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PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

# Mental Health Service St John's Park Facility

*Brought up by Ms Butler and ordered by the House of Assembly to be printed.*

MEMBERS OF THE COMMITTEE

| Legislative Council | House of Assembly |
|---|---|
| Ms *Rattray* | Ms *Butler* |
| Mr *Valentine(Chair)* | Mr *Ellis* |
| | Mr *Tucker* |

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# 1 INTRODUCTION

The Committee has the honour to report to the House of Assembly in accordance with the provisions of the *Public Works Committee Act 1914* on the -

## Mental Health Service St John's Park Facility

# 2 BACKGROUND

2.1 This reference recommended the Committee approve works to construct a state-of-the-art purpose-built mental health facility at St John's Park. The new facility will provide access to 'best practice' contemporary care at the appropriate level of acuity, as part of an integrated service delivery mode. It will house both the Southern Mental Health Beds Development (SMHBD) and an Eating Disorders Treatment Centre, known as the Tasmanian Eating Disorders Service (TEDS).

2.2 The services provided within the proposed facilities will be in accordance with a new mental health care system. The facilities are designed to provide an appropriate built environment to support consumers of the mental health service through improving metal health outcomes and maximising recovery whilst providing a contemporary work environment for staff and service providers.

2.3 Consumers will be able to access a range of community mental health services, including clinical mental health, general health, employment, disability, housing, and social services. People will also be able to access group support, peer support, personalised support and family and carer support.

2.4 The proposed work involves:

- Construction of a new two-storey building that will provide for best practise mental health and eating disorder care needs;
- New landscaping connecting to the existing open space;
- Car park and drop-off-point servicing the new development; and
- Construction of interior spaces that will provide for best practice mental health care needs with high quality interior design features and a strong residential ambience.

2.5 The SMHBD will function as a Mental Health Integration Hub (MHIH), and will provide both inpatient and outpatient services. MHIHs are a key component of the new model of delivering mental health services to the Tasmanian community. The aim of an MHIH is to transform the way people navigate services and access supports for their mental health by providing access to integrated psychosocial supports and services in a single location, and consistent with recovery-oriented practice guidelines.

2.6 The role of the new SMHBD will be to:

- Alleviate pressure on hospital admissions by providing appropriate intervention for people with non-acute mental illness in the first instance. The centre will

provide integrated clinical and community-based care, enabling people to 'step up' into a more intensive level of care from the community if needed and to 'step down' from acute hospital care into community-based care, when ready. They will be offered a range of services including short term accommodation and capacity-building supports to assist them to manage their own mental ill-health and recovery.

- Provide strong connections with all aspects of the Tasmanian Mental Health Service system. It will also be a 'one stop shop' for people with mental health issues and suicidal distress and their family and carers, offering a three-bed wing (included within the total 15 bed provision) for this purpose.
- Provide consumers with access to a range of community mental health, clinical mental health, general health, employment, disability, housing and social services. Consumers will also be able to access group support, mutual support, personalised support and family and carer support.

2.7 The SMHBD will provide the following built facilities to support service delivery:

- A welcoming entry and concierge reception;
- Support spaces for service providers including Community Sector Organisations, primary health services, and private providers;
- Safe Haven space with kitchenette;
- Secure staff areas and amenities;
- 15-bed residential accommodation for short-term stay with ensuite facilities; and
- Associated ancillary facilities for dining and lounge areas, kitchen, laundry, and amenities; and
- Safe rooms and de-escalation spaces.

2.8 Tasmania does not currently provide a single coordinated approach to eating disorder treatment within the public health system. Current treatment for eating disorders is delivered through a range of services and providers in the public, private and primary care sectors, some of which specialise in treatment of eating disorders, and some of which are generalist teams or services. The new Tasmanian Eating Disorders Service (TEDS) will address gaps in the current eating disorder service system and introduce more effective stepped care. It will do this by providing a residential treatment stream and day/evening programs for people with a primary diagnosis of an eating disorder.

2.9 The role of the TEDS will be to:

- Intersect with other services and service providers currently delivering treatment for eating disorders. These include services delivered by the Tasmanian Health Services, such as hospital inpatient services addressing medical instability or their corresponding outpatient clinics providing medical monitoring or management, Child and Adolescent Mental Health Services (CAMHS), and Adult Community Mental Health Services (ACMHS). TEDS will

also intersect with private providers such as mental health clinicians providing ED treatment, or medical specialists supporting specific health concerns or issues.

- Include a Consultation Liaison (CL) function. This will increase the capacity of existing medical professionals and service providers through in-reach and outreach activities, to effectively support people with an eating disorder, and their treating clinicians. Where relevant and appropriate, the CL function may include family members, carers and supportive others.
- Deliver education and training to family members, carers and supportive others of people engaged with the service; to health professionals; and to other sectors as appropriate and relevant, subject to capacity.

2.10 The TEDS will provide the following built facilities to support service delivery:

- A welcoming entry and concierge reception;
- Support spaces for service providers of the day/night programme;
- Secure staff areas and amenities; and
- 12-bed residential programme accommodation, with associated kitchen, dining and lounge areas, and ancillary amenities.

# 3 PROJECT COSTS

3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work is $21.5 million.

