Mental health intensive care framework

Office of the Chief Mental Health Nurse

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Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people.
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Office of the Chief Mental Health Nurse

Foreword

We are pleased to offer this framework into Victoria's specialist mental health services. For some time now, services and clinicians have acknowledged that high dependency units (HDU) in mental health inpatient services are only one of many environments to provide a higher level of individual care to people when they are experiencing acute symptoms and vulnerability.

This framework provides clinicians, services, consumers and carers with clear direction regarding the role of mental health intensive care within Victorian mental health inpatient units. The framework was developed in response to the State-wide High Dependency Unit Project (2016), the *Chief Psychiatrist's audit of inpatient deaths 2011–2014* (Department of Health and Human Services 2017b), the Mental Health Complaints Commission's (2018) *The right to be safe* report, as well as the 10-year review of restraint practices in Victoria. This framework is significantly informed by feedback and the experiences of consumers, carers and clinicians who consistently reported mental health intensive care areas are prison-like, non-therapeutic and unsafe.

Mental health intensive care is a specialised care type that responds to people when they are experiencing acute symptoms and vulnerability. It requires purposeful and collaborative communication and engagement with consumers, carers and an interprofessional team to deliver therapeutic engagement, interventions and activities that promote supportive, recovery-focused care.

The *Mental health intensive care framework* represents a shift in our understandings of care and engagement when people are at their most vulnerable, moving from a culture of control to a culture of care. This work draws on the expertise of consumers, carers and clinicians through their experiences of current practices and a collective desire to move care beyond being about a space where symptoms are 'managed'. In effect, the expectation of contemporary mental health intensive care requires parity of esteem to be comparable with the investment of skill, education and resources of other health experiences, valuing mental health and physical health equally.

Mental health intensive care requires a specialist and skilled workforce oriented to providing high care in a way that best responds to an individual's needs. It relies on collaboration, skilled use of the healthcare setting, supporting safety and the therapeutic milieu. This framework challenges a long-held notion and trend of practice that singled out low-stimulus restrictive environments as the most appropriate care environment for people with intensive mental health care needs. Throughout its development, stakeholders highlighted the need to reorient care around meaningful connection, getting to know people and their preferences, offering a range of activities with therapeutic benefits, promoting choice and increasing the focus on recovery and trauma-informed care.

The framework further identifies and highlights key contemporary and best practice principles that are vital for mental health practice. It is with genuine connection, interest and compassion that we will promote human rights and recovery for all Victorians.

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Chief Mental Health Nurse

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Chief Psychiatrist

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Acknowledgements

This framework has been developed with the support and active participation of many people. In particular, the Office of the Chief Mental Health Nurse would like to acknowledge the valued contribution of consumers, carers and clinicians who have informed this work by sharing their experiences of mental health intensive care and high dependency units.

Expert reference groups

Mental Health Intensive Care Reference Group

(Invited panel of clinical, consumer and carer representatives, peak bodies, specialist services and government agencies)

Stakeholder forums

VMIAC consumer consultations

Tandem carer consultations

Mental Health Intensive Care Training Working Group

Centre for Psychiatric Nursing – The University of Melbourne

Victorian Senior and Speciality Mental Health Nurse Forums

Chief Psychiatrist's Authorised Psychiatrist Forum

Victorian Mental Health Interprofessional Leadership Network

Key messages

Mental health intensive care is a specialist care type that provides supportive, safe and therapeutic engagement to individuals experiencing increased vulnerability during an acute phase of mental illness. The framework's focuses on the needs of the person and the promotion of choice and **engagement**. Mental health intensive care responds to individual vulnerabilities and risks when the severity of symptoms, distress or other factors such as environment, relationships, trauma history and social determinants affect a person's ability to self-manage.

Moving beyond high dependency units, mental health intensive care can be delivered in any treatment environment and is not restricted to a secure area within the inpatient unit.

This means any person requiring advanced assessment, observation and engagement will have access to support irrespective of location.

Mental health intensive care is organised to:

- create specialist resources and interventions
- implement mechanisms for continuous and collaborative appraisal
- prioritise early identification and awareness of deterioration
- address processes for timely escalation.

All decisions regarding mental health intensive care acknowledge:

- an assumption of people's capacity in all decision making
- consumers' rights, preferences and recovery goals
- a legal obligation to provide least restrictive treatment
- the anticipated benefits and risks related to the care type
- safety for all
- operational support and clinical readiness.

