Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ROBERT FISKE

I, Robert Fiske, Chief Executive Officer Victorian Health & Human Services Building Authority, of L20/50 Lonsdale Street, Melbourne, Vic 3000, say as follows:

i. I am authorized by the Department of Health & Human Services (DHHS) to make this statement.

ii. I make this statement based on my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Background & Experience

1. My full name together with postnominals, is as follows: Mr Robert Alfred Fiske, BA, MBA.

2. I am an experienced senior executive with extensive experience across major capital infrastructure projects, asset management and maintenance programs. I have been the CEO of Victorian Health & Human Services Building Authority (**VHHSBA**) for three years.

3. My previous roles include the following:

   (a) General Manager Development Otakaro (NZ), where I was responsible for the construction program for the Christchurch Earthquake Crown Anchor Projects;

   (b) Head of Non-Process Infrastructure BHP Billiton Iron Ore, where I was responsible for the capital, operations and maintenance of all non-mining infrastructure;

   (c) Chief Operating Officer Transfield North America, where I was responsible for major infrastructure, operations and maintenance business to large US based clients;

   (d) General Manager Operations, Transfield Services, where I was responsible for Australian and NZ Government, Defence,

Telecommunications and Resources infrastructure capital and maintenance contracts; and

(e) Commissioned Officer of the Australian Regular Army and Graduate of the Australian Defence Force Academy and Royal Military College Duntroon.

Attached to this statement and marked RF-1 is a summary of my Curriculum Vitae.

Current Role & Responsibilities

4. In my current role as CEO of VHHSBA, I am responsible for the planning, asset strategy and delivery of the capital program for DHHS and lead an executive team of professionals, technical specialists, consultants and contractors to deliver the program.

Introductory Comments

5. Well planned and designed mental health infrastructure plays a critical role in supporting the delivery of contemporary models of care that stabilise and promote the recovery of people with severe mental illness. It can also improve workforce recruitment and retention, community safety and the amenity of the area surrounding a facility. Adequate planning incorporating co-design with people with a personal experience of mental illness can result in exceptional outcomes like the Thomas Embling Hospital (**TEH**) Secure Psychiatric Intensive Care Unit (**SPICU**). This project recently won and was one of only two Australian projects shortlisted for, a 2020 European Healthcare Design Award in the category of mental health design.

6. There are considerable challenges associated with ensuring the most vulnerable Victorians can access high quality mental health infrastructure and bed-based services. Currently, capacity constraints mean the length of stay at TEH is dependent on bed availability rather than clinical or security needs. Further, the constraints create bottlenecks for patients in the prison system requiring compulsory mental health treatment and for patients at TEH needing to 'step up' and 'step down' within the facility to ensure treatment reflects their needs. Insufficient bed capacity also affects Forensicare's ability to proactively service civil patients (patients of area mental health services) due to the demand pressures from forensic and security patients.

7. Some existing infrastructure at TEH is also ageing, no longer robust enough or fit for purpose and unable to support contemporary models of care for bed-based

services. For example, current infrastructure constraints at TEH mean women receive intensive, acute and subacute care in a single unit, preventing implementation of a stepped care model and compromising their recovery. Further, extended and transitional rehabilitation for women is provided within mixed gender units risking their sexual safety.

8. There are significant lead times involved in the development of health and mental health infrastructure. In addition to the design, procurement and construction phases it is critical that rigorous service planning, master-planning, feasibility and model of care planning is completed. Additionally, the best infrastructure outcomes are typically a result of applying a design development process that allows for an inclusive and iterative co-design process with people with a personal experience of mental illness. Depending on the size, scale and procurement model it is typical that major building developments will undergo two years of planning, approvals, design and documentation followed by a three-year physical construction phase. Issues of decanting, the brownfield or greenfield nature of a site and any consequential work requirements will further impact these timeframes.

9. VHHSBA is committed to ensuring the planning, design and delivery of mental health, forensic mental health and forensic disability infrastructure is guided by the best available data and evidence, the input of project partners and value for money considerations.

Forensic mental health services

10. Considerable work has been undertaken to develop a forensic mental health bed expansion strategy to enable the delivery of contemporary models of care in a modern, therapeutic and recovery-focused environment. VHHSBA's Forensic Mental Health Expansion project seeks to develop facilities at TEH that simultaneously meet demand for forensic mental health beds through to 2036 whilst also rebuilding outdated infrastructure. The various elements of this work are outlined below.

Projecting demand for bed-based forensic mental health services

11. Demand modelling for forensic mental health beds has used a consistent methodology over recent years and is based on population forecasts from census data and prisoner number forecasts. The current modelling (November 2019) has

used updated census data, resulting in greater confidence and no residual impact on demand forecasts.

12. Forensicare has recently led extensive service planning, with the new Forensicare Service Plan finalised in September 2020 after consideration by the VHHSBA Forensicare Steering Committee. The Service Plan identifies that the total required bed numbers to meet Forensicare's future demand for forensic mental health beds are 239 in 2025/26, increasing to 275 in 2035/36. This number includes the existing 136 beds at the Fairfield site. The Service Plan does not forecast the future demand for forensic disability beds.

13. Forensicare's Service Plan has sought to emphasise medium secure bed capacity in its forecasting to better enable care provision based on clinical and security needs. The extract below from the Service Plan provides an overview of the bed-based requirements for patient cohorts based on high, medium and low security settings and clinical needs.

Gender	Patient cohort	Current capacity	Required capacity 2020/21	Required capacity 2025/26	Required capacity 2035/36
Males	Acute – High*	42	60	68	78
	Subacute - Medium	10	36	41	47
	Rehab (Extended care) - Medium	14	55	61	70
	Rehab (Transition to community and extended care) - Low	22	36	40	46
Total (Male)		**88**	**187**	**209**	**241**
Females	Acute – High*	12	5	10	12
	Subacute – Medium	-	6	7	8
	Rehab (Extended care) – Medium	-	6	7	8
	Rehab (Transition to community and extended care) - Low	-	5	5	6
Total (Female)		**12**	**26**	**30**	**34**
Total (Mixed gender)**		**36**	**-**	**-**	**-**
Total		**136**	**213**	**239**	**275**

* includes 4 proposed male and 2 proposed female segregation beds by 2035/36
** Relates to Daintree and Jardine rehabilitation units which include a small number of female patients

Fig 1 Forensicare Bed-based services

14. Table 2 (below) also maps the demand for beds by each of the three patient cohorts:

    (a) Forensic Patients - Forensic patients who have been found not guilty by reason of mental impairment or unfit to be tried under the Crimes (Mental

Impairment and Unfitness to be Tried) Act 1997 and are liable for supervision on a custodial supervision order.