The following table and explanatory notes provide the current cost estimate for the project:

| | |
|---|---|
| *Building Services and Works* | *$ 13,405,955* |
| *Car Park & External Works* | *$ 1,024,445* |
| *Site Services Infrastructure Upgrades* | *$ 453,600* |
| *Tasmanian Arts Scheme* | *$ 80,000* |
| *Furniture, Fittings and Equipment, AV systems and ICT Infrastructure* | *$ 750,000* |
| *Design Development and Construction Contingency (12.5% total)* | *$ 1,861,000* |
| *Demolition (completed)* | *$ 120,000* |
| *Design Consultancies & Management* | *$ 1,380,000* |
| ***TOTAL*** | ***$ 19,075,000*** *excluding GST* |

*Inclusions within the Project Budget Estimate:*

*i. Capital building works – the cost of all base building works, building services and fitout works associated with each stage, part and sub-part and presented accordingly.*

*ii. Contingency amounts for:*
- *Design (7.5%) – to cover limited scope of work increases during the design phase as detailed briefing and design are developed.*
- *Construction (5%) – to cover contract variation costs for defined risks.*

*iii. Furniture and equipment procurement – furniture shall comprise:*
- *New built-in furniture items e.g. at Reception areas.*
- *New individual office furniture e.g. ergonomic chairs, desks, bookshelves in individual offices and open plan staff offices.*

# 4 EVIDENCE

4.1 The Committee commenced its inquiry on Monday, 9 May last with an inspection of the site of the proposed works. The Committee then returned to Committee Room 1, Parliament House, whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Dale Webster, Deputy Secretary, Community Mental Health and Wellbeing, Department of Health;
- George Clarke, General Manager – Mental Health, Alcohol and Drug Directorate, Department of Health
- Andrew Hargrave, Director, Programming and Delivery Infrastructure Services, Department of Health
- Mark Leis – Project Manager, Programming and Delivery, Infrastructure Services, Department of Health (via video link), and
- Peter Scott, Director, Xsquared Architects.

The following Committee Members were present:

- Hon Rob Valentine MLC;
- Ms Jen Butler MP (via video link); and
- Mr Felix Ellis MP.

***Overview***

4.2 Mr Webster provided background on the Department of Health's strategy for planning service delivery and associated infrastructure and how this had identified the need for the proposed works. Mr Webster also provided an overview of the proposed works, including the facilities and services that will be available:

> ***Mr WEBSTER*** *- The Department of Health is establishing serious strategic frameworks to aid planning for services. They include: My Healthcare Future; Health Workforce 2040; Rethink Mental Health plan; and the Digital Health Strategy. Informing planning specific to mental health services have been the Mental Health Reform Task Force Report, the Child, Adolescent Mental Health Services review and report, the Roy Fagan Centre review and report, the Prisoner Mental Health Taskforce report and the Forensic Mental Health review.*
>
> *This planning and these series of reviews have informed us in a number of ways, including helping us to decide on our infrastructure needs.*
>
> *The first of those needs has been addressed with the new southern acute inpatient unit of the Royal Hobart Hospital in September 2020; the mental health short stay unit at the Royal Hobart Hospital in February 2021. Work is currently underway in Hobart and Launceston to better locate our community mental health teams, including the first of 27 beds being 12 beds at the Peacock Centre, to open in November this year.*
>
> *The reforms also identified the need for Safe Havens or spaces for people to go, particularly after hours, just to be around others. One-stop shop, or* [mental health] *integration hubs* [MHIHs]*, where state and community sector services can be delivered or entered upon as one, sub-acute mental health beds and an eating disorder service.*

*Peacock, I just referred to, and now St Johns Park, are designed to meet these specific needs in the south, with some statewide operations. The building we are submitting to the committee today will deliver a Safe Haven, an integration hub, sub-acute beds, eating disorders residential service, and a southern eating disorder's day centre. The model of care for these services has been developed in conjunction with our community. In particular, our consumers through Flourish, their supporters through Mental Health Families and Friends, and drawing on external expertise such as the input from the Butterfly Foundation.*

*The design of the buildings and the model of care takes in the concepts of mindfulness, by creating moments of pause using the outlook as well as the internal and external built environment to create a residential scale of building within a landscaped open environment.*

*The building is not on the scale of a busy hospital. In particular, the eating disorders unit will house up to 12 people. Importantly, the bedrooms can be reconfigured to accommodate single or shared rooms, or to increase the number of therapeutic treatment rooms depending on the need. Six to eight will be typical numbers in that unit.*

*The Safe Haven will allow for drop-in and will replace the Emergency Department waiting room for a lot of clients, particularly those with suicidal ideation not requiring non-psychiatric medical treatment. It will allow for you to grab a coffee or a snack, or have a chat, or just stop and feel less vulnerable with your own thoughts.*

*The integration hub will mean that we don't need referrals that move you around buildings across the city. The services will be together on site at St Johns Park.*

*Sub-acute beds will continue to take pressure off our acute wards, but also provide the necessary slightly longer place for consumers to be hospitalised in a more conducive environment to their stage of ill health.*

### *The Facility's Role in the Statewide Model for Mental Health Care*

4.3 The Committee questioned the witnesses on the facility's place in the statewide model for the delivery of mental health services to the Tasmanian community:

***Mr WEBSTER -*** *In one sense, it's another version of the Peacock Centre, as you said, but more broadly than that, we've got other features out there, and the main one is the eating disorders. When we looked at the Eating Disorders Service, what our planning told us is that the number of people coming in will vary between that six to 12, and up to 12, but it'll be about that six to eight people at one time. To create a therapeutic environment for that group, if we built three centres across the state - or four centres as we have with our hospitals - you'd only have one or two patients in each centre, and that doesn't build a therapeutic community.*

*So, the decision is that we'll have a statewide residential hub for eating disorders and that will be part of St John's Park. But then we need to create an environment where people go back to their own community. With the Eating Disorders, at St John's Park will be the southern day centre service attached to the residential service but we'll replicate that in both the north and north-west so that when people leave the residential component of their therapy they've got ongoing therapy in their local community and their local environment so that's connecting our statewide service to our regional services.*

*The Safe Haven will be localised. We will replicate that in other centres so there's one at the Peacock Centre and we will have another one in other centres as well, so they'll be replicated. The sub-acute beds, in the main, will be state-based beds because the tertiary hospital and the largest of our inpatient units is here in Hobart. It is regular that we have people transferring from other parts of the state for more specialist treatment at the Royal Hobart Hospital so we'll treat the sub-acute beds in that way. However, having said that, we have an acute ward in Launceston and our planning is - and we are going through this process - we build a mental health precinct in Launceston. We will take into account - 'okay, we have acute beds, what's the next step? Do we need sub-acute beds within our mental health precinct? Do we need to*

