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THE PARLIAMENTARY STANDI NG COMMITTEE ON PUBLIC WORKS MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON WEDNESDAY 2 SEPTEMBER 2020

Dr AARON GROVES, CHIEF PSYCHIATRIST, OFFICE OF THE CHIEF PSYCHIATRIST, MENTAL HEALTH, ALCOHOL AND DRUG DIRECTORATE, **Mr MARK LEIS**, PROJECT MANAGER, CAPITAL WORKS INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH, AND **Mr PETER SCOTT**, ARCHITECT, DIRECTOR, XSQUARED ARCHITECTS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Valentine) - Welcome, gentlemen, to this hearing with regard to the Peacock Centre Public Works Committee. It is my pleasure to introduce members of the committee - Jacquie Petrusma, Tania Rattray, and Felix Ellis who we welcome to the committee today because he has recently been elected to the position and because Joan Rylah has stepped out of parliament. Welcome, Felix, I am sure you'll enjoy every part of this particular process.

Ms RATTRAY - Hear, hear, Chair, we'll guide him all the way.

CHAIR - I'm sure you will.

We have a message from her Excellency, the Governor in Council with regard to the Peacock Centre Redevelopment. Mr Secretary, can you please read the message from her Excellency, the Governor in Council?

Mr SECRETARY - Pursuant to section 16(2) of the Public Works Committee Act 1914, the Governor refers the undermentioned proposed Public Works of the Parliamentary Standing Committee on Public Works to consider and report thereon -

> Pursuant to section 16(3) of the act, the estimated cost of such work when completed is $9.24 million - the Peacock Centre Redevelopment Project.

CHAIR - Thank you, Mr Secretary.

We have one submission we're in receipt of from the Department of Health. Can I have a member to move that the submission be received and taken into evidence and published?

Mrs PETRUSMA - I put that.

Motion carried.

CHAIR - Thank you. I believe there are no scheduled public witnesses today, Mr Secretary.

Thank you for appearing before the committee. The committee is pleased to hear your evidence today. Before you begin giving your evidence, I'd like to inform you of some of the important aspects of these committee proceedings.

First, a committee hearing is a proceeding in parliament. This means it receives the protection of parliamentary privilege. It is an important legal protection that allows individuals giving evidence to a parliamentary committee to speak with complete freedom without the fear of being sued or questioned in any court or place out of parliament. It applies to ensure that parliament receives the very best information when conducting its inquiries. It is important to be aware that this protection is not accorded to you if statements that may be defamatory are repeated or referred to by you outside the confines of the parliamentary proceedings. This is a public hearing. Members of the public and journalists may be present and this means your evidence may be reported and it is being broadcast today.

Do you understand?

Messrs LEIS, GROVES AND SCOTT - Yes.

CHAIR - Would you like to make an opening statement?

Dr GROVES - Yes, I would, Chair.

On behalf of the Department of Health, we'd like to thank you for this opportunity to present where we have got to with site known as the Peacock Centre.

I might start by quickly going through the history in relation to the site. Dr William Davidson Peacock was a very prominent Tasmanian born in 1847 in Gloucestershire. He came to Tasmania in 1869; he was a pioneer in the fruit growing industry in Tasmania and ended up working in business with Henry Jones.

Sadly, Dr Peacock died in 1921 but part of his bequest was that his then family home known as Ruardean would be available to the Tasmanian government for use as a convalescent home. In 1940, the then Premier of Tasmania agreed to the terms of the bequest and between 1940 and 1943, the facility was adapted to be able to run as a convalescent home. It opened as such in 1943 as the WD Peacock Convalescent Hospital.

Between 1943 and the mid-1990s, it was used for a number of different purposes related to the provision of health services but from the mid-1990s until 2016 it was used as a community mental health facility. It was an outpatient facility for people who have more severe forms of mental illness to come and get services from that facility. Sadly, a large proportion of the upper floor of the building was destroyed in a fire on 7 December 2016. Between that time and now, planning has been underway to determine what future use should be for that site.

When the current Government was returned in March 2018, it made a commitment to establishing a residential unit within the Peacock Centre. Originally that was considered to be a 15-bed facility with another 10 beds to be established at another site close to the Royal Hobart Hospital. In addition the Government committed to establishing what was referred to as the Mental Health Integration Taskforce for Southern Tasmania.

The background to this is that we have a state plan for mental health, which is affectionately known as Rethink. As one of its key actions the Rethink mental health plan looks to provide better integration of mental health services between inpatient and community and across sectors. The Government in announcing the commitment to establish more subacute

beds in Southern Tasmania asked that a task force look at how to better integrate that and provide it with advice about those subacute beds.

I had the privilege of chairing that task force. It commenced in May 2018 and produced its final report to the then Secretary of the Department of Health in April 2019. There were 51 people involved in the task force. It was an extensive task force that looked at all aspects of mental health care that needed to be integrated in southern Tasmania. This was across the lifespan and included people's lived experience of mental illness, a range of clinicians, families and friends of people with mental illness and it made 21 recommendations to government.

On 30 July 2019, the Government released its response to that report. In it, it dealt with two of the recommendations from the integration task force; recommendations 13 and 14 which related to the establishment of an integration hub approach towards mental health and that the first two of those hub concepts would be at the St Johns Park site in New Town and at the Peacock Centre in North Hobart.

Since that time a considerable amount of work has been devoted to developing service models appropriate for the integration hub and also what the site of the Peacock Centre would be able to deliver for people in Tasmania with mental illness who need to access services.

What I wanted to do was to talk briefly about the concept that falls behind what we are trying to deliver at the Peacock Centre. As you may be aware, traditionally mental illness has been a set of conditions that attract a fair degree of stigma and discrimination within the community throughout the world. It has meant that, by and large, a mental illness was treated in standalone psychiatric hospitals that had the quality of feeling like an asylum until the 1980s and 1990s in Australia, at which time processes to ensure that people can access services when they are most unwell at general hospitals commenced. However, in parts of the world that have progressed to a more modern model, the capacity to provide care for people in their own home when facilities are more homelike and in the community has become a growing trend rather than the need for people to be hospitalised unnecessarily if they can get the level of care that would be needed in a more homelike setting. That has become a favoured model, not only throughout Australia but in other western economies.

That was the underlying logic behind the development of the services on the Peacock Centre site. What is envisaged is a 12-bed facility in which people will be able to get overnight residential care. This care at a level that is equivalent to an adult inpatient unit such as that provided at the Royal Hobart Hospital, but where the medical or hospital care is not required - that is, it is intensive mental health care, but it doesn't require intensive medical care.

In addition to that, the site is suitable for a range of other services that people can access during the daytime. It is well known that people with mental illness in inpatient care need to access a range of other services that people can access during the daytime, and it was considered that this facility would be suitable for developing for what is called an integration hub. This allows people with a range of different mental health problems to access services during the day that are not just devoted to their mental health care but also in relation to disability care, housing and a range of other types of services they might wish to access. In other words, it would encourage people with mental illness to come to the facility and access that range of services during the day.

In addition, it is hoped that two further types of service will be run through that hub area on the ground floor of the facility. One of those services is referred to as a safe haven, a space for people who may be in distress to come as an alternative to an emergency department where they can get comfort and care, assessment and treatment, rather than having to do that in a busy emergency department, which has been well established is not a suitable place for people in suicidal crisis or suicidal distress to attend.

We are also looking at a concept where we can have what is referred to as a 'recovery college'. This is an educational program, usually developed and delivered by a mixture of people with lived experienced and professionals, that is around the concept of a person's rehabilitation and return to the community back to full participation. This is a concept that has been developed and trialled in several parts of Australia, but we do not currently have a recovery college within Tasmania. The site, therefore, will have multiple different aspects to it and it has been designed to take that into account.

The other aspect about the design - and I will ask Peter Scott to talk more specifically about the design features of the building - is the capacity to have a very homelike environment throughout that is welcoming and encourages people to come and visit, rather than the somewhat stigmatising approach that hospitals, particularly long-term hospitals, have in that they tend not to be welcoming and not facilitate people's recovery.

As a consequence, we have used every opportunity to think about aspects as straightforward as bedrooms having a more homelike environment rather than a hospital, through to how the open spaces would flow, be accessed and available, and how areas such as kitchens and lounges are more in keeping with a homelike environment whilst needing to keep the privacy and confidentiality of those people who are resident in the facility for short periods of time.

CHAIR - I thought that was particularly well described in the submission.

Dr GROVES - Thank you. It is important to recognise, in keeping with that, that we imagine that the average length of time a person will spend in the facility is in the order of seven to 10 days in the admitted areas, although people who would be in what I refer to as suicidal distress are often there for much shorter periods of time, like a day or two, before they can return home. Some, of course, need longer periods of time of care than that, but that is roughly what the expectation is for the service.

CHAIR - So it is short term rather than long term?

Dr GROVES - That's right.

The other important aspect is that people with mental illness often have comorbidity with drug and alcohol problems. This service is not primarily designed to treat drug and alcohol problems in and of its own accord. If people come to this facility who also have drug and alcohol problems, we will ensure they get treatment as well, but the primary focus of this facility is for people who have mental illness or are in suicidal distress.

What I thought I might do is talk a little bit about the process we followed to get to this point. There has been widespread consultation with the public and the community throughout the process. We had a very robust project user group that included people with lived

experience, families and friends, providers, and a range of other people who went through a process of looking at all the different considerations for the building and how that should be put in place. Most recently, we have also needed to include experts in infection control to ensure that those areas of the facility that may be exposed to medical material are of a level that means we can safely operate that facility, which was not a consideration we had at the beginning of the processes, as people might well be aware. Again, we can answer further questions about that if needed for the committee.

I might pause at that point and ask Peter to talk a little about the design philosophy and other aspects of the design, as the leader architect for the process.