'The thing I needed the most was being able to have someone sit there and listen to my experiences and believe in what I was saying.'

– Consumer, HDU Video Project, 2018

Mental health principles

There are **12 mental health principles** that underpin the Victorian *Mental Health Act 2014*.

- Persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible, with voluntary assessment and treatment preferred.
- Persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.
- Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.
- Persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
- Persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.
- Persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.
- Persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.
- Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to.
- Children and young person's receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.
- Children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected.
- Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.
- Carers (including children) for persons receiving mental health services should have their role recognised, respected and supported (Part 2, s.11).

People must have regard to these principles when undertaking their roles, including when they are supporting mental health intensive care services.

Definitions

Common terms used in this document

Mental health intensive care

Mental health intensive care is a specialist care type providing support, safety and therapeutic engagement for individuals experiencing increased risk vulnerability associated with an acute mental illness.

Mental health intensive care areas

Mental health intensive care areas (MHICAs) are discrete spaces within a mental health acute inpatient unit dedicated to the safe treatment of people with increased risk and vulnerability.

Previous guidelines have referred to MHICAs as 'high dependency units' (HDUs) and 'psychiatric intensive care units'. These areas are routinely locked to prevent free movement into or out of the area.

Refer to: Chief Psychiatrist's high dependency guideline (Department of Human Services 2002)

Evidence-based practice

Evidence-based practice (EBP) is an approach to care that integrates the best available research evidence with clinical expertise and patient values.[1]

It involves translating evidence into practice, also known as knowledge translation, and ensuring that 'stakeholders (health practitioners, patients, family and carers) are aware of and use research evidence to inform their health and healthcare decision-making'.[2]

Refer to: Implementing evidence-based practice <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/resources/improving-access/ia-evidence>

Interprofessional teams

An interprofessional team reflects diverse professions and holds collective wisdom, a range of skills and experiences and a joint commitment to leading change for recovery.

A note about language

There are a range of terms employed in mental health literature to refer to people accessing mental health services, such as consumers, clients, services users and patients. In this document, wherever possible, the terms 'person', 'individual', 'people with lived experience' and 'people accessing mental health services' are used to model humanistic language in line with a recovery approach.

Refer to: Framework for recovery-oriented practice (Department of Health 2011a)

1 Sackett D et al. 2000, 'Evidence-Based Medicine: How to Practice and Teach' EBM, 2nd edition. Churchill Livingstone, Edinburgh, p1.
2 Grimshaw JM, Eccles MP, Lavis JN, Hill SJ & Squires JE 2012, 'Knowledge translation of research findings', *Implement Sci,* 7(50):50.

Purpose and scope

Purpose

The *Mental health intensive care framework*:

- provides guidance to individual clinicians and service leaders to develop, implement and evaluate policies and procedures supporting safety and therapeutic engagement for individuals experiencing significant vulnerability associated with an acute illness
- creates a consistent approach to mental health intensive care in Victorian specialist mental health services
- complements existing professional standards and related practice frameworks.

Scope

This framework applies to Victorian designated mental health services across all practice settings and all age ranges. Mental health intensive care can be provided in any care setting, including:

- MHICAs
- mental health inpatient units
- medical and surgical units
- emergency departments.

Evidence for change

In preparing this framework, the Office of the Chief Psychiatrist and the Office of the Chief Mental Health Nurse have collected and analysed evidence from consumers, carers and clinicians about their experience in HDUs. These accounts reflected a shared negative experience of HDUs marked by inconsistent models of care, reduced facilities and a lack of therapeutic interventions and activities. Most salient of all were descriptions of the space being 'prison like' for consumers, staff and carers. These experiences form the need for change and for mental health services to develop an enhanced practice and awareness of engagement.

Worldwide there is a well-recognised and significant body of knowledge highlighting the need for reform of mental health care environments, particularly those that impose restriction (Bowers et al. 2008, 2015; Gwinner & Ward 2013; Zigmond 1995). In recent years, the Victorian Office of the Chief Psychiatrist and the Office of the Chief Mental Health Nurse have responded by investing in a range of research initiatives and frameworks to reduce restrictive interventions including the *Providing a safe environment for all: framework for reducing restrictive interventions* (Department of Health 2013), the *Framework for recovery-oriented practice* (2011a), the State-wide High Dependency Unit Project (2016) and continued investment in Safewards Victoria.