(b) Security Patients - Security patients are prisoners that require compulsory mental health treatment under the Mental Health Act (2014) (the Act) or require mental health treatment that can only be provided safely in a hospital setting, on a Secure Treatment Order (**STO**). TEH is the only hospital in Victoria that can admit security patients for treatment.

(c) Civil Patients - Civil patients (defined as compulsory patients under the Act) are patients of area mental health services (**AMHS**) who are on a temporary treatment order (**TTO**) or compulsory treatment order (**CTO**) under the Act and are currently admitted to TEH. Any security patient who has their sentence end, or who is granted bail while they are admitted to TEH will have the order converted to a CTO and their care and treatment will continue at TEH until the patient can safely be transitioned into the care of their local AMHS. Other patients with high levels of risk may be admitted to TEH as determined by the Chief Psychiatrist, although at present there is insufficient capacity to do so.

Patient cohort	Current capacity	Required capacity 2018	Required capacity 2021	Required capacity 2026	Required capacity 2031	Required capacity 2036
Security patients	27	77	99	116	125	134
Forensic patients	107	101	102	109	117	125
Civil patients	2	11	12	14	15	16
Total	136	189	213	239	257	275

Note: Bed numbers do not include DFATS
Source: Forensicare (2019). Review of Forensic Bed numbers (based on the bed forecast model) endorsed by the VHHSBA/Forensicare Steering Committee in 2019.

15. Due to the continued growth in demand from Forensic and Security Patients, TEH has not been able to provide a service to Civil Patients from AMHSs, who require treatment and support in a forensic setting. This causes significant difficulty for AMHS's in having to manage patients whose risk levels are deemed to be well beyond what can be provided for in AMHS treatment settings.

16. Note that modelling for civil patients has been based on historical utilisation patterns and current thresholds. It includes:

(a) provisions for patients on an STO whose sentence concludes while they are in TEH and need the order to be converted to an ITO;

(b) capacity to admit a small number of civil patients with high levels of risk – where other services, including AMHSs, are unable to manage them – and the Chief Psychiatrist determines Forensicare should admit them; and

(c) modelling that indicates that ¾ will need a high secure acute setting with ¼ able to be accommodated in a medium secure setting.

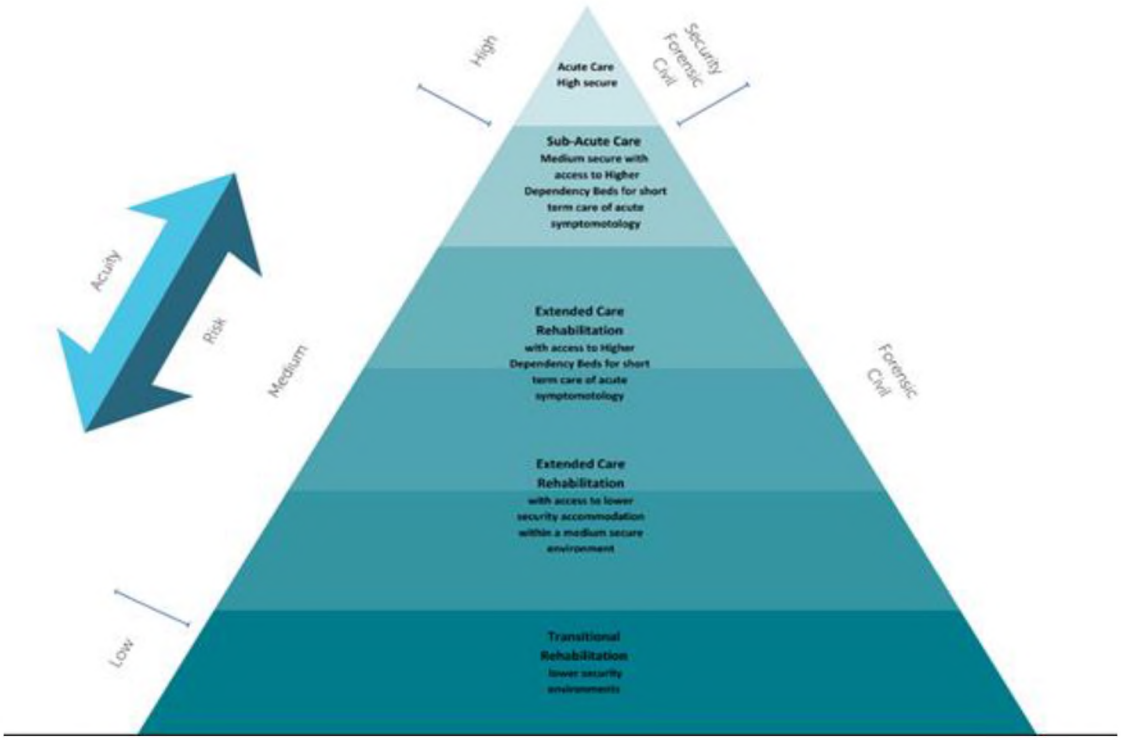
17. However, it has not included all unmet demand for civil capacity as the model is based on extrapolation from numbers in preceding years that may be impacted by lack of current bed capacity and historical impediments to admission of civil patients – resulting in an underestimation of demand.

Projecting demand for bed-based forensic disability services

18. The forensic disability program provides treatment and support services for people with cognitive impairment involved, or at risk of involvement, in the justice system, including both secure residential treatment (currently 19 beds) and non-secure accommodation (currently 57 beds across 12 facilities throughout Victoria). The Disability Forensic Assessment and Treatment Service (**DFATS**), adjacent to the TEH, is a key component of the forensic disability service system and the broader criminal justice system in providing secure residential and community treatment programs. These services contribute to overall community safety by providing treatment and support to offenders to improve quality of life and address behaviours of concern to reduce risk of offending. The DFATS residential treatment facility is ageing and requires capital investment to support and ensure that contemporary models of treatment and care can be provided to residents.

Models of care for the delivery of forensic mental health services

19. Models of care at TEH continue to evolve and patient cohorts have become increasingly more complex. The diagram below illustrates the complexity across acuity levels and security requirements of patient cohorts that is further complicated by factors such as gender, age and treatment length of stay.



20. Forensicare is currently considering a model of care that articulates the continuum of service interventions available to patients, depending on their unique needs and circumstances. It considers the complexity of mental illnesses, criminogenic and comorbid substance use, high risk behaviour issues associated with forensic mental health patient cohorts and guides clinical pathway planning based on streams of care.

