**PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE**

**Inquiry into budget estimates 2009–10**

Melbourne — 19 May 2009

Members

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Witnesses

Ms L. Neville, Minister for Mental Health,

Ms F. Thorn, Secretary,

Ms A. Hall, Executive Director, Financial and Corporate Services, and

Ms G. Callister, Executive Director, Mental Health and Drugs, Department of Human Services.

**The CHAIR** — I welcome the Minister for Mental Health. I also welcome Ms Fran Thorn, secretary; Mr Alan Hall, executive director, financial and corporate services; and Ms Gill Callister, executive director, mental health and drugs, all from the Department of Human Services. I invite the minister to proceed with her presentation. She has no more than 5 minutes.

**Overheads shown.**

**Ms NEVILLE** — Thank you, Chair. People will remember that last year I spoke about the green paper, which outlined possible areas of reform in mental health. That was backed up by some funding to seed reform, $128 million. Since that time we have done extensive consultation with stakeholders, carers and consumers. In fact, we received over 200 submissions and 1200 people were involved in developing the strategy.

In March this year I released the mental health reform strategy, which will significantly shift the way in which we respond and deliver mental health support and services in our community. It is the first time we have had a whole-of-government approach and a whole-of-life approach to mental health in Victoria. This year's budget of $182 million in this area will see us being able to make significant new investment in our key priority reform areas.

The graph shows that we are spending almost double the amount on mental health since we were elected. In 2009–10, the mental health budget, which excludes capital, will be $945 million, which is a 108 per cent increase over the last 10 years. We have also continued to invest in capital, so last year we put $34 million into capital funding, and more than $74 million will be provided in this budget.

Beyond these reforms, the other things that we have been doing this year include the review of the Mental Health Act — a major review of that — the psycho-social response to bushfires. We have opened new acute beds at Maroondah and started the works at the Northern Hospital. We have appointed Australia's first chief child psychiatrist, who is Dr Sandra Radovini.

Turning to the year ahead, the priorities on this slide reflect the key reform areas of the mental health strategy, and the budget initiatives, which I will go through in a moment, really support each of those priorities and will start to achieve reform in each of those areas. This will give the committee a bit of a sense of where the $182 million investment will go: $21 million will go to improving our early-in-life responses.

We know, for example, the incidence and the development of mental illness are disproportionate for those people under 21. This is about ensuring that our mental health system has a better capacity to meet the needs of children and young people through things like expanding the CAMHS in schools program to identify and intervene with primary school aged children who have emerging and existing behavioural disturbances; strengthening youth early intervention teams; and we have also been doing considerable work within our school system to ensure early identification and support.

There will be enhancement of the pathways to care, which will see further investment in enhanced mental health triage services, which will expand on the funding we provided last year to centralise in six metropolitan and regional area mental health services a 24-hours a day, seven days a week, specialist mental health triage response. This will occur over the next two years, freeing up capacity in our CAT teams.

We also have a strong focus on providing additional support for those at the forensic end, those people who are engaged or involved at some level around our justice system, for example. This will provide some funding for what we are calling expert portfolio-holders to assist these particular people to gain better access to expert advice and support.

There is also a strong focus on recovery and building foundations for recovery. We have allocated $37.7 million, which, again, builds on what we provided last year. We will see new dedicated care coordinators providing support for up to 300 consumers with comprehensive care plans and tailored support packages to support them in accessing the correct health, community and social security services that they need. There are also an additional 50 support packages linked to stable housing, and we will also be piloting a new mental health list in the Melbourne Magistrates Court.

There is also a strong focus on our workforce capacity, with an allocation of $6.6 million, which will enable us to establish a new institute of mental health and workforce development focused on training, education and

recruitment, and there will be some particular time-limited positions to help us drive governance changes in local communities and ensure that we are able to implement our reform processes.

As I said, there is also investment in health service capacity and also in beds. There is $66 million to complete the Dandenong Hospital redevelopment, $8 million for two youth PARC facilities — which will be the first of their kind — and also some money to build some capacity at the Geelong Swanston Centre, with eight new beds.