*bring together our integration hubs and those sorts of things?', and the same in the north-west?*

*The other major thing is that we need to integrate with the Commonwealth reforms so-called Head to Health. They are providing kids' Head to Health and adult Head to Health so we won't be replicating the integration hub in the north because the Commonwealth is funding a Head to Heath centre. A Head to Health centre is almost the same as an integration hub with a few variations on a theme. It's actually looking at our planning on a statewide basis and saying 'what do we need, where?' across the state.*

### *Proposed Design*

4.4 The Committee noted that the physical environment would be non-institutional in nature. The witnesses expanded on this by describing how the design principles expressed in the functional design of the facility would meet the needs of users, put people at ease and aid in recovery:

***CHAIR*** *- You describe the physical environment as, 'The development will be familiar, comfortable and residential style'. It is not exactly like a home, is it? Can you describe that?*

***Mr WEBSTER*** *- No, it's not a home. It is still a hospital or therapeutic environment. I will probably throw to Mr Scott about his design. The idea is that in the building you don't feel like you're in the typical hospital environment.*

***CHAIR*** *- A more domestic feel about it.*

***Mr WEBSTER*** *- Exactly. Which is why we are not building on a massive scale with a 200-bed hospital. We are building it as two 12- to 15-bed hospital wings, but then you build into that environment. There are a few photos in there that Peter has included. It is really down to the skill of the architect.*

***Mr SCOTT*** *- Chair, perhaps another way of looking at that is that we are targeting a non-institutional aesthetic. The term 'residential' is used to draw a comparison with an institutional environment. The focus is on using domestic- and residential-style design cues to*

***CHAIR*** *- Which helps with their normalisation.*

***Mr SCOTT*** *- Absolutely.*

*…*

***Mr SCOTT*** *- ……For self-determination for users and short-term residents, the facility is a critical component and covers many of these things. I can expand on each of these, but in summary so that it doesn't take too long, the underlying principle behind the facility is one of an interaction between users and clinicians and staff. It's not again a hierarchical arrangement. Users are given a sense of self-empowerment, that they are equally sharing in the resolution of the issues they confront. Communication is key.*

***CHAIR*** *- Control of their own destiny, so to speak.*

***Mr SCOTT*** *- That is expressed from a design perspective by not having the staff overtly separated from the users. There is a concierge model of greeting, so you don't have receptionists at a reception point, but you actually have a floating concierge-style staff member who can draw users into them or take them to a place where they feel comfortable.*

*……It's a layered approach. When you walk through the door, TEDS mental health facility, there will be someone there. They will be non-confrontational in their approach to you. They*

*may be standing rather sitting, they may be located in the waiting space rather than behind a piece of joinery. If you don't want to talk to them that's okay, but in the layout of both facilities there's an intuitive wayfinding embedded in the design. If you look at the plans you see both have a long corridor down the middle. It's not a narrow institutional corridor, it's a broad, expansive social space. It draws you down through the facility to the point at which you need to interact with the services provided. That is true both on the day level and on the residential level.*

*The Safe Haven is located on the ground floor at the far end away from the entry, so you're drawn through. If you rock up at 8 p.m. and you want to use the facility, you will enter as a member of the public, unannounced. You'll meet a concierge because the facility will be staffed and they will direct you to the Safe Haven where you can be helped.*

*It is obvious where you are going to. There is a window so you can see daylight right at the end of the pathway. You have an intuitive wayfinding methodology embedded in the design to draw users to the point within the facility that they need to be.*

*……Communication, personal space and destiny: the Department has been generous enough to provide a budget to allow us to create lots and lots of diverse spaces for people to find a point of rest. If you do not feel comfortable in this space under the stairs, let's say, you can sit in this room over here. You can go to the Safe Haven over here, you can sit at the top of the stairs over there. You can sit outside in a heavily landscaped precinct. That way we are providing the maximum opportunity for people to feel comfortable and in control of their care.*

*Choice and control: probably similar. Again, giving people the opportunity to access the services in a variety of spacial media. There is not one consultation room type replicated. The consultation rooms are geometrically different and they are furnished differently. One might have a couch in it and one might have two easy chairs in it. You can navigate to a place where you feel the most comfortable.*

*Sensory considerations: we are very focused on the use of natural materials and high levels of landscaping. The form of the building is designed to maximise access to natural light and views out. It is not the most efficient footprint because that would be basically a cube. It is one that maximises the perimeter of the building. That is why it has two wings, so you have lots of access very close to you to natural daylight, the views outside and landscaping attached to the buildings. There are planter boxes and the like on the first floor.*

*Spatial clarity and organisation: there's an embedded intuitive wayfinding in its design, as I described before.*

*Decor choices: we have a focus on naturalistic and domestic-style finishes, so that people can feel it is a deinstitutionalised environment. I think that has been a key principle and one we have explored heavily at the Peacock Centre, which we are now applying here.*

*……Positive distractions: embedded within the program for the facility is not just the design of the facility. We are facilitating views out to Mt Direction, Mt Wellington and across to the city. There is also a large focus on providing art within the facility, both as part of the funded program and part of the Art Site Scheme. That would be embedded both within the building and in the landscaping. These are things that take people away from their point of stress to a point of distraction, be it the artwork or the design or the view out of the window, or indeed the interaction with others in the Safe Haven.*

*Social interaction: probably the same. Lots of opportunities for and spaces embedded in the design for people to provide themselves with distractions via social interaction, or to get the support they need, in Safe Haven for example, or in a consultation environment. A strong focus on an environment that provides sense of safety. Again, de-institutionalising the design*

*makes people feel more at home, which of itself provides a degree of psychological safety to those users.*

