Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning

0131 Mental Health – Overarching Guideline

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Australasian Health Facility Guidelines

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The AusHFG are an initiative of the Australasian Health Infrastructure Alliance (AHIA). AHIA membership is comprised of representatives from government health infrastructure planning and delivery entities in all jurisdictions in Australia and New Zealand.

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CULTURAL ACKNOWLEDGEMENT AND TERMINOLOGY

The Australasian Health Facility Guidelines (AusHFG) are developed in collaboration with stakeholders across Australia and Aotearoa, New Zealand.

Acknowledgement of Country

We acknowledge the Aboriginal people as traditional owners and continuing custodians of the land throughout Australia and the Torres Strait Islander people as the traditional owners and continuing custodians of the land throughout the Torres Strait Islands. We acknowledge their connection to land, sea and community and pay respects to Elders past, present and emerging.

Acknowledgement of Te Tiriti o Waitangi

We acknowledge Māori as tangata whenua in Aotearoa New Zealand; Te Tiriti o Waitangi obligations have been considered in developing these resources.

Terminology and Language in the AusHFG

Throughout the AusHFG resources, the term 'Indigenous Peoples' is used to refer to both the Aboriginal and Torres Strait Islander Peoples of Australia and Māori of Aotearoa, New Zealand. Where references to specific cultural requirements or examples are described, the terms 'Aboriginal Peoples', Torres Strait Islander Peoples' and 'Māori' are used specifically. The AusHFG respect the right of Indigenous Peoples to describe their own cultural identities which may include these or other terms, including particular sovereign peoples or traditional place names.

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01 INTRODUCTION

1.1 PREAMBLE

The Australasian Health Facility Guidelines (AusHFG) (www.healthfacilityguidelines.com.au) are freely available resources for health services and project teams across Australia and New Zealand to support better planning, design, procurement and management of health facilities.

The AusHFG are an initiative of the Australasian Health Infrastructure Alliance (AHIA), a cross-jurisdictional collaboration of all health authorities across Australia and New Zealand. Part A of the AusHFG provides further information relating to the purpose, structure and use of these resources. It is acknowledged that the application of the AusHFG varies between jurisdictions across Australia and New Zealand.

This AusHFG Health Planning Unit (HPU) has been reviewed and updated by AHIA following an extensive consultation process with clinical, operational and technical experts, as well as people with lived and living experience of mental illness. The consultation process was completed in 2023.

1.2 INTRODUCTION

The Mental Health – Overarching Guideline describes the generic planning and design requirements that should be considered when planning mental health inpatient units. This document contains information that is common across all mental health inpatient units and should be read in conjunction with service specific HPU documents. These service specific documents include:

- HPU 132 Child and Adolescent Mental Health Unit
- HPU 133 Psychiatric Emergency Care Centre (PECC)
- HPU 134 Adult Acute Mental Health Inpatient Unit
- HPU 135 Older People's Acute Mental Health Inpatient Unit
- HPU 136 Non Acute Mental Health Unit which includes rehabilitation, extended care and low to medium secure forensic services
- HPU 137 Mental Health Intensive Care Unit.

This document is not intended to inform the planning and design of acute forensic units, residential supported accommodation and community based, non-acute mental health facilities.

This document should also be read in conjunction with the Australasian Health Facility Guideline (AusHFG) generic requirements and standard components described in:

- Part A: Introduction and Instructions for Use
- Part B: Section 80 - General Requirements and Section 90 - Standard Components
- Part C: Design for Access, Mobility, Safety and Security
- Part D: Infection Prevention and Control.

Additional AusHFG resources that complement this HPU include:

- HPU 300 Emergency Unit (which may be the first point of contact in healthcare facilities for mentally unwell consumers)
- HPU 155 Ambulatory Care Unit (which can be used to plan ambulatory / community services)
- Arts in Health Framework
- Culturally Sensitive Planning and Design.

1.3   POLICY FRAMEWORK

Before undertaking a project, planners and project staff should familiarise themselves with individual jurisdictional plans, regulations, policies, service specific guidelines, and reports. Some key documents include:

- Principles for the Protection of People with Mental Health Illness and the Improvement of Mental Health Care, United Nations, 1991

- The National Mental Health and Suicide Prevention Agreement, 2022

- National Safety and Quality Health Service Standards, Second edition – 2021, supported by:
  - o User Guide for Health Services Providing Care for People with Mental Health Issues, 2018
  - o Map of the National Safety and Quality Health Service Standards (second edition) with the National Standards for Mental Health Services, 2018
  - o User Guide for Acute and Community Mental Health Services, 2022

- Mental Health Statement on Rights and Responsibilities, Commonwealth of Australia, 2012

- Australian Government Productivity Commission Mental Health Inquiry Report, 2020

- A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers, Australian Health Ministers Advisory Council, Commonwealth of Australia, 2013

- A Case for Change: Position Paper on Seclusion, Restraint and Restrictive Practices in Mental Health Services, National Mental Health Commission, May 2015.

Jurisdictional policy information, where available, is contained in the Further Reading section of this HPU.

1.4   DESCRIPTION OF MENTAL HEALTH INPATIENT UNITS

Mental health inpatient units are an important component of a comprehensive mental health system and aim to provide environments that are safe, comfortable, therapeutic, support healing, culturally safe and responsive recovery-oriented care in the least restrictive environment possible. Mental health inpatient units will vary in size, target population (e.g., adult or child and adolescent), clinical presentations (e.g., sub-acute, acute, or intensive care) and admission type (e.g., voluntary, or involuntary).

The National safety priorities in mental health: a national plan for reducing harm (2005), lists some key principles that influence the planning and design of mental health inpatient units. These include:

- consumer and carer rights to dignity, respect, and privacy

- consumer and carer involvement in service planning

- a right to be treated in the least restrictive environment

- the environment provided for mental health services is safe for consumers, carers, families, visitors, and staff.

Planning and design of mental health inpatient units should support recovery-oriented models of service delivery. The Framework for Recovery-oriented Practice, published by the Department of Health Victoria (2011) describes this as mental health care that:

- Encourages self-determination and self-management of mental health and wellbeing.

- Involves personalised care that is responsive to people's unique strengths, circumstances, needs and preferences.

- Supports people to define their goals, wishes and aspirations. This involves a holistic approach that addresses a range of factors that impact people's wellbeing, such as housing, education and employment, and family and social relationships which support people's social and community inclusion.

Models of care will need to consider local jurisdictional directions and cultural requirements. For example, facilities in New Zealand (NZ) will need to consider Mātauranga Māori models of service delivery.

1.5   TERMINOLOGY

The terminology below is used throughout this document, however it is acknowledged that terminology varies between and within jurisdictions.

Admission: the act of transferring care from community or another environment to a specialised mental health service that provides 24-hour care in a psychiatric facility or a specialised mental health unit. Admission begins as soon as the individual arrives on the unit.

Anti-ligature design: refers to products that are designed with the purpose of preventing or reducing the risk of ligature attachment to the product to minimise the risk of self-harm. When this term is used in this document, it is expected the product will be of a type specifically manufactured and marketed as **anti-ligature / ligature resistant**, has been tested prior to installation or has a proven track record, and is installed in accordance with the manufacturer's instructions. The design documentation will also need to consider anti-ligature design in specifications and design details.

Arts: arts in health is a non-pharmacological approach to care, to support self-regulation, reduce medication use and improve rates of re-admission and/or length of stay in mental- and other -health services. As documented in the Arts in Health Infrastructure Framework, Arts in health infrastructure compromises two non-exclusive components:

- Creative projects that form part of the built environment such as public artworks and/or permanent cultural assets.

- Health real-estate for activation of creative and/or therapeutic arts programs.

Arts in mental health facilities may include but are not limited to engagement with one or more categories: performing arts, visual arts, design and craft, literature, culture, online, digital and electronic arts. The term "artworks" refers to creative products of all disciplines created through these engagements.

Carer: A person who cares for or otherwise supports a person living with mental illness. A carer has a close relationship with the person living with mental illness and may be a family member / whānau, friend, neighbour, or member of a broader community (The Fifth National Mental Health and Suicide Prevention Plan, 2017).

Consumer: In the mental health context, the patient is referred to as the 'consumer.' Some jurisdictions and projects may utilise alternative terminology, such as 'person' or 'person with lived experience', however where possible, this document and other related Mental Health HPU will use the term consumer.

De-escalation: The use of techniques aimed at defusing anger and averting aggression. This may include verbal and non-verbal communication skills and the use of medication administered with the consumer's consent. (Agency for Clinical Innovation, 2019). The function of a 'de-escalation area' is to provide a low stimulus room for consumers to access by choice if required with the view to avoiding the need for seclusion.

Discharge / Transition of Care: refers to the process by which the psychiatrist transfers or discharges a consumer to facilitate continuity of care. **Discharge** is the act of concluding an episode of care within an inpatient or other clinical setting. This may include handing over responsibility of the care to another service or care provider or discharge to a person's place of choice such as a community team, a general practitioner (GP), or the consumer's own home.

Transition of Care is the movement of consumer to another inpatient mental health facility or a community-based service under the care of other health professionals for continuation of care where the consumer's needs can be better met.

Involuntary treatment: refers to people who are compulsorily detained in hospital and/or treated in community services under mental health legislation for the purpose of assessment or provision of appropriate treatment or care (Australian Institute of Health and Welfare, 2023). **Voluntary patients** are those who provide informed consent for mental health assessment, treatment and/or admission and may discharge themselves at any time by informing hospital staff.

Mental Health High Dependency Area: a dedicated unit or zone (depending on the number of beds) within a mental health acute inpatient unit that provides for a higher level of observation. It should be capable of being secured from the acute inpatient unit as a separate pod, but able to be used as an unlocked facility at other times. A higher level of attention to building fabric and design of fixtures, fittings, and equipment will be required within this zone.