Mr SCOTT - I guess I need to preface what I would say by saying we worked in tandem with Dr Stephanie Liddicoat, who is an architect and also one of Australia's leading mental health facility researchers and design consultants. A lot of the images included in the submission are drawn from her initial and subsequent responses to the brief the department had provided, and those images provided the touchstone for the design philosophy and the approach we wanted to take in unfolding a response to the department's brief.

The three overarching philosophical ambitions of the design were that personal agency and empowerment were enabled so that users of the facility, be they residents or drop-in, drop-out users, have an opportunity to feel they are actually in charge of what happens to them and are not the victims of a system, hence the highly residential approach. There is an advantage in using the existing Peacock Centre, which was a mental health facility, because we know from the project user group that it was treated with affection by many of the people who used it and therefore many of those continuing potential users of the facility have a positive memory of going to the Peacock Centre, not a negative one, so we want to build on that residential sensibility in the design because we feel it provides a response to the desire to empower the users and residents at the facility.

The second was to reduce stigma. Again, a key fundamental design approach to the reducing stigma is to make the transition from the public realm to the institutional realm a less confronting one, so everything about the design, both outside and inside the building - so the landscape, the approach, and then the passage through the entry and into the user spaces within the building - is designed to make that transition nonconfrontational so that people don't feel like they are a pawn in a system but feel they are still empowered and can control whether they go left or whether they go right, whether they sit in the café or wait in the waiting area.

Even the transition from the street to the front door includes places where people coming to the centre can pause, reflect, build confidence, and then move on. The garden we are creating on the Elphinstone Road side of the building has places where people can sit and wait or they can meet with their friends or wait for their family to come in with them. On the pathway down there are places to sit, and a significant intervention on the ground floor of the building is that we have opened up that space so that when you enter it is really transparent and you don't feel trapped in an institutional environment. For example, the emergency department at the RHH is subterranean and there is no outlook, but in this case you can see right through the building to the gardens on the southern side, you can see people in the Safe Haven Café and you can see people activating the ground floor in a number of spaces.

As you move through the building, that same reduction of stigma is characterised by the choice of residential-style fittings, fixtures, materials and furniture, and we have worked quite

hard with the department to pursue an alternative furniture agenda to one that is normally used in mental health facilities.

The final design philosophy is contributing to a sustainable community. The Safe Haven café is a key component in binding the users and residents of the facility with the broader North Hobart community and the community more broadly. It is a space of commonality so it is open to residents, users, their family, their friends, their supporters and even members of the community more broadly. I think that is the ambition of the Mental Health Service that it is used in that way.

So those underlying philosophies lay in our approach in our design. Then I suppose there are two fundamental aspects to the design implementation beyond those and they are -

(1) Addressing that desire for a residential characterisation of the building so that all levels within it, be it in the existing restored building or in the new wing, have a degree of comfort for users and do not feel institutional, that the building feels residential.

(2) Heritage restoration, which was not really a critical aspect of the mental health project delivery but is actually a critical element of the architectural response. The value that previous users of the Peacock Centre had applied to the existing residential building is something we wish to restore. Therefore, the architectural restoration is essential to that same sense that they would have a place of familiarity as well as new place of residential amenity.

I can talk through each of the spaces if you like, but that is probably quite a lot of detail.

CHAIR - We normally go through the report page by page so some of the questions will come out of that, I am sure of that, but we have an opportunity for an overarching question or two. I will kick off and then other members may have other questions that they wish to ask.

Quite often when we see things come before us, not necessarily as the Public Works Committee but as members, we see this phrase 'best practice' - this is best practice. I always think to myself, 'How do we know it is best practice?'. It's more like better practice because you could probably never be sure. Can you give me an understanding - and you sort of went through this a little bit in the preamble - of the processes you have gone through to make sure that what we are putting in place here is indeed best practice? It is a phrase that we use, but can we demonstrate that?

Dr GROVES - Yes, Mr Chair, I would be delighted to do that. I sadly need to admit to a 20-year history as a clinical planner in Australia, having now worked in four different states: Western Australia originally, Queensland, South Australia and then to Tasmania.

Ms RATTRAY - You saved the best for last.

Dr GROVES - I did indeed. I think that through that period of time, I have been fortunate at a national level to be exposed not only to an opportunity to see what is best practice in Australia but also to start to see what are developments and trends throughout the world. Since

the 1980s the town of Trieste in Italy has been regarded by the World Health Organization as the best practice model for community mental health in the world.

It is actually a World Health Organization collaborating centre. I have had the good fortune to visit Trieste on a couple of occasions during my career to look at the model there and how they continue to progress with their developments. I was fortunate enough to go back there in September last year with two colleagues from Tasmania to the last World Health Organization conference held in Trieste. It gave me an opportunity to see the developments they have there and how they are able to establish a world-class service with the lowest number of inpatient beds, but the highest number of integrated community centres and sites to provide services across their system.

Interestingly, for those of you who will, I am sure, take the opportunity after this to visit Trieste to prove that I am correct, it is a small city of roughly the same size as Hobart. There are about 240 000 people in Trieste, which is the capital of Friuli province in north-east Italy. It has only six beds in its general hospital compared with the number we have here. It has a busy emergency department, but then it has a range of facilities that provide beds, much as we are describing we will do at the Peacock Centre in St Johns Park. The other feature that's important is their capacity to provide 24-hour/7-day-a-week care in the community for people.

I'm not for one minute trying to say that Hobart is like Trieste. Trieste is an Italian community with a very high amount of informal care and a number of other things going for it that make it much easier for it to get by with the services that it has. I think the lessons from Trieste are the type of lessons that we are introducing as a concept moving forward here.

This was a focus of the work of the Mental Health Integration Taskforce. I am pleased to say that the integration task force agreed with those recommendations, having had an opportunity to look through a visionary new way of trying to provide services. We see the Peacock Centre and subsequent developments as being a central part of moving towards a community-based system that doesn't lead to gaps in the service system and which becomes a very important part of what we need to provide going forward.

I'm happy to reassure the committee that I think this is world's best practice as we move forward - not just Australian best practice.

Ms RATTRAY - With regard to the model that you talked about in Trieste, in your view does that particular community have more community support or more family support wrapped around the people who need services? Is that what you were referring to when you said you don't for one minute think it's like Hobart, and perhaps Tasmania more generally? We don't do as well at looking after our own?

Dr GROVES - Yes. I think that's absolutely fair to say. It's probably worthwhile understanding that the history of Trieste goes back to 1971 when they decided to close their standalone psychiatric hospital - the equivalent of what was the Royal Derwent Hospital. At that time, they had about a 1000-bed hospital and they've gone from 1000 beds to six so they have a nearly 50-year history of closing down their psychiatric hospital and incorporating it into the community.

If I can perhaps use a good example: if you hop in a taxi from anywhere in downtown Trieste and ask to go where the mental health hospital used to be, any taxi driver will speak

with pride about what they've actually done in their community as opposed to what might be a usual response when you say, 'Can you please take me to the local psychiatric hospital?' anywhere in Australia. I think that says a lot for how they've reduced stigma and discrimination and have as a whole-of-community response owned mental health as something they want to address. I think that 50 years of adherently sticking to a model that says 'We will do the best we can for people in our community with mental health problems' leads to that type of response.

It's interesting that when people in Trieste were asked whether if there was less funding, they would want to change the philosophy and go back to how it is elsewhere, they said, 'That would be really difficult because we have two generations of mental health staff who believe this. It would take us a long time to untrain them in a community-based approach', and that would not be the approach in most parts of Australia.

Ms RATTRAY - So that's why there's this focus on a residential home environment rather than that clinical approach that we get through a hospital situation?

Dr GROVES - Yes, that's right.

It's also worth saying that at that conference there were participants from more than 30 countries and probably 15 countries had a presentation at some point of how they were adapting to the Trieste model, including several from Italy. There is almost a gradient in Italy between the north and the south. The north of Italy has more incorporation of the principles that underline the Trieste model. To the south where they've been less able to do that, you can, therefore, see as a consequence those facilities or those provinces within Italy that have high numbers of beds but don't feel like they have enough beds for their mental health problems through to those that have a lesser number of beds and feel that they have more. That's to do with the balance of their investment and the approach that both the community and the mental health and health sectors have to looking after people with mental health problems.

It is worth saying, though, that that is still a 20-year aspirational type of approach and we need to start somewhere.

Mrs PETRUSMA - As the Chair was saying before, I think this is a really good briefing document and submission because I could visualise the centre as we were going through it, so I wanted to thank you for the tour of the facility that is going to look very dramatically different in the future. It doesn't say what year the original building was actually built anywhere in the documents. Do we know roughly at all?

Ms RATTRAY - We decided it was about 100 years old, didn't we?

Mr SCOTT - It could be 1910 or thereabouts.

Dr GROVES - Dr Peacock was in it in 1912, so it's certainly in that period of a couple of years before then.

Mrs PETRUSMA - It is probably good to say now in overview what heritage issues you faced because heritage is mentioned in just about every single page of the document, both in regard to the building and the gardens.

Mr SCOTT - The heritage components are multifaceted. There is the requirements of the bequest, and that is not overtly a heritage issue, but it relates to the heritage fabric of the site. The second is the fact it is a Heritage-listed property. It is on the Tasmanian Heritage register and on the Hobart City Council Heritage register, so it has a number of statutory thresholds that we need to address. The bequest has guided our response to how we address the heritage importance of the building. The requirement is to return it to a high level of both aesthetic and functionality.

Before we really set foot on that path to a restoration, we engaged a heritage consultant and a team that included a historian who looked into the history of Dr Peacock and the historical context which led him to build that house in that location, and that informs us about how we might respond subsequently in a restoration. Then we had an assessment made of the building and the ability for us to refurbish or restore it, because at one time it was considered after the fire that it would need to be demolished and that is a possibility, but the state of the building is not such that it requires it. Given the context that it is quite important to the community, if it is possible to retain it, we should make every effort to do so and that is the commitment the department has made.