The State-wide High Dependency Unit Project concurred with past research highlighting that HDUs require attention to environmental design, skill acquisition and resourcing.

> While it was overwhelmingly clear that services strive to provide intense and therapeutic high dependency care, the mechanisms to achieve this within a targeted short-term length of stay was, however, often poorly defined or limited by the environment being small or not fit to purpose, or resourcing that was either insufficient to meet the need or not sufficiently expert to address both the safety and therapeutic needs for the complex cohort accessing HDU. Examples of stress-reducing environments, and innovative preventative and therapeutic approaches, and multidisciplinary review and accountability mechanisms were identified in the conduct of this review, that could be useful to be shared across services to enhance the quality and safety of HDU care.
>
> Source: State-wide High Dependency Unit Project, 2016

> Promoting practice that enhances identification of potential risks and triggers and establishes self-regulating strategies for consumers early in the admission is imperative for both safe management and treatment planning. Achieving this will require effective consumer and carer engagement from a suitably skilled and experienced workforce with a repertoire tailored to manage complex individual and group behaviours of concern and vulnerability, as well as the ability to trial and evaluate the effectiveness of a suite of evidence-based interventions.
>
> Source: State-wide High Dependency Unit Project, 2016

'We need to champion the promotion of engagement, creativity and choice.'
– Clinician, Mental Health Intensive Care Expert Reference Group, 2019

Interviews with consumers, carers and clinicians found that people experiencing acute distress are often confronted by restrictive practices and withdrawal of engagement and seeking help appeared linked to the risk of re-traumatisation.

Mental health intensive care brings together a specialist evidence-based suite of interventions focusing on clinical skills, tailored environments, resourcing and early intervention.

The framework

The framework

Mental health intensive care is a specialist care type providing support, safety and therapeutic engagement for individuals experiencing increased risk vulnerability associated with an acute mental illness. This framework encompasses five clinical practice domains underpinned by seven practice principles that are designed to place a person's needs at the centre of all decisions.

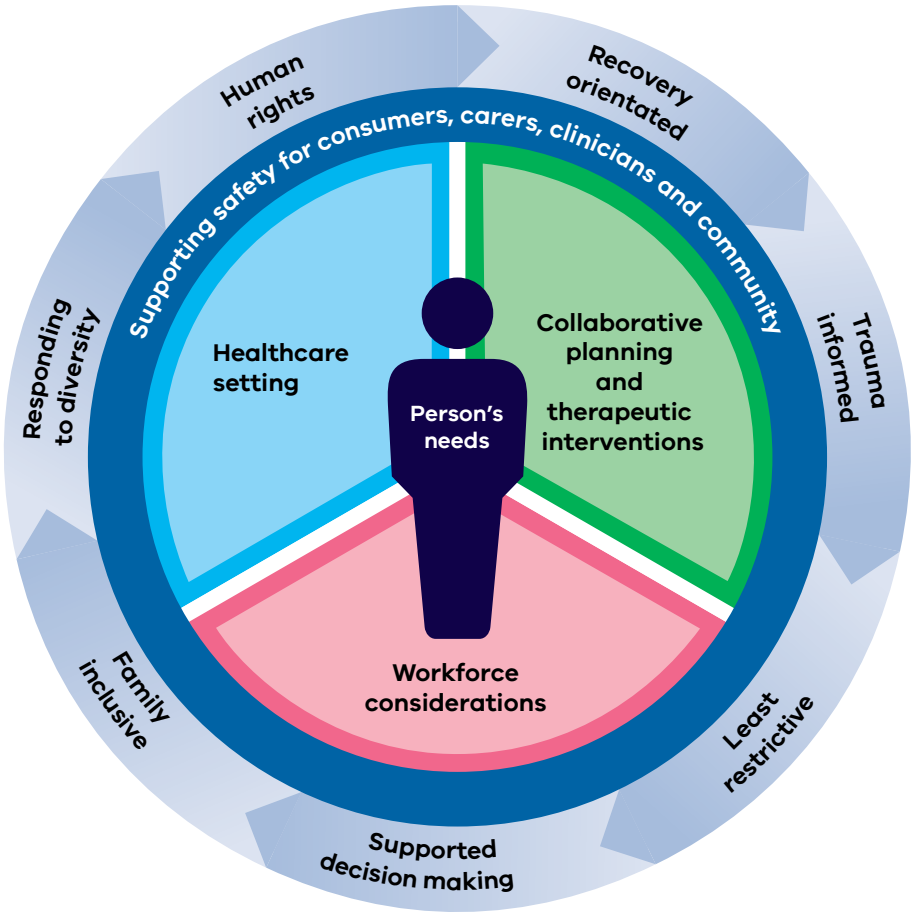
Providing equal consideration and preparation to each aspect of care, the framework will enable better operational and clinical preparation, awareness and evaluation when engaging people with acute care needs across Victoria.