Among the other areas in this portfolio, alcohol perhaps remains one of the biggest challenges facing government and the community, given the levels of harmful drinking in our community, particularly among young people, the health impacts and of course the link to violence.

Last year we released our alcohol action plan and allocated $37 million in this area. As a result of that we have seen the introduction of new services, for example, 175 young people and their families benefiting from therapeutic intervention programs. We have also had some new intervention programs, for example, the 'Will you handle your alcohol? Or will alcohol handle you?' campaign which was launched in January, encouraging people to think about their alcohol use and the risks around violence.

Also this year we launched the blueprint for alcohol and other drug treatment services. This maps out a client-centred and service-focused reform agenda for Victoria's alcohol and drug sector. As in mental health, a key focus is on prevention and early intervention, and some funding has been provided to VAADA, the peak body, to assist in kick-starting the implementation.

Also this year we have released the amphetamine-type stimulant strategy, which will guide work to continue to prevent and reduce the supply, use of and demand for amphetamine-type stimulants.

We are also providing $127.5 million in ongoing funding for prevention and treatment programs, including funding for 802 beds, and, combined, these continue our strong efforts in preventing the uptake of drugs, alcohol misuse as well as providing the necessary support and treatment services required for those who need additional assistance.

I am conscious of the time, Chair, so I will quickly go to the next slide. I wanted to mention one thing, which is the Overdale alcohol and drug service. This was a service that was unfortunately destroyed in the bushfires at Kilmore. We had a successful evacuation, so there were no issues on the day, but this has meant our bed capacity at the moment has been reduced by 16 beds, and we are working with the Salvation Army to get an interim service in place by the end of June and also to plan for a new permanent service.

**The CHAIR** — Thanks, Minister. Going back to your mental health reform strategy, which over four years is $182.1 million, where you have got seven headings; and I am also conscious that in appendix A of budget paper 3, page 286, you have got another listing there; also the DHS initiatives. Can you give us a table with your seven headings and then the subheadings over the four years in terms of the expenditure under the various programs that you have got here in the budget so we can have a better understanding of how it all fits in?

**Ms NEVILLE** — Yes.

**Ms PENNICUIK** — Minister, many people in the community, including refugees and those who have lived here for a long time and do not speak English or who have English as a second language, encounter barriers in accessing mental health services. For example, a visit to a GP is required to get a referral to a specialist, and often there are no interpreter services available to assist in that process or in other processes in the mental health system. Is there any funding in the budget for interpreter services in the mental health system to assist people from non-English-speaking backgrounds access mental health services?

**Ms NEVILLE** — There is no additional funding, but we have an ongoing program that provides access to interpreting services for people who are accessing our mental health services.

**Ms PENNICUIK** — Certainly we are being approached by people who are saying that they are having trouble accessing it. Have you got any idea of the unmet need in that area? Was the department keeping an eye on that?

**Ms CALLISTER** — I think all clients who are accessing the public mental health system and need an interpreter service are able to access the interpreter service. It is not a barrier to receiving treatment or care, that people cannot receive an interpreter service. That is available through the public mental health program, as the minister said.

**Ms PENNICUIK** — Obviously we are getting feedback from people about their not being able to access — —

**Ms NEVILLE** — There may be a difference between those who are going to a GP, for example. GPs obviously provide primary care as delivered by the commonwealth. It is a bit hard to give you the full details of how the strategy works, but there is a focus in the strategy about how to ensure particular access and improvements to services for particular groups in our community who are more disadvantaged and less able to access those services.

Obviously CALD communities are one. We also have some specialist services around for survivors of torture. That is going to be an increasing need given the areas where we have refugees coming from, and obviously also indigenous communities as well. Sitting underneath in the strategy are new ways of working, new supports, how do we provide better access to critical mental health services for those particular groups?