21. The model of care under consideration articulates three phases of care for consumers across all service streams:

    (a) Understanding needs and strengths: Mental health assessment and clinical assessment of risk of a newly referred or current consumer. Assessment may be in the form of primary assessment, or secondary or tertiary consultation.

    (b) Recovery: Consists of three sub-phases of hope and empowerment, build and strengthen, and connection, which are undertaken progressively, celebrating even incremental positive changes. Each consumer's clinical pathway is unique and designed around their individual needs.

(c) Journey transition to the community: Providing care and supervision together with system partners to meet holistic needs for consumers moving out of the forensic system into the community.

22. The model of care is to be operationalised within each service stream through detailed pathways across service settings. The pathways reflect not only the different consumer cohorts but also clinical and security needs. It is important to note that pathways are not always linear, and a person may move between multiple Forensicare services, depending on a range of factors including mental health needs, security needs or any changes to their legal status.

Optimal characteristics for the delivery of forensic bed-based services

23. Selecting a site to be used to deliver forensic bed-based services involves considering a range of issues including technical features of the land parcel as well as features or characteristics of the site and its environs that support the implementation of the Model of Care.

24. The site should be of a sufficient size and shape so that:

(a) distinct zones or precincts can be established to accommodate patients with varying requirements for security and support, thereby ensuring that patients can receive care in the least restrictive environment possible;

(b) ideal spatial relationships and proximities can be achieved between the different security precincts as well as between the buildings and functions within each precinct so that the Model of Care can be implemented within a safe, therapeutic environment;

(c) services can be expanded beyond the current projected demand for services to protect the long-term viability of the site and maximise the return on investment;

(d) there is sufficient open space in appropriate locations to enable assets still being planned to be systematically replaced when they reach the end of their useful service life; and

(e) opportunities exist for the potential co-location of related activities that contribute to enhanced outcomes for patients, staff, the health service, the broader community and government;

25. The site should ideally be located where it has good connectivity via road, bike paths and public transport networks so that:

(a) it is readily accessible to key referral points into and out of the forensic mental health service system (e.g. courts and prisons), supporting system wide efficiency and providing enhanced access to forensic bed-based services;

(b) it is convenient for staff to access so the health service can attract and retain the highly skilled, specialist workforce it requires to deliver safe and effective therapy and care; and

(c) logistics support can be provided in an efficient, timely manner.

26. The site and its location should also support patients in their recovery and transition back into the community by:

(a) enabling patients granted leave easy access to a range of off-campus amenities and opportunities for meaningful engagement in education, recreation, socialising and employment activities; and

(b) removing barriers that discourage visits by patients' family members, carers, friends and professional visitors. e.g. linked to public transport, road connections, central metropolitan location for ease of access by visitors travelling from regional areas.

27. The site should be located, sized and planned so that it:

(a) protects patient privacy; and

(b) presents an attractive, non-stigmatising aspect to its setting.

28. Patients with high support needs who are deprived of their liberty so they can receive treatment over several months or years must have their right to humane treatment respected and supported by the physical environment in which they are detained. It is critical that the site provide patients, regardless of their acuity or security level, with ready access to external areas and natural environments that:

(a) are dedicated to each security zone and to each consumer cohort within the forensic services precinct; and

(b) are purpose designed to accommodate the full range of residential, therapeutic, health, educational and other services required to support the patient's recovery.

Infrastructure as an enabler: Planning for the redevelopment and expansion of Thomas Embling Hospital

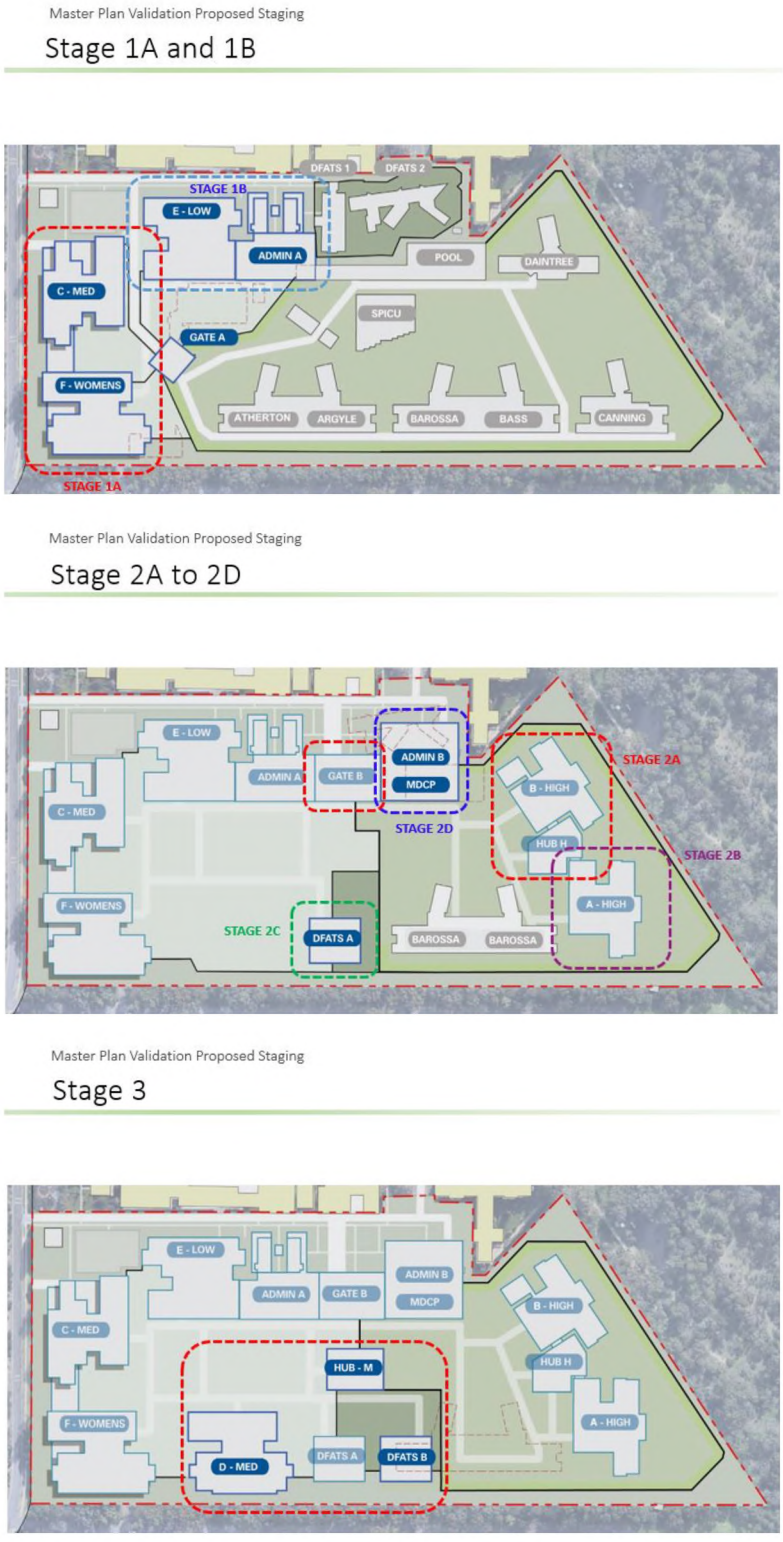
29. VHHSBA's Forensic Mental Health Expansion Project has used the proposed Forensicare bed-based requirements, identified in Fig 1 above, and separate DFATS modelling as key planning inputs for the redevelopment expansion strategy.