The *Mental health intensive care framework* complements the safeguards and principles of the Mental Health Act and builds on and highlights objectives set out in guidelines including: *Nursing observation through engagement in psychiatric inpatient care* (Department of Health and Human Services 2019b), *Framework for recovery oriented practice* (Department of Health and Human Services 2011), *Providing a safe environment for all: framework for reducing restrictive interventions* (Department of Health and Human Services 2013) and *Working together with families and carers: Chief Psychiatrist's guideline* (Department of Health and Human Services 2018).

Refer to: *Mental health intensive care framework* references for comprehensive framework and guideline listings.

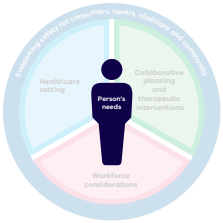
Figure 1 provides a visual depiction of the framework and its principles.

Figure 1: The framework



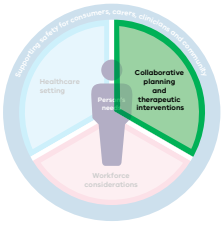
Domains

Person's needs



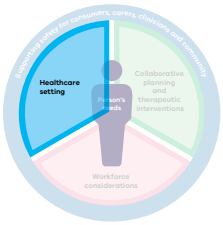
At the centre of this framework is the holistic identification of the person's needs and preferences through a collaborative process that engages the consumer, carers and clinicians. Understanding the individual's needs will assist to better respond to acute deterioration and increased vulnerability or safety issues.

Collaborative planning and therapeutic interventions



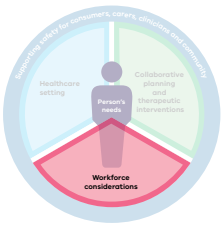
The planning process is consultative and collaborative, and treatment has a comprehensive outlook that encourages autonomy, self-regulation and safety. There are mechanisms for dynamic appraisal, nursing engagement, assessment and early identification of deterioration, and processes for timely escalation.

Healthcare setting



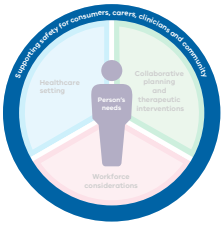
Based on the person's needs and preferences, appraise the options available for where to provide care. Consider the potential benefits and vulnerabilities posed by the treatment environment, as well as the broader needs of the communal environment. Choose the healthcare setting that is least restrictive and best supports the person's safety needs.

Workforce considerations



Consider the resources, skills and experience necessary to meet the person's needs, maintain safety and enhance therapeutic engagement. Mental health intensive care requires specialist skills, appropriate resourcing and interprofessional input to promote resilience, knowledge and expertise.

Supporting safety



An overarching domain that supports safety for all when providing mental health intensive care includes the **consumer, carer, clinician** and **community**. Promoting safety and wellbeing for all is an iterative and continuous process that considers the consumer's needs and safety issues, the communal and environmental risks and the safety and support requirements of staff.

Principles

A commitment to the following principles underpins mental health intensive care.

Human rights

People receiving mental health intensive care have the same rights as all other people receiving care through public mental health services. Victoria's Mental Health Act and the *Victorian Charter of Human Rights and Responsibilities Act 2006* provides protections of consumers' rights. Services and clinicians must uphold and protect human rights, which includes knowing, understanding and applying human rights perspectives and protections in their work.

Refer to: Charter of Human Rights and Responsibilities Act 2006

Recovery-oriented service provision

In the paradigm of mental health, the concept of recovery refers to a unique personal experience, process or journey that each person defines and leads in relation to their wellbeing. It is different from clinical recovery. While recovery is owned by and unique to each individual, mental health services have a role in creating an environment that supports and does not interfere with people's recovery efforts. The *Framework for recovery-oriented practice* (Department of Health 2011a) underpins the practice of all Victorian mental health services. The framework outlines the core principles, key capabilities and practices required for mental health services to operate in ways that optimally support people's recovery journey. Clinicians delivering mental health intensive care will provide a recovery-oriented service with the aim of supporting individuals to define and work towards their personal goals.