As we moved forward we needed a framework to approach that restoration. There was no framework, no conservation management plan and no documentation really within the Tasmanian Heritage body that would enable us to be guided, so we commissioned a heritage consultant to write a conservation management approach for the building. That was done without us having done any design work so it does not influence that - it simply sets out the best course of action for returning the building to a degree of heritage restoration.

The thrust of that report, which is about 300 pages long, is that we should seek to do as much restoration to its original condition as possible as a nod to the bequest, but also a nod to the opportunity because so much of the existing building actually is still extant. Partly through the fact it is not that old and partly through the fact that later additions and changes did not fundamentally damage the fabric of the building. Obviously the roof has been burned off but beyond that, as we saw this morning, a fair amount of the internal fabric is actually original to the building.

With that sort of background in mind, we then approached it and we have quite a lot of experience doing heritage work and restoration. Our approach has been twofold. One is to wherever possible retain and restore the original fabric of the building, so the brickwork, the plaster, the tin ceiling, the flooring, some of which is not original but some is. Where we are not able to restore what is there - for example, the ceilings and the roof that are absolutely missing - or where that restoration is in conflict either with medical practice or best mental health outcomes, we use an appropriate response. I think you mentioned how we would treat the ceiling. The plasterboard will look exactly like the original lath and plaster ceiling, but it has a functional and cost-effective response. Similarly, internal paintwork in 1910 would have been linseed oil-based, would have had toxic pigments added, is not very durable and has a matt finish. Those sorts of wall finishes are not compatible with the modern mental health facility so within the realms of guidance included in the plan the heritage consultant provided there is room for us to have a bit of flexibility about how we respond to that.

Fundamentally, the first step is to retain and restore what we can, and, second, sensitively adapt a response where we need to, with new ceilings, for example, and selectively make new selections that are compatible with the functionality of the building and the existing heritage

context. The new part of the building, the extension, is not part of that so the insertion of any substantive new work adjacent to the existing building is part of a heritage response as well, which has been clearly filtered through the heritage management plan the heritage consultant provided.

The key measures we adopted in the new work were that it should be subservient in terms of scale, setting, placement on the site of the Dr Peacock's original house, that it should respond in terms of best practice to the recommendations of the Burra Charter, the fundamental underlying go-to document in terms of heritage response, and that it should be different and differentiate itself from, and not mimic the forms of, the heritage building it might be adjacent to or joined to.

In that sense we deliberately chose a suite of materials that both respond to the mental health brief and therefore are domestic in character, but which are different from the fabric of the original building. We saw this morning the original 1970s nurses home extension had chosen to try to mimic - badly, in my opinion - the form and materials of the Peacock house and had thus diminished it. We feel that an insertion that has clear separation and connection to the building, while it is clearly different in time and style, is actually a better response and a more consistent heritage response to the brief of the Burra Charter. That design is then filtered back through to the heritage consultant, who does the heritage impact assessment at arm's length from the design and ensures we have responded appropriately to the conservation management principles set out at the outset. The heritage consultant's approach is staged and sort of slots in between the work we do and the design we ended up with and has the full support of the heritage consultant and the Tasmanian Heritage Council, and now the full support of Hobart's City Council's heritage officer.

Mrs PETRUSMA - We talked about infection control in the COVID-19 environment. For example, if you had a matt paint, it is harder to do a deep clean and everything. Has your brief now changed to incorporate more easy cleaning surfaces in bedrooms and throughout the place? We hope we will not have an incident like the one at the North West Regional Hospital again, but do you have a deep clean scenario?

Dr GROVES - Of course, but unfortunately infectious diseases are such that if it is not one, it might be another. I think the important thing is we have tried to strike the balance between the facility being generally for people to visit during the day and the residential feel of the area where people stay overnight which still needs to retain that residential feel, but areas where there is likely to be direct clinical contact or exposure to medical materials that should be the areas that can allow a deep clean if needed to an infection control standard. Peter might want to talk a little bit about how we have done that.

Mr SCOTT - Our job has had a number of influences and one of them is the Australian Health Facility Guidelines. That was part of the original brief to the architects from the department, but in some cases that is at odds with the mental health ambitions Aaron has outlined. Places that have much more overtly clinical requirements like the medication room, the treatment room, the sanitiser room, cleaning rooms, storerooms, which are not obviously in use, and in the visual area of the users and residents are treated to a high level of compliance with the HFG, but areas like the existing house will have a timber floor. That is probably not best practice infection control as a flooring material. It was considered more important that it has the correct ambience and that it responds appropriately to the heritage significance of that fabric. That was considered by the project user group, including infection control input, to be

an appropriate compromise between pure infection control and producing a best practice mental health facility.

Dr GROVES - To add to that, we will have appropriate areas for people to wash and have access to gels and various other things that they need to comply with occupational health and safety. The bedrooms themselves are likely to be more like, but not the same, as a domestic bedroom. Similarly, the hallways are more akin to what you would find in a house than what you would find in a hospital ward. So, it is striking a balance between the transition between those areas and then the areas that do need to comply with an infection control standard. That is actually the important bit we have needed to deal with. I think Peter has described the areas where infection control was a primary goal, and those areas where a homelike therapeutic approach was all that was needed.

CHAIR - Thank you all for coming today. Dr Groves, would you be able to give us a sense, just at the outset, of how the Peacock facility figured in with the broader mental health response in Tasmania prior to it becoming non-operational? What it looked like when it wasn't working and how you hope it will fit in once it is back up and running?

Dr GROVES - Sure. Before 2016, it was a community mental health facility for adults. It tended to have mostly office space where people would provide consulting services, so psychologists, mental health nurses and allied health staff were the mainstay, but there were also psychiatrists and sometimes psychiatrists-in-training providing services from the facility. People tended to come on an appointment basis, so that they would come for their allotted time. They would probably come beforehand, come to their appointment, and possibly be seen by another clinician afterwards. It tended to be one-on-one consultation, and then they would leave, and the rest of their care would occur in the community. There weren't really extensive day programs, for example, that were run. There was not an approach where groups of people were seen for prolonged periods of time.

The provision of the current mental health helpline was through that facility. That is a triage assessment and booking service, and that is also a part of our current mental health reforms that operated from that facility.

In 2016, when the current facility became unusable, those facilities therefore moved to other parts of Hobart and were provided out of other places. But what was not provided during that period of time was any acute beds. There were certainly no extensive day programs, there was not a capacity for people to drop in without appointments. It was generally encouraged that people would come in to appointments.

CHAIR - Thank you for that.

We will go to the report specifically and work our way through from beginning to end, as we like to do, so that we don't miss anything.

Does anyone have any questions on page 3? I have already asked one with regard to best practice.

Ms RATTRAY - Chair, I'm not sure if it's a bit early to talk about the exterior and the show-and-tell items we have with regard to the new build part of this project?

CHAIR - We can do it now, if you want and if it's there on the page.

Ms RATTRAY - It talks about the exterior. I raised some concerns onsite this morning around what sort of timber would be used as cladding on the outside of the new part of project, given that we know how harsh Tasmanian winters are. I have been reassured by Peter that the materials being sourced which are going to be used on this have significant guarantees with them. I'd like Peter to share that with the committee. Thank you.

Mr SCOTT - Forewarned is forearmed and I appreciate that. I have come not only with samples and tools, but also with some data notes I could read from.

The new extension is predominantly clad in timber. It has a concrete and block work and timber frame construction, but the cladding is designed to be timber. Specifically it is to give it a different character than the Peacock Centre.

Ms RATTRAY - Hence meeting the Burra Charter?

Mr SCOTT - Yes, absolutely, but also to give it a residential character so it does not feel like an intimidating institutional building.

The two materials, and I'm happy to pass them over if you'd like to handle them, are the same, and we're using both. At the upper level we have screens that you can see through or which are visibly permeable. On the lower floor we have cladding which is solid and basically this is a shiplap board that has a weather seal on it.

This is redwood; it's an American product. I used to live and work in America. Redwood is used for decking in America. It is naturally a highly durable softwood material but this particular material is heat treated. It's called Thermawood and it carries a greater than 25-year guarantee unfinished. In the state you see it in here, it carries a longer guarantee than Colorbond roofing. From our perspective, it is a highly durable and highly appropriate wood for the external cladding of the building.

CHAIR - More appropriate than macrocarpa?

Mr SCOTT - Absolutely. Macrocarpa is a particular material with a high durability but it also has a high propensity to split, warp and crack, so it's probably not an appropriate material for a high-quality, highly finished, best-practice building. It's probably more appropriate for a more rustic appearance.

Ms RATTRAY - I'm devastated; it's on the outside of my house.

Mr SCOTT - That is not the only cladding, though. This is spotted gum. I've wrapped it with clingwrap because it has a charred finish and will leave a black mark on your hand if you handle it, but feel free to unwrap and have a play with it.

Spotted gum, again, is a highly durable Australian hardwood. It's often used for exterior cladding completely untreated or with a clear oil coat. This has a particular Japanese-style of charring and the charcoal coating gives the product an additional layer of protection. Spotted gum of itself is a highly durable hardwood. It's then got an additional layer of protection and

it is oiled out of the factory and it would then be subsequently oiled as part of a maintenance regime.

CHAIR - It's the corten equivalent of the wood world?

Mr SCOTT - Exactly.

Then we have a third product, which is sequoia pine. This is the baked product I spoke about.

Ms RATTRAY - This is the New Zealand product.

Mr SCOTT - This is the New Zealand product. You can feel how heavy it is. This is a remarkable product. This is quite expensive, but it's used by the Parks and Wildlife Service in highly exposed situations. In a class 2 exposure, which is an above-ground use, we would use this, for example, for the pergola for the building or when we were looking at those finials that would go across the roof where maintenance and access would be a particular problem. This product in its raw state has a 50-year guarantee. It has a warranty greater than twice as long as Colorbond. From our perspective, the timber selections we've made for the exterior of the new building are absolutely appropriate and will not impose a maintenance burden on the department.

CHAIR - They would be used on wilderness walkways and those sorts of things, is that what you're saying?

