

Mental Health Facility Guidelines – Issues

- 4 current guidelines: adult acute; child and adolescent; ambulatory mental health care; PECC
- 2 in development: older persons mental health acute; non-acute mental health
- Need identified for others: subacute adult, OPMH extended treatment; secure – high/ extended treatment / medium secure; broader model to suit a range of EDs; PICU
- Youth – not well catered for in adult facilities; up to 24 years
- Different terminology used in different jurisdictions- requires glossary to aid understanding
- Grossing allowance important – includes circulation %, etc
- Contingency allowance also important
- Clearly stated model of care critical BEFORE any work done on design and planning
- Should guidelines refer to staffing levels?
- Ensure consumers are at the centre of process from the outset - ?need better systems and processes to achieve this
- Minimise stigma as much as possible
- Dignity, privacy and safety
- Comfort, light and space internally
- Comfortable, homely, welcoming, open (not locked)
- Domestic, homelike environment
- Small homelike facilities in community preferred over hospital campus
- Normalised campus design eg. Village green, communal area
- Welcoming entrance – not disembodied voice or heavy glass doors
- Outside space – courtyards, access to fresh air, smoking access, gardens, trees
- Design of outdoor courtyards – size and height of perimeter wall important
- Natural environment very important for healing
- Place of recovery
- Lots of space – for recreation/creative activity/ skills development/quiet areas/ arts and craft rooms / communal kitchens for self-catering
- Signage important
- Acoustics / Soundproofing important
- Reception counter – must be able to talk to real people, obtain advice and assistance
- Accessibility to staff – design of nurses station critical
- Staff areas: seek to deinstitutionalise central staff station but maintain good lines of sight and transparency but not at expense of high quality therapeutic environment;
- Staff need high quality space off the unit to facilitate rest and refreshment in high-stress environment; can share staff facilities whilst still accessible
- ?Time out rooms (soft comfort rooms) for staff
- Quiet/de-escalation room
- Seclusion room – should we even include this?
- Seclusion/De-escalation: focus on clinical skill development; include sensory and comfort rooms, privacy and space; locate seclusion to protect privacy and dignity; separate entry; acoustic and visual separation; separate de-escalation vs. separate seclusion;

- Harm minimisation necessary for safe premises but need common sense approach to risk containment
- ECT suite
- Family visiting areas and facilities for carers
- Special needs consumers e.g. mother and baby, indigenous, dual disability, etc
- Gymnasium, swimming pool, basketball court
- Design that impacts on interaction between staff and consumers
- Continue connection/interaction with community – reflect in design
- Positive duty to act in accordance with human rights
- Human rights influenced design and environment
- Controversies: smoking (?only outdoor areas); right to self-expression (e.g. graffiti); dual diagnosis and drug use; security in least restrictive environment; searches for contraband (no strip searches); forensic patients; fixed or heavy furniture; safety glass, doors, etc
- Sexual safety
- No overcrowding
- Space for Mental Health Tribunal hearings
- Objective must be recovery and rehabilitation
- Access to outside – email, internet, newspaper, etc
- Size depends on model of care and efficiency:
- Pod design allows for flexibility of use
- Flexibility of design – care with mixing gender and specific groups
- Flexibility in design to meet changing needs over time
- Research and administration space
- Design to enable least restrictive care – therapeutic but also safe and secure
Note: safety and security have a broader context – procedural, physical, relational – not just design
- Consistent built form response – agreed elements eg. fencing, courtyard space, mix of single and double rooms, robustness of building fabric, safety designs, spatial zoning of units, patient flow through unit e.g. from ED in to unit
- Elements required as a responses to the legal framework within which the units operate e.g. gun safes, emergency admission protocols, magistrate room design requirements,
- Are there differences between inner city vs urban vs rural vs remote
- What design is attractive to staff and may contribute to workforce retention?
- Require performance specifications e.g. re fittings and fixtures
- Design to improve the continuum of care
- Patient amenity and choice important including capacity to move between indoor and outdoor; deinstitutionalised; bedroom size determined by length of stay, model of care and other characteristics and design response; ensuites in HDU;
- Structured day approach: patients engaged in meaningful activities therefore separate residential space and program/activity spaces
- Privacy and dignity: single gender units; patient key to own room; flexible design to enable creation of sub-units for other vulnerable groups; single-loaded corridor around courtyard provides access to every room from two directions; quiet lounges off bedroom wings enable creation of sub-units; duress alarms for patients

- Patient/environment: avoid stressors that may result in patient disturbance; increase circulation to avoid sense of crowding; patient choice in recreation areas
- Move to smaller Units: 15 beds – look to smaller sub-units but shared common facilities
- Single vs Multi-storey unit: single storey preferred for acute beds but can design multi-storey with adequate access to outdoor space.
- Link with medical/diagnostic services; medical gases throughout; vinyl not carpet in ICU; own dirty utility and bathroom