Mental Health Intensive Care Unit: a dedicated unit that provides specialist mental health services for the management and treatment of individuals with complex, high acuity, and severe behavioural disturbances associated with mental health illness, including drug and alcohol dual diagnosis. May also be referred to as a Psychiatric Intensive Care Unit.

Pods: physically distinct but flexible clusters of consumer bedrooms. Each pod may have their own dedicated and/or shared support areas, to enable cohorting of consumers according to their needs. The configuration of pods, number of beds and extent of shared support rooms will vary depending on the jurisdiction, consumers' needs and project requirements. Pods require staff visibility from a central zone and may or may not be closed off with swipe card access. Pods in mental health facilities are sometimes referred to as 'wings', 'units', 'clusters' or 'zones'.

Recovery: Recovery is understood to be more than reduction in clinical symptoms, and as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues (Commonwealth of Australia. A national framework for recovery-oriented mental health services: Policy and theory, 2013).

Restraint: Restraint is the restriction of an individual's freedom of movement by physical, chemical, or mechanical means. This applies to consumers receiving specialist mental health care regardless of the setting (National Mental Health Seclusion and Restraint Project 2007–2009).

Seclusion: the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave (Mental Health and Wellbeing Bill 2022). The use of seclusion is detailed in jurisdictional Mental Health Acts and policies.

Sensory modulation: Sensory modulation involves supporting and guiding people in using senses such as sight, sounds, smells, touch, taste and movement to self-manage and change emotional state. The use of sensory tools supports individuals to learn self-soothing techniques and change their current emotional and behavioural responses to a stressful situation. (Te Pou, 2023).

Trauma informed design: refers to design that consciously addresses the sensitivities and vulnerabilities of people who have experienced trauma. Spaces are created that promote feelings of psychological and physical safety, promote healing and recovery, and do not traumatise or re-traumatise a consumer.

1.6   OVERARCHING PLANNING AND DESIGN PRINCIPLES

The physical environment and ambience of an acute mental health inpatient unit will impact on consumer recovery, outcomes and the safety of those consumers and staff working within the service. This guideline provides overarching principles that seek to promote positive physical environments so that optimal recovery outcomes for consumers can be achieved.

Mental health inpatient units will also support the needs and activities of carers, families and friends, staff, peer workers, students, official visitors, and other stakeholders.

Design Principle	This may be achieved by
Co-design / Person-Centred The design is responsive to the needs of consumers, their support networks, and staff.	• Involving people with lived and living experience and their cultural representatives as equal partners throughout the entire planning and design process alongside clinicians, staff, and other experts.

Recovery Focus
 	
The environment promotes person centred recovery and wellbeing and supports consumer aspirations and goals.
	• Providing spaces that create a healing environment that can be used for therapeutic activities, entertainment, social interaction, education and activities of daily living.
	
	• Enabling consumers to personalise their space, express their own creativity, and have control over their environment by providing opportunities for patients to display pictures, stories, photos etc.
	
	• Supporting a holistic approach to the health and wellbeing of consumers by designing spaces that provide:
	   o access to activities, equipment and outdoor space, that promote physical, emotional and social wellbeing and alleviate boredom,
	   o natural light, pleasant external outlook, connection to nature and consideration of the sensory experience,
	   o clinical space that can be used for the assessment and treatment of physical and mental health.

Trauma Informed Design
 	
The design consciously addresses the sensitivities and vulnerabilities of people who have experienced trauma.
	• Creating spaces that promote feelings of psychological and physical safety, promote healing and recovery, and do not traumatise a consumer. This includes:
	   o spaces with clear sightlines and few barriers,
	   o spaces that are 'right-sized' for the proposed activities and expected number of participants,
	   o design that reduces the feeling of overcrowding,
	   o provision of spaces that allow privacy and support individuals to move to more appropriate settings if distressed,
	   o maximising natural light and access to outdoor / green spaces.
	
	• Inclusion of soothing and calming spaces that support sensory modulation and de-escalation.

Welcoming Environment The environment is welcoming, safe, and supportive for consumers, family, carers, supporters, and other visitors.	• Providing a non-institutional appearance, with an environment that has a residential look, feel and scale. • Providing a high-quality design and materials that communicates to consumers that they are valued. • Enabling physical and visual access to outdoor space as nature is inherent to good health and wellbeing. • Sizing and distributing the rooms appropriately to ensure the number of people in the space is not socially overwhelming.
Culturally Sensitive Design and Acknowledgement of Diversity	• Engaging and consulting with local Indigenous and other cultural representatives to ensure cultural practices and local needs are incorporated within the design of the facility.

Design Principle	This may be achieved by
Internal and external spaces are culturally and spiritually responsive, inclusive, safe, and welcoming.	• Including spaces that promote respect, diversity, and cultural safety in a sensitive, inclusive way. • Providing spaces to support whānau involvement (in New Zealand) & other cultural family traditions during the consumer's stay in the facility. • Including culturally appropriate environments including access to culturally responsive activities such as karakia (NZ).
Support Effective Relationships with Staff The design supports positive relationships and interactions between consumers and those who provide input into their care, working as partners in care.	• Promoting flexible use of spaces to meet the needs of the consumers. This may include spaces that provide for privacy, group activities, education, arts and other activities, physical activity, and social interaction. • Delivering staff spaces that have a direct consumer interface and are designed to support engagement and connection with consumers.
Foster and Maintain Meaningful Connections with Support Networks The environment encourages strong and continuous relationships with family, friends and other support people.	• Providing spaces that are comfortable, attractive and feel safe to encourage family, friends, children and carers to visit. • Supporting flexibility and choice of suitable spaces for small or large groups to meet and to allow for a diversity of needs. • Enabling family / carers to stay overnight, where required to support the model of care. • Providing appropriate spaces that support private meetings including consumer meetings with cultural supports, clinical staff, advocates, peer support workforce, employment support and lawyers. • Supporting access to phones and technology to maintain relationships.
Safe Environment The delivery of a safe and appropriate environment, that considers the physical, psychological, and cultural safety of all.	• Balancing the principles of choice and positive risk-taking and that of a duty of care and safety. Inpatient environments will accommodate a range of vulnerable consumers, and strategies to protect them must be considered. • Providing good sight lines for staff to internal and external consumer living areas and ensuring consumers can see and easily access staff. • Delivering flexible areas / zones that can readily respond to different consumer cohorts and individual requirements (e.g., separation of younger and older consumers in smaller facilities). • Providing spaces which ensure gender affirming signs and spaces. • Delivering consumer spaces that have anti-ligature fittings. • Providing spaces which enable use of least restrictive practice.
Staff Wellbeing Staff feel safe and supported with spaces away from the clinical environment to enable staff to relax.	• Providing an adequate number of appropriately sized and well-located staff workspaces. These spaces should consider the education and training needs of staff. • Providing appropriately sized and attractive staff break spaces to enable staff to refresh and rest so they can perform at their best and feel valued. • Providing staff spaces that are separate from consumer spaces.

HPU 131 Mental Health - Overarching Guideline, Revision 2.0, January 2024

02 PLANNING

2.1 OPERATIONAL MODELS

2.1.1 Service Configuration

A mental health inpatient unit may be located:

- in a stand-alone building on an acute hospital site, either as a single unit or as part of a dedicated mental health precinct

- as a dedicated unit within a hospital building

- located on another health-related site.

2.1.2 Bed Numbers

The number of beds provided in a mental health inpatient unit will vary according to the service needs identified in the service plan, the model of care, the role of the unit within the context of other mental health services in the region, required staffing ratios, and the need to ensure service delivery is safe, cost effective, and sustainable.

The design should enable larger units (e.g., 25 beds) to be subdivided into smaller operational 'pods' to provide a more therapeutic environment for consumers, to support gender safety and to enable cohorting of consumers with differing support needs, while retaining operational efficiencies.

In some circumstances, a smaller number of high dependency beds may be needed to manage a range of acute conditions and behaviours. This arrangement in pods will allow some key infrastructure, such as main entry, staff workspace and selected meeting rooms, to be shared.

It is also important to consider infection prevention and control planning to be able to cohort people into smaller clusters in response to a pandemic, as well as infectious cases and surges outside of pandemics.

Bedroom configurations in general units and high dependency 'pods' should also promote efficient staffing ratios.

For recommendations relating to each service type, refer to the service specific HPUs.

2.2 OPERATIONAL POLICIES

2.2.1 General

Operational policies impact on the capital and recurrent costs of a facility. The cost implications of proposed policies should be fully evaluated to ensure the most cost-effective solutions are provided.

Refer to AusHFG Part B: Section 80 General Requirements for further information.

2.2.2 Management of Acute Medical Comorbidities

Space should be provided to enable a range of medical related assessments and simple treatments (e.g., consult and treatment rooms). Consumers with complex medical conditions will be managed in general inpatient units.

2.2.3 Medication Management

A medication room is required for secure storage of medications. A combined medication and clean store space may be considered depending on local jurisdictional policy. Systems for administering medications may vary and may include the use of mobile trolleys (traditional or electronic) that provide medications to each consumer within the unit in various locations.

2.2.4 Arts Materials and Implements

Secure storage space is required for storage of arts materials and specialist equipment e.g., larger musical instruments.

2.2.5 Electroconvulsive Therapy (ECT)

ECT and recovery should only be undertaken in a day procedure unit, operating unit or dedicated and fully equipped ECT suite, either within an acute hospital campus or within a mental health complex, depending on jurisdictional requirements. Facilities for ECT are not addressed in this HPU.

Refer to jurisdictional policies for further information.

2.2.6 Medical Emergencies

Medical emergencies will be managed in accordance with local arrangements. A resuscitation trolley and portable suction and oxygen should be readily available in a secure staff only area such as the staff station or treatment room.