Mr SCOTT - It is not actually used in foot traffic areas, but if they were creating a toilet in a national park, it is the go-to. Does that help address your concerns?

Ms RATTRAY - Thank you, it does give me some level of comfort - always this type of ongoing maintenance is of a concern and when you are part of a process where you are authorising the allocation of $9.24 million, it needs to have some reassurance around it that it will stand the test of time.

Mr SCOTT - Absolutely.

Mrs PETRUSMA - I am interested in the mention on page 3 about the heritage gardens. Can you just talk about the work that has gone into the gardens as well, please?

Mr SCOTT - Absolutely. As we saw this morning, the garden space will fall into a southern and northern component. The northern component has very little remnant of the original Dr Peacock garden and he was a very keen gardener. The records show that he not only personally engaged in gardening but he also engaged gardeners and his local community to come and harvest his garden. They used to have fetes and things in his garden where they would sell produce he had grown on the site.

What we see now being a rather degraded car park is not really representative of what it was like 80 years ago.

CHAIR - It was probably a more extensive property too then, wouldn't it have been?

Mr SCOTT - No, no the title is exactly as it was. I think Elphinstone Road may have impinged on the northern aspect of the site but nonetheless it is the original extent. And it is a double block. If you look from Swan Street, it is actually one of the largest blocks on the street. But the southern garden, although it has lost some of the detail - and there are historic photographs of the garden from the 1920s - still remains the structure that was there when the house was built, including almost all the original stonework. There is a rather nice gateway that comes in from Swan Street with an arch and some cast-iron work and then there are sandstone steps that lead up from that gateway to the old original front door. All of that stonework and all that planting is to be stabilised and returned to as good a condition as it can be. Where there are remnants of the historical planting - we believe some of the roses as well as the large trees we saw - some of the roses across the front of the garden are clearly evident in 1920s photos when Dr Peacock was still alive or certainly when his wife was still alive.

There are remnants possibly of those original rose plants on site and we are looking to reinforce that planting to return a greater sense of what it was actually like on the day that it was laid out. Our approach is generally to retain and restore the garden just as with the heritage house but also to reinforce its ability to be appreciated. I talked about creating that little flat area in front of the greenhouse, for example. These would be areas of repose within the garden that would allow people to appreciate and reflect outside as opposed to inside. Then as we approach the garden aspect of the northern side, where it is basically between the two car parks, we just stood there and it is a rubbish tip. We would basically see a beautiful garden created between those two spaces where people can both spill out from the building, they could look out from the building or as they enter the building they could use it as a point of repose before entry.

CHAIR - With respect to the roof, the roof is not there because it was burnt out. Was that originally slate or was it corrugated iron?

Mr SCOTT - It was Welsh slate.

CHAIR - It was slate, and is it being replaced with slate?

Mr SCOTT - I can tell you exactly the approach that we are taking to the roof. When the building passed from private ownership to the state government, the first records we have are that the roof leaked and there was a series of complaints about the slate being defective. It was replaced with a Wunderlich clay tile which persisted until 2016. The Wunderlich clay tile does two things: it is about the same weight as a slate roof, but it has a completely different aesthetic and although potentially we could have looked to restore that clay tile material we have looked to replicate the original form of the building with an artificial slate. It will not have the vulnerability of the original Welsh slate. It will not have the cost of Welsh slate but it will look exactly the same as Welsh slate. If I had thought about it, I would have brought an example but there is a photograph in the submission of the external materials that we are proposing and there is a tiny image of the slate there.

When we say we are going to take a heritage restoration approach, we are definitely trying to achieve a visual appearance that is as close to its original form as possible.

CHAIR - The life of that slate?

Mr SCOTT - Fifty years. It may degrade but it is not brittle, so it is not going to offer the same risks of leakage that a true slate roof would.

CHAIR - And the capping?

Mr SCOTT - It would be consistent with the original ones so they would be galvanised iron. We are trying to avoid using lead on the building. It would have had lead flashings. You mentioned best practice and we are looking to implement many aspects of the world building standard and using toxic materials is at odds with that standard.

Ms RATTRAY - In regard to the discrete addition of an external plant room. Will that be house-heating apparatus? What is that used for?

Mr SCOTT - There is a central plant system driving the heating, cooling and ventilation so it is a compressor in effect. It is a big one like a chiller and it would sit north of the main car park in timber enclosure. It would be discrete, it is quite a big thing, but it is going to be a discrete element within the landscape.

Ms RATTRAY - Will the noise be discreet as well that goes along with that?

Mr SCOTT - Chillers make very little noise.

Ms RATTRAY - There will be no issues with neighbours saying that the plant is exceeding the noise levels and the EPA won't asked to investigate?

Mr SCOTT - Nothing in this building will exceed statutory noise levels.

CHAIR - Is that the heat pump-style technology?

Mr SCOTT - It is but at a commercial scale.

CHAIR - Moving on, if we don't have any further questions on page 3, to page 4.

Ms RATTRAY - In regard to the interior - and we have already had some discussion around bringing back the original part of the Peacock facility, restoring it to its former glory, as well as making it adaptable to the aims of the project - what about accessing the skills that are needed for restoring the historical features of the building? Is there any issue with that in Tasmania, given that we are living in COVID-19?

Mr SCOTT - I do hear you but the skills are available and indeed the heritage skills required for the restoration probably are not at the maximum extent of what would be a challenge. I think they are in the central expertise level of the available Tasmanian trades that we have access to.

Ms RATTRAY - I was very pleasantly surprised at the way that a lot of the leadlighting was still intact, absolutely beautiful leadlighting throughout the building. There was only a couple of areas that I noticed that would need to be redone again so that was fortunate, and those beautiful mantelpieces.

Mrs PETRUSMA - In regards to their project program, I believe the DA has been approved by council. It is going to tender in September and then construction will commence in November 2020 and be completed over the next year - that is quick advertising and then commencement a couple of months later. Due to COVID-19, do you still believe that those time lines will be realised?

Dr GROVES - I might let Mark talk to that, but it is probably right at the very end of November at the earliest.

Mr LEIS - That would certainly be the case. It has been an extensive design process. Working our way through council, we are looking to run a few processes in parallel across this period to catch it back up and also we understand the market is crying out for these sorts of jobs so we're looking to move as quickly as possible with that. I haven't yet talked to builders about the time they need, but we were looking to go to tender in the next few weeks, depending on council getting back to us with our building and plumbing approval. They will be the things that will hold us up in the process because we need that certainty to ensure we're meeting the value-for-money requirements.

CHAIR - Just for the record, it has been through development application approval. There were some access issues with a neighbour, but that has been dealt with through that process so that's not necessarily something we can deal with at this committee level, I believe.

Mr LEIS - That's correct.

Mr ELLIS - Chair, I noticed on page 4 that there will be en suite facilities for all bedrooms. From the look of the existing site, that was definitely not the case. I am not sure whether this would be to you, Dr Groves, or to Peter, but would you like to talk about community expectations now as opposed to previously about having en suite facilities in each bedroom in these residential facilities?

Mr SCOTT - It would clearly be our expectation that best practice of a mental health facility or indeed any health facility of this nature would have independent sanitary facilities. I go back to that empowerment philosophy that underlaid so much of our design approach, that people should be in control of what they do whilst in the facility. Being able to go to the bathroom without asking someone is absolutely fundamental to that sort of control so having en suites that are private and personal is a critical component of the delivery.

You asked Aaron about the immediate history of the building prior to the fire but some time before that it had accommodated more than 30 residents and they would have had dormitory-style accommodation and shared bathrooms, and that probably is a long way from best practice in this time.

Dr GROVES - That was probably from 1943 when they opened as a convalescent home until the early to mid-1970s. It is very difficult for us to know when it moved from that into other purposes.

Mr ELLIS - My understanding of infection control, particularly with some of the challenges that other residential facilities are having currently with coronavirus, is that having en suite bathrooms for all residents makes infection control a lot easier in residential-style facilities.

Dr GROVES - That's correct.

Mrs PETRUSMA - You mentioned the Safe Haven Café in the introduction. I think it's a wonderful concept that you are inviting the wider community to come there to have a coffee. Will people come and buy a cuppa or can they just drop in and have a cup of tea or coffee?

Dr GROVES - The focus is primarily on those people who might come because they want to access the service, so they might be in distress and are coming for a particular reason. What we want to do is try to encourage the community to have some ownership of the facility and be involved in the facility so how we might make it available for people to come and access it out of hours or on a weekend is something we need to sort through with how we'll do the facility. What we don't want is to be a competitor to the café strip just down the road. We don't see ourselves as that, but we want to encourage people who come and use the facility on a regular basis to learn a skill, one of which may be, for example, to be a barista in the same way that we would hope that the greenhouse, which has a heritage component and is part of the bequest, might afford an opportunity for people to learn either a horticultural or other green-type of skill so that they don't just come there for therapy, they're there for rehabilitation and skill acquisition.

Precisely how we do that is still to be determined. The important principle is that Safe Haven Café is about giving a space for people to come and feel relaxed and to be able to say what's happening rather than what we sometimes understand occurs in a busy emergency department.

We have unashamedly adapted a program that's been running in the United Kingdom in many of the NHS trusts where they have these facilities that tend to be drop-in centres, often right in the middle of a village or town, and they encourage people to come. What tends to happen is that it's often people who have mental health problems or all sorts of other distresses who will come. It is often run by consumers or peers, but with a small amount of clinical component parts to ensure there is a clinical pathway if somebody needs that, and that's really the way we have gone about it.

There is one currently at St Vincent's Hospital in Melbourne and they run it as a café but it's also a drop-in centre and library resource centre, so it has a number of different aspects. We are looking at how we establish it within our site so that from our perspective, it will be run as a café but will be more than just a café and more than just a safe space, it will be somewhere where people can get a number of different skills.

CHAIR - Not as commercialised, though, as you are indicating?

Dr GROVES - No. It's a place where people can be relaxed and come and have a chat about what is happening in a much more informal way.

