years is for new nursing capacity for Koori resource services to provide medical and health support to Aboriginal people accessing services due to drug and alcohol use. As I said, the state budget also provides funding to continue what has been a very successful program in St Kilda — the alcohol and drug treatment and harm reduction services. This builds on the funding that we committed to deliver the Victorian alcohol action plan — $37.2 million over four years — which was announced in the 2008–09 budget. As I said earlier, we have made significant progress in rolling out all of those initiatives that were part of that, so that is providing additional treatment services, providing additional interventions with families, providing additional capacity amongst GPs to work with people with alcohol and drug issues, and of course we have also undertaken the awareness campaign 'Will You Handle Your Alcohol? Or Will Alcohol Handle You?' which ran last year. That campaign was targeted to 18-to-30 year-olds who were very much involved in talking to us about what are the messages that work.

I mentioned the ecstasy campaign that we are about to commence. Since that alcohol campaign we have also undertaken a campaign around cannabis use and particularly its mental health issues, again raising awareness amongst young people about the risks of cannabis use. Certainly cannabis use has stabilised and it has trended down over a period of time. Across a range — whether it is treatment, rehabilitation services, early intervention or awareness campaigns — we have a comprehensive program and investment to improve the way we respond to people who have drug and alcohol issues in our community.

Ms PENNICUIK — Minister, in its budget submission the Australian Medical Association made the point that nearly two-thirds of female patients in psychiatric wards in Victoria have been sexually abused or harassed by other patients. It recommends additional capacity to ensure that patients can be treated in single-sex wards and that ensuring single-sex wards for mental health patients be a critical priority in the next phase of the strategy. Also, the budget includes, I think, $37 million for compulsory mental health treatment in anticipation of new legislation, so what budget allocation has there been for the separation of women and men in acute mental health wards as recommended by the AMA and by Women's Health West?

Ms NEVILLE — This is a really important issue about the way that we can respond to individual needs within acute inpatient settings where obviously you can already have issues around people's safety and security. Back in 2008 the department undertook a project to have a look at gender sensitivity and safety in adult acute wards. Each health service is required to document critical incidents but also, as part of the gender sensitivity project, highlight ways in which they are going to improve women's safety.

The recommendations that came out of that review included new service and clinical guidelines, so it is not just about the physical separation but how those issues are managed within acute inpatient wards and ensuring staff have the capacity to respond and prevent incidents. There is monitoring service performance and looking at

alternative options in terms of treatment environments, and of course obviously in redevelopments looking at opportunities to design new facilities in a way that enhances opportunities to be gender sensitive — to have separate wings. For example, the Maroondah Hospital, which I opened last year, does have separate wings that can be shut off and all the rooms have capacity to be locked. Most of the rooms now are all private with ensuites — again, not shared rooms.

All of those things are going to enhance women's safety — everyone's safety — within an acute inpatient ward. We also know with new facilities, that if they are designed right — the Northern Hospital is a great example of this and Maroondah is another — then you will start to see improvements generally around reductions in needing to use seclusion or any of those mechanisms to manage behaviours, just because of the nature of the environment that you can create through new development. The other day I opened a refurbished PARC service in Flemington. They have also been able to, within that refurbishment process, create a separate bedroom area for women. This is a high priority to ensure that as we design new facilities we are able to incorporate for everyone's safety locked doors, single rooms and ensuites but also to create opportunities for women-only areas and family areas as well so that people can bring family members in. Particularly when people are about to transition back into the community, it is very important in terms of their recovery process to have that link.

We did also provide one-off grants to inpatient units. Obviously it is easier when you have got a greenfield site and you are creating new facilities, but we are looking at opportunities in existing facilities for those places to be able to develop areas that are separate for women and create a separate and safe environment.

The Dandenong hospital, construction of which has commenced, will also have a separate area for women, as will the secure and extended care unit component of the Dandenong hospital redevelopment.

Ms PENNICUIK — Just a clarification, given that that is such a high incidence of abuse or harassment — I understand everything you have said, and I comprehend that it is more than just the physical separation — what I would like to know is at what stage will it be complete that there is physical separation or the ability for the sexes to be separated in all the institutions or in the patient services?

Ms NEVILLE — We are obviously undertaking major capital developments, and in all those capital developments that is what has been incorporated. In existing ones that are not yet up or do not need capital developments, as I said, we have given grants so that they can create some spaces that are safer. As I said, part of being able to manage those issues is also around making sure your staff have the skills and capacity to be able to manage those issues and prevent that. It is a priority in all new developments. We have given some funding to existing ones which are part of redevelopments so they can create those opportunities, and as we develop — whether they are PARC services or major hospital developments — making sure that you are designing it right at the start so that in future you do not have to go back and reconfigure in order to provide those separate areas for women.