2.2.7 Firearm Security - Police

Requirements will vary depending on jurisdiction specific firearm acts, regulations, and policies.

Police officers accessing the mental health inpatient unit should have the ability to disarm at the entry and store weapons and related equipment within a gun safe. The local area command (LAC) should be consulted in firearm security during the planning and design phase.

2.2.8 Medical Records

Health services increasingly use an electronic patient record, therefore networked computer access and the supporting information technology (IT) infrastructure will be needed throughout the unit.

A mobile Wi-Fi enabled IT solution, such as workstation on wheels or portable laptop / tablet, also promotes interactions between staff and consumers.

2.2.9 Seclusion and Restraint

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommends minimising and, where possible, eliminating the use of seclusion and restraint for consumers with mental illness or disorder (2021).

RANZCP recommend ensuring people with lived and living experience of mental health conditions are involved in designing policies, frameworks, and spaces for best methods to minimise the use of seclusion and restraint in mental health services (2021). The unit should ensure safe and culturally appropriate staffing levels to support de-escalation.

A first line of strategy is self-management / increased self-determination, usually undertaken in a range of spaces accessible within the inpatient unit (e.g., quiet, activity and sensory modulation spaces). De-escalation strategies provide an opportunity for the consumer to separate for a period of time from others. This can be done within a segregated area of the inpatient unit.

For further information refer to:

- seclusion room requirements (refer to Standard Component)
- jurisdictional policies and legislation on seclusion and restraint.

2.2.10 Sexual Safety

Health services have a duty of care for all consumers who may be particularly vulnerable, have experienced past trauma, and be at significant risk of further trauma. The layout of the physical environment, and protocols regarding its use, must support the sexual safety of all consumers. For further information, refer to jurisdictional policies.

2.2.11 Smoking, Vaping, and E-cigarettes

In most jurisdictions, healthcare campuses are designated smoke-free areas. Supports will be put in place to assist the consumer during their stay.

Refer to jurisdictional policies for further information regarding smoking.

2.2.12 Families / Carers / Supporters

Maintaining a strong and continuous relationship between consumer and family / carers / supporters is important in the therapeutic recovery model in a mental health service.

Spaces such as Family / Carer Lounge will be provided within the unit whilst other spaces, such as overnight rooms for rural consumer supporters may be provided as part of the facility or in a nearby location.

The family / carer space provided in the unit will be dedicated to family, carers, and supporters. The needs of users, cultural considerations, as well as the needs of visiting young children will be important considerations in the design of this space.

Local jurisdictional policies and the consumer cohort needs will determine the provision and operation of these spaces. For NZ refer to Pae Ora Act for additional information regarding local requirements such as whānau room.

2.2.13 Staffing

Staff work as a multidisciplinary team and may include, in a permanent or visiting capacity:

- administrative staff
- allied health staff
- cleaning, maintenance, and food services staff
- medical staff
- nursing staff
- other support workers (including but not limited to, Art Therapists, Music Therapists, Aboriginal, Torres Strait Islander and Māori health workers, and Alcohol and Other Drugs staff)
- peer support workers
- security and other emergency response staff.

Visitors, official visitors, mental health advocates, case workers, and students should also be considered when assessing staff facilities and visitor amenities. Local jurisdictional policies should be referred to when planning staff workspace.

2.3 PLANNING MODELS

2.3.1 Location

Consumer access to attractive, safe, and risk assessed outdoor areas is a major consideration when planning mental health inpatient units. Increasingly, land availability on acute hospital sites is limited, particularly in metropolitan areas. While a ground floor location provides easy access to outdoor areas, it may lack privacy and be overshadowed and overlooked by adjacent buildings.

Units provided in upper levels of a building also need a safe and risk assessed outdoor area. It may be easier in this scenario to provide outlook and privacy from a courtyard area. Screening should be safe and secure while enhancing the outlook and ambience of the space.

Units that are part of a general healthcare facility should be located to facilitate the movement of staff and consumers to and from other units (e.g., ECT suite, medical imaging services). The location of the unit should allow discreet, non-public transfer of consumers from the emergency department and rapid responses in emergencies.

2.3.2 Shared Facilities

There may be opportunities to share facilities where several inpatient units are collocated. For example, a single main public entry may be provided, or selected staff areas and amenities shared. The designated formal hearings rooms and meeting rooms may also be shared but should have ease of access from, and be in close proximity to, all consumer, visitor, and staff areas.

The provision of gender neutral / unisex amenities should be considered as an option in addition to gender specific facilities. These facilities should address the environmental, physical, cultural and social needs of all individuals who access the facility.

Where a group of services is collocated in a mental health precinct, each service should have its own recreational and therapeutic outdoor area. Sharing of facilities should not compromise the ability of staff to supervise consumers and provide therapeutic care in either zone, nor compromise the safety and security of consumers, carers, staff, and visitors.

2.4 FUNCTIONAL AREAS

A mental health inpatient unit will broadly accommodate the following functional zones:

- main entry

- reception and waiting (this will include a meeting room used for Tribunals)

- admission & discharge and assessment rooms (e.g., consult and/or interview rooms)

- consumer areas:

  o single bedrooms with dedicated ensuites that may be configured into separate pods (with consideration for bariatric and accessible consumer bedrooms and ensuites)

  o communal living and activity areas including sensory modulation

  o therapy and treatment areas

- family / carer / supporter spaces

- visiting areas

- clinical treatment areas including seclusion and/or de-escalation suite (where provided)

- outdoor areas

- clinical and non-clinical support areas

- staff areas including workspace and amenities.

Other additional considerations for the functional zones includes:

- A secure entrance for emergency vehicles such as ambulance or police vehicles may also be required. The secure entrance will provide a warm welcoming space and have easy access to a de-escalation space.

Refer to service specific HPU for further information.

2.5 FUNCTIONAL RELATIONSHIPS

2.5.1 External

Mental health inpatient units should consider timely access to emergency services in the event that a transfer of a consumer to and from the service be required. Access for stretchers and emergency vehicles are important considerations during planning.

Mental health inpatient units located on a hospital site will need easy access to a range of services such as medical imaging and operating theatres (for ECT).

Refer to service specific HPUs for details relating to each service as this may vary depending on the service acuity and location.

2.5.2 Internal

The entry, reception, and waiting area should act as a secure access control point to inpatient areas. Where possible, consumers will enter via the main entry although a secure emergency entrance is required in most acute inpatient environments.

Consumer areas will be arranged so that bedrooms are separated from communal areas to reduce noise and make observation easier. Access to secure outdoor areas should be provided from communal areas of the unit.

Separate consumer and selected clinical support will be required for high dependency areas provided as part of an acute mental health inpatient unit. In small units, it may be possible to share some infrastructure, such as a staff station, to better utilise staff resources. The seclusion and/or de-escalation suite will be located adjacent to the high dependency area. A secure entrance, for emergency vehicles such as ambulance or police, will provide quick and direct access to the seclusion and/or de-escalation suite and the high dependency area. Refer to local jurisdictional policies on seclusion and de-escalation rooms use for additional information.

Clinical support rooms and spaces should only be accessible by staff. Selected rooms and spaces accessed frequently by clinical staff need to be located so that significant staff time is not lost travelling between them and engagement with consumers is not compromised.

Staff workspaces and amenities should only be accessible by staff and while they can be located adjacent to other areas of the unit, staff should not have to travel through clinical areas to access this space.

03 DESIGN

3.1 ACCESSIBILITY

3.1.1 External

The mental health inpatient unit requires a dedicated main entry for consumers, their families, carers, and staff if located in a stand-alone location.

A separate and secure entry point for consumer admissions, such as police-assisted transfers, may be required for select acute services.

Refer to Section 2.5 Functional Relationships for further information.

A separate access point may be required, depending on the scale and location of the facility, for the delivery and removal of food, linen, supplies, and waste. Access will be controlled by staff.

3.1.2 Internal

Where several units are accommodated within one building, travel should not occur through other units in the facility.

3.2 PARKING

Parking requirements include:

- all weather drop-off at the main entrance (where provided as a stand-alone facility)
- nearby accessible parking
- parking for logistics vehicles
- short-term parking for emergency services vehicles, out of hours community / crisis teams, judges and district inspectors as required by the local jurisdiction.

Should the facility be located on a larger healthcare site, visitors will typically access visitor parking on site.

For staff parking, refer to AusHFG Part C: Section 6.0 Safety and Security.

3.3 DISASTER PLANNING

Mental health inpatient services need to be included in the broader disaster planning for the health service.

Refer to AusHFG Part B: Section 80 – General Requirements for further information.

3.4 INFECTION PREVENTION AND CONTROL

Infection prevention and control risks differ to those in acute medical and surgical inpatient environments. Measures should be commensurate with consumers that are generally ambulant and self-caring, however, hand hygiene, environmental cleaning, and surface and finishes selections, including artwork surface finishes in relation to displayed artworks, are important. The flexible cluster configuration in mental health inpatient units may also inherently assist in the prevention of infection transmission throughout the unit by assisting with separation of pods. During infection outbreaks, physical separation as well HVAC control to designated pods may be implemented.

Project team and staff must refer to jurisdictional policies relating to infection prevention and control in mental health units. Operational practices may be established instead of installing dedicated building elements to provide hand hygiene products. Alcohol-based hand rub will be mounted in staff only areas. Clinically approved alternative preparations may be used in consumer areas that reduce risks associated with ingestion of the product.

Sensor taps should be used on clinical basins in areas accessible to consumers as they reduce risks associated with tapware.

Refer to:

- AusHFG Part D: Infection, Prevention and Control

- AusHFG Pandemic Preparedness – Health Infrastructure Planning and Design Guidance

- jurisdictional policies.