CHAIR - In the DA that went to council, would it have mentioned that aspect and got an airing?

Dr GROVES - Yes.

Mrs PETRUSMA - In the general project scope, I notice it talks about accessibility. Are you able to outline how accessibility for people living with disability is incorporated generally throughout the building?

Mr SCOTT - The facility as it exists now has very little disability access. The proposal is that we provide a disabled path for travel, either from Elphinstone Road directly to the front door, or from a disabled parking bay within car park 2 directly to the front door, and that we provide level access within the ground floor. The doorways are all of a width that would allow someone in a wheelchair to use them and there will be no steps or level changes within that ground floor.

From that ground floor, there is a lift being proposed within the new wing that would take somebody who was disabled to the top floor. There is an access toilet on the ground floor as well as ambulant toilets and there's a disabled toilet on the first floor. There are two disability access-sized residential rooms.

CHAIR - Moving to page 5, you mention that the proposed height of the new building will be lower than the existing 1960s addition and will be set further from the site boundary, therefore creating less shadow on neighbouring properties. Is that significant or are there slightly less shadows? Can you describe that to us?

Mr SCOTT - We provided comprehensive shadow diagrams to council as part of the development application process, but equally they show predominantly that shadows from both the existing building and the new building fall within the site and not on adjoining properties, so the impact either way on neighbours is minimal, if not non-existent, but nonetheless the envelope of the new building, the new extension, is smaller than the envelope of the existing one and therefore inherently its impact, not just shadow but visually, is reduced.

CHAIR - And it's set back further from the neighbour?

Mr SCOTT - It is set back a little further from the neighbour. We have quite a complex easement down that western side of the site, which contains a sewer and a TasNetworks high-voltage cable, so there are various reasons why we would want to set back further from that boundary, not least to minimise the impact of the new development on the neighbour.

CHAIR - It's all insulated walls and those sorts of thing, presumably?

Mr SCOTT - Of course, yes.

CHAIR - The access from Swan Street you are talking about, the sandstone arch and sandstone steps and the like, is that intended to be used or is that now simply going to be a feature from Swan Street?

Mr SCOTT - We envisage it can be used. You can traverse from Swan Street to the front door and the front door will be the primary entry point of the building. The existing front door is unlikely to provide an access point, but we would envisage primary entry from Elphinstone Road.

Dr GROVES - For residents and families who would be visiting a resident, we would certainly encourage the entry to be from Elphinstone Road. There may be people who know

the facility well who come to the hub and who, for example, might be coming to the greenhouse where it might be convenient for them to come that way, but the number who would actually access the property from that area will be very low and we won't be encouraging it.

CHAIR - I was thinking of some who may wish to be there for some service or other that they do not want to be seen by all and sundry. Is there a more private entry opportunity? That is why I was asking the question. It doesn't appear that is going to be intended.

Dr GROVES - No, it isn't intended that way. Again, we are trying to get the balance between reducing stigma and discrimination and respecting people's privacy. I think that if people for whatever reason need to access the site and maintain that, there are important ways in which you greet and/or meet somebody and encourage them to access what they need to do without compromising how the building flows.

CHAIR - Hopefully, we will grow as a community in terms of accepting people who have mental disability the same as any other disability.

Dr GROVES - The available evidence is we have as a community in the last 20 years. I think there is a number of national things we have done to better understand depression and anxiety and suicide. Perhaps what we haven't done so well is people with quite severe mental disorders such as schizophrenia and bipolar disorder. Part of what we are encouraging now is to start to have that community understanding and know that most people - for example, with schizophrenia and bipolar disorder - live in our communities, they do not live in hospitals.

CHAIR - Thank you. Anything further on page 5?

Mrs PETRUSMA - To follow on from Dr Groves' comments. Under Design approach, the second last sentence talks about the lack of community engagement - 'the activities of the centre represent a social loss to the neighbourhood'. Would you be able to expand further on why it is a social loss to the neighbourhood?

Mr SCOTT - The comments here are about its current state.

Mrs PETRUSMA - That's right, so what it represents now in its current state as a social loss. Why is that?

Mr SCOTT - We actually did work in the Peacock Centre in 2006. We were familiar with the community that used it back then. It was evident that the community embraced it and embraced it the sense that they accepted its function. They liked it being used and activated and they were comfortable with the use to which it was put.

Through our community engagement there has been a really strong sense that people wish to see the building restored and returned to use. They are still comfortable with the projected use for it. In that sense I think the community has expressed to us through the community engagement process that they cannot wait for something positive to happen on the site.

Dr GROVES - The other thing is that at least one, if not two, of our immediate neighbours have spoken positively about their experiences interacting with people who visited the site previously. Of course, that has been lost.

Ms RATTRAY - Not so keen on the possums anymore?

Dr GROVES - Not the current one on the ground floor.

Ms RATTRAY - Dr Groves, in your overview you talked about a 15-bed facility, but it is definitely a 12-bed facility. Did you reference 15?

Dr GROVES - That is correct. The original government announcement was for 15 beds at the Peacock Centre and 10 to be built at Mistral Place. When we looked at the feasibility of the Mistral Place site, we soon found that was not going to work. A lot of work was then done to consider what an alternative site might be. Later, in 2018, the Government approved the move from 25 beds to 27, but with 12 of them being at the Peacock Centre site, which was more suitable for there, and the 10 beds proposed for Mistral to be a 15-bed site at St John's Park. That was a subsequent government decision, not the original election commitment.

Ms RATTRAY - Thank you; just a clarification there.

CHAIR - Any questions on page 6? I have one.

With respect to the second dot point under, 'It is also noted that' -

> the service operating out of the Peacock Centre prior to the fire did not provide overnight accommodation and subsequently did not meet the terms of the bequest. As such it is not possible to return this service to this location.

Yet we have accommodation units - I do not quite understand that.

Dr GROVES - What perhaps was meant by that was there was overnight accommodation for several decades and then, certainly for the last two decades, there was not overnight accommodation. You could not include everything in 2016 in the building because you would not be able to do overnight accommodations. If you follow the logic of where I have come from -

CHAIR - I think I do.

Dr GROVES - You could not have the existing 2016 facilities and have overnight accommodation. They would not all fit. Therefore, some things were lost to make sure we have the overnight accommodation and comply with the bequest.

CHAIR - So you are complying with the bequest and you are going to have overnight accommodation. That is exactly what I wanted to hear.

Dr GROVES - That is what we are going to have.

CHAIR - Thank you for that.

Ms RATTRAY - Twelve beds.

Dr GROVES - Yes.

CHAIR - At the top of the page you have -

> Accordingly the building must be repaired to provide a fit-for-purpose facility for Tasmanian Health Service consistent with the trust arrangement and Tasmanian Heritage Council requirements.

Clearly, you are trying to satisfy two levels of things here; the heritage council and the trust arrangements. You are saying this is being achieved with this project?

Dr GROVES - That is correct.

CHAIR - Safety of staff -

> The facility must create a 12-bed mental health facility meeting the terms of the bequest. The facility is to provide a discrete area for staff, separate from the consumers, which allows for better security and a better environment for both consumers and staff.

Obviously, safety of staff is an important aspect. Are you able to expand in any way? I know we are moving towards being a more normalised environment, but those safety aspects also need to be included. Do you want to cover how that is being approached so that staff are being protected as they can be in the event - and we would hope it does not happen, as it did leading up to the fire - there is a circumstance that causes concern?

Dr GROVES - I might talk first of all about the operational model and the various different component parts, then Peter might add any physical aspects of how the built design achieves that.

The first thing is that the building will have a presence 24/7 and that was not the case before. Sorry, I should have perhaps mentioned that. It really only operated through extended day hours, whereas we will now have staff 24/7. I think having a presence there continuously always helps with those particular people.

CHAIR - How many?

Dr GROVES - On a nightshift we are likely to have three people in the residential area. That is the minimum staffing level we usually have for 12 beds. During the day we will have a lot more staff, of course, involved in the residential area and then we will have a number of staff downstairs. But I think the important aspect is the 24/7 staffing for facility.

The second aspect that is important is that there is the ability to make a separation between the top floor and the bottom floor. The bottom floor would be closed. It would be inaccessible to the community from sometime late in the evening until early in the morning when the staff come to that area but because there will still be staff in the building that will allow for an obvious presence in the building. I think that is a really important aspect.

The next thing is the relational aspects. An important part of securities in the built design is the quality of the relationship between residents and/or people who use the facility and the staff. One of the difficulties before with having people who would visit and have short periods of time in the service is the capacity to get to know them well, to know their mental state or

any other aspects of why they might be visiting the building. If they are there as residents, it is much easier to get to know exactly what is happening with their mental state and, in particular, the motivations they may have. Similarly, the people who are going to come and access services during the day are likely to be there for longer periods and there is a greater capacity to understand who is appropriate to access services from the building and who might be less appropriate to access services from the building, in which case we give them a pathway to where it would be better for them to go.

They're the operational aspects, and I suppose the relational aspects and one aspect of the build design, which is that people on the first level aren't accessing the ground level out of hours, and that would be locked.

CHAIR - Are 12 beds funded at this point?

Dr GROVES - Yes. The operational funding is available for them; in fact the Government announced there's operational funding available for all 27 beds.

CHAIR - Thank you. Are there any other questions on page 6? Page 7?

Mr ELLIS - Chair, can I lead off on the note it was damaged by arson. Perhaps, Mr Scott, you'd like to speak about, for example, if we had a similar situation occur as the previous arson incident, what measures would be in place now to ensure we don't have the same level of catastrophic damage?

Mr SCOTT - Absolutely, and surely that's been front of mind as the department and ourselves approached this project.

First of all from a spatial design perspective, the original reception where the fire initiated in 2016 was an outlier to the footprint of the building. Therefore, it was like an exposed, vulnerable aspect of the design of the building whereas now the entry is a soft thing not a hard one- you don't come to a reception desk where there's a clear barrier between you and them; you come into a soft space where there is no barrier and where you can filter into the building. You're never quite out or in so the hostility created by a hard entry is eliminated.