Ms PENNICUIK — Does that include all existing facilities that got some money towards that?

Ms NEVILLE — I think it was 20 inpatient units. Obviously, those that were getting redeveloped you are not providing that resource to, any one that is going through a major redevelopment.

Ms PENNICUIK — I might follow that up with the department.

Ms NEVILLE — We can provide that detailed information.

Ms PENNICUIK — Could you do that?

Dr SYKES — Minister, my question relates to budget paper 3, pages 97 and 98, on drug prevention and control. The most recent report in 2007–08 of the health and wellbeing expenditure series from the Australian Institute of Health and Welfare reveals that your government spends the least of any state, per person, on the prevention of hazardous and harmful drug use. In spite of the commentary about the initiatives in relation to drugs and alcohol, given that your government has been underfunding this output measure since 2007–08, with a per year increase of about 1.3 per cent, not even keeping up with inflation, can you confirm that your government still spends the least of any state in this area?

Ms NEVILLE — I am surprised that you did not ask me the other question.

Dr SYKES — Oh, this is the tricky move!

The CHAIR — Just one question at a time, please.

Ms NEVILLE — The one that you told me the other day you are desperate to get an answer on. We might do that separately.

Dr SYKES — You can answer that in your answer, Minister. I am very happy to have that.

Ms NEVILLE — What I can confirm is that what we have spent in this area since 1999 is over $510 million. Drug and alcohol outputs sit not just in the mental health and drug area. They sit some in health and some in the justice area, so they are spread across government in terms of the responses, because you have got different communities, different needs and different programs that sit across different areas of government. So when I am talking about this, the $510 million is part of the Victorian government's drug initiative.

In our first term we committed $77 million to that; $178 million was committed over four years in 2003–04 to 2006–07; and $201 million was recommitted over four years 2007–08 to 2010–11 for the whole-of-the government Victorian drug strategy. As I said, it is allocated to human services — or health, now — the Department of Justice, and in fact some sits in the Department of Education and Early Childhood Development. Our component, which is the outputs that you are referring to, is $148 million over the four years, which includes $135.8 million for drug services output group, $5.2 million for the mental health output group, and $7.1 million for youth services and youth justice output groups. So again, sitting across a number of areas.

This funding provides for a range of drug prevention education programs, drug treatment, rehabilitation and forensic programs, dual-diagnosis responses, juvenile justice, custodial services, and other initiatives such as the Victorian Drug and Alcohol Prevention Council, the Koori youth healing service, local drug strategies in five inner city municipalities and a range of family support programs. Of course, there was the $37 million, which I have spoken about to, which was to implement the alcohol action plan, and of course this budget also contains $20 million over the four years for additional alcohol and drug services in our growth corridors, specialist response to Koori people with drug and alcohol issues, and the St Kilda harm reduction program. So the output in 2010–11 in the drugs output group is $135.7 million.

I should also say that during that period, with the investment that we have made, we have also been able to increase our drug treatment beds in Victoria from 431; in the next financial year that figure will be 802. We also provided a total of 6141 episodes of care to 4511 clients through the rehabilitation and withdrawal programs.

Can I also say that often with these things you are not comparing apples with apples because the programs that we run in Victoria are much more community-based programs. In fact, most of our drug and alcohol services are not inpatient, as in hospital inpatient withdrawal units; they are community-based. The reason we have that system is that they deliver better outcomes. They are also more cost-effective in terms of the dollar spend for communities than inpatient hospital-based drug and alcohol services.

Dr SYKES — Chair, just a seek clarification through you: Minister, my interpretation of your concluding comments was that you are questioning the completeness of the table prepared by the Australian Institute of Health and Welfare. They indicate, that in 2007–08 the Australia-wide is nearly $12 per person, with Victoria at $8.34, but Tasmania at $19.73 and the Northern Territory at $44.68.

The CHAIR — The minister, to clarify quickly, please.

Ms NEVILLE — There are a number of ways. Obviously, comparing it to the drug outputs — as I have indicated, there are a whole lot of drug and alcohol programs that will not be that drug output budget that we have.

Dr SYKES — But you might expect that this organisation would also have sought to gather that information from each and every state.

Ms NEVILLE — This is a common issue across a range of areas where you try to compile information across states, where there are different types of services you have different ways of classifying services and where funding sits. So it is often very difficult to compare apples with apples. What I have indicated is that we have a very different service system; we have made substantial investments in drug and alcohol services across

a number of areas of government and those services are making a difference and there are more beds and more treatments.

The CHAIR —Dr Sykes has a question that I would like to put on notice. It is: given the outstanding success of outreach worker Ivan Lister, will the minister commit to fully funding his position for the next four years? We will take that one on notice.

I thank Dr Edwards for her attendance.

Witnesses withdrew.