**Ms HUPPERT** — Minister, as the Chair mentioned, page 286 in budget paper 3 outlines a number of initiatives in the mental health reform strategy. I draw attention to one of line items 'Early in life: improving mental health outcomes for children, young people and their families'. I know you touched on this briefly in your presentation. I wonder if you could provide the committee with some more information about the action taken to improve the responsiveness of mental health services for children and young people during the forward estimates period?

**Ms NEVILLE** — This is — not wanting to say the others are not critical — a very critical area in terms of how we want to reform our system. We know, for example, that about 14 per cent of children and young people aged 4 to 17 are affected by mental illness at some point. This goes up to 26 per cent between the ages of 16 and 24. We also know that 75 per cent of severe mental health issues occur before somebody is 25. It has a significant impact on children and young people.

Yet probably across the world the focus on children's and young people's mental health has been a bit unrecognised. What the strategy talks about is that if we are able to invest early and earlier in life, we can provide much better outcomes for children and young people; we can prevent and we can also minimise the impact of mental illness on children and young people.

The budget provides $21.3 million specifically targeted at achieving better mental health outcomes for children and young people. Of this, $13.8 million over four years has been provided to the Child and Youth Mental Health Service Redesign initiative. This is about ensuring that we are able to provide a strengthened response for young people up to the age of 25. At the moment we really see young people transition from the youth mental health service system from about the age of 18. That is often a really critical transition period. As you have seen from all those figures — given the incidence between 16 and 24 — this is about ensuring that there are age-appropriate targeted services up to the age of 25.

A further $8 million is being provided to develop two youth PARC services — that is, prevention and recovery care services. We have quite a number of those across the state now, but these are the first time that we will have specific services targeted at young people. These operate as a step-up, step-down facility. Hopefully for young people particularly it is a step-up to prevent the need for an acute hospital inpatient admission so that people can spend some time and get the support they need as quickly as possible in the development of their illness to prevent the need to spend time in an acute hospital ward.

There is also $3 million for a new youth justice mental health initiative, which will provide clinical treatment and care coordination support for young people involved in our youth justice services. One of the key priorities of the strategy is to redesign and connect services and programs to get better mental health outcomes across the board, particularly in our schools.

In collaboration with the education department we will better use student support service officers and make sure that they are plugged into the wider mental health service, particularly providing secondary consultation with

our CAMHS services to ensure that we are able to identify kids at risk of mental illness very early on and ensure that they are getting the support, services and treatment that they need.

As I mentioned in my presentation, we are also extending our CASEA or CAMHS in Schools Early Action program. It will be extended to more metropolitan and rural regions. This is really about identification of primary school children who are at risk of things like conduct disorder, and intervening earlier. Certainly so far that program has been extremely successful in shifting behaviours and in longer term outcomes for young children. We also continue our support of FaPMI, which is for families where a parent has a mental illness. All of these services are contributing to improvements in our response to children and young people and building on some of the demonstration projects that we funded in last year's budget.

**Dr SYKES** — Minister, before I ask my question in relation to crisis assessment and treatment services, can I on behalf of the people of drought-affected north-east Victoria thank you for organising continuation of funding of Ivan Lister, an outreach worker who has done an outstanding job in relation to not just drought but other matters, including bushfires. I also understand that you are actually working on a continuation of funding for Kyabram community services that provide a similar service.

You are giving me a nod that that is all happening?

**Ms NEVILLE** — Certainly Ivan, yes.

**Dr SYKES** — In relation to the crisis assessment and treatment services, known as CATS, you put up a slide there before indicating $11.2 million. Is that to go to supporting the CAT services? The reason I ask is that the Boston Consulting Group put out a report in July 2006 which indicated that the CAT services were seriously underresourced. In the last few weeks I actually had a meeting involving Ivan Lister and the local police addressing this issue of dealing with people with either mental health problems or stress and the difficulty of the local police accessing CAT or professional backup services to help them handle situations, with the potential consequence of some very bad outcomes. Is that $11.2 million to strengthen the CAT service?