3.5 ENVIRONMENTAL CONSIDERATIONS

An attractive, comfortable, non-institutional, and safe environment will impact positively on consumers, visitors, and staff. The design of the environment will address the sensitivities and vulnerabilities of people who have experienced trauma.

3.5.1 Scale

An appropriate scale in mental health inpatient units will assist in creating a safe and therapeutic environment as it increases in size. Scale can be achieved by:

- designing spaces that facilitate consumer choice (e.g., provision of smaller private areas, mid-sized semi-communal, and a large communal area or areas)

- clustering bedrooms into 'pods' rather than large wings

- avoiding overcrowding by planning space to accommodate the expected number of users

- separation of zones such as bedrooms from communal activity areas

- a simple layout which reduces the need for signage.

3.5.2 Acoustics

Effective management of noise levels will improve the therapeutic nature of the environment and promote a sense of calm and a feeling of safety.

Ceiling heights, wall and door construction, furnishings, and finishes need to be specified to optimise the acoustic environment and reduce unwanted noise.

Areas requiring special attention include consult, treatment, and interview rooms. Bedrooms should be located away from larger communal areas.

In acoustically treated rooms, return air grilles should also be acoustically treated to avoid transfer of conversations to adjacent areas. Door grilles should not be installed.

Emergency and communication systems (e.g., duress or nurse call), should be installed in a way that does not generate disturbing noises. Alternatives include linking these systems to phones or pagers or utilising other alert systems such as lights.

Consideration should also be given to acoustic treatments, such as carpet, in communal areas of a mental health inpatient unit to help reduce noise levels.

3.5.3 Lighting

A well-designed lighting scheme, both natural and artificial, will improve the amenity, therapeutic environment and safety of the mental health facility. Lighting systems should provide a pleasant, calming, and domestic style approach where possible.

The use of natural light should be maximised in consumer and staff areas while avoiding shadow and glare. Too much direct sunlight can adversely affect consumers with medication-related photosensitivity or neurodiversity. Consideration should be given to how the lighting is controlled within communal areas as different consumers have differing needs regarding lighting. Consumers should be able to control the light, both natural and artificial, in their bedrooms.

Modern lighting systems can be programmed to change colour cast throughout the day to support the natural sleep and wake cycle. Darkness should be maximised at night to enhance sleep. Night lighting is recommended in bedrooms as consumers may experience sleep disturbances. This lighting will be locally controlled and should facilitate discreet observation by staff. For increased sexual safety the use of motion sensor lighting is to be considered. Night lights may also be provided as a fall prevention strategy. If provided, they should be positioned so as not to disturb sleep. Low-level wall lighting (300mm from the finished floor level) with light projected towards the floor should be considered in bedrooms and corridors to illuminate the floor and maintain low levels of lighting at night for consumers and staff.

The inclusion of integrated blinds to consumers' bedroom windows is one option for managing external light and privacy.

Refer to Section 3.9.11 for information on lighting furniture, fittings and equipment (FFE).

3.5.4   Interior Design, Arts & Restorative Environments

Interior Design

Décor should be contemporary and provide visual interest and promote a welcoming, warm and therapeutic atmosphere.

The selection of FFE, colour, artwork, and other decorative images in mental health facilities may vary depending on particular areas within a unit and should aim to eliminate an institutional feel and provide a home like environment. Local consumers groups should be encouraged to participate in the co-design process for these items among others to assist with informing the most appropriate interior décor for the facility.

Some patterns, such as lines or grids, should be avoided as they can generate optical and kinaesthetic illusions. Similarly, shiny or reflective surfaces should be avoided. Provision must be given to continual improvement, upgrades and maintenance of the built environment décor.

Arts

Artworks, music and dance, literature and other modes of self-expression are an important feature of a mental health inpatient facility, recommended to be professionally curated and artist led.

Thoughtfully selected and displayed artworks can create an inclusive, more welcoming environment, reducing the institutional feel and promoting a sense of wellbeing, cultural safety, representation and social connectedness to improve peer support.

Artworks can define functional areas, support wayfinding and provide therapeutic support to the consumer demographic, for escalation or de-escalation of behaviours.

Successful arts interventions in mental health settings include calming imagery to hold imagination for extended periods of time. Avoiding highly detailed abstracted imagery and portraits, highly reflective surfaces, violent, sharp red geometrics or swirling vortices is recommended.

For further information, refer to AusHFG: Arts in Health Framework.

Sensory Environments

The aim of multisensory environments is to stimulate positive emotions, down-regulate negative emotions, provide relaxation benefits, and enhance feelings of control and choice.

Their design typically includes some of the following: pastel-coloured walls, a massage chair, beanbags, bubble columns, light projectors, sound machines, aromatherapy diffusers, and weighted blankets.

Sensory materials and/or experiences are particularly important in sensory modulation rooms. It is impactful when they create a sense of infinite space through the use of blackened rooms and ambient light, music, hard and soft chairs / recliners, to create the sense of being in a totally different world from the clinical ward. This intervention reduces medication and improves speed of self-regulation.

3.5.5 Privacy

A major challenge in the design of inpatient accommodation is the need to ensure consumers and staff can see each other, while also ensuring consumer privacy.

Strategies to enhance consumer privacy include:

- provision of single bedrooms with dedicated ensuites

- ability of the consumer to control access to their bedroom (with staff able to over-ride access in the event of an emergency)

- integral viewing panel with privacy blinds that consumers can control (with staff override)

- acoustic treatment

- provision of, and access to, private spaces for consumers to meet with family, friends and visitors (with consideration given to the inclusion of facilities for overnight stay where required)

- design to allow areas that can be separated for dedicated use by consumers, if necessary

- discreet location of high dependency area and quiet rooms

- reduced vision into the unit and its outdoor spaces, from public areas.

The provision of separate staff areas within the unit will enhance privacy for staff to undertake confidential work and hold meetings. Staff rest areas, such as staff rooms, should be located away from main consumer areas within the unit.

3.6 SPACE STANDARDS AND COMPONENTS

3.6.1 Human Engineering

Human engineering covers those aspects of design that permit effective, appropriate, safe, and dignified use by all people, including those with disabilities, bariatric needs and older consumers. Consideration should be given to the width of beds, corridors and storage spaces for lifters and other mobility equipment.

Refer to AusHFG Part C: Section 04 Human Engineering for further information.

3.6.2 Ergonomics

The build and design of the unit should not expose consumers, staff, visitors, and maintenance personnel to risks or injury.

Refer to AusHFG Part C: Section 04 Human Engineering for further information.

3.7 SAFETY AND SECURITY

3.7.1 General Principles

A safe and secure environment in mental health inpatient units is more likely to be achieved when a combination of security and additional measures are well understood and incorporated into planning and design so that the unit provides a therapeutic environment and is both safe and feels safe.

Perceptions of safety are equally important for consumers and staff however, it is important not to over rely on or over design the security aspects of a facility, so that it becomes overly overt and non-therapeutic.

The dimensions of security, as described in the UK Department of Health's Health Building Note 03-01 Adult Acute Mental Health Units (2013), include:

- Relational security which is defined as 'the knowledge and understanding that staff have of a consumer and of the environment, and the translation of that information into appropriate responses and care'.

- Procedural security which relates to the 'proper application of a set of procedures, routines and checking.' This ensures safe practices are 'embedded and applied in a consistent way'.

- Physical security which relates to the design of the unit. Where possible, security should be unobtrusive and part of the building fabric.

The layout of the unit should assist staff to carry out their duties safely to supervise consumers by allowing or restricting access to areas in a manner which is consistent with consumers' needs and abilities. Staff should be able to observe consumer movements and activities as naturally as possible.

Safety and security considerations should be incorporated into early planning and ergonomic design so that all safety and security measures enable, support, and enhance the operational needs of the facility without being overly obtrusive or overt. The adoption of a risk management and harm minimisation approach is essential, and a risk register should be maintained. This will promote operational and design solutions that reduce or eliminate the institutional feel of the facility and the need for overt security features (e.g., CCTV) where they are allowed by the Australian or New Zealand Mental Health Act.

All consult and interview rooms should have two points of egress with doors opening in the direction of egress. Furniture arrangements should encourage informal discussions whilst not obstructing staff exit routes.

A risk assessment should identify the level of risk associated with each zone / area across the unit and should considerate the activities expected to be undertaken within and between areas. An example of the delineation of unit zones by different levels of risk is shown in the table below:

Risk	Zone
High	Individual consumer access rooms, such as seclusion rooms, bedrooms and ensuites.
Moderate	Shared consumer access areas, such as lounge and interview rooms.
Low	Non-consumer access areas, such as staff room.

Consideration of safety and security risks should continue to be addressed and reviewed during the construction, commissioning, and post occupancy stages.

For additional information, refer to:

- AusHFG Part C: Section 06 Security

- National Safety and Quality Health Service (NSQHS) Standards (second edition) with the National Standards for Mental Health Services (NSMHS).

The following information will address physical security aspects.

3.7.2   Reducing harm

During the planning and design of new mental health facilities, the project team (including clinical staff) should conduct reviews of architectural plans, prototypes, specifications, and products at key decision stages to identify, minimise and/or eliminate risk.

Anti-ligature design and products are also used as strategies to reduce harm and are covered in more detail in the following section.

3.7.3   Physical Safety Requirements

Anti-ligature / ligature resistant design

There is currently no consensus on the definition of anti-ligature in Australia therefore there is no available accreditation or certification of anti-ligature products for use in mental health facilities. To reduce risks and minimise harm, all fittings and fixtures used in consumer areas of the building should be:

- selected following a risk assessment

- selected appropriate to the level of risks

- evaluated and compared to jurisdictional and accreditation requirements

- reviewed and tested by the staff in conjunction with the project team or demonstrated to have a proven track record

- selected based on latest peer-reviewed information & resources

- compared with other anti-ligature products like per like

- analysed based on supplier product claims and testing results

- assessed with consideration of capital, maintenance, and operational costs

- installed in accordance with the manufacturer's instructions.