30. The Fairfield site of TEH has been assessed and confirmed as the best option for expansion to accommodate the future bed requirements for both Forensicare and DFATS within a contemporary setting. A yield analysis, supported by a masterplan validation approach which tested the capacity of the site, identified that current and unmet demand can be delivered over three key stages at Fairfield to create a world class setting. All services being delivered on the one site enables the development of a centre of excellence in forensic staff development and care.

31. To confirm this approach, a masterplan validation process was established to achieve this at the Fairfield campus, with staging options now developed to progress the first phase of the masterplan, subject to consideration by government. This has been informed by the recently finalised Forensicare bed-based service plan (based on demand modelling on previous agreed projections), DHHS' endorsed bed requirement for the proposed forensic disability residential treatment facility and an asset assessment of the existing facilities. Forensicare is projected to require an additional 103 beds by 2025/26, with the forecasts required across different patient cohorts included in the Forensicare Service Plan shown in Figure 1 above. This masterplan validation work was completed in September 2020, with an overview of the staging approach displayed below in Figure 2.

32. Priority critical enabling works planning has commenced, representing a "no regrets" investment that provides updates to end of life infrastructure in preparation for the redevelopment. These works include demolition of assets to allow for redevelopment and upgrades of significant utility infrastructure.

Fig 2 Full masterplan staging of TEH (September 2020)



33. VHHSBA has worked closely with Forensicare and DHHS DFATS based on model of care objectives to finalise the long-term TEH masterplan approach, resolving several site considerations such as yield, phasing and model of care benefits to deliver contemporary therapeutic treatment outcomes. The full masterplan staging meets these objectives by ensuring the following model of care priorities are achieved:

    (a) providing a stepped model of care across levels of acuity and security (the current model of care can only be provided within a high security precinct, resulting in limitations for a stepped care approach);

    (b) gender sensitive care in appropriate and safe treatment environments (particularly for women); and

    (c) access for forensic disability, forensic and civil patients and enablement of sensitive segregation care.

34. The co-location of the DFATS and TEH on the Fairfield site provides opportunities for both services across therapeutic, clinical and operational functional domains to support service efficiencies and effectiveness. These opportunities arise given their points of interface and interaction, including through shared physical boundaries and access points, as well as an overlapping sub-cohort – people with dual disability (co-occurring mental illness and intellectual disability) – who require the provision of forensic disability supports and psychiatric clinical services.

35. The full staging masterplan approach has been developed collaboratively with VHHSBA, Forensicare, Mental Health and Drugs Branch (DHHS), Forensic Disability Services and Disability and Communities Branch (DHHS), and Justice Health (Department of Justice and Community Safety). The future bed configuration clearly delineates between 'high', 'medium', and 'low' security and clinical needs, includes gender-specific beds for women (and other design features to improve sexual safety, as set out further in my statement below), a low-secure transition care unit and a low-secure unit that caters for the needs of older patients. The staging for the full masterplan is shown in Figure 2 above.

36. The considerations of how expansion of forensic bed-based services could be staged are based on several factors including:

    (a) investing in stages that best align with model of care, service planning and demand;

(b) ensuring a sense of place making and enhancing the precinct;

(c) not limiting or blocking future stages of investment; and

(d) minimal disruption to the site, current consumers and staff (including security, noise and minimising decanting stages).

37. The full staged masterplan approach identified in Figure 2 will require all forensic beds to be ultimately redeveloped. However, this would be over many years given the number of additional beds and potential timing of staging options.

38. Implementation of the full master plan, which ultimately redevelops all current beds at TEH, would require a significant investment by government. This investment is offset in part by the re-direction of funding from correctional services, where people requiring secure forensic beds are often otherwise placed, towards more therapeutic services orientated towards treatment and rehabilitation. High level programming has been developed for the first stage of expansion (Stage 1A), which includes a 48-bed men's medium security building and 34-bed women's precinct. This has an estimated program timeframe of 4 years from funding. The exact timeframe to implement would be a function of the final approved staging scope determined by government (if a larger or smaller project) and the need to modify any planning to meet the final recommendations of the Royal Commission.

Incorporating the perspectives of lived experience people in master planning

39. The perspectives of people with lived experience of forensic mental health services has been critical in the co-design process undertaken to plan for the future of the TEH campus. The process commenced with master-planning in 2016, followed by masterplan validation in 2020 and has continued into the Feasibility Study currently underway.

40. COVID-19 restrictions have resulted in the input of all parties being via Microsoft Teams. While this was initially expected to be a barrier to involvement of those with lived experience, it seems to have in fact "democratised" the process with all users able to submit questions and add comments via multiple channels. All "chat" has been monitored and responded to in the meetings and incorporated in the project brief by the project consultants.

41. Lived experience representatives and current patients have brought valuable insights to the project planning. Co-design workshops with active support from Forensicare staff have occurred. They have also participated in smaller focused

workshops responding to particular themes e.g. landscape, women's precinct design.

42. When current patients have been unable to participate in workshops, Forensicare staff and lived experience representatives have engaged with them one on one outside the workshop process to elicit their input and have brought that information back to the planning team.

43. The perspectives of people with a lived experience of forensic mental health services will continue to be included in any subsequent planning stages e.g. physical and virtual reality (**VR**) prototypes would be used during schematic design to enable all stakeholders to test the design of generic spaces and the layout of units.

Therapeutic design of forensic mental health facilities

44. The foundation of design for therapeutic forensic mental health facilities is the concept of "the therapeutic use of security"[1], with security understood as comprised of the following three elements:

    (a) Physical security covers aspects of environmental and building design that include safety and restraint, such as safety-windows, locks, walls and alarm systems.