*...*

***Mr SCOTT** - ..... Regarding the functional layout, we have worked very closely with Dale and with Mark to make the design as efficient as it can be, and it is considerably more efficient than the starting points. I really appreciate the support of the Department in achieving a design which maintains a high level of usability for the people who will come and use the facility.*

*That means inventing space which has no overt purpose other than to provide a point of rest for people within the facility at a moment in time when they are not actually in a room doing a meeting, or in a dining room having a meal, but they just want to sit somewhere, do a crossword or something. The design has been able to embed that in it as well.*

4.5 The Committee also asked the witnesses to describe how the design of the TEDS facility would contribute to recovery:

***Ms BUTLER** - ..... I think that for a lot of people who are recovering from disordered eating, my understanding that it's a very personal journey for them and they require a lot of privacy within that recovery. Is that part of your design focus as well? Is ensuring that privacy through the design whilst also being part of the facility as well? It would be a hard one to balance, but I know a big part of recovery is that privacy, and that ability to have their own space and time to think.*

***Mr SCOTT** - ..... Responding to every single eating disorder trigger is virtually impossible..... Notwithstanding that, the TEDS facility includes spaces which are co-located with the places in which food is addressed or prepared, which are proximate to those zones of food preparation, and which are remote from those areas of food preparation to try to provide as many opportunities for people to find a place and at a moment in time where they are comfortable, in that facility. The design absolutely tries to address every one of those triggers, but I'd have to acknowledge there will be a situation where that has to be managed on an operational level and cannot be managed by the design, because triggers include smells. The smell of your hamburger might go down the corridor and that is something that is very difficult to completely mitigate.*

4.6 The Department's submission also highlighted the proposed facility would provide significant advantages for the efficient and effective delivery of mental health services to the community. The Committee asked the witnesses to explain how the design would achieve this:

***Mr WEBSTER** - ..... So, if we take St John's Park, the first example of that is the fact we've co-located the Tasmanian Eating Disorder Service and the eating disorder beds with the southern sub-acute beds so that we have that multi-purpose. That allows us to share services and get an economy of scale in that building, which has saved considerable money.*

*The second thing is the flexibility of spaces, and as I've already said, while we can house up to 12 patients in the TEDS wing, ideally, it's six to eight, but the rooms are configured so that they can be changed to shared rooms, or indeed converted to therapeutic rooms so that people can retreat to them for therapy. So, those sorts of things. Reusing land that we already have within our suite is another example of us of using assets strategically rather than going out to look for new land and those sorts of things.*

*The other thing within the envelope that we're putting out there is we're looking beyond 'let's have our sub-acute beds here and let's have our integration hub here and our Safe Haven here'. We've said, 'no, no, let's bring these services together,' because they work together, but secondly, it means that we've got a number of staff always on site that can actually intersect*

*and overlap with each other, including staff from the community sector, which is important to recognise that more so than other parts of health, the mental health sector very much needs to integrate with its community sector. So, whilst we have that sort of primary care versus acute care split for the main parts of health, parts of the primary care of mental health sits with us, some with the community sector, and vice versa, so we need to make sure that we're more fully integrated.*

*All of those are examples, as I said. The actual environment we've created out there - or will create out there - so it makes use of the site so that you can have a therapeutic environment that has an outlook, and those sorts of things. It is too easy to say, 'we can build a big building and get economy of scales', it's actually getting a small building that's got that economy of scale as well, and I think we've achieved that in this design.*

4.7 The Committee recognised the task of balancing the safety and security aspects of the facility with design measures to promote the psychological health and wellbeing of users was difficult yet important, for the welfare of both users and staff. The Committee sought to understand how this balance had been achieved in the proposed design:

***CHAIR*** *- On the safety side of it, obviously external gardens play a very important part in the health and wellbeing of people psychologically, having a space to 'hang out'. Are you in some way putting in a fence or whatever? I know that's not something that would be considered. How are you handling that side of it, if somebody is experiencing an episode of some sort, they want to get outside, they want to experience that open-air environment rather than being cloistered inside, and yet they're an at risk person?*

***Mr SCOTT*** *- I am an architect and our job is to respond to a brief, but part of the method of managing people in stress is an operational one, not a design one. This is not a facility where people are secured against their will, and therefore if they choose to walk out the door they can. That is really managed from an operational perspective, not from a design perspective.*

*That said, there are spaces outside attached to the building that are secure, but the purpose of that is so that users can bring their family, so if they have young kids and they want them to be outside, they don't wander off into the bush. They have a secure and safe environment for those family members to be on-site. Equally for the TEDS facility, it's not fenced per se, but there are secure areas so that people can go out and have a sandwich without being overlooked.*

*The security is not to retain people within but to limit unwanted interaction from others. The question of fencing is not a simple one to answer, but I think it's not a 'secure facility', and fencing when it's provided is not for the purposes of retaining people within the facility, it's actually to aid them in providing security and safety.*

***CHAIR*** *- ……The second storey outdoor spaces that you spoke of earlier obviously require some safety features. How are you handling that?*

***Mr SCOTT*** *- ……For example, where there is a terrace it has a balustrade around, so that it is a safe and secure place to be outside.*

***CHAIR*** *- What sort of height are we talking about for spaces that overlook an open area?*

***Mr SCOTT*** *- A metre-high balustrade. Again, it is that balance between a user-friendly space that is safe and makes people feel comfortable, as opposed to one which gives an impression of enclosure or entrapment. We could put a 1.5 metre glass balustrade in but it would leave users thinking that they are basically in prison. That is not the intention.*

***……****There is a subtle distinction to be drawn between comfort and safety and a feeling of institutionalisation. Wherever we have had that conundrum to resolve we steered towards user comfort and away from the institutionalisation of safety. People can still walk out the front door.*

***CHAIR** - When it comes to design of fixtures and fittings and we are talking about hanging points and the capacity for someone to injure themselves by jumping from a height, it is a difficult balance.*