Architects and designers should focus on a design that eliminates and reduces areas of risk in terms of ligature. A risk zoning and ligature risk assessment should be undertaken by every facility The level of risk will inform the level of anti-ligature requirements that are to be incorporated into the unit. Not all products in consumer accessible areas require anti-ligature design. For example, although mental health units typically seek to provide solutions to minimise risk, a balanced approach to design is required on Older Peoples Mental Health Units to optimise safety and independence.

Products that are marketed as anti-ligature include, but are not limited to, window and door hardware, hinges, hooks, plumbing, curtain rails, artworks and bathroom fixtures. In some circumstances, the item may rely on a load release system where the item gives way when its maximum load bearing capacity (typically 15kgs) is exceeded (e.g., curtain rail). Other anti-ligature items are fixed but designed in such a way as to prevent a ligature being attached to them.

The project team and the health service must satisfy themselves that, as well as meeting the specific performance specification, load release items do not become a hazard (e.g., a heavy magnetised curtain rail with a breaking strain of 15kgs is capable of being used as a weapon).

Anti-ligature design and products will often mitigate rather than eliminate the risk and therefore additional operational responses are needed, including:

- staff training (to ensure known environmental risks are understood)

- clinical risk assessment and management

- routine inspection and testing (to ensure safety systems and equipment are in good working order)

- special arrangement with maintenance (to ensure anti-ligature replacement and maintenance is upheld)

- ensuring strategies are in place to monitor and prevent potentially dangerous items being brought into the inpatient unit by consumers, family, carers or friends.

For further information on anti-ligature FFE refer to Section 3.9 Furniture, Fittings and Equipment.

It is acknowledged that retrofitting of anti-ligature fittings in older mental health facilities to align with AusHFG recommendations can be a challenging and expensive process. It is important that a risk assessment is conducted to ensure that retrofitting is done in a manner that will result in the reduction of ligature risks and not present additional difficulties relating to maintenance issues or breakage leading to potential harm.

Refer to Access Control in Section 3.10.7.

3.7.4 Observation and Communications

Therapeutic relationships between staff and consumers are essential. Creating an environment where staff and consumers can see each other and removing barriers to communication can have therapeutic benefits. Enhancing opportunities for communication builds trust and rapport and promotes social interactions. Design can positively contribute while ensuring the safety of consumers, visitors and staff is maintained.

Arrangement of Staff Spaces within a Clinical Unit

Where possible, staff areas such as staff bases, or stations should not be a barrier to communication with consumers and visitors. Open staff / consumer interface areas are preferred with minimal or no use of security glazing, where the approach is supported through risk assessment. This enhances staff and consumer engagement and facilitates clinical observation.

The safety of staff must never be compromised during consumer engagements and observation. The safety and security of staff working in these open areas are paramount whilst continuing to provide a therapeutic engagement opportunity for consumers who view these areas as the central point for engaging with staff. The discussions during early stage of planning should involve mutually agreeable extents of barrier designs and systems to protect staff and allow them to retreat to a relatively safe position before or at the onset of consumer aggression.

Staff will need access to an adjacent workspace or clinical workroom that provides a quiet, secure, and private location for phone calls, writing up clinical notes, discussions, and storage of equipment such as duress, mobile duress hardwired back-up system, bedroom residual-current device (RCD) switch panel and fire mimic panel. This room will also provide a location for staff to retreat to in the event of a security incident.

General Observation

Ensure ease of observation for staff to permit continuous monitoring via:

- a line of sight from staff station or bases to common areas such as communal lounge, dining, activity, consumer corridors and outdoor areas

- inclusion of vision panels to seclusion rooms, consumer bedrooms, meeting, and interview rooms

- inclusion of video intercom systems monitored from the staff station (to ensure external key entry points are observed so that visitors to the unit can be managed out-of-hours)

- minimising, and where possible eliminating, blind spots during design. Where this cannot be achieved, framed infilled parabolic mirrors to observe blind spots should be utilised.

Refer to Section 3.10.8 for CCTV Surveillance and Section 3.10.9 for Duress Alarm Systems.

3.8 FINISHES AND BUILDING ELEMENTS

3.8.1 Building Strategies

Building elements include walls, floors, ceilings, doors, windows, and corridors.

Architects, designers, artists, engineers, and builders should recognise and understand that the fabric utilised in a mental health inpatient unit needs to be significantly more robust than in other healthcare units. Particular attention should be given to walls, doors, ceilings, and glazing, both in terms of acoustic management and the potential for damage, self-harm, and potential for use as weapons. A robust finish will reduce maintenance costs over the life of the facility.

Selection of materials or fixtures should also consider ease of replacement or repair. Consumers and staff repeatedly comment that the quality of the construction and finishes, and the lack of timely building maintenance, can have a real impact on the atmosphere of the unit.

The performance specification for each finish may vary depending on the type of environment. For example, a seclusion room, high dependency area, or mental health intensive care unit will require

a higher level of robustness compared with lower risk environments or those continuously observed by staff.

3.8.2   Ceiling Finishes

A thorough, well-documented risk assessment should be undertaken by the project team prior to selecting ceiling finishes.

Risk	Zone	Features
High	High risk areas including individual consumer access rooms, such as seclusion rooms, bedrooms and ensuites.	• Ceilings to these areas should resist damage and prevent consumer access to roof spaces. They will be constructed from solid sheet impact resistant plasterboard. • Ceiling heights must be 2,700mm minimum. • The structural integrity and detailing of both ceilings and the various components routinely fixed within them such as air conditioning outlets, lights and fire detectors should be anti-ligature type, ideally flush mounted and tamper resistant. Installation must not create weak points that may provide access into the ceiling space. Mechanical fixings should be securely fastened and tamper proof. • Access panels should be located outside of high-risk areas, including bedrooms. Where Wi-Fi installation requiring access panel is required in bedrooms, risk assessment needs to be undertaken. • Consideration given to additional escape proof material, attached to the plasterboard, may be indicated where observation is difficult.
Moderate	Shared consumer access areas, such as lounge and interview rooms.	• Ceilings to these areas should resist damage and prevent consumer access to roof spaces. They will be constructed from solid sheet plasterboard. Where carpet or other soft furnishings are not used, solid sheet acoustic rated ceiling should be considered to avoid noise transfer. Ceiling tiles may be considered in rooms accessible by consumers where they are accompanied by a staff member. • Ceiling heights must be 2,700mm minimum. • The structural integrity and detailing of both ceilings and the various components routinely fixed within them such as air conditioning outlets, lights and fire detectors should be anti-ligature type, ideally flush mounted and tamper resistant. Installation should not create weak points that may provide access into the ceiling space. Mechanical fixings should be securely fastened and tamper proof. • Access panels should be located in rooms that can be locked or when in use are actively supervised by staff.
Low	Non-consumer access areas, such as staff room.	• Ceiling to these areas can be constructed from plaster board or ceiling tiles.

Refer to AusHFG Part C Section 3.0 Amenity, Safety and Design Tolerances for further information.

3.8.3 Floor Finishes

Refer to jurisdictional policies regarding local approaches to floor finishes. The selection of floor finishes can positively influence the ambience of a mental health inpatient unit and reduce unwanted noise.

Non-slip flooring is required in wet areas and slip resistant in other areas. Consider the use of acoustic vinyl in consumer accessible corridors, activity rooms, dining rooms and areas subject to heavy use. Carpet can be used in lounge areas, interview, meeting and group rooms, and staff workspaces.

3.8.4 Wall Construction and Finishes

Type	Performance	Considerations
External	• restrict unauthorised access or egress • should be vertical and detailed to make climbing difficult (e.g., no projections to be used as a foothold).	• type of material used • height of wall in relation to the facility roof.
Internal	• should be vertical and detailed to make climbing difficult (e.g., no projections to be used as a foothold) • in consumer areas, particularly high-risk areas, should be able to resist significant assault • washable • resistant to physical impact • vinyl joins must be welded • wall partitions should be taken up into the ceiling space to reduce the transmission of sound between rooms where acoustic privacy is required or where noise is generated such as between a utility room and quiet room.	• strategies for increasing impact resistance should be assessed by the project team and may include: ○ type of material used ○ use of plywood behind the wall ○ smaller distance between the wall studs.

Refer to AusHFG Part C Section 3.0 Amenity, Safety and Design Tolerances for further information.

3.8.5 Corridors

All corridors, with the exception of those in staff only areas, should have a minimum clear width of 2000mm. Where hand or bumper rails are installed, the minimum clear width is rail to rail or bumper to bumper.

Where hand or bumper rails are installed in consumer accessible areas, these will be anti-ligature type, fixed in line with the manufacturer's specification, and have rounded edges.

3.8.6 Doors

Doors and door hardware are complex fittings to review in relation to consumer accessed spaces within a mental health inpatient unit as there will always be a number of rooms that will need doors for privacy, safety, and security and most doors will have potential ligature points. Any door that is operable in any direction will have potential ligature issues that may be difficult to design out. There is currently no national guideline for door standards in mental health. Careful detailing of the door, door frames, and associated hardware within a mental health inpatient unit is important to ensure a safe and secure environment is provided. Doors within the bedroom suite, especially the ensuite door, present a high risk and therefore attention to detailing the door hardware is essential. In general, doors will be solid core with standard height in all areas within the unit or those on a perimeter or to secure zones.

Bedroom doors require vision panel of sufficient size to enable staff to easily view room perimeter. Vision panel require privacy blinds that patients can control but staff can override.