**The CHAIR** — You will find it on the first slide about the health reform strategy.

**Ms NEVILLE** — There are a number of services that really go to this issue around pathways to care. What we know is that generally the community is very unclear about how to access mental health services wherever they might sit, whether in primary health from GPs or right through. People are very unclear. We are trying to improve that whole pathways to care response as well as our emergency response as part of that. In the last budget we committed to a 24/7 line which is for the whole community, and that will be up and running later this year.

That will provide a one-stop shop core in case you are worried about yourself or someone else and are not sure where to go. That is about ensuring that people are getting access quickly to the right care. It might be that they need to see a GP, they might actually need the specialist end of the service or they may need a CAT team to respond. That service will play some of that role. It will not replace the specialist mental health services, but it will be able to identify people who may require more of an emergency response.

In addition to that we are rolling out the 24/7 mental health triage service. At the moment we have 21 area mental health services that have CAT clinicians and they all operate relatively differently. Some have a triage service you can ring, and that function plays a role in doing an assessment of need, what sorts of supports and services that person might need and how urgent it is. Some do it that way. Some do a bit of triage, and some other clinicians respond to an incident. Some places work well, and some do not work very well.

What we want to do is have a more consistent model and some models that actually deliver better responses. The mental health triage service, some of which we are rolling out now and which will be rolled out with some additional money, will provide a one-point entry into your area mental health service where people will know who you are. The people who are in our specialist system in particular generally know who those people are and what sort of response is needed, and they can make assessments about CAT teams, police attending and whatever the issues might be, and about whether the response is access through the emergency department, where we have some specialist CAT team services as well.

In addition to that there have been some really good models which we will look at. For example, Southern Health, Victoria Police and the ambulance services have been working together to provide a better joined-up response between a CAT clinician and the police in responding to and supporting people who are in crisis with a mental health service. So, yes and no; that money is about ensuring that we are able to have a consistent model across the state for access to the specialist mental health service and for people who are in crisis. It will also enable us to do some reform of CAT teams.

People have often complained about them becoming only an emergency response. The crisis assessment part of the title is a bit unfortunate, but they really do a little assessment and they do a little treatment, and we want to refocus them a bit more to be able to do some more short-term responses. We think the combination along that pathway of care and range of services will enable us to improve access, support and treatment right across the board.

**Dr SYKES** — Just focusing on the crisis response component, as a result of the investment will there be a strengthening of the crisis response component; and if so, what measures do you have in place to measure the improvement in performance?

**Ms NEVILLE** — What it does is basically free up CAT teams to do what they should be doing.

**Dr SYKES** — So there will be a strengthening of CAT response?

**Ms NEVILLE** — At the moment CAT teams are doing both of these things. We are going to have additional resources in triage, which will be separate, and the CAT teams can respond better. We are giving them more capacity to do that.

**Dr SYKES** — And do you have a performance indicator to indicate that what you are hoping will be achieved — a better response — has been achieved? How you are going to measure whether that is achieved? You can take on notice, if you like, what performance indicators you have.

**Ms NEVILLE** — There are a number in the strategy outline. We already have a series of KPIs, but obviously part of the strategy and moving forward will also be about what other new outcome measures we want to achieve if we put in place new services. A lot of the early life services, for example, are very new; we have no KPIs, so we need to continue to enhance that. But certainly what goes to the issue of performance will be about admission rates, waits in emergency departments — all of those KPIs will help us assess outcomes. Each service obviously provides us daily with information about their response times and who they have responded to, so we have that detail, but we need to continue to ensure that our performance measures match the direction we want to go in terms of the reform of the mental health system.

**Dr SYKES** — I think the first measure is whether they able to respond or not to the request, and then the second is the response time, so if you could have a look at that, because right now there is an issue of not being able to respond.

**The CHAIR** — There is a performance indicator there, but any extra information you can provide would be good.

**Mr SCOTT** — Minister, I refer you to budget paper 3, pages 320 and 321, where there is a table A.6 headed 'Asset initiatives — human services'. Can you inform the committee about mental health capital works programs?