    (b) Relational security focuses on a more qualitative viewpoint: the patient–professional relationship, knowledge of specific patients' history and a general understanding of the forensic patient population.

    (c) Procedural security focuses on policies and procedures that maintain safety and security, e.g. search protocols and surveillance of restricted items.

45. Forensic mental health facilities should, at their most basic level, provide a physical environment that meets the varying physical security requirements of its occupants and the spaces within it should be designed and configured to support relational and procedural security.

46. The therapeutic use of security establishes the safe and stable environment in which patients are enabled to achieve "a better quality of life" and to make real

[1] Allan Seppanan et al., 2018. Modern forensic psychiatric hospital design: clinical, legal and structural aspects. *International Journal of Mental Health Systems* 12 (58) p3.

treatment progress through "effective, individualized medical interventions" and engagement in "rehabilitative social interaction, such as multidisciplinary teamwork, occupational therapy and other meaningful activities."[2]

47. The provision of adequate spaces for therapeutic activities and their location so that they are readily and safely accessible and provide maximum benefit to patients is critical in creating a therapeutic design. A significant learning from the recently opened SPICU at TEH is that even acutely unwell patients seek and obtain benefit from participation in a therapeutic program. Consequently, the model proposed for the future redevelopment of TEH is a stepped model in which patients in high acuity units will access most of their therapy in spaces immediately adjacent to the residential area of their unit, although separated sufficiently from the residential spaces to encourage a sense of separation from "home-life". A relatively small number of therapy spaces will be provided in a central therapy hub in the high secure zone so patients can, for example, be trialled attending activities off unit, before transitioning to the medium security precinct. In the medium secure precinct, approximately 50% of therapeutic spaces will remain immediately adjacent to the residential area of units, with the balance of the spaces provided in a central therapy hub dedicated to that precinct. This is intended to further normalise the daily act of "going out" for work, education or recreation. It is assumed that patients in the low security units would access the majority of their therapeutic and other activities off campus in the community.

48. Project participants with lived experience conveyed a strong message that the physical environment should convey a sense of hope and of being valued, with the internal and external spaces they inhabit on a day to day basis changing and "softening" to reflect and further encourage their progress along a pathway to recovery. While the proposed new Forensicare facilities adopt a degree of standardisation for future flexibility in terms of the numbers of beds on each floor level, each precinct will have its own unique character and while the buildings within each precinct will share common architectural design elements, the units on each floor level will look and feel different. Every floor level will have access to landscaped courtyard areas with

[2] Allan Seppanan et al., 2018. Modern forensic psychiatric hospital design: clinical, legal and structural aspects. *International Journal of Mental Health Systems* 12 (58) pp3-4.

good access to sunlight and view and interior finishes will also reflect the changing requirements of the occupants.

49. A design response that addresses the specific needs of the high number of female patients with a history of trauma was also identified as critically important by project partners with lived experience. They were very supportive of the concept of a purpose-designed, safe and supportive precinct only for women and in which women could receive all aspects of their care, whether high acuity, subacute, rehabilitation or transition to the community. Elements of the design of a women's precinct which were identified as important included feeling safe, which means not having male patients accessing their building at all, not being observable by male patients even when accessing their external areas, being able to personalise their personal and shared spaces with arts, photos, plants and to have "softer" more colourful interiors rather than having the colour scheme of a traditional hospital.

50. Further elements of design that are important to consider in the planning and design process for forensic facilities are identified by evidence-based research. Evidence-based research into the design of mental health care environments generally and forensic mental health care facilities in particular is an emerging field from which it is difficult to develop generalisable "rules" for design. The research does however point to several factors as potentially contributing to the creation of a therapeutic environment. These include:

    (a) A "homelike", non-institutional look and feel[3].

    (b) Providing patients with all single bedrooms is proposed to enhance their sense of autonomy and it is thought that this may lead to improved engagement in therapeutic activities[4].

    (c) Providing patients with the ability "to regulate their own level of social contact while in psychiatric care" is also recommended.[5]

    (d) Avoiding crowding in forensic units is also proposed to reduce the incidence of aggression.[6]

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[3] Seppanan et al., 2018. Modern forensic psychiatric hospital design: clinical, legal and structural aspects. *International Journal of Mental Health Systems* 12 (58) p3.
[4] *Ibid*, p5.
[5] *Ibid*, p3.
[6] Palmstierna, Huitfeldt and Wistedt, 1991. The Relationship of Crowding and Aggressive Behaviour on a Psychiatric Intensive Care Unit. *Hospital and Community Psychiatry* 42 (12) pp1237-1240.

51. Each of these factors supports the achievement of a therapeutic environment in multiple ways, both alone and in combination with other factors.

Mental health infrastructure

Research focused on mental health infrastructure and innovation

52. There is little published research on the design and quality of acute inpatient accommodation for people with serious mental illness. Developed hospital sites can rarely provide ideal environments for new mental health facilities. Mental health facilities require a calm, open and re-assuring environment with privacy from overlooking neighbourhoods, a green outlook, and access to high quality open space.

53. Recent research commissioned by VHHSBA into mental health facilities has demonstrated the following trends:

    (a) Multistorey campuses in both forensic and non-forensic mental health facilities around the world. Projects with greater floor areas (and hence beds/consumers) tend to be located closer to urban centres, which may be because larger facilities are more heavily reliant on facilities that are provided in these urban centres and draw more heavily on staffing requirements from larger populations to meet specialist needs.

    (b) Campus planning models which carefully consider the normalisation of behaviour as part of a recovery-focused model of care, establish strong connections with the external environment through incidental travel and orient consumers through placed based architecture.

    (c) Typologies for inpatient accommodation reflecting specific cultural bias with European countries preferring courtyard layouts (defined by clusters of bedrooms arranged around one or many courtyards with typically single loaded corridors) and American and Canadian examples more likely to be Peninsula models (defined by clusters of bedroom spaces arranged in wings with typically dead-end corridors).

    (d) The incorporation of a Therapeutic Treatment Hub (**TTH**) within facilities to provide both therapeutic and shared social spaces for consumers. These seek to 'normalise' the daily consumer whilst simultaneously providing an opportunity to engage with the broader community through shared facilities/social enterprise.

(e) The benefits of establishing connections with nature and freedom of movement for consumers, particularly in secure mental health facilities, cannot be underestimated. Accessible and non-accessible landscape both on natural ground and raised in multistorey solutions have been successfully provided in several case studies, and less successfully in others.