Zone/Room	Features
Bedrooms	• Require higher levels of performance. • Single leaf, fitted with all anti-ligature hardware, including a shrouded, continuous anti-ligature hinge and the ability to be outward opening to enable staff access in the event of an emergency. • Include a mental health designed viewing panel in high dependency and acute areas. Requirement for viewing panels in sub-acute bedrooms to be determined by a thorough, well documented risk assessment by the project team.

Seclusion Room	• Doors within this room require higher levels of performance as detailed below:
	    ○ Single leaf and outward opening to 180°.
	    ○ Wide enough to admit a consumer with at least two escorts (refer to AusHFG Seclusion Room Standard Component).
	    ○ Robust, solid, with impact resistant construction
	    ○ Door frames should be sturdy enough to resist repeated targeted levels of force.
	    ○ At least four door hinges, which should be recessed, and pins protected to prevent removal.
	    ○ Door locks are multipoint, heavy duty, quickly secured and released, able to withstand a considerable amount of repeated and targeted force, and resist breakage.
	    ○ Include a viewing panel but this should be specified to resist being damaged or broken.

Ensuite	• Should open outwards.
	• Should be able to be opened quickly in an emergency without the use of special tools.
	• Door type for these high-risk areas should be considered after a robust risk assessment has been undertaken. Types of doors may vary based on jurisdictional policy, and project teams should explore innovative solutions and review lessons learnt within their own and other jurisdictions. Examples of door types include:
	    ○ angled cut downs – may be provided at the top of the door, or top and bottom
	    ○ ligature alarm doors
	    ○ commercial grade sliding doors
	    ○ cavity sliding doors
	    ○ leaf / magnetic doors
	• Whilst ensuite doors present the most significant risk, they are important in ensuring consumers feel a sense of normalcy, feel protected and offer a sense of privacy, and this should be considered when selecting door type.

Toilet (shared access)	• Should not open directly onto communal areas and should be outward opening.

Refer to the relevant AusHFG standard components for additional information.

Other general considerations include:

- Aluminium acoustic door seals should not be used on doors in consumer areas as these can be removed.

- Taking care with the design of inward opening doors. If double-hinged with removable stops to enable outward opening in an emergency, the room acoustics may be compromised.

- Consideration of specifying whole door systems instead of separately specifying and procuring doors, associated hardware, and other components.

- Anti-ligature door hardware needed on all consumer accessible doors with special attention given to those in bedrooms and ensuites.

Refer to AusHFG Part C: Section 3.0 Amenity, Safety and Design Tolerances for further information.

3.8.7 Shutters

Alternatives to shutters are preferred wherever possible. The use of shutters to secure selected areas (e.g., servery and consumer accessible beverage bays) can create a harsh commercial feel to the environment.

Where shutters are used to secure selected areas, Work Health and Safety (WHS) requirements to be considered include:

- Shutters should be motorised rather than manually operated.

- Locks on shutters located so that staff do not have to stoop to unlock.

- Should be sturdy and impact resistant.

3.8.8 Windows and Glazing

Access to natural light and a pleasant outlook contribute to the positive ambience of a mental health inpatient unit.

External windows in consumer bedrooms should allow for a consumer to see the outside from their bed.

Careful attention is needed to the design of windows, their fixings, and hardware.

Toughened laminated security glazing is recommended in all areas occupied by consumers. A thorough, well-documented risk assessment should be conducted by the project team and security professional to ensure the right glazing product is chosen for each situation. For example, high risk areas may use a security glass where both the glass and laminate are thicker. Consider the action of the glass if broken to reduce the risk of harm to consumers and staff. The management of maintenance and repair if a pane is broken should also be considered.

Polycarbonate should not be used as it suffers from surface scratching and deteriorates, thereby reducing vision.

In areas where damage to glass may be anticipated, large panes should be avoided as smaller panes are inherently stronger for a given thickness than larger panes.

Windows in the building façade should be a minimum of 600mm AFFL and this is especially important where mental health units are included as part of a multistorey building.

In consumer areas, all window frames should be heavy duty (commercial frame) construction, fixed from the outside, and securely fixed to the wall fabric.

Opening windows in bedrooms present a ligature risk and this should be carefully considered by design and clinical teams. Closed windows are preferred. Where provided, opening windows should be designed so that they will not allow egress, passing of contraband, and locks will be managed by staff. The window system and hardware will be a purpose designed assemblage suitable for the context.

Fly screens, attached to openable windows, should be secured so they cannot be removed by consumers but should be removable by staff to allow window cleaning.

Privacy of consumers in the room from outside should also be considered. For units built over multiple levels, consideration must be given to appropriate glazing that ensures privacy of those accessing areas on lower levels, particularly courtyards / outdoor patient areas.

3.8.9 Outdoor Areas

Outdoor areas, ideally with views, are integral components of a mental health inpatient unit and are essential to the consumers' recovery and wellbeing. These areas provide opportunities for social engagement, reflection, and form a safe and therapeutic part of the service. Murals may also be

included in outdoor areas to provide a distraction and minimise the custodial appearance of the space.

Allowances for outdoor spaces should be included in schedules of accommodation. Project teams should consider the distribution and number of outdoor spaces depending on the consumer cohort and model of care. Consider line of sight and staffing numbers required for consumer supervision when planning outdoor spaces.

Outdoor areas should be comfortable and provide all-weather access, balancing open and undercover areas where possible. Outdoor spaces should allow for a range of activities, such as walking, sitting, quiet reflection, creative practice, gardening, and other outdoor activities. Spaces should be codesigned with consumers to ensure the space meets the needs of local consumers.

Landscaping is essential for promoting a feeling of space and tranquillity and connection with nature. There are many imaginative solutions available for creating a special area for consumers, visitors, and staff such as herb or flower gardens.

Landscaping and planting elements should be assessed for risks. Ensure vegetation does not include plants that are noxious / poisonous or tall trees that may provide ligature points. Physical elements such as furniture, garden structures, outdoor lighting, watering systems, artwork and other elements should be risk assessed for ligature points similarly to indoor environment.

Separate courtyards or terraces should be provided for general use and the high dependency area. Outdoor spaces should be accessed via communal areas, such as the lounge, dining and activity spaces and be visible from the staff station. Outdoor areas for general use should have multiple entry and exit points as they relate to areas / zones of the facility to ensure different groups can utilise these areas safely and staff have multiple egress points.

Outdoor areas may be fully enclosed by buildings (courtyard) that act as perimeter security, or open-ended, requiring perimeter walls or fencing. Perimeter fencing is discussed in more detail later in this document.

The project should undertake a risk assessment during planning to assist in maintaining a balance between safety and wellbeing. Refer to service specific HPUs for further details on outdoor space.

Outdoor space for staff use should be considered.

3.8.10 Perimeter Wall and Fencing

The height of walls or fencing that form part of a secure boundary should not create a custodial environment nor increase the possibility of falling injuries should an attempt be made by a consumer to abscond. Walls or perimeter fencing should also provide consumers with adequate privacy enabling them to access outdoor spaces without a feeling of being observed externally.

The design should avoid handhold and foothold points to prevent scaling and incorporate barriers to prevent unauthorised access or the exchange of contraband from public areas outside the unit. Landscape features, fixed furniture, plantings, and outdoor lighting should be set back from the perimeter wall or fence to avoid purchase points. Where landscaping features are placed adjacent to the perimeter wall, the height of the wall should be adjusted accordingly. It should be noted that the design approach will vary depending on the location of the unit (e.g., on-grade or above ground).

Avoiding blind spots is imperative to facilitating good observation of consumers by staff and vice versa. There are no precise guidelines recommended for fence or wall height and this may vary from 3.5m in a general inpatient acute unit to 4.5m in high dependency areas, intensive care units or multistorey buildings. The wall height of 4.5m generally cannot be scaled by two average height consumers by one standing on the other's shoulders.

The type of wall or fencing selected needs to align and reflect the requirements for security in line with the model of care for the unit. The consumer profile and topography of the area should be considered when determining fence or wall height (e.g., young and fit or elderly consumers, land sloping away) and the degree of security required as determined by a thorough risk assessment.

Outlook and views are highly desirable as is cross ventilation.

The design solution for outdoor areas located above ground may need to consider the fall height should a consumer scale a perimeter wall.

Public artworks such as painterly murals or artfully designed perforated screens can shape spaces and distract from security fencing, masking custodial setting, and in some cases, can provide feeling of openness and enhanced connection to external environments.

3.9   FIXTURES, FITTINGS AND EQUIPMENT

3.9.1   Definitions

Room Data and Room Layout Sheets in the AusHFG define fixtures, fittings, and equipment (FFE). There are range of mental health specific resources available. Refer to:

- Standard Components - Room Data Sheets (RDS) and Room Layout Sheets (RLS)
- AusHFG Part F: Section 680 Furniture Fittings and Equipment.

3.9.2   General Principles

The risk profile within individual units must be considered when selecting FFE. As outlined in section 3.7.1, a risk assessment should identify the level of risk associated with each area across the unit and FFE selected accordingly.

The potential of self-harm by consumers is a concern in mental health inpatient units, with risk associated with all ligature points. As it is not possible to always observe all consumers at all times, selection of fixtures and fittings is important to eliminate or reduce risk of self-harm. Any fitting or fixture capable of supporting a consumer's weight should be avoided unless it is an item of furniture intended to bear a consumer's weight. Consideration of introduced risk such as furniture selection into high-risk areas is also important.

Fixtures and fittings selected for mental health inpatient units should be of a type specifically manufactured and marketed as anti-ligature / ligature resistant and installed in accordance with the manufacturer's instructions. Individual items should also be assessed by the project team on a project-by-project basis prior to installation or have a proven track record to ensure that they do not create any additional safety hazards for consumers, visitors, and staff. For example, edges on joinery should be chamfered.