So from a psychological perspective, the embedment of reception functions within the core of the building is a design strategy to mitigate against the potential for somebody to be agitated in that circumstance. Then it was a clear direction from the department that we fit fire sprinklers to the building - new and old - and a fully compliant fire detection system that sits within that.

From that perspective, if there was a catastrophic arson incident in, let's say, the entry area, the passive aspects of the building design should be able to manage it until such time as the fire brigade is able to get to the site and put it out.

CHAIR - Thanks. Moving on, page 7, page 8.

Mrs PETRUSMA - With regard to page 8, Chair, the Mental Health Integration Hub is an excellent concept. St John's is the next one. Are there other areas of the state or is that the next part of the conversation?

Ms RATTRAY - They are going north after this.

Dr GROVES - Sometime after the Tasmanian Government announced the Peacock Centre and St John's Park development, at the last federal election the Commonwealth Government announced what its refers to as adult walk-in mental health centres. Over time, it's become apparent that language has changed and what the Commonwealth is proposing to invest in each state is one centre similar to what the Tasmanian Government is doing to centres in Hobart.

The Commonwealth Government has clearly decided that that would be in Launceston and so they will be providing funding to Primary Health Tasmania to do that because it's a Commonwealth Government investment. We've been working very closely with Primary Health Tasmania and they understand our business model. They've been part of our operational service planning system so that they can think about what they develop in Launceston that's similar to but not necessarily identical to what we are developing down in Hobart.

One of the aspects that is different is that the Commonwealth funding doesn't extend to having overnight care so it's extended hours, but it wouldn't have the capacity for people who are distress to stay overnight. They would need to go to the Launceston General Hospital.

That gets us from zero to three. How we go further from there is something we will need to see over time. I do know that the current Commonwealth minister for Health has talked about potentially having as many as 100 of these across the country, in time, but we do not know the time frame for that or how many that would represent in Tasmania. We think the notion of heading much along the lines we are developing is a very good thing.

CHAIR - Is that all for page 8 - page 9?

Mrs PETRUSMA - In regard to the National Disability Insurance Scheme, I think it is an excellent idea that it will actually include a dedicated presence from the NDIA because it has been harder for people with mental health to actually get NDIS packages. So will that be a dedicated presence? Do we know how many hours a week or day?

Dr GROVES - These are the types of things we will need to start to sit down with service providers and other agencies to determine the number of rooms we have available in the hub area, and probably on the basis of having those half-day sessions, so somebody providing services for half a day. This probably gives us up to 40 spaces during the month, five rooms, two a day, so there is quite a degree of capacity for that. I think we need to then sit down with organisations such as the NDIA and say, 'Well, what is the best way of doing that? Is that somebody who is actually going to be a coordinator, somebody who does assessments, what might it actually be.'

There will be different needs for different people. Some may be just looking at seeing whether they are eligible; others might be starting to try to get an understanding of how to coordinate the services they want. It will really depend on where people are on their pathway from trying to understand what can be provided, through to making an application, through to trying to coordinate services they might have if they are eligible.

Mrs PETRUSMA - I thought it was really good because that way they do not have to go to the main centre in Hobart, which could be intimidating for anyone with a disability but especially living with mental health. I think it's a really good inclusion in the facility.

Dr GROVES - Just to follow on from what you have said, if they are familiar with the facility and they come, and, for example, they are accessing disability support services, they might also have housing needs and a range of other needs. They are the types of things that they could access so it brings that notion of a one-stop shop that you would be aware the Tasmanian Government has already developed in other parts of social policy. It is very much emulating that but specifically to mental health.

Mrs PETRUSMA - Joined-up services.

Dr GROVES - Absolutely.

CHAIR - You talk on page 9 about family spaces, and during the site tour I asked about those who may come through your door with post-natal depression. Could you just describe for us where the boundary lies or lay with respect to the sorts of circumstances this site will be able to cope with and what it will not be able to cope with?

Dr GROVES - It should be able to help with providing those people who are just visiting on a day basis to access advice about everything from parenting and mother crafting type services right through to psychological treatments and supports and other treatments that a woman or a family might need if somebody has a postnatal mental health problem.

If the person's problems are more severe than that and they were needing to access overnight care but short of what would be provided by either St Helens or the new Royal Hobart Hospital acute mental health unit, that could be accommodated there. It is not specifically designed, though, to take a number of women who would have infants with them so we also do not think the demand is necessarily there for that type of service at that level. We are envisaging that we probably need one available bed for us between Peacock Centre and St John's Park. How we best deliver that is part of also rationalising what is across two services.

I do not want to perhaps complicate matters with this particular development but we are also aware of a Commonwealth commitment to develop an eating disorders residential treatment facility in Hobart. Our current preferred site for that is at St John's Park. We are exploring whether that ultimately will be built as a companion to the current proposed hub and acute beds at St John's Park. If that's the case, it may mean that a younger group of people would access that particular site, and that is probably the demographic that also fits with mothers with children. We are really trying to go through the delineation model for that, but from our perspective, if in the interim it was appropriate for somebody to be knitted into care and they have an infant, we would look at how we could do that at the Peacock Centre site.

CHAIR - It's more of an incidental nature rather than it being specifically designed for that purpose.

Dr GROVES - Yes, and I might point out for the record that I think we need to understand that the level of clinical need that can be looked after in this facility is short of an acute inpatient unit, so, for example, women who experience puerperal psychosis, which is the most severe form of puerperal illness, wouldn't be appropriate for this particular facility. That

really needs a highly specialised unit and ultimately we need to think about how we best provide that, even more than St Helens can provide. Women with puerperal psychosis can become unwell very quickly and often need a locked or contained environment and involuntary care from time to time, as sad as that sounds, and that is not something St Helens can provide.

Mrs PETRUSMA - Under exercise space, it says a mental health integration hub should have a general gym and exercise area?

Dr GROVES - I might talk about the principles and then Peter can talk about the practicality. One of the important aspects to understand is that people with more severe forms of mental illness are often put on medications which cause metabolic syndrome, so they often put on weight and that brings with it a number of significant health problems. We know that people with severe mental illness unfortunately die much younger than the general population, 12 to 15 years before their peers, so an important part of providing a comprehensive approach is to address that. We want to encourage exercise physiologists, dietitians and other people to be a part of the service model so that people with mental illness have their physical health care needs met, particularly earlier on in their illness, but if people come with advanced signs of metabolic syndrome, we can do that. Certainly if they are admitted to the unit and there is capacity for them to access exercise areas which they might be doing for the very first time, that would be a very good starting point.

Peter, would you like to talk about that?

Mr SCOTT -Very briefly. One of the largest rooms on the ground floor is called the therapy room, which is designed to be a wet area finish so it can be used for art activities, clay activities or exercise, so that would be an appropriate place for that program to be delivered. It has storage specific for items for exercise that could be stored there so that seems like a -

Mrs RATTRAY - Like an exercise bike or a rowing machine or something like that?

Mr SCOTT - There's probably not room for an exercise bike but that doesn't mean there is not additional storage elsewhere within the facility for pieces of equipment like that.

Mrs PETRUSMA - So probably more hand weights, resistance bands and the like?

Dr GROVES - Yes. Free weights and resistance bands are probably the things we tend to use more often.

Mrs PETRUSMA - It is more strength training because the medications they are on affect stability and -

Dr GROVES - Yes. Most exercise physiologists would be able to get them out of the cupboard and use them, rather than using what we might understand as gym equipment.

Mr SCOTT - And then there are a number of slightly smaller multi-use rooms, so if the therapy room was in use for another function and people wanted to exercise, there are a couple of meeting rooms either in the centre of the ground floor facing out across the garden or on the terrace facing out across the garden, or the meeting rooms in the corner next to the old front door. Potentially any of those would be appropriate for guided or unguided exercise. Equally,

the garden is available for people who just want to walk around and get exercise and fresh air. One of the great advantages of this site is it has extensive grounds so that possibility exists.

CHAIR - And that is sometimes needed. I remember we were doing a tour through the Royal Hobart Hospital at some point, I can't remember what the context was, except that mental health patients sometimes need to be outdoors and not feel constrained by the walls.

Dr GROVES - It's highly preferable.

CHAIR - You mention on this page 'life domain services'. It may be described somewhere here but I can't see it. Are they just a service provider?

Dr GROVES - No, we were trying to use a phrase to catch all four services beyond just providing better health services, so everything from physical health care, disability, housing, legal support, educational support and vocational support - all those aspects of a person's life where you might want to have access to services.

CHAIR - That's okay; it just had capitals and I thought it was an organisation of some sort I had missed. It is interesting that it is not just about mental health, it is about other aspects. It is interesting how you are going to manage the number of people who come through the door. Talking about housing issues might be one thing, let alone dealing with people with mental health issues.

Dr GROVES - It is the way in which we promote what the facility is there for. The hub we are promoting is for people who have mental health problems or mental illness who need to access a range of services. It is not for people who do not have mental illness, but often people come and say, 'I have this particular problem; however, these are the things that are worrying me'. It is difficult if you say, 'We can deal with that aspect but we can't deal with these other things', and people often do not follow up on that.

CHAIR - Thanks for clarifying that.

Ms RATTRAY - I am interested in the kitchen and food preparation spaces. Obviously it will have the appropriate kitchen facilities, so are we expecting that residents of this facility will use the kitchen facilities? Is that the idea?

Mr SCOTT - Yes.

Dr GROVES - A very important part of the modern model, such as Trieste, is trying to return people to their functioning as quickly as possible. What often happens is that somebody goes to a hospital and then they don't need to do anything for themselves, whereas we are trying to encourage people to self-care as soon as they can.

Ms RATTRAY - But other people may need to come in to prepare food as well. Is there enough space for those wanting to provide their own food and those who need to be preparing food for residents who are not in the right space to do that?

Dr GROVES - Yes, it is striking the balance between the meals that are provided to residents and those residents who start to prepare or understand how to prepare meals.