**Ms NEVILLE** — Again, one of the key priorities that sits under the reform strategy is continuing to ensure that we can respond to demand pressure by building our capacity in the mental health system. This requires us to continue to invest in infrastructure but also in new services so that we are providing both more capacity in what we do now and also new services that better respond in a better way to the incidence of mental illness. In the 2009–10 budget we continue to build on the mental health capital developments that we have announced in recent years. Funding of $74 million was announced, which will see us being able to deliver our commitment in Dandenong to the redevelopment of the Dandenong Hospital. This will increase inpatient beds from 77 to 120, comprising additional adult acute beds and aged and secure extended care beds, and it will provide 30 additional residential beds in the Dandenong area mental health service.

Last year we provided $3 million for detailed planning, and this will meet the $69 million funding commitment that the government made in 2006 to upgrade and expand the services in this important growth area.

**The CHAIR** — Can you clarify, maybe on notice, just what the figures are, because you have mentioned $74 million and $69 million, and in the budget paper there is $66 million.

**Ms NEVILLE** — Yes, $66 million. I was just saying last year we provided $3 million for the planning of it in the 2008–09 budget, which gives you the $69 million.

**The CHAIR** — Thank you.

**Ms NEVILLE** — In addition to the development of the new acute facilities at Barwon Health we have also allocated funding to increase the capacity of the mental health beds at the Swanston Centre in Geelong, which will see an additional eight acute mental health beds. This will enable us in the medium term to meet the increasing pressures on beds in the Barwon region whilst we continue to do the planning for the long-term redevelopment of the Geelong Hospital. These are on top of some of our more recent capital developments. There was capital funding in 2005–06 of $25 million for the development of two new 25-bed adult acute units at the Maroondah Hospital, which will increase the beds from 30 to 50. The first stage of that project opened in 2008, and the second stage is about to be completed and will open in July of this year.

In the 2007–08 capital budget for mental health $26.6 million was provided, including $15.5 million for the Northern Hospital redevelopment project, which will expand inpatient beds from 25 to 50, and works on that project have commenced and will be completed by about July of next year. There was also $20 million in the 2007–08 and 2008–09 budgets to meet the government's commitment to the expansion of the PARC services.

The first 20 of these beds at Deer Park are due to be completed this month, and the remaining 50 in purpose-built facilities at Ringwood, Preston, Broadmeadows, Clayton and Frankston will be completed next year. As I mentioned before, we have provided the additional PARC beds — the youth PARC beds — in this particular budget. There has also been the funding of money to redevelop veterans mental health, which will be the centre for trauma-related mental health, and $17 million was provided between 2007 and 2009 for that. There is also money for the Ballarat hospital to improve its mental health adult acute unit, with $5.5 million provided last year.

Capital investments over the last few years, combined with these capital investments in this budget, are really building our core capacity, but also as I said building new services and PARC services to provide access for people to more appropriate care and treatment.

**Mr RICH-PHILLIPS** — Minister, I would like to ask you about the ice strategy. In early 2007 then Premier Bracks made a substantial announcement that the government would undertake the development of a strategy for a pre-emptive strike in the war on ice. Since then and up until now, with the release of the strategy, we have seen nothing. I understand the strategy was basically released on the DHS website at the end of April, with no fanfare and no announcement by you or any other comment from government. The war on ice has basically turned into a quiet release of a document somewhere down the bottom of the DHS website. So my question is: what funding has been provided explicitly in the 2009–10 budget for the implementation of that strategy, and what time frames are in place for the implementation of the programs under that strategy document?

**Ms NEVILLE** — We have had a very strong focus on the issue of ice, but amphetamines more broadly. Our aim in this area is to ensure that we continue to see a consistent and declining use of ice, and in Victoria we have seen that over the last few years. We have not seen a spike or growth in the use of ice, unlike some areas across the world and across Australia. We have been investing very significantly in prevention but also in terms of our ongoing treatment programs to ensure that people who have an issue with the use of amphetamines can get the treatment that they need.