***Mr WEBSTER** - You need to also take into account dynamic safety. It is really important that the staff are on the floor, the staff are intersecting, the staff are monitoring the level the patient is at. Calling them a patient in that sense.*

***CHAIR** - So that is modified accordingly in terms of staff presence?*

***Mr WEBSTER** - That's right. An incredibly settled person might be out on the balcony by themselves. Someone who's quite aroused might need a staff member out there at the same time. You get that dynamic safety from the staffing.*

### *The Role of the Recovery College*

4.8 The Committee noted that a Recovery College would be one of the services offered in the SMHBD. The Recovery College is a relatively new concept being integrated into the statewide model for mental health care, and focuses on education, rather than therapy, to assist in a person's rehabilitation and return to full participation in the community. The Committee sought further information on the role and benefits of the Recovery College:

***Mr ELLIS** - I might just ask about the Recovery College. Can you give us a sense for what the reasoning is behind it, any academic literature ……without going into too much detail - but in terms of why we think this model is an effective model of care, versus what they're saying there of a more therapeutic model?*

***Mr WEBSTER** - Sometimes, particularly with medium/long-term mental illness, you start to lose the skills to live, literally, so the skill to actually learn how to schedule your time, in some cases the skill to cook, and those sorts of things. The idea of a Recovery College is to say that through the issues you're having with your mental health illness, you may actually be deskilled in a whole lot of different areas. Rather than look at that as a therapy that you need to go through, looking at it as an education you need to go through.*

*The other thing is that learning about your condition can be incredibly empowering, so it's also that side of it. This is very much tied to the whole concept of people learning from lived experience and intersecting with lived experience, people who have similar lived experiences to learn. It's a skills approach. For some people, their ill health will continue for incredibly long times, or even their whole life. Having an approach to it that is a set of skills that help you cope with that lifelong illness is another reason you would take an education approach rather than a therapeutic approach.*

*It is being used quite widely in Australia these days, particularly in New South Wales. Our chief psychiatrist Dr Groves is particularly interested in the development of this in Tasmania as another one of the suite of approaches that we take, because the longer-term is part of what we need to focus on and make sure that they're not redeveloping acute illness.*

### *The Role of the Safe Haven*

4.9 The Committee noted that another of the new services was the Safe Haven. The Safe Haven is a space for people who may experiencing situational distress or

suicidal thoughts, and is an alternative to seeking assistance through an Emergency Department. The Safe Haven will enable those in need to receive immediate support from staff trained to provide comfort and care, assessment and treatment, rather than having to do that in a busy Emergency Department, which is well recognised as unsuitable for these purposes. The Committee sought further information on the role and benefits of the Safe Haven:

> ***Mr WEBSTER*** *- ……Importantly, in the Safe Haven, generally they're used because you need to be around others. The important worker here is, in fact, the peer worker, the lived experience worker, who is interacting, just making sure that people are getting what they need, which might be just a quiet corner, or it may be a chat, or it may be just a coffee or a meal. The idea of the Safe Haven is - I think I said earlier - that person who doesn't feel safe enough to be at home, doesn't feel safe enough to be away from, and so generally these days they'll attend the ED, and they'll be in the waiting room at the ED……which is not a great place, but they just want to be around someone. Indeed, it's not a great place, and it's so busy, et cetera, it's probably adding to the anxiety and the stress levels, et cetera. We want to get them out of that space into this much quieter space, and provide them literally with a Safe Haven so that they can do what they need to in that period where they feel they need that support.*
>
> ***Ms BUTLER*** *- …… those Safe Haven Hub operating hours, I suppose it's a bit too early, as we were saying before, to figure out exactly what would be required but, currently, with the situation where people will, say, attend the Launceston General Hospital because they feel like they're going to harm themselves or they've attempted to and so forth, will there be a capacity within those Safe Haven Hubs for those people to attend, and what happens if they do attend but they're not able to access it? Can you run through what that looks like at the moment? That seems to be a big part of the need?*
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> ***Mr WEBSTER*** *- Typically, the majority of those sort of presentations at our Emergency Department are, understandably, in the hours of darkness. If we look at the one that runs at the Royal Prince Alfred Hospital in New South Wales, they open as soon as it gets dark and they close about an hour after it gets light. They get the people through the darkness but you don't just send people out the door when it gets light, it is around 8 o'clock, et cetera. Services are opening up so you will refer them.*
>
> *If someone has just come in because they feel they need to spend some time with other people then there's probably not much of a referral. But if they're really seriously suicidal then you're doing a hot referral to another service whether your assessment is that they're acute or whether they're already in contact with a case manager that you can put them in touch with. You are actually using the space to do those hot referrals as well.*
>
> *Your hours of service match to what the need is. We will typically when we're opening the Safe Haven Hub, we'll have a look at what are the presentations at the ED, having said hours of darkness are critical periods. Christmas Day is also a day where you might want to open all day. You match your Safe Haven to the need that's in the community. As I said, the RPA one, which has been running now for a few years, the hours of darkness are their core hours.*
>
> *……It is important to say that you don't just go there and then you leave after 12 hours. During that time we try to intersect services. We're getting to know you. If you're already connected to services then the next morning we try to reconnect you. If during the night we need the PACER service, then we would get it. All those things have to be factored into this.*

*If we look at our ED, a lot of these presentations are in the window from about 8 p.m. until midnight, rather than past midnight. Your service needs are not going to finish at midnight. You'll need to have the space open and available to you through the night.*

*All of those things go with the model of care for a Safe Haven.*

### *Role of the TEDS*

4.10 The Committee noted that the TEDS was being established to address gaps in the current eating disorder service system, and to provide a coordinated approach to eating disorder treatment within the public health system. The Committee sought further information from the witnesses on the role of the TEDS:

***Ms BUTLER** - … … Currently, in the south and in the north, people who suffer from disordered eating enter into the hospital system. That's often for acute assistance to full weight restoration and to get their weight up to a healthy level and then, after that period of time, the mental health support starts. Can you explain to me how this will work with the current practices? Where the people who do have disordered eating begin and are they then transitioned over to the St John's facility? How is it going to work on a practical level?*

***Mr WEBSTER** - On the practical level there will still be a few cases that will go to acute hospitals because they may be at a level of condition which we would see as 'non-psychiatric medical' so that would still be done in the acute hospital setting. However, it's more typical that people aren't at that acute non-psychiatric medical level; they are more at the psychiatric medical level so they currently go to our acute facilities across the north-west, Launceston General Hospital or at Hobart, and then they transition to community.*

*This will replace the acute in-patient for the psychiatric medical side of it so you'll still have, as you said, some people get to the point where they need that help to get their weight back up. That would be seen as 'non-psychiatric medical'. In some cases, that will still happen at an acute hospital but the vast majority of people won't go to the acute hospitals, they'll go to this facility or residential facility first. This is incredibly important and means that the mental health inputs start alongside the medical inputs at the centre. The third element of this is the non-residential component, or the day centre component, which is the normalising component. This is generally the longer part of the therapy. We'd want an acute intervention within the residential setting, followed by a very long therapeutic environment close to their community.*

### *TEDS Capacity and Demand*

4.11 The Committee sought to understand how the capacity of the TEDS had been determined, and the anticipated demand for the service:

***Ms BUTLER** - I think the studies show that a full recovery from having a disordered eating illness is about seven years. I'm interested in where the data was developed from for how many beds this facility would require. There is a huge need out there in the community at the moment. I found some figures in here, but I think they were from 2018 to 2020. How were those numbers developed?*

***Mr WEBSTER -** The first thing we did was we involved in our planning the Butterfly Foundation, which runs the eating disorders programs across Queensland mainly, but they do run in other states. It's drawing on their experience.*

*Second, we mapped the inpatient and mental health intersections with people with eating disorders. Typically we think it'll be six to eight, but we've allowed for flexibility in allowing for 12, because it could be up to that number at any one time. That's not how many clients we would have in this service at any one time; that's the number in the residential facility. The number across our day services will be considerably higher than that. I can't bring the number*

*to mind, but we're assuming with looking at the data, for the north-west, around 20, slightly bigger in the north, and in the south about the same. The spread isn't equal across the state. We recognise there is an issue in the north-west that's particular to the north-west.*

***Mr ELLIS** - ..... Can you give the committee a sense of what our breakdown is in the comparison between the number of people with eating disorders that we might expect to see at this facility and the number of people with eating disorders we might expect to see at our day services, particularly statewide?*

***Mr WEBSTER** - Thanks, Mr Ellis. Typically six to eight at any one time, but as Ms Butler said the recovery time for eating disorders, particularly when they become chronic and severe, is incredibly long. At any one time, within the service, we're probably looking at having around 80 to 100 people getting direct services. That probably means we've got multiple hundreds in various stages of recovery and they may be referred to the occasional contact from our continuing care team, or they may have been referred back to general practice or primary care providers. Because of the nature of this particular disorder, and the length of time it takes to fully recover, it's a really difficult cohort to pinpoint to a number, but we would say that at any one time we're probably in that 80 to 100 more direct service deliveries.*

***Mr ELLIS** - It is potentially a long tail in terms of the number of people and time with which they're interacting with the day service?*

***Mr WEBSTER -** That is right, a particularly long tail. But the important thing is that the goal is to get back into community. With that comes the old-fashioned term of 'normalisation', but it's important in this space, so that's why the residential service has to start looking at you preparing your own meals and those sorts of things. The day service has to reinforce going out and purchasing meals instead of skipping meals. All of those sorts of things take a long time to retrain the mind to think that way about food, if you have an eating disorder. The number of relapses that will occur within this particular disorder is large, so it is quite a tail and, as I said, services may extend for anything up to - as Ms Butler said - the typical is seven years, but it could be a lot longer than that for some people, so a very long tail on this group.*

### *Ensuring Adequate Staffing*

4.12 The Committee recognised that a key to delivering the full range of proposed services was not only having an appropriate facility but having sufficient trained staff. The Committee sought further information from the witnesses on the measures that would be taken by the Department to ensure there would be sufficient trained staff to effectively deliver the planned range of services:

***Ms BUTLER** - ..... What measures do you have in place to make sure that you're going to be able to staff this facility with the dieticians and the proper psychological assistance and the GP services, and also the pathology services? Do you have a plan and a strategy for that? The last thing you want is to build this beautiful facility and have the same problems we have at the moment with people still not being able to access.*

***Mr WEBSTER -** Through you, Chair, that's an incredibly important question. Upfront I mentioned that part of our planning is Health Workforce 2040. We're developing a number of immediate strategies in how we employ people, a number of medium-term and a number of long-term. If I start with the immediate term, it is advertising, particularly internationally and in the larger states to try to attract people here. We have staff whose specific role is interstate and international recruitment.*

*The second part is making ourselves more attractive. We are working with University of Tasmania to change the courses they offer. We haven't had a Chair of Psychiatry at UTAS for*

*the past few years since the retirement of Professor Ken Kirkby. We are hopeful that within the next few months that Chair of Psychiatry will be reappointed. We think it is really important that if we are going to attract registrars to train in Tasmania that our university has a Chair of Psychiatry that has good standing. A good example of that is attracting Professor Brett McDermott into our CAMHS area. His reputation is already having some benefits for us in terms of recruitment of psychiatrists to the state. Most recently, in attracting one we managed to attract their partner. We get two for the price of one in that child and adolescent space.*

*Our medium term is to improve our reputation, through things like UTAS. The long term is the course mix at UTAS, particularly across allied health. From next year the university is offering post-graduate courses in physiotherapy, occupational therapy, and I have forgotten the third one. It is the first time they have done that in quite some time. We think that is important because those people will then do their placements within our system. That gives us the chance to attract them further.*