High, medium and low secure services for mental health services

54. VHHSBA works with definitions of high, medium and low secure services only in the context of forensic services, where these categories are more widely used and understood and often have specific design requirements mandated by legislation, regulations or standards. In AMHS operated inpatient units it is typical to refer simply to general care areas (the open unit) and high dependency or high care areas (the locked part of the unit), although each project may vary according to the proposed model of care, e.g. the more recent introduction of the concept of a medium care area as a flexible, intermediary space between general care and high care.

Planning for demand for mental health services

55. The Mental Health and Drugs Branch (**MHDB**) has completed the development of its Victorian planning tool which assists it to understand unmet demand for mental health services. The tool has the capacity to adjust model of care related variables, including length of stay and access to community-based services, both of which have a demonstrable impact on the forecasting of unmet demand.

Planning for and prioritising investments in mental health infrastructure

56. VHHSBA commissioned the development of an infrastructure prioritisation planning tool in 2018 to assist prioritising the planning investment. The tool, often described as the Plan to Plan tool, presupposes certain weightings against three variables: demand (based on data provided by the DHHS Health and Wellbeing Division), asset life and condition (2014 asset revaluation information which is currently being reassessed) and network criticality (hospital network criticality categorisation) to determine a list of prioritised hospital sites across Victoria requiring planning investment because of the combination of demand, condition or criticality. The Plan to Plan tool can analyse regional or metropolitan sites and prioritise all 2500+ sites within the portfolio or prioritise and focus on a 'top 20

list'. Note that two of these three variables (demand and asset life and condition) are updated periodically, informing a biannual update of the Plan to Plan tool. The top 20 planning list is often seen as a proxy for capital investment. The weightings ascribed to the variables can be adjusted to vary the outputs to consider differing policy priorities, which often results in a re-sorting of the investment priorities in the top 20 list.

57. The Plan to Plan tool lists the top 20 projects at state-wide, metropolitan and regional levels. It does not, however, separate out different building typologies (e.g. mental health accommodation and public sector aged care). The tool is currently being refreshed to consider the applicability of the current variables for mental health infrastructure, noting nonetheless that mental health services are often accommodated within a broader medical hospital campus and it is often impractical to separate the two for planning purposes in this instance.

58. Once service and capital planning has been approved to proceed, significant entity-based service planning and asset planning is completed. This information informs capital planning (campus masterplan) which in turn determines which projects require further detailed development through a feasibility stage. Once these important planning steps have been completed, then a capital business case for consideration by government can be prepared. For projects above a certain value and risk, Gateway reviews (independent assurance reviews coordinated by the Department of Treasury and Finance (**DTF**)) are undertaken at set points in the project lifecycle.

59. Over recent years, many hospital masterplans and feasibility studies have actively pursued the inclusion of mental health infrastructure renewal as a priority. This has been done through the integration of mental health accommodation in medical surgical infrastructure proposals. These proposals are a physical manifestation of contemporary care models embedding further mainstreaming principles. This approach also addresses the stigmatisation associated with standalone mental health facilities built post deinstitutionalisation and now well beyond their useful lifespan.

Planning mental health services as part of new hospital builds

60. Planning for new hospital builds commences with the completion of a service plan for the campus. The service plan identifies the full suite of services currently provided on the campus (in the case of an existing facility) and the projected

demand for services over a defined time period. Service planning addresses the full range of services, including mental health services, and related services such as alcohol and other drugs and emergency departments. Where the service plan does not project the demand for mental health inpatient beds, master-planning of a campus should identify potential future development zones that could accommodate these or other services should the need arise in future.

Exemplar mental health facilities and balancing adherence to guidelines

61. The Australasian Health Facility Guidelines (**AusHFGs**) are a nationally agreed set of design guidelines that attempt to capture the baseline requirements for the design of healthcare environments. The mental health sections of the AusHFGs are based on a review of a number of recently completed mental health facilities in Victoria and other jurisdictions and input from an Expert Reference Group comprised of clinical, program and design staff and some limited input from those with lived experience. The final draft of the Guidelines was reviewed by a broad range of stakeholders across all jurisdictions prior to publication.

62. The design of therapeutic environments for people with mental illness is complex. The Guidelines focus on and address spatial issues of patient safety, privacy and amenity, the core spaces and ancillary support spaces required by staff to safely and efficiently deliver therapeutic interventions, staff amenity and spaces to support family/carer engagement.

63. The AusHFGs of themselves will not guarantee a good design outcome. They are only one input required to achieve a therapeutic environment for people with mental illness and do not negate the need for a highly skilled design team leading a comprehensive, creative, co-design process that engages multiple voices and perspectives including those with lived experience of mental illness and grapples with achieving an acceptable balance between risk and a human centred, therapeutic built outcome.

64. It is standard practice in Victoria, in line with the AusHFGs, to provide all single bedrooms with dedicated ensuites in new mental health inpatient units. This provides patients with personal space that is under their control, which they can personalise, and use to regulate the degree of social interaction they have with others.

65. Victoria also generally uses a courtyard typology for the design of acute mental health inpatient units. This locates “clusters” of bedrooms off single-loaded

corridors around courtyard spaces. Each cluster is typically provided with a small sub-lounge so that it can operate as a sub-unit of the larger unit as needed to accommodate gender safety, support cohorting by age or some other factor, generally lower the level of stimulation that patients are exposed to, or separate patients who may not get along. It also provides great natural light and easy access to an outdoor space that can be for the sole use of that cluster of beds as required and usually is not dependent on staff being available to supervise a separate external garden area because it can be viewed from strategically located staff bases, corridors and shared areas that open into it. These design features have proven to be useful strategies in several acute mental health inpatient units and seem to be equally if not more useful in the design of forensic mental health inpatient units.

66. Another important factor in the design of therapeutic forensic mental health units is to support the reduction of the use of seclusion and restraint. Contemporary designs for mental health inpatient units provide a graduated series of spaces that patients can access to either self-regulate or work with staff to manage negative thoughts or impulses when they arise, as an alternative to seclusion. These alternative spaces include quiet rooms, sensory rooms and de-escalation rooms. These spaces play a vital role in assisting forensic patients in their recovery and reducing the use of seclusion and restraint which can exacerbate existing trauma.

67. Salutogenic design, which is an approach to design that focuses on factors that are health promoting and enhance well-being, is frequently referenced in the design of mental health facilities. It has links to concepts of human centred design and a strong association with the long-standing belief in the restorative power of nature. It advocates strongly for patients to have access to outdoor space. This view is supported by a recent observational study which noted that patients and staff seem to take any opportunity to "spend time in nature outside the built environment"[7]. The authors suggest that this provides patients and staff with a counter balance to the restrictions imposed by the structured internal environment and supports "the basic needs of both clients and staff to have an ongoing connection to the world beyond the walls of the institution"[8].