Fixtures and fittings should meet the required function, be safe, durable, tamper-proof, and concealed where possible, ensuring they are flush with the surfaces to which they are attached or are designed in a way that prevents attachment of anything around them (e.g., cords or belts). It is critical to ensure that if anything is or can be attached to the fixture or fitting, that it will break away when a weight of 15kgs is applied.

Fixtures and fittings should be kept to a minimum and be non-breakable. They should also:

- have no ligature points, where possible
- provide no access to electrical wires, where possible
- where needed, include shatterproof glass windows (which cannot be removed or damaged by the consumer)
- secure all ceiling-mounted fittings and fixtures.

Project teams should consult with and visit recently completed units regarding the ongoing performance of fittings and fixtures to learn from their experiences.

Anti-ligature fixtures and fittings are a speciality item that should be considered throughout planning and design stages so that they can be ordered from speciality suppliers and avoid causing delays in construction. Anti-ligature fixtures and fittings are not required in non-consumer areas.

3.9.3 Fixings: Artwork, Signage, and Mirrors

A risk assessment should be undertaken to determine the type and fixing mechanism of artworks, signage and mirrors. A map of anti-ligature risk zones in the facility may be useful in this context. In higher risk areas artwork, signage, and mirrors should be rigidly fixed to walls with concealed, flush, and tamper-proof mountings.

Appropriate artworks can be installed in even the most high-risk zones. Tamper-proof materials are preferred, avoiding materials that when broken become sharp. Mural scale works on vinyl by artists may be appropriate. Some spaces, such as dining rooms are both high risk and priority areas for art placement. The use of vinyl should be carefully planned (e.g., the surface on which the image is attached should be flat, not easily damaged with the removal of the wall vinyl, and largely free of distractions such as handrails, power points, monitors, clocks, and temperature, evacuation diagrams etc and appropriately lit to enhance the effect).

Signage should be easy to read and support those with differing levels of literacy or language skills to help improve accessibility. Vinyl signage is not recommended as letters are easy to remove.

Ensure that mirrors are made from safety glass or other appropriate impact-resistant and shatter proof construction, are scratch proof and free from distortion. Mirrors are to be fully glued to a backing, using anti-pick caulking, to avoid distortion and prevent loose fragments of broken glass or other material. Mirrors are to be securely screw fixed into position.

For further information, refer to:

- AusHFG: Arts in Health Framework
- AusHFG Part C: Design for Access, Mobility, Safety and Security
- Wayfinding for Healthcare Facilities, NSW Government 2022

3.9.4 Furniture

Furniture selection should be tailored to the individual facility, be selected after a robust risk assessment, and aligned to the risk associated with the unit or area in which it is included. Furniture selection should contribute to the warmth, ambience, and aesthetics of the unit and should promote a domestic, home-like atmosphere with consideration given to the quality, durability, and comfort of the furniture. Where built-in furniture is used, comfort and usability should be prioritised.

Loose furniture should be comfortable and robust, with consideration given to the ability to lift and the weight, dependent on the level of risk and model of care. Furniture, such as chairs, should be selected to ensure that they do not provide access to screws, staples, or cavities.

Coverings for mattresses and furniture should be resistant to fire, damage, and tampering.

Beds in consumer bedrooms should meet clinical requirements, maximise comfort, and minimise any risk of use as a low ligature point and manual handling risks for staff.

Mattresses should have a high fire resistance rating and should not be inner sprung, especially in areas accommodating highly acute consumers.

3.9.5 Plumbing Fixtures

All fixtures and fittings used within the consumer ensuites and bathrooms should be of a type specifically manufactured and marketed as anti-ligature and installed in accordance with the manufacturer's instructions.

Plumbing fixtures and finished elements within the mental health unit are subject to selection by the design team.

Plumbing fixtures and fittings should be concealed or shrouded with tamper-proof fixtures and resistant to breakage and removal. Where possible, toilet cisterns should be concealed, and basins shrouded with tamper-proof fixtures and resistant to breakage and removal. This applies to consumer toilets and to all visitor toilets located within the inpatient unit that may be accessible to

consumers. Additionally, concealment methods shall be provided to prohibit access to fixture hoses such as those connected to washing machines in ADL washrooms.

Recessed toilet roll dispensers are recommended to be used in high-risk areas i.e. seclusion ensuites.

In hybrid instances where bathrooms serve as accessible and non-accessible in the mental health inpatient unit, all plumbing fixtures are to be anti-ligature accordingly.

The positioning of shower heads is to consider the jet trajectory of the wall mounted anti-ligature nozzles.

The positioning of basin tapware is to consider the travel range of the handle such that it does not clash with the basin and/or mirror.

Consideration shall be given to the location of thermostatic mixing valves and the manufacturer requirements with the associated anti-ligature valve box.

Refer to Section 3.10.12 Hydraulics for water flow isolation requirements.

3.9.6   Rails, Hooks, and Handles

Inclusion of rails, hooks, and handles should be installed in alignment with jurisdictional policies. Horizontal grab rails should be avoided in toilets and showers. Anti-ligature type handrails should be installed vertically. Anti-ligature type handrails may be installed horizontally in designated accessible toilets.

Collapsible anti-ligature type hooks must be provided in alignment with jurisdictional policies. In some jurisdictions, the provision of these is not supported. In other jurisdictions only the use of rubber hooks is allowed, assuming they meet anti-ligature specifications, have been installed in accordance with the manufacturer's instructions and have been tested prior to installation or have a proven track record.

The provision of towel rails should be avoided. Alternative arrangements for towel storage, such as a shelf integrated with the vanity, or collapsible anti-ligature type hooks should be considered.

All hardware to cupboards, including hinges and handles, should be anti-ligature type if accessed by consumers. Consider using fittings with incorporated moulded hand pulls to avoid the need for handles. Cupboards accessed only by staff should be lockable.

3.9.7   Shower Curtains and Tracks

Shower curtains and tracks are no longer advised as both present a significant risk and potential for misuse. Ensuites should be designed so that the shower cubicle is appropriately sited within the room, floors are graded appropriately, and the water rate is controlled to prevent excessive splashing. When the use of shower curtains and tracks is endorsed after risk assessment, consider the breaking strain of the tracks and tear resistance of the shower curtains.

3.9.8   Window Treatments

Curtains, roller, and venetian blinds with cords should not be used in consumer bedrooms. Alternative means of protecting consumer privacy should be considered (e.g., venetian blinds integrated with a double-glazed window unit with anti-ligature controls).

The facility should be designed to eliminate or reduce the need for external shading of windows. However, where external shading is required, the design should adopt the same safety principles as for fittings and fixtures to minimise potential risks.

Curtains used in consumer recreational areas should have tracks mounted flush to the ceiling with a breaking strain of 15 kgs. Consideration should also be given to fabric type, (e.g., with respect to weight and thickness, to reduce the potential for tearing).

3.9.9 Storage

The level and type of storage should be based on the type of mental health unit and a robust risk assessment. Built in, open shelved joinery units should be provided within consumer bedrooms to accommodate their possessions. Consideration should be given to the option of a lockable unit for personal belongings, either in the bedroom or common areas, depending on the level of risk identified.

Refer to Section 3.9.6 re the provision of collapsible anti-ligature type hooks.

3.9.10 Other

Light fittings, smoke, and thermal detectors should be of a type specifically marketed and manufactured as anti-ligature, ideally flush mounted, and installed in accordance with the manufacturer's instructions. They should be tamper-proof and incapable of supporting a consumer's weight.

The project team should refer to the local jurisdictional requirements for management of consumer risks and carry out a site-specific risk assessment.

Equipment located in ceiling cavities, such as cables, should be secured above consumer areas.

3.9.11 Lighting

Provision of adjustable or dimmable lighting, rather than on and off lighting, can provide consumers the ability to control lighting levels and can lead to a reduction in stress in areas such as sensory modulation room. Varied lighting types such as general, reading and night lights in the consumer bedroom allows the consumer to adjust the lighting to suit their needs.

Light fittings, including reading lights, should be of a type specifically marketed and manufactured as anti-ligature type, and installed in accordance with the manufacturer's instructions. They should be correctly installed with mechanical fixing which are tamper-proof.

Refer to AS/NZS 1680.2.5 Hospital and Medical Tasks for general guidelines on illuminance levels.

Refer to Section 3.5.3 for information on lighting environmental considerations.

3.10   BUILDING SERVICE REQUIREMENTS

3.10.1 Electrical Services

All areas used by consumers will be body protected.

Review local jurisdictional requirements for standby power coverage (e.g., extended UPS autonomy for security systems).

The residual current devices (RCDs) used to protect each consumer bedroom and ensuite will be located in a staff only access area such as the staff station or clinical work room space.

General power outlets (GPO's) will be installed with tamper-proof screws.

Where needed, electrical supply shut-off systems should be installed in the staff station.

3.10.2 Lighting Control

Provision of adjustable or dimmable lighting, rather than on and off lighting, provides consumers the ability to control lighting levels and can lead to a reduction in stress.

3.10.3 Air Handling Systems

Air grilles and diffusers located in consumer accessible areas should be an anti-ligature type. The outlets and the equipment used should be designed and built to:

- prevent the insertion of foreign objects
- provide tamper-proof fasteners

- ensure all convector or heating, ventilation, and air conditioning (HVAC) enclosures expressed in the room have rounded corners and closures fastened with tamper-proof screws

- vents should be fixed to the ceiling to prevent access to the roof cavity.

The position of air grilles in consumer bedrooms should be carefully considered so that furniture, joinery units etc. do not provide consumers easy access to them.

They should be positioned to maximise consumer comfort (e.g., not located directly over the bed where cold air may be 'dumped' rather than diffused).