CHAIR - Is there anything in particular that the Peacock Centre falls short on providing here which is constrained by the site itself? With the model you are talking about, does the Peacock Centre fit perfectly into that or are there constraints that reduce what you would like to have happen but cannot because of the site itself?

Dr GROVES - The simple answer is that we believe with time there is going to be a need for a lot of this and that's why we need St John's Park as well. This site isn't big enough to cater for all people in southern Tasmania to be able to access and get these services so we will perhaps need to have a geographical understanding of who accesses it rather than it being for everybody.

CHAIR - It is more the nature of the services on the site that I was interested in.

Dr GROVES - Yes, there is that first aspect. The second aspect is that it is designed for people who need short accesses to residential care. It is not designed, for example, to have people who need prolonged lengths of stay in very similar services, and again that is subject to other reforms we need to do. It can't do that and it's not designed to do that as a consequence. Other than that, we believe it does have the footprint to provide the range of services we envisage within the model.

CHAIR - Thank you. We have gone through consultation and talked about support of the neighbours, and they are very supportive of this, I believe. Is that right?

Dr GROVES - Yes.

CHAIR - There were no planning appeals mounted so that gives you a good indication of that.

Mr ELLIS - Dr Groves, it is noted that family representatives were part of the Project User Group. Can you give the committee a sense of what it's like to be a family member of someone in perhaps an older facility that would have predated the new Peacock facility we're putting in now and how that experience might be different?

Dr GROVES - Yes, I think that, without wanting to be critical of the service model that we've had before in the past in the state, families haven't been encouraged to be part of the treatment of people who come and access services with mental health problems.

Our hospitals tend to have limited visiting hours, they're not particularly welcoming. I don't think that mental health hospitals differ terribly much from general hospitals in that particular regard. They have a very clinical and not very intimate feel about them.

Second, our community mental health services tend to be very much about providing direct care to the individual who comes to access services. Whilst there are some family groups and some supports of families, again, that's not a great feature of the model anywhere in Australia.

How this differs is that families in particular will be encouraged to be part of the treatment approach for people who access and need residential care and also will be encouraged to come and provide a better understanding of what they can do to assist somebody with a mental health problem.

For example, we don't run a large number of courses for family members to better understand mental illness, to understand what they can do to assist people with mental illness. A recovery college is often about teaching people with skills to better understand what they can do to help, support and assist people with mental illness and so it becomes more of a feature of what we do in this hub than what we've traditionally done. We would expect that a good recovery college would have families and family members who have that range of skills to be able to contribute and run some of those courses. Again, we have limited capacity of doing that in Tasmania.

CHAIR - I might talk about 4.2 - Project User Group. At the top of page 13 you talk about -

> … discuss furnishings, landscape, artwork, flooring, and developing culturally appropriate and welcoming spaces for MHS Infrastructure Committee consideration.

Being a multicultural community - as we now have been, I'm sure, for some time - are there are particular cultures that need to be catered for in this development that you are providing that you believe is necessary? Or is there not much difference in terms of multicultural issues in the area of mental health?

Dr GROVES - I think the most important bit is to be culturally safe for the Tasmanian Aboriginal communities. We've spoken with them on a couple of occasions recently about how we ensure we achieve that across both this site and St John's Park. There are a number of different ways in which we can do that.

Other than that, I think that for people who come from non-English speaking backgrounds and people who come from other cultures we need to have a very pluralistic approach. It's very hard when we are as multicultural as we are to say we can try to cater specifically for each individual group. A lot of that is about how we ensure the service model is available and accessible to people from different cultures, compared with the design of a building that tries to be culturally safe for Tasmanian Aboriginal communities.

I know Mark might want to comment on this, but we've recently been doing a bit of work about the finishing touches of a building to achieve that. I will hand over to him.

Mr LEIS - As part of it you will see in there there's the art grant - the Tasmanian Art Scheme. We've engaged with the Tasmanian Aboriginal Centre in prepping that artwork to look at, again, how they can participate in that and open those avenues to making a more sensitive site.

CHAIR - With respect to dealing with somebody who is from a non-English speaking background - say, someone who is Greek or Italian - how do you handle people who are coming through the door who simply cannot be understood? What services do you have available to be able to deal with that? No doubt you have spaces in the building you can take them to.

Dr GROVES - Peter has talked a little bit about the flow and the soft entry into the building. What we are trying to encourage is a role of, if you like, being a concierge, somebody who welcomes and greets people and understand their needs. There is likely to be a small number of people who undertake that role. Consequently if they are in a situation such as you

have described where there a significant language barrier, there is everything from how we access interpreter services right the way through to who else might be a family member or a natural connection for them to help understand. We do not want to be in a situation where we are turning away somebody. We simply cannot do that. It may be better if the person is not instantly distressed and needing to be comforted at the time that we try to make an alternative time for them to come back where we have somebody who can help get a better communication with them.

The same thing also applies for people who may be deaf. Again we need to make sure we have people who can sign or have the ability to communicate with people who are deaf or hard of hearing so that we can do that. They are very specific skills in mental health. This is an area that has often not been done well before in the past with people with mental health problems. One of the clinical scenarios we see quite often is people who come in who are deaf and have relied on family members to interpret for them but there may be trauma. The perpetrator might be one of the people translating for them and therefore you do not get a full story. We are more acutely aware of that now in mental health services than in the past. The same thing applies with interpreter services. One needs to be careful - because somebody speaks the same language does not mean they are from the same culture or ethnic background. That can introduce its own complexities.

There is a very deep understanding of those issues and we need to make sure that this service can take this into account when people access it.

CHAIR - It is a general problem you would have regardless of site, obviously. Okay moving on to page 14, which talks about recovery-oriented practice; you talked about that a little in your overview, I think. Pages 15, 16, 17, 18?

Ms RATTRAY - We have quite a few ticks against those areas already.

CHAIR - We have already dealt with quite a lot of it. On page 19, I have highlighted -

> For example, the use of contemporary acrylic paint finishes is considered to be compatible with this aspect of the Bequest …

My question is: why not Porter's Paints to the architect?

Mr SCOTT - I can respond to that. Porter's Paint tends to be matte and soft and not durable enough for a mental health commercial facility.

CHAIR - That is a simple answer, thank you.

Mrs PETRUSMA - We have already talked about maintenance, Chair.

CHAIR - Yes, we have. Page 20. 'Privacy from overlooking is achieved by the use of extensive planting'. I was thinking of trees, but not ones that interrupt pipes. I look at the size of those silver birches on that site and I think, 'They must be blocking up so many pipes in that area.'. No doubt you will look at the suitability of plants for the particular site, ones that are non-invasive in a root sense?

Mr SCOTT - We are also incorporating a brand new stormwater disposal system so we're treating all the existing stormwater services as redundant, whether blocked or not.

CHAIR - You're doing a whole new drainage system?

Mr SCOTT - Yes.

CHAIR - Good.

Page 21 - we've talked about most of that, no questions there. Page 22? On the tour we talked about client safety and, dare I say it, hanging points and those sorts of things. Do you want to put a comment on the record as to the approach that's been taken there?

Dr GROVES - An important part of the area accessed by residents is how we make it suicide-safe as opposed to suicide-proof. The largest component part of that is making good assessments and mitigation. We don't think that creating a homelike environment that comforts people is appropriately offset by making it ligature-free. Making it ligature-free, in fact, is the counter to that so we're going to ensure that we get, again, relational support for people. That is the quality of the relationship between the clinicians looking after them and them being well-trained in suicide mitigation and supporting people and compassionate care to achieve the outcome of reducing the likelihood of suicide within the building compared with making it ligature-free and complying with, for example, the Australian Health Facility Guidelines for an inpatient unit because we're not seeing it's an inpatient unit.

That will mean, of course, from time to time, some people will come and will be in a high level of distress who can be accommodated within this building. Or they might come but be medically unsafe, which would mean they would need to be transferred to the inpatient unit at the Royal Hobart Hospital. That's a clear pathway we would have available to us at any time because that part of it is a Tasmanian government-operated facility so there's no barrier between there and the inpatient unit. I think it's important to keep in mind.

CHAIR - It's good that the aspect of normalisation in terms of living space is being considered here, even the paintings on the wall and those sorts of things. I thought that was very positive. Page 23?

Mrs PETRUSMA - With regard to page 23 and the dining room, is food being provided through the Royal Hobart Hospital or is it cooked on site?

Mr LEIS - Yes. There is going to be a combination of options available there. We'll certainly be looking at, not the full hospital B-pod service, but the THS facilities now offering meals or service that are vacuum-packed and can be put in the fridge to be pulled out and activated appropriately using that service.

Ms RATTRAY - For a late night or late evening admission or something like that where you can give them some food and have something ready to go, sandwiches cut up and ready to go?

Mr LEIS - Yes. Those options are all planned to be available.

CHAIR - Page 24? Page 25?

Ms RATTRAY - Page 25, Chair, with regard to the staff courtyard are there any of those courtyard areas or that particular area for staff that will have some shelter? It's not always a fine day.

Mr SCOTT - That is a good question.

Ms RATTRAY - I hope so; they're all good questions.

Mr SCOTT - The first floor overhangs the ground floor above the staff courtyard. It is probably going to be no-smoking site, so they won't be standing out there smoking but if they want to sit and it is inclement, they can get outside and not get wet. They can sit in the greenhouse too.

Ms RATTRAY - Yes, they could.

Dr GROVES - They can also sit in the pergola area adjacent to the greenhouse.

Mr SCOTT - Yes but that doesn't necessarily give rain protection.

Dr GROVES - It gives protection from the sun on those burning February days.

Ms RATTRAY - As long as there is somewhere with some shelter that staff or others might like to access.

Mrs PETRUSMA - In regard to that, are there smoking areas on site as well? Some people might need to. Is there otherwise a program to access?