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[7] Connellan, Due and Riggs, 2011. Gardens of the Mind: Nature, Power and Design for Mental Health. Edited by Chen, Stappers and Roozenberfg. *Diversity and Unity: Proceedings of the IASDR2011, the 4th World Conference on Design Research*. The Netherlands.
[8] *Ibid.*

68. This is particularly relevant for forensic mental health facilities in which patients have much longer lengths of stay. Planning for access to external space in the proposed new facilities at TEH recognises the significance of access to external space and is informed by a functional design brief prepared for external areas. Generous courtyards on each floor level of the low-rise buildings will provide patients and staff with ready access to desirable outdoor spaces and views that expands the horizon beyond their contained world.

69. The Orygen Youth Health facility successfully moved beyond institutional design features and provides an effective balance between requirements of the AusHFGs and the aspirations of the service provider and their consumers. Orygen (The National Centre of Excellence in Youth Mental Health) and Orygen Youth Health championed an effective co-design process that ensured the views of consumers were incorporated into the design.

70. It should be noted that there are no AusHFGs specifically for the design of ambulatory care and research facilities for young people seeking assistance with mental health concerns. Requirements in terms of design guidance for the Orygen Youth Health facility were extrapolated from the overarching AusHFGs guideline for mental health facilities.

71. When the project team proposed a design feature that was in conflict with this guidance, an outcome would be negotiated between Orygen and VHHSBA through the regular project governance processes. For example, the AusHFGs require all mental health consult rooms to have dual access/egress to meet requirements for a safe workplace for staff. Orygen did not want their facility to look institutional and argued that their consumers did not have the same risk profile as adult consumers. It was agreed that 50 per cent of consult rooms would be provided with dual access/egress and that these could be used by staff when engaging with a new user of the service or with users that staff assessed as being particularly agitated. This decision was documented to demonstrate that a considered approach had been taken that weighed risk against amenity and a therapeutic environment.

72. The architecture and interior design team subsequently designed the consult rooms so that the secondary access/egress opened onto an external deck. This not only met the requirement for a safe workplace but created an attractive and radically different ambience with consumers and staff able to choose to have their

session on the more relaxed setting of the deck or with the doors open to the landscape.

73. The project received the 2019 European Healthcare Design Award for Mental Health Design and was shortlisted for a number of other design awards.

Effectively embedding therapeutic aspects of design into the service and capital planning process

74. The therapeutic aspects of a design are more likely to be embedded into the service and capital planning process when:

    (a) the criteria for selection of design consultants includes specific expertise in managing an effective co-design process; and

    (b) the full project team, which includes the full suite of consultants, health service representatives, VHHSBA representatives, other DHHS representatives and those with lived experience are engaged in an extensive co-design process.

75. This needs to be supported by:

    (a) updating the relevant sections of the AusHFGs to incorporate enhanced guidance and resources on key design elements that support the provision of a therapeutic, non-institutional environment with greater input from those with lived experience. (Note: the relevant sections of the AusHFGs were updated in 2018 and are scheduled for routine review in approximately one year);

    (b) updating VHHSBA capital project planning, design and delivery process guideline documents to include the co-design requirements;

    (c) updating the Standard Consultancy Brief to include the requirement for expertise in leading a co-design process as one of the criteria for selection; and

    (d) including those with lived experience in project governance structures at the appropriate level to ensure that the aspiration of therapeutic design is not lost under pressure of time and cost.

Active asset management with a view to renew and redevelop

76. DHHS' asset management system reflects its system steward role in setting portfolio standards and guidelines, monitoring compliance and providing specialist advice, knowledge and expertise to support health service providers.

77. Renewal of assets is typically undertaken to ensure the:

    (a) reliability of the existing infrastructure to deliver the services that it was installed to facilitate (e.g. replacing the roof on a facility);

    (b) infrastructure is of sufficient quality to meet service requirements (e.g. recarpeting of a bedroom); and

    (c) services are sustained, not grown.

78. Continuous changes in compliance and regulatory standards overlays a complexity to asset renewal that is very challenging. It is often difficult to meet compliance standards or upgrade infrastructure because of the age, original design, enabling infrastructure or the need for material co-dependent projects to be funded. Building Code requirements are regularly updated and govern the requirement for mandatory upgrade and renewal requirements and triggers. Most triggers are at an asset renewal, refurbishment or change in use point. It is regularly the case that a partial renewal project within a much larger building complex will trigger upgrade requirements for the entirety of a building or much larger project than anticipated. Noting the age and condition of existing infrastructure within the broader portfolio this becomes challenging in terms of determining the size scale and scope of any asset renewal and the feasibility of delivering it. It often means that mental health upgrade and renewal cannot be considered in isolation from other building occupants and use.

79. As many mental health facilities are embedded in public health service portfolios, the planning process for renewal has comprised a bottom up approach where individual health services identify needs through asset management plans and observation of defects in the existing assets. Projects are then prioritised based on risk, condition and funding availability.

80. Following the establishment of VHHSBA, the Asset Management Establishment Project was initiated to establish a systematic and coordinated approach to asset management in the health sector – including renewal planning. A key outcome of this project has been the development of renewal approaches to strengthen the

existing bottom up approach and integrate with forward projections and predictive modelling techniques incorporating condition and risk.

81. A pragmatic condition assessment framework was established to form the basis for condition assessment programs across the portfolio, and the framework aligns with the International Infrastructure Management Manual (**IIMM**) and risk management techniques. The framework measures the current condition of the asset based on its remaining useful life, maintenance history and asset life extension strategies. The framework also accommodates for measuring the criticality of the asset based on determining the impact of the services provided when the asset fails. Combining both measurements, an asset risk score is allocated, which informs the investment action needed to mitigate the risks accordingly.

82. The framework is easily applied against engineering infrastructure assets (building services). However, for the building structure and fabric the decision making is more complex as there are other contributing factors. In many cases, the asset might be in a good condition however the existing configuration or material used is not appropriate to meet the current clinical services standard. Building fabric replacement is challenging at a component level and this triggers the need to consider a more holistic view for the investment needed (i.e. refurbishing a whole building with all of its enabling services and upgrading compliance standards).

83. To date, VHHSBA has conducted condition assessments for 46 hospital campuses (around 37% of all main hospitals sites), 54 mental health facilities (around 31% of the mental health portfolio) and 17 metropolitan residential aged care facilities. This does not currently include community mental health facilities. The findings are recorded in an online dashboard enabling visualisation and retrieval of data. The below image shows a screenshot from the tool and its capability.