3.10.4 Information and Communications Technology (ICT)

Systems used within the mental health inpatient unit environment may include:

- wireless technology for both staff and consumers to support devices

- TV and entertainment systems for consumers

- music system

- duress systems, both fixed and mobile

- voice and data (telephone and computers)

- motion sensors, such as those used for monitoring activity / movement and falls prevention, used in consumer bedrooms

- electronic medical records

- e-medication management systems

- computer and internet access for consumers (consideration should be given to a separate high-speed and high-grade internet platform for consumers and visitors)

- teleconferencing, videoconferencing, telehealth, tribunals and telepsychiatry facilities that are used for staff education, management, and consumer services

- CCTV.

Consultation with the project ICT manager and the health entity's ICT services are required to assist with planning IT networks that are enabled to support consumer streaming services and the consumers own devices for educational or entertainment purposes.

Also refer to specific local jurisdiction long term ICT strategies and AusHFG Part C: Design for Access, Mobility, Safety and Security section 6 Security.

3.10.5 Nurse Call, Staff Assist, and Emergency Call System

Inclusion of nurse call, staff assist, and emergency call systems are dependent on jurisdictional and local policies, and the project requirement.

Nurse call is a local consumer to staff call, staff assist is a local staff to staff call, and emergency call is medical emergency linked to the hospital wide emergency call system. It is acknowledged that there may be variations on these dependent on jurisdictional policies.

Most consumers admitted to a mental health inpatient unit will be largely ambulant and self-caring. However, it is important to consider that some consumers may present with medical comorbidities which may pose special requirements such as equipment to aid with mobility or care assistance which requires secure storage.

The provision of nurse call systems in each consumer bedroom and ensuite are to be considered. Where staff assist and emergency call are provided, careful consideration of the location is required due to the risk of being inappropriately activated.

Any system installed should be compatible with systems used throughout the facility and capable of staff override.

Staff assistance and psychiatric emergencies would be managed by local health service protocols. Medical emergencies will need access to the hospital's cardiac arrest system.

3.10.6 Medical Gases

Medical gases are not routinely required in mental health inpatient units. Some access may be required in selected clinical environments such as those managing older people. Portable oxygen and suction will, however, need to be available for any medical emergencies and to support consumers recovering from a procedure.

If medical gases are required, medical gas outlets and medical services panels need to be anti-ligature and to be locked in a cupboard.

It is recommended that alarm panels and valve boxes are located in a staff station or any administrative area not accessible to consumers.

3.10.7 Access Control

Access control systems that are well considered and planned early in the design, will promote ease of movement around the facility and ensure the safety and security of consumers, visitors, and staff. Access control systems will be a combination of electronic (swipe card readers) and keys. Electronic systems will have key override in the event of a power failure. In addition, manual locks will be installed onto all perimeter doors and doors between areas of operation to enable operational continuity in the event of a prolonged power failure.

Units should be designed with controlled entry and exit points so that movements in and out by consumers, visitors, and visiting staff can be monitored. This is normally achieved by the use of an airlock. At main entry points, reception staff provide additional support by monitoring the main entry and providing an access control point into the clinical areas of the unit.

All rooms should have the ability to be locked and have provision for staff to override the locking system where required (e.g., bedrooms and ensuites). The choice of an opening system, electronic or key, will depend on the number of staff or consumers that access the space. Electronic systems will routinely be used to promote free movement of staff or where there is a high volume of staff access required. If jurisdictional policy allows, keys may be used where access is limited to a small number of staff.

When the unit is located within a multi-storey building, the lock system must ensure that there can be no unauthorised and unsupervised access to external spaces above ground level, such as balconies or the roof, unless these are specifically designed for use by consumers. Refer to Section 3.10.11 for consumer access requirements to fire stairs during evacuation.

All consumer bedrooms should have consumer-controlled access to promote the safety of consumers.

Staff must be able to override locks to gain access to consumer zones and bedrooms in the event of an emergency, or to secure these rooms for reasons of operational security.

Ensuite doors may be provided with a privacy latch but must also be able to be overridden by staff in the event of an emergency.

3.10.8 Closed Circuit Television (CCTV) Surveillance

CCTV use should be determined by jurisdictional policy and may be useful for monitoring:

- selected internal areas such as stairways, reception lobbies, service corridors
- external areas such as perimeters, the main entry, and other entry and egress points.

The use of CCTV in mental health inpatient units should not:

- reduce the therapeutic interaction between staff and consumers
- be used as an alternative to direct and active clinical observation by staff as this may have a negative impact on therapeutic rapport and infringe on a consumer's right to privacy.

The use of CCTV in consumer bedrooms, ensuites and other private spaces is not supported.

The use of remotely managed CCTV in areas such as de-escalation areas including seclusion rooms is not recommended as the images do not accurately provide a status of the consumer's physical health and should not replace direct physical supervision by staff.

Staff must be present and directly monitor consumers in high-risk areas such as seclusion rooms, high dependency area or intensive care units.

The layout of the mental health inpatient unit should provide effective lines of sight and eliminate blind spots. CCTV should be operable under a range of lighting conditions such as artificial and natural lighting.

Public entrance CCTV cameras should be monitored centrally and be integrated into the campus-wide security system. CCTV cameras installed in consumer areas will be monitored locally.

The New Zealand Mental Health Act specifies that people receiving care in a mental health facility have the right to be informed when areas where 'care or treatment' occurs are being recorded (by video or audio); this includes admission areas, courtyards, and rooms within the facility. Consent must be given by all consumers occupying the facility. For specific Mental Health Act CCTV installation requirements for New Zealand mental health facilities, refer to Section 4.2.

3.10.9 Duress Alarm System

A well-designed duress alarm system will improve the safety and security of staff and consumers by allowing staff to indicate when and where additional assistance and support is needed.

A system of personal or mobile duress alarms utilising real time location system (RTLS) technology should operate throughout the unit and in all outdoor areas accessed by consumers. Mobile duress systems operate using Wi-Fi infrastructure. In mental health inpatient units, the Wi-Fi infrastructure will be ideally installed in ceiling cavities.

Duress alarm systems and their operation must align with local jurisdictional policy and may be a combination of:

- mobile duress alarms with Wi-Fi location finders set at regular intervals and linked to a real time monitoring facility

- fixed duress alarms, particularly in areas where staff work in a relatively fixed position (e.g., receptions, staff stations, consult rooms, and tribunal meeting rooms).

Staff, and in some cases visitors (e.g., official visitors), should be provided with, and trained in, the use of mobile duress alarms. An appropriate response mechanism should be in place and will be based on local operational guidelines. There should be a sufficient number of mobile duress alarms to ensure that all staff and relevant visitors can carry one whilst in the unit.

In all consumer areas where de-escalation may be required, a mobile or fixed duress point should be available and activated to ensure staff are supported appropriately. Duress alarm systems must be always monitored from a staffed position to ensure activation of the device initiates an appropriate response.

The charger and related PC for personal duress alarms should be located in a staff only area such as the clinical workroom and be accessible 24 hours per day.

Location of fixed duress call points is critical to ensure that:

- Staff can activate an alarm discreetly.

- Duress calls cannot be activated by consumers or children.

- Duress calls cannot be activated accidentally (e.g., by a chair being pushed back).

3.10.10 Motion Sensors

Motion sensors, also known as presence alarms, inside bedroom doorways or door heads can be a useful adjunct to observation of consumers at night but do not replace observation and

engagement policies, which must be adhered to. They can be used to alert staff to consumers who may have left their bedroom and who may be in distress, or who may try to gain access to another consumer's room. These systems will generally be activated as needed.

3.10.11 Fire Systems

In general, fire requirements are covered by:

- AS 1670.1:2018 Fire detection, warning, control and intercom systems
- Local jurisdictional policies.

Fire systems should be based on early and robust engagement with fire engineers. The fire protection elements provided to a mental health ward or building must consider the operational and end user requirements. Significant staff training shall be undertaken to ensure the intended safety outcomes are achieved.

In relation to provisions for fire protection services the design shall comply with the minimum requirements of the current Building Code of Australia or New Zealand, and its relevant reference standards as it pertains to:

- fire hydrants
- fire sprinklers
- fire detection and alarm systems
- emergency warning and intercom systems
- portable fire extinguishers.

The following listed requirements shall be provided at a minimum to suit the operational expectations of this guideline:

- Fire exit doors will fail secure in the event of a fire.
- Fire hydrants, fire hose reels, and fire extinguishers shall be in recessed cupboards with lockable doors (no exposed fire protection equipment).
- Doors to fire protection equipment cupboards will only be openable by staff.
- Fire protection equipment such as sprinklers, detectors, speakers etc. shall be selected and installed in an anti-ligature arrangement.
- Speakers shall be located to minimise harm to patients but to the degree necessary to warn the staff, or in accordance with the prescribed operational procedures of the facility.

Where the listed requirements above (or any other project specific requirement) are not in accordance with the Building Code of Australia or New Zealand and its reference standards requirements a fire performance solution will be required, and consultation undertaken with the local fire brigade by a fire safety engineer to ensure the final outcome is suitable and accepted.

Selected fabrics, soft furnishings and items such as mattresses should have a low flame index.

In general, the fire protection requirements are covered by the:

- Building Code of Australia
- New Zealand Building Code
- Relevant Australian Standards
- Local and jurisdictional policies
- Australasian Health Facility Guidelines

3.10.12 Hydraulics

The ability to isolate water flow shall be considered in high acuity mental health units (mental health intensive care and high dependency units). An emergency shutdown button should be provided within a staff only area that is linked to a normally open solenoid control valve on the incoming water supply to the unit. Additional considerations for isolation at each TMV individually may be implemented based on a risk assessment and input from the clinical users of the proposed facility.

04 APPENDICES

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