Part of the package that was announced by the Premier back in 2007 was to develop an amphetamine-type strategy, which was released in a meeting with stakeholders, who have been very much party to this. The strategy has been very much a partnership with ourselves and the non-government sector and experts in this area in developing the way forward in terms of what our focus should be in tackling and preventing the use of amphetamines in Victoria, particularly amongst our young people.

Some of the priority areas that sit under that strategy include things like prevention and early intervention, like targeted awareness campaigns — you might have seen the 'ice: it's a dirty drug' campaign; the strengthening of prevention and early intervention strategies; the provision of sterile injecting equipment, particularly outside standard hours; in the treatment area, looking at how we strengthen our psychological interventions, how we ensure that we are picking up on other issues, like mental health issues, how we ensure that there is a focus on families, on parents.

Drug users are often parents as well, and we need to focus around protecting and supporting children and families as a whole. We have a focus in treatment around ensuring specialist addiction medicine access as well. That is a new area of work, and we are investing significantly in that and in understanding addiction. Specialist addiction medicine units will play a vital role in that.

There is also a strong focus on workforce — how do we increase the capacity of GPs, how do we increase the capacity of the alcohol and drug sector? And through clinical guidelines and training, how do we increase brief interventions and other referrals, and what are the sort of training and workforce development issues to ensure that we are able to respond to people who use amphetamines?

There are also things that sit outside my area, obviously in justice and law enforcement, about supply issues and ensuring targeted awareness campaigns on drug users who drive cars. So there has been a very strong focus on that, as well as implementing some of the restrictions around precursor chemicals.

The task force that developed this strategy, as I said, had leading experts from drugs, from the health sector, CALD communities — so it is a very broad-ranging task force — and it is really I suppose their efforts that saw the result of that. It is their views and their experience that are reflected in the strategy.

In terms of some of the things that we have been doing to address the issues since February 2007, as I said we had the media prevention campaign, 'ice: it's a dirty drug'; we strengthened legislation regarding pill presses; we developed clinical guidelines; we have got new prevention and community education and funding for drug hot spots and treatment services to assist people.

One of the good things about our drug treatment services is its capacity to be able to respond and shift to meet changing drug patterns in our community. There has been funding for information to parents, which was distributed through schools, helping them understand the risk signs of their children using ice, and what they can and should be able to do about it; further training for alcohol and drug workers; as I said, new clinical guidelines for methamphetamine addiction; money to train staff and volunteers at the family drug helpline so that people could seek information following both our campaign and also the distribution of information to parents; the funding of primary health services and local drug strategies across five drug hot spots in Melbourne also occurred.

As I said, there are a number of other things that we do that sit within the justice portfolio in relation to methamphetamine use and driving, drug driving; changes in legislation around ice pipes; access to precursor chemicals that go to making amphetamines. So it has been across DHS and DOJ by way of response to this issue. It is making a difference in terms of keeping down the use of amphetamines in our community, particularly amongst young people, and we will continue to focus on it.

**Mr RICH-PHILLIPS** — The question, Minister, related to the strategy that was released in April — whether there is any explicit funding provided in this budget to address the initiatives in that strategy, or are you basically saying what is in the strategy is simply what you have already been doing?

**Ms NEVILLE** — As I said when I did the presentation on the alcohol and drug area, we continue to have our drug and alcohol output, which funds our treatment services, it funds our prevention services — —

**Mr RICH-PHILLIPS** — But does that address specific initiatives out of the amphetamine strategy?

**Ms NEVILLE** — Yes. The drug and alcohol blueprint, combined with the amphetamine task force, and the money that we have given to VAADA is about how we implement that. Some of it is about what sort of services we need to provide, and some of it is about the structure of our drug and alcohol treatment services, and we will be working with VAADA to implement the amphetamine-type strategy and also the drug blueprint.

**The CHAIR** — I thank the Minister for Mental Health, Mr Hall, Ms Callister and Ms Thorn for their attendance.

**Witnesses withdrew.**