Dr GROVES - There will need to be a dedicated smoking area. As a never-smoker as opposed to a non-smoker, I would like that to be somewhere closer to Launceston than Hobart but we will have to have that on site. Sadly, and without wanting to speak in any way disparagingly about our staff, of course, our staff also have too many who smoke. Yes, that is something we need to take into account with the site.

One of the important parts of what we will be trying to encourage though, much like addressing metabolic syndrome, is having nicotine replacement and smoking cessation-type programs that we will be offering for people. For those residents, it would be an important part of what they do. That will not be immediately successful for all people, and we will need to take into account a smoking area.

CHAIR - You mentioned secure storage of personal items and medication. Is that a lockable facility within each room?

Dr GROVES - Yes.

CHAIR - Which the resident would have access to?

Dr GROVES - That would need to be dealt with on an individual basis. Again, consistent with the recovery concept and personal autonomy, you would want to encourage people, but you would need to make an individual assessment of each person. What you would not want is to have somebody go into their room, and not appropriately get that assessment

correct, and then, for example, access medications or other things which then puts them at risk. That is very much built into the service model and the nursing model to ensure that is done and the use of that is on an individual basis, not on a carte blanche basis.

CHAIR - Thank you. Page 26 - a memorial garden commemorates those who have lost their lives to mental illness.

Dr GROVES - This has been a feature of much of the community discussion with us. We have a number of people who have been engaged with our processes in the department over the last few years who are family members who have lost people to suicide. They have encouraged us to think about having a reflective place available for them to access from time to time. This is a very difficult issue for a number of people. Doing this respectfully in a way that is not drawing attention to suicide is a very difficult balance to make.

There is now an emerging literature about how to do this well and appropriately. We are still in the phases of determining whether it is best to be at this site or possibly at the St John's Park site. We certainly only need one site; we do not need one at each facility. It may be that the areas at St John's Park might be more appropriate for it to be over time than at the Peacock Centre site.

Within our Project User Group, we have people who, sadly, have lost family members to suicide who have been part of our negotiations and discussions with them. We have tried to make sure that we are going to be able to do this in a sensitive way, in one place across one of these two sites. The memorialisation is to be done as unobtrusively and privately as is possible. It is not necessarily so much that it is a garden, but that it is a small area within the garden where it would be done.

CHAIR - Any further questions on pages 26, 27, 28?

Mr ELLIS - Chair, can I double-check with Mr Scott - the round grey existing materials spot, where are we looking at those materials?

Mr SCOTT - In your print that grey circle is the new slate roof to the Peacock Centre.

CHAIR - Okay. On page 28, it says there has also been a strong emphasis in response to the WELL Building Standard. What does 'WELL' mean?

Mr SCOTT - It actually stands for 'well'. When the department first approached us, it said it wanted a gold-standard mental health facility, so that is really where we were coming from. We suggested that one of the ways in which that could be delivered in a measurable way was to adopt the WELL Building Standard and seek certification of the project. The WELL Building Standard is an American program designed to measure the health and wellbeing that a building delivers to its occupants and residents; it has hundreds of criteria which are split about 50/50 between operational ones, such as providing food and flexible working arrangements, and designed ones, so things like filtering water to eliminate toxins and so on.

We had a long discussion with the department over many months and meetings about whether it was even possible for a large organisation like the Department of Health to implement the full range of criteria that the WELL Building Standard encompasses because the WELL Building Standard is all or nothing. You can't get certification if you don't meet any

one of the threshold requirements, and beyond the threshold requirements, there is a series of optional facilities you can get to build up points to achieve a certain gold, platinum or silver standard.

Ultimately it was not possible for a department of the size and complexity of the Department of Health to deliver on all the operational aspects of the WELL Building Standard, so a decision was made that the department would not seek certification of this project, but equally there was a commitment that we would implement all, to the extent possible, of the design aspects of the WELL Building Standard, and that encompasses about 300 criteria. They range across 10 basic groups - air, water, thermal comfort, beauty - there's a whole range; I have brought a cheat sheet which is my original submission to the department. There is a series of criteria for the WELL Building Standard covering, air, water, nourishment, light, movement, thermal comfort, sound, materials, mind, humidity and innovation. We have adopted perhaps 90 per cent of the design criteria within the design of the building, so it truly is a best-practice facility.

The intent of the WELL Building Standard is that residents and, critically, staff are able to occupy a space that provides them with comfort, beauty, views and natural ventilation - all the things you would aspire to in a workplace or residency in a commercial setting. That is what the WELL Building Standard is and we applaud the department's commitment to deliver in this project.

CHAIR - So 'WELL' doesn't stand for anything other than 'well'?

Mr SCOTT - Correct. It's one of the few building measurement tools that focuses on health and wellbeing rather than energy efficiency or material use et cetera.

CHAIR - Thank you, well described. It is interesting to read how the contemporary research also emphasises how the physical spaces of entry and waiting influence a consumer's perception of the care that will be received. Quite clearly very important. Page 32?

Mrs RATTRAY - Page 32 -

CHAIR - I know what you're going to say and I'm going to give you the answer.

Mrs RATTRAY - Thank you. In regard to 6.2, but if anyone wants to go to 6.1, I am happy to wait.

CHAIR - No, you're right.

Mrs RATTRAY - Paragraph 6.2 is about the Tasmanian Government's Art Site Scheme. I noticed when you were answering the question about the proposed memorial aspect of the project, you indicated that the design is currently being pursued through the Art Site Scheme. If that memorial does not go ahead at the Peacock site and goes ahead at the St Johns site, what is envisaged under the $80 000 allocation?

Mr LEIS - At the moment we are looking at two components to that - an external component looking at bringing mosaic or artwork into the path on the way down into the facility, and an internal art scheme of either photographs or prints that will provide a therapeutic essence from the provider rooms downstairs and a consistency in those as well as two upstairs.

You would have seen quite a few of the pictures in here; if you look, there are two art pieces in each room and the larger rooms as well, so the plan is to use half that budget towards the interior and half towards the exterior.

Ms RATTRAY - Is there a focus on Tasmanian artists?

Mr LEIS - That scheme is open only to Tasmanian artists.

Ms RATTRAY - Thank you; that's music to my ears.

Mr ELLIS - What about the post-occupancy allowance?

Mr LEIS - That is around the operationalisation of the facility. Often we do builds like this and just sort of say to the department, 'Right, there it is', and that's it. This is allowing for those last few changes and little things like bins and other elements that will help with the move in and other things like moving the staff in there and getting them going as well, so that is an additional allowance to make that smooth rather than scrabbling or taking shortcuts at the end and not quite getting those finishing elements right.

Mr ELLIS - So, in this case it would be essentially to allow for the complexity of what it might take to get everything up and running?

Ms RATTRAY - Like bedding and that type of thing?

Mr LEIS - Yes, we have the furniture and equipment allowance there, but often once you occupy those spaces, to make it that homelike environment, they are not necessarily fully allowed for the extra little pieces in the room that really give it that homely environment.

Ms RATTRAY - And the 35 sanitiser dispensers now.

Dr GROVES - We have already considered the sanitiser areas so we are clear what people do in and out of their own room and what we need in hallways and other areas of the residential areas, so the contingency is covering for that.

CHAIR - Can you tell us where the $360 000 is, because if you look at the project total, you have $9 240 000 and it actually adds up to $9 600 000, and I think it sits in the construction costs, which should be $7 040 000 rather than $7 400 000 - would that be right?

Ms RATTRAY - One thing you will learn is that this committee is forensic.

CHAIR - I think it is a transposition error. I learnt an old trick many years ago that if the difference between what it adds up to and what the total says is exactly divisible by nine, it is a transposition error.

Mr LEIS - That error probably goes to me as the project manager. My apologies to our project sponsor.

CHAIR - Am I right?

Mr LEIS - Yes.

CHAIR - It is $7 040 000 rather than $7 400 000.

Mr LEIS - That is correct.

CHAIR - So, for the record, it is $9.240 million, but it adds up to $9.6 million. I am asking you whether it is transpositional.

Mr LEIS - Yes, because it is the combined elements of what we are tendering. I looked at the final quantity survey that came through and that has confirmed we are on budget for $9.24 million.

CHAIR - So it has to be a transpositional error somewhere?

Mr LEIS - Yes, it's a problem of putting a Word template in an Excel item.

CHAIR - As long as we have it recorded, that is the important thing.

Ms RATTRAY - And that the tender document reflects that change?

Mr LEIS - Yes, it most certainly will.

CHAIR - Recommendations - any questions on that, page 33? Any questions on any of the diagrams presented to us at the end of the document? I think we went through that a little bit on the site visit. There's lots of extra information there. Does anyone have any questions about those diagrams?

Do you wish to make any closing comments?

Dr GROVES - We thank the committee very much for allowing us the opportunity to come along and talk about this proposal. We are excited about this proposal. We see it as part of how we develop a modern mental health service in Tasmania so we look forward to hearing back from the committee.

CHAIR - We have some questions before you go. The final questions that we always ask of every project that we deal with.

Ms RATTRAY - These are the tough questions; the others were easy.

CHAIR - They're very important.

Does the proposed works meet an identified need or needs or solve a recognised problem?

Dr GROVES - Yes, it does. I think I've covered that through the evidence I've given.

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

Dr GROVES - Yes.

CHAIR - Are the proposed works fit for purpose?

Dr GROVES - Yes.

CHAIR - Do the proposed works provide value for money?

Dr GROVES - Yes.

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

Dr GROVES - Yes.

CHAIR - Thank you. Those questions are based on the provisions of the Public Works Committee Act 1914, but they are as relevant today as they were the day they went into that document, I'm sure.

I remind you again on the statement made right at the beginning, that your evidence, whatever you've said today, is protected by parliamentary privilege and once you leave the table you need to be aware that privilege does not attach to comments you may make to anyone, including the media, even if you're just repeating what you said to us. Do you understand that?

Messrs LEIS, GROVES and SCOTT - Yes.

CHAIR - Thank you very much. The committee will now retire to consider the submission.

THE WITNESSES WITHDREW.