Refer to: Framework for recovery-oriented practice (Department of Health 2011a)

Trauma-informed care

This term encompasses an understanding of, and responsiveness to, the impact of trauma that emphasises physical, psychological and emotional safety, and practices that ensure a universal precaution approach. Trauma-informed services understand the profound neurological, biological, psychological and social effects of trauma and violence on the individual and appreciate the high prevalence of traumatic experiences in people who receive mental health services (Mueser et al. 1998). A trauma-informed approach is based on the recognition that many behaviours and responses (often seen as symptoms) expressed by people are directly related to traumatic experiences. Services must take an active role in preventing re-traumatisation.

Refer to: Trauma-informed care: position statement (Department of Health of Health and Human Services 2018d)

Supported decision making

The Mental Health Act establishes a supported decision-making model that will enable and support people under compulsory care to make or participate in decisions about their treatment and determine their individual path to recovery. Legal mechanisms in the Act that enable supported decision making include a presumption of capacity, advance statements, nominated persons and the right to seek a second psychiatric opinion.

Refer to: Recovery and supported decision making: position statement (Department of Health and Human Services 2018c)

Family and carer-inclusive practice

An individual's family and social relationships play an important role in supporting recovery. Families and carers should be recognised, respected and supported as partners in providing support and care. This includes early identification and inclusion in assessment, treatment and ongoing care. Services must consider the impact of mental illness on families and carers, including children, and provide active support and opportunities for service engagement and feedback.

Refer to: Working together with families and carers: guideline (Department of Health and Human Services 2018e)

Responding to diversity

As an integral part of their practice, mental health clinicians must recognise, respect and respond to the diverse needs, values and circumstances of each person, such as their gender, family circumstances, culture, language, religion, sexual and gender identity, age and disability. Responding to diversity recognises that people with mental ill health are likely to have poorer outcomes in a range of social health domains such as employment, housing, financial and health due to the impacts and consequence of stigma. Mental health intensive care is designed to respond to the unique needs of individuals in an intensive caring and therapeutic environment.

Mental health services should give regard to the *Cultural responsiveness framework: guidelines for Victorian health services* (Department of Health 2009a).

Refer to: Diversity: position statement (Department of Health and Human Services 2018b)

Least restrictive

The aims and objectives of the Mental Health Act set out the principles of care in the least restrictive environment consistent with effective treatment and care. These aims serve as a foundation for all professionals working with people who have a mental illness. Services will explain the reason for any restrictions on a person's human rights or interference with a person's rights, privacy, dignity or self-respect; these restrictions will be kept to the minimum necessary to provide treatment and care. Services must explore all possible alternative engagement and associated interventions before employing restrictive interventions.

Refer to: Bodily restraint and seclusion: position statement (Department of Health and Human Services 2018a)

Using this framework

Within each domain, there are three sections:

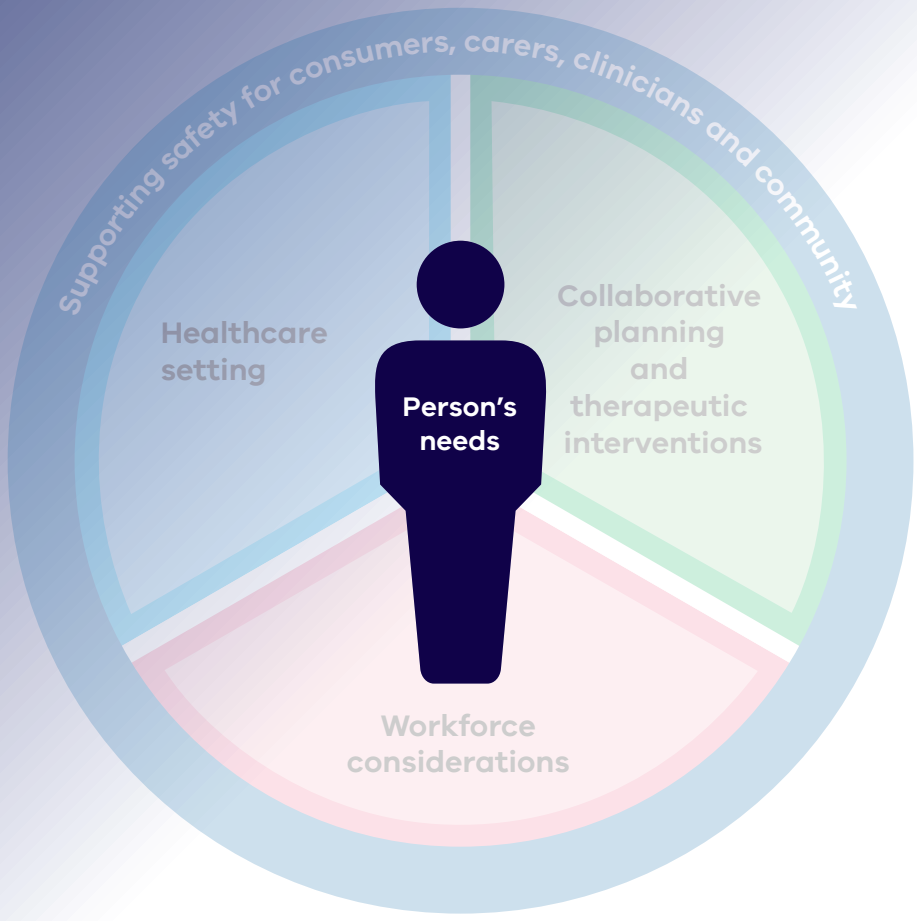
- a **description** of the domain and how it relates to the framework
- **clinical practice standards** governing service provision and decision making
- **practice guidance** highlighting how the principles can be applied in each domain.

The framework also includes sections on the mental health intensive care pathway and leadership considerations.

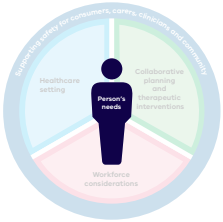
To guide implementation in services, a matrix template referencing the domains and principles is provided as **Appendix 1.**

Reflective questions appear at the end of each domain. These are indicated by a reflection icon. Reflection questions can be for individual reflection or to prompt discussion in group reflection.

Person's needs



Person's needs



Description

Identifying a person's needs and preferences occurs through a collaborative consumer-led process that also engages family, carers and clinicians. Mental health intensive care provides an escalated response to an individual when they are experiencing an acute deterioration of their mental state requiring increased engagement and consideration of safety needs.

Being able to identify, understand and respond to the emotions of others and ourselves – referred to as possessing emotional intelligence – leads to better consumer outcomes and increases nurse satisfaction in hospital settings (Kooker et al. 2007). Knowing how to make sense of what a person may be feeling and the reasons why, alongside understanding your own emotional state and its impact, is critical to undertaking quality assessments in the high-demand environment of mental health intensive care.

Often the journey accompanying an admission to an MHICA can be extremely frightening. It may have involved intense feelings and events, police, an ambulance ride and waiting in an emergency area. During a mental health intensive care assessment, what you can see may not be a symptom but a natural response to fear, concern and, in some cases, trauma.

Acknowledging what happened along the way, and reassuring people that they are safe, can be effective in reducing distress and shift the course of someone's experience. It can help determine who is best ready to respond to individual needs, and for the team to support one another.

Establishing therapeutic engagement moves away from a discourse of pathology and risk to a discourse about human need and responses. For mental health intensive care, it reveals vital information about need.

Clinical practice standards

Mental health services will have in place frameworks to guide assessment, observation and engagement practices that support the consumer's ability to build rapport and trusting relationships with clinical staff. This helps clinical staff to develop an understanding of the person receiving care and their unique needs. This includes identifying:

- the person's individual strengths
- the person's perspectives, priorities, needs and preferences for care
- the static and dynamic factors that influence the potential risks, vulnerabilities and safety needs of the person.

Identifying and responding to risk while remaining aware of an individual's needs is a continuous process and requires mental health services to collaborate with consumers in a compatible environment, promoting safety and wellbeing for all.

Forming an opinion about the person's needs is a consultative process that will consider:

- the mental health principles of the Mental Health Act and the Victorian Charter of Human Rights and Responsibilities
- the views and preferences of the person, their family and/or carers
- the views and preferences documented in an advance statement or via a nominated person.

'We are very poor at understanding a person's need for sleep or for activity; this involves thinking beyond a one-size-fits-all or pharmaceutical response.'

– Clinical reviewer, HDU Project Working Group, 2019

Practice guidance

Respecting and responding to diversity

Mental health services must consider the needs of particularly vulnerable people and ensure that planning and decision making reflect this. The potential for exposure to harm within MHICAs, as well as in other treatment settings, should be appraised, and alternative locations for treatment and resourcing should be considered, particularly for individuals with a history or current experiences of trauma.

Considering mental health intensive care as an option should include assessing people's lived experiences and their needs, preferences, identities and circumstances, including age and cultural background. Mental health intensive care should always uphold people's physical, sexual and emotional safety. Planning mental health intensive care may require additional assessments of any specialist needs relevant to diversity including (but not limited to) the following:

Aboriginal and Torres Strait Islander status

Strengthening access to culturally responsive, safe and appropriate mental health services for Aboriginal people is a key domain in *Balit Murrup: Aboriginal social emotional wellbeing framework 2017–2027* (Department of Health and Human Services 2017a). Balit Murrup's objective is to reduce the health gap attributed to suicide, mental illness and psychological distress between Aboriginal Victorians and the general population. Connection to culture, family, community and country are built into approaches for mental health intensive care.

Embracing Aboriginal concepts of social and emotional wellbeing can assist services, clinicians and support staff to:

- situate mental health risk and protective factors within the broader social, cultural and historical determinants
- enable a strengths-based approach to supporting resilience through a 'whole-of-person' approach (in a therapeutic setting, for example, it encourages clients to direct their own healing and recovery)
- have an awareness of the importance of gender
- encourage access to and engagement with Aboriginal hospital liaison officers.

Refer to: Balit Murrup: Aboriginal social emotional wellbeing framework 2017–2027 (Department of Health and Human Services 2017a)

Gender and sexuality

A person's vulnerabilities and experiences can vary in relation to their gender, and this can affect their health care and level of safety. Lesbian, gay, bisexual, transgender and intersex people are often adversely affected by discrimination and stigma and might not have their individual needs met in inpatient settings.

Men and women can present with different needs that are incompatible with each other. Be alert and respond to communal environments that can lead to increased risk or vulnerability. Support opportunities to provide mental health intensive care in gender-safe spaces, such as women-only areas. To ensure that nursing practice is gender-sensitive, nurses should refine their practices in accordance with the *Service guideline on gender sensitivity and safety* (Department of Health 2011b).

Cultural awareness and diversity

Maintaining cultural connectedness can support recovery. Be careful not to assume an appreciation of the ethnic, spiritual and cultural needs and the importance of these to the person. Mental health services should aim to support a continued sense of connectedness to individual identity when providing mental health intensive care. Consider the person's communication needs at the earliest opportunity, and plan how to facilitate and support communication.

Refer to: Cultural responsiveness framework: guidelines for Victorian health services (Department of Health 2009a); Delivering for diversity: Cultural diversity plan 2016–2019 (Department of Health and Human Services 2016b)

At a minimum ensure people receiving mental health intensive care have access to:

- written information available in a range of languages
- telephone interpreters
- space for spiritual rituals.

Older people

Older people often present with a range of comorbid disorders, which can increase their level of risk. They may also have experienced bereavement, social isolation and loss of function or role. Engage with family and carers to improve understanding of the person's history, preferences, strengths and needs. The needs of older people in an acute inpatient unit are often diverse. Assessing communal and individual risk factors, vulnerabilities and mitigation strategies is required. Mental health services must ensure processes are in place to provide a full physical examination on admission, including a neurological examination, with planning to address any safety needs that arise from the assessment. Use of appropriate models supporting individuals and workforce in dementia care requires focus and prioritisation for services caring for older people.

Refer to Dementia Training Australia https://www.dta.com.au/.

Children and young people

When a child or young person is receiving mental health intensive care, they will have a different experience of their rights, and it is important that any limitation to these rights is safeguarded in accordance with the Mental Health Act.

Discussions with the young person and their families and carers about the most appropriate treatment environment for the minor is crucial, and a consensus should be sought.

The decision to initiate mental health intensive care for a child or young person should align with the considerations described for adults, and should specifically:

- be collaborative, where possible involving the child/young person and their parents/carers
- carefully weigh the benefits against the potential associated harm – these include exposure to traumatising incidents, isolation from peers and reduced access to family members or other support people.