84. VHHSBA is working with Victorian health services to leverage their capability in managing asset information and updating their asset registers which will be absorbed on a regular basis in a central Asset Information Management System (**AIMS**) used in strategic planning and managing portfolio risks.

Statewide planning for mental health system design, services, and infrastructure

85. The Victorian Government's Statewide design, service and infrastructure plan for Victoria's health system 2017-2037 provides the planning framework that will guide service, workforce and infrastructure investment in Victoria's health system over the next 20 years.

86. The plan describes the following system design principles to guide decisions about planning and development of services and infrastructure, in a way that supports Victoria's longer-term vision for the health system:

(a) Health system design is driven by population need, underpinned by strong prevention and early intervention systems to improve health outcomes.

(b) Victoria's health services have clear role delineation, are geographically coordinated, and are well-connected to the broader health and social care system.

(c) Where safe and appropriate, services will be delivered outside of the hospital setting and as close to home as possible.

(d) Enhanced system configuration and more flexible use of resources will release existing capacity in our health services and better distribute new capacity.

(e) Designated tertiary referral/specialist health services have a key role in ensuring access to patients from across Victoria who require higher complexity care.

(f) The causal relationship between the volume of services being provided and the quality of these services will be reflected in system design and service planning.

(g) The prioritisation and distribution of high cost medical equipment across the system will promote alignment of roles, capability and capacity.

87. The plan also identifies five priority areas that seek to respond to growing pressures on our health system by charting a path forward over the coming 20 years:

(a) building a proactive system that promotes health and anticipates demand;

(b) creating a safety and quality-led system;

(c) integrating care across the health and social service system;

(d) strengthening regional and rural health services; and

(e) investing in the future—the next generation of healthcare.

88. The plan describes Victoria's current infrastructure pipeline over a five-year period, including Melbourne growth areas and other metropolitan and regional areas. Dedicated mental health priorities are the expansion of forensic mental

health services, redevelopment of Orygen Youth Mental Health (Parkville), renewal of mental health and alcohol and other drugs services facilities, establishment of the Statewide Child and Family Mental Health Intensive Treatment Centre, more intensive care services at Mildura Base Hospital and redesign of the acute mental health unit and new mental health prevention and recovery care service and additional drug treatment residential rehabilitation services for the Ballarat community.

sign here ►

print name ROBERT ALFRED FISKE

date 15/10/20

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RF-1

This is the attachment marked 'RF-1' referred to in the witness statement of Robert Alfred Fiske dated 14 October 2020.

Robert Fiske

SUMMARY

I am an experienced Senior Executive with a demonstrated history of successfully establishing, leading and improving multi-billion-dollar complex Infrastructure, Operations and Maintenance organisations across multiple industries, both within Australia and Internationally. I am a change leader who thrives on a mandate to deliver. I am committed to developing and fostering a high performing achievement-oriented culture, clear accountability, and measurable performance with strong operating disciplines and collaborative stakeholder management.

SKILLS

- Safety Leader
- Organizational & Executive leadership
- Complex Operational and Capital Programs Management
- Project / Program / Portfolio Management
- Change management
- Business development, Recruitment
- Business planning
- Capital Development & Construction Program Leadership
- Negotiation & Commerciality
- Asset Management, Logistics and Maintenance Management
- Process re-engineering and Business Optimization
- Productivity & Cost Performance
- Risk & Compliance Management
- Relationship and Stakeholder Management
- Complex Procurement

EXPERIENCE

Chief Executive Officer, Victorian Health & Human Services Building Authority,
October 2017-Current
Melbourne, Vic

I have led the establishment and stand-up of the Victorian Health & Human Services Building Authority (VHHSBA). VHHSBA has responsibility for the asset strategy for all current infrastructure assets within the health, mental health and aged care portfolio. The asset base is approximately $25Bn worth of assets and 2200 individual buildings/facilities.

In addition, I am responsible for overseeing the delivery of the capital programs for Health, Mental Health, Aged Care and Ambulance Victoria.

The funded capital program spans sustaining capital grant programs as well as major projects (High Value High Risk, Public Private Partnerships and traditional construction programs). Projects include:

- The New Footscray Hospital ($1.5Bn),
- Ballarat Base Hospital ($540M),
- Frankston Hospital ($564M),
- Casey Hospital ($139M),
- Joan Kirner Women's & Children's ($229M),
- Victorian Ambulance Stations ($139M)
- Royal Victorian Eye & Ear Hospital ($311M)
- Victorian Heart Hospital ($542M)
- Wantirna Aged Care & St Georges Aged Care ($130M)
- North West Women's and Orygen Youth PARC ($25M)
- 100 beds Alcohol & Drugs Expansion ($45M)

VHHSBA typically manages the planning (pre funding) of approximately 20+ projects simultaneously and is responsible for developing capital and funding investment cases submitted to Government.

A core responsibility of my role is also managing the range of key stakeholder relationships including; Advisory Board, Project/Program Boards/Steering Committees with Victorian Health Services, Ministerial Offices, and central agency collaborations

General Manager - Development, Ōtākaro Limited, 2016 - 2017
Christchurch, NZ

Reporting to the CEO, I was responsible for the establishment of the project delivery function for the planning, procurement and construction for the Key Anchor Projects supporting the Canterbury Earthquake Rebuild.

I successfully transitioned all of the NZ Government anchor projects into construction or early works. This included:

- The Christchurch Convention & Exhibition Centre Te-Pae($330M),
- Metropolitan Sports Centre ($256M),
- Avon River Precinct ($137M),
- East Frame Residential Development (900 Townhouses and Apartments),
- South Frame and the Accessible City Roadworks ($97M).

Head of Non Process Infrastructure, BHP Billiton (Iron Ore),
2011- 2015
Perth, WA

National General Manager, Compass Group UK,
2010-2011

Melbourne, VIC

Chief Operating Officer, Transfield North America (USM),
2007- 2010
Philadelphia, USA

General Manager - Operations, Transfield Services **2002-**
2007
Melbourne, VIC

Regional Manager - WA / Victoria, Transfield Services, **1999-**
2002
WA & VIC

Commissioned Officer, Australian Army,
1985-1999

EDUCATION AND TRAINING

Masters of Business Administration (MBA)
Southern Cross University

Bachelor of Arts (BA)
University of New South Wales

Graduate of the Royal Military College Duntroon, Canberra

Graduate of the Australian Defence Force Academy, Canberra