*It is not actually in this mental health space but we have a graduate program running at oral health this year for the first time in 10 years. Those are the sorts of programs that are rolling across Health as part of Health Workforce 2040, to bring people down and then hopefully keep them here because they find us an attractive place to be.*

### *Catering*

4.13 The Committee sought further information on the catering arrangements for the facility:

***CHAIR** - An important aspect of this whole development is catering. Clearly there is a need for catering, you have a 24-7 on-site facility. How are you going to see that handled? I'm talking about the facilities you need for food storage and for preparing food. Will there be people to prepare food, or is it going to be up to the individuals themselves?*

***Mr WEBSTER** - It's a mixture of both of those. On the TEDS side, we would be teaching people about food again. The kitchens there are quite vital in doing that. There will be a number of kitchens and spaces. We envisage we would run it as we do Roy Fagan, where breakfast is prepared by staff and clients on site. Typically lunch comes from our Cambridge facility. Dinner the same. Afternoon tea and snacks are then provided on site.*

***CHAIR** - You bring a lot of that in?*

***Mr WEBSTER** - Yes. You bring that service in for some of the main meals. Obviously TEDS is slightly different because that is also about learning the skills of preparation. It is part of the therapy.*

### *Consultation and Influence on Design*

4.14 The Committee was interested to understand what consultation had been undertaken, and how this consultation had influenced the design of the facility:

***CHAIR** - …… Perhaps you can give us some comfort about the level of consultation that has been undertaken. I note that a number of the supporting community services like Flourish, Mental Health Families and Friends and Butterfly were involved. How significant was that involvement and did they have a lot of input into how this facility was going to be developed and the needs of their clients met?*

***Mr WEBSTER** - All of those groups were directly involved, not just in consultation, but also in the oversight of consultation. Flourish and Butterfly in particular were directly involved and were part of the oversight committee for the model of care for eating disorders before it was signed off. We made sure they were comfortable with it.*

*The whole process designed by our infrastructure team when we do infrastructure is to have what I call steering committees, which tend to be Departmental, but then we bring in project control groups, which is about joint or co-designing with our community and our consumers, depending on the facility. Our consumer community, our community sector organisation will be working in it, it's an integration hub, so we've worked with them on the model of the integration hub. Involved in this is probably a group of 50 or 60 people, having different inputs from all over the place.*

***Mr LEIS** - ……There's been quite extensive consultation through the design process, where we've had those larger work groups pouring over the design. There have been more than a couple of goes across the last 18 months to get this right. We now have designs that all the stakeholders are happy with.*

***CHAIR** - Were there many points of contention between the two types of development we're talking about?*

***Mr LEIS** - ……It would be fair to say that there's been a robust process, and they have been resolved through the process*

***Mr WEBSTER** - If I'm completely honest with the committee, there have been a couple of show stoppers that we've had to send back to rework. While it's a co-located building we are running two very different services, in fact a range of services.*

***……**It's delayed us slightly, but I think it's a better product that everyone's quite comfortable with.*

### *Hours of Operation*

4.15 The Committee recognised that having a range of services would result in each service having different operating hours. The Committee sought to understand how the operating hours of each service would be determined:

***CHAIR** - …… hours of operation and work patterns. It's obviously not going to be 24/7 by the sound of it. It's going to be driven by demand, is it? Is that basically it?*

***Mr WEBSTER** - That's right. Different services will have different hours of operations. Obviously, TEDS - the residential component, is 24/7; the sub-acute is 24/7, but the Safe Haven Hub predictably tends to be late in the evening through the next morning type of thing or a bit longer than that.*

*I'll use PACER as the example. We run that 16 hours a day but they're the 16 hours a day where we'll have the biggest impact. So we'll design these and, of course, integration hubs where we're drawing on the community sector, they're not funded to run 24/7 so they're, obviously, more a Monday to Friday, 9 to 5-type of arrangement. It's a real mix in this centre.*

***CHAIR** - I suppose as service provision evolves, you'll get a better feel for what that sort of employment needs to be.*

### *Public Transport Access*

4.16 Recognising that those accessing the facility may not drive, may not wish to drive, or may not have their own transport, the Committee questioned the witnesses on what public transport options were available within the area:

***Ms BUTLER** - I want to ask about public transport access to the facility for members of the public who are visiting, or even people who are coming to the facility for the day. A lot of people don't drive as it's quite expensive. What are the public transport options for people around that facility?*

***Mr WEBSTER** - ……Through you, Chair, there are two significant bus routes. One is the Main Road bus service which is at the bottom of Ogilvie High, just below this building site. The second is the Creek Road route. The Creek Road route - I checked since this morning - is a bus service that comes into St John's Park. The bus stop is directly below this site, approximately 80 metres below, right next to Rosary Gardens residential aged care facility.*

*……A bus service enters the site, as well as the two major public transport routes which go either side of the facility.*

### *Provision of Car Parking*

4.17 The Committee also sought an assurance there was adequate car parking available for staff, those accessing the facility's services and visitors:

***Ms BUTLER** - …… is there a separate carpark for staff? ……Is there going to be enough parking for people using the site, people working at the site and people visiting the site?*

***Mr SCOTT** - We have had a traffic consultant do an assessment of the required number of parking spaces. There are 30 spaces provided. They're not adequate for the full complement of the facility, but the site includes hundreds of carparking spaces that are not immediate to this site. The traffic engineer's analysis of current usage and of projected usage was that 30 spaces was more than adequate for the cohort and staff who would use this facility, since many of those users don't actually have a car or use a car in the way that we would. Therefore, the staff requirement could be adequately catered for by other parking within the greater St John's Park precinct.*

### *Capacity to Deliver the Project Within the Budget*

4.18 The Committee noted the estimated cost of the project included a contingency value of 12.5%, but there was no allowance for escalation. The Committee sought further information on the allowances in the budget, the impact the availability of materials may have on the budget and the witnesses' views on the probability of completing the project as currently scoped within the approved funding allocation:

***Ms BUTLER** - I can see here you've got a contingency of 12.5 per cent. That is quite significant. Is that the going rate at the moment for contingencies? Or has that been developed based on this project?*

***Mr SCOTT** - ……That's probably a sensible allocation given market conditions. I don't know that we'll need it from a design perspective, but I think the project will probably need it from a market conditions perspective.*

***Ms BUTLER** - Are some of the materials that I can see in the beautiful pictures going to be hard to acquire? Demand is really difficult, especially for timber products at the moment. Is that part of that contingency? Could there potentially be a change in design based on what materials you are able to access?*

***Mr SCOTT** - If I draw on the experience of the Peacock Centre project, which is obviously going through procurement of materials right now, the builder's been very proactive in identifying areas where we have supply chain issues. Generally, it's been a cost issue as much as it's been unavailability of product.*

*……Our experience with the Peacock Centre process probably has helped us to identify the areas where there may be logistic or availability challenges…… We have also narrowed down the selection of materials for the Peacock Centre from Australian suppliers…… We know there is a higher degree of ability to control supply chain than if it's made in Austria or Germany or China. I think we're aware of the challenges, and we'd work through the process of specification and selection to minimise the potential impacts on the project of the selections*

*we make. That would mean that you should be confident there would be the minimum number of substitutions through the process of seeing this project to completion.*

***CHAIR** - Just looking at the project budget and reading the supporting the statements, one thing I didn't see in there - which we see quite a lot - is a thing called 'escalation' which is slightly different to 'contingency'. Or is it the same in your book?*

*A contingency is for things that maybe unforeseen that occur and you just need that extra dollar to do a particular component but escalation as you were really pointing out earlier - in today's day and age - some of them have 20 per cent. I am just wondering if 12-and-a-half for contingency is one thing, but escalation may well be a significant thing going forward.*

***Mr WEBSTER** - Generally, escalation is built into longer-term projects when the build is over a longer period than this one. Certainly larger projects.*

***……** It is something we will need to manage in the current environment. That's a big issue for us because there is some uncertainty in building tenders and then building tender processes. We haven't built it in here because of the short length of the project compared to a project like the one last year which was the building of the prison which was over a five- or six-year period and $200 million. We built in escalation there because you're certainly going to be hit with inflation over that time.*

***CHAIR** - So could it ever get to the point where you don't have the funds to complete the project as stated here? Are there components you could pare back if you needed to? It wouldn't be a case of not going ahead maybe? Just a matter of not doing it to the fullest extent?*

***Mr WEBSTER** - It could. I wouldn't like it to, but it could, and of course we are contractually obliged to provide the Eating Disorder Service building with the Commonwealth so obviously that is a priority within there. We believe within this envelope - as at today - we can do it. Yes, there are occasions when we have to withdraw and rethink, but given the time frame of this and the amount of time we've spent getting to this point, we've got as much confidence that we could have in the current environment.*

### *Is the Project a Good Use of Public Money?*

4.19 In assessing any proposed public work, the Committee seeks an assurance that each project meets a recognised need and the investment of public money provides value to the Tasmanian community. The Committee questioned Mr Webster who confirmed that the project will meet an identified need, provides value for money and is a good use of public funds:

***CHAIR** - ……Does the proposed works meet an identified need or needs or solve a recognised problem?*

***Mr WEBSTER** - It certainly does and it fits with the long-term planning of the Department.*

***CHAIR** - Are the proposed works the best solution to meet identified needs or solve a recognised problem within the allocated budget?*

***Mr WEBSTER** - We certainly believe that it does. Yes.*

***CHAIR** - Are the proposed works fit-for-purpose?*

***Mr WEBSTER** - Yes.*

***CHAIR** - Do the proposed works provide value for money?*

***Mr WEBSTER** - I believe they do and in fact, because of the way we have designed this we've actually built-in additional value for money.*

***CHAIR*** *- Are the proposed works a good use of public funds?*

***Mr WEBSTER -*** *I believe so.*

# 5 DOCUMENTS TAKEN INTO EVIDENCE

5.1 The following document was taken into evidence and considered by the Committee:

- *Southern Mental Health Beds Development & Tasmanian Eating Disorders Service*, Submission to the Parliamentary Standing Committee on Public Works, Department of Health, May 2022.

# 6 CONCLUSION AND RECOMMENDATION

6.1 The Committee is satisfied that the need for the proposed works has been established. Once the Mental Health Service St John's Park Facility is completed, the Southern Mental Health Beds Development component will contribute to the delivery of an integrated, best practice mental health service for the Southern Tasmanian Community, and the Tasmanian Eating Disorders Service component will offer a coordinated and more effective stepped care approach to the treatment of eating disorders.

6.2 The Southern Mental Health Beds Development component will provide integrated access to a range of mental health and associated social and support services, and will also include a 15-bed residential short-term stay accommodation unit, Recovery College and Safe Haven.

6.3 The accommodation unit will provide for sub-acute, short-term care, to cater for those needing overnight, intensive mental health care, but who do not require intensive medical care. The Recovery College will focus on education, rather than therapy, to assist people in their rehabilitation and journey back to full participation in the community. The Safe Haven will have appropriately trained staff who will provide care and support to persons with suicidal thoughts or in situational distress, in an environment that is more welcoming, comforting and calming than a hospital emergency department.

6.4 The Tasmanian Eating Disorders Service component will include a 12-bed accommodation unit, which will allow for a 24/7 residential treatment program. It will also include facilities where day/evening programs can be delivered.

6.5 Accordingly, the Committee recommends the Mental Health Service St John's Park Facility, at an estimated cost of $19.075 million, in accordance with the documentation submitted.

**Parliament House**
**Hobart**
**16 June 2022**

**Hon Rob Valentine MLC**
**Chair**