Ideally, take a stepped approach to transitioning a person to mental health intensive care, offering the child or young person gradual, intensified support and guidance on strategies to self-manage and regulate distressing symptoms. Offer children and young people a range of evidence-based and developmentally appropriate therapies including sensory modulation, co-regulating engagement strategies and resources.

'Compassion … What I need most in HDU is someone to take the time and get to know me for who I am. Not just someone who is having a meltdown.'

– Consumer, HDU Video Project, 2018

Dual disability

Give the needs of people who present with a dual disability (intellectual disability or autism spectrum disorders and a mental illness) careful consideration before undergoing mental health intensive care. Challenges such as a lack of familiarity with the environment and care providers, change in routine, different or new expectations, and limited access to their attuned communication partners may lead to increased arousal and distress. It could also lead to disturbed behaviour, which can increase the risk of restrictive interventions. This is particularly problematic to individuals for whom behaviour is a primary means of communication.

Mental health services should liaise with families, carers, nominated persons and other usual supports to develop a comprehensive understanding of the individual's communication needs, along with features and factors that affect the person's impulse control, self-soothing behaviours and information and sensory processing. Use tailored communication, positive behaviour support strategies and increased allied health interventions including speech pathology. Consider the need for additional resourcing and ensure staff are familiar with the unique features of autism spectrum disorder and intellectual disability that can affect the effectiveness of interventions and the care type.

Dual diagnosis

People with dual diagnosis have both mental illness and a substance use problem. Services in both these sectors must be able to respond to their needs. As part of mental health intensive care assessment, treatment and recovery planning, ensure understanding of the person's preferred substances, common usage, their motivations for substance use and how to manage substance withdrawal, cravings and intoxication. Mental health intensive care services should have clear processes and protocols for supporting people with dual diagnosis including how they will apply an integrated approach to assessment and treatment that is recovery and strengths-focused.

Refer to: Mental health intensive care pathway: Assessments – Substance use disorders and acute intoxication

Person's needs and family violence

Multi-agency risk assessment and management framework

The new *Multi-agency risk assessment and management framework* (MARAM) has been developed as part of the Royal Commission into Family Violence recommendations (Department of Justice and Community Safety 2018). The MARAM aims to increase the safety of all Victorians by ensuring that identification, assessment and management of family violence risk is shared by organisations across the state.

All government departments need to align policies with the MARAM. Equally, all organisations prescribed under MARAM (including clinical mental health services) are also required to bring their policies into alignment.

If a family violence assessment has been undertaken, clinicians should be familiar with the person's current (lack of) safety before discussing planning of mental health intensive care. If family violence was not identified and is identified during conversations, the person's safety is paramount. Undertake a family violence risk assessment. If needed, seek support or secondary consultation from clinicians trained in family violence assessment or from a specialist family violence service for support. While evidence indicates that mostly women, children and young people experience family violence, elderly people and people in same-sex relationships can also experience such violence. The *Working together with families and carers: Chief Psychiatrist's guideline* (Department of Health and Human Services 2018) provides relevant information specific to clinical mental health services regarding family violence. Refer to the document's guidance on a range of issues including organisational responsibilities and clinical practice guidance. Understanding the safety needs of family members, including children, is important to include in routine care planning and discharge.

Physical health needs

Consumers and carers participating in the HDU Video Project (2018) often spoke about compromises to their physical health when they were unwell; and the need for the care type to respond to their physical health needs, including needs for sleep and exercise.

Mental health services should ensure that the physical health needs of persons receiving mental health intensive care align with the *Equally well in Victoria* (Department of Health and Human Services 2019a). Qualified medical and nursing staff should be available to ensure physical examinations are conducted, necessary investigations completed and adverse medication effects managed. Key points to manage include the following:

- Document the physical health needs of consumers transferred from emergency departments and other medical units and detail these in the transfer of care.
- If necessary, increase physical health monitoring because consumers may be unable to communicate symptoms to clinicians.
- Consumers may also be subject to new/increased pharmacological treatment that may cause impairment to their physical health.
- Mental health services should have in place local operational guidelines that provide advice to staff and departments on identifying and assessing physical health needs.

Refer to: Equally well in Victoria (Department of Health and Human Services 2019a)

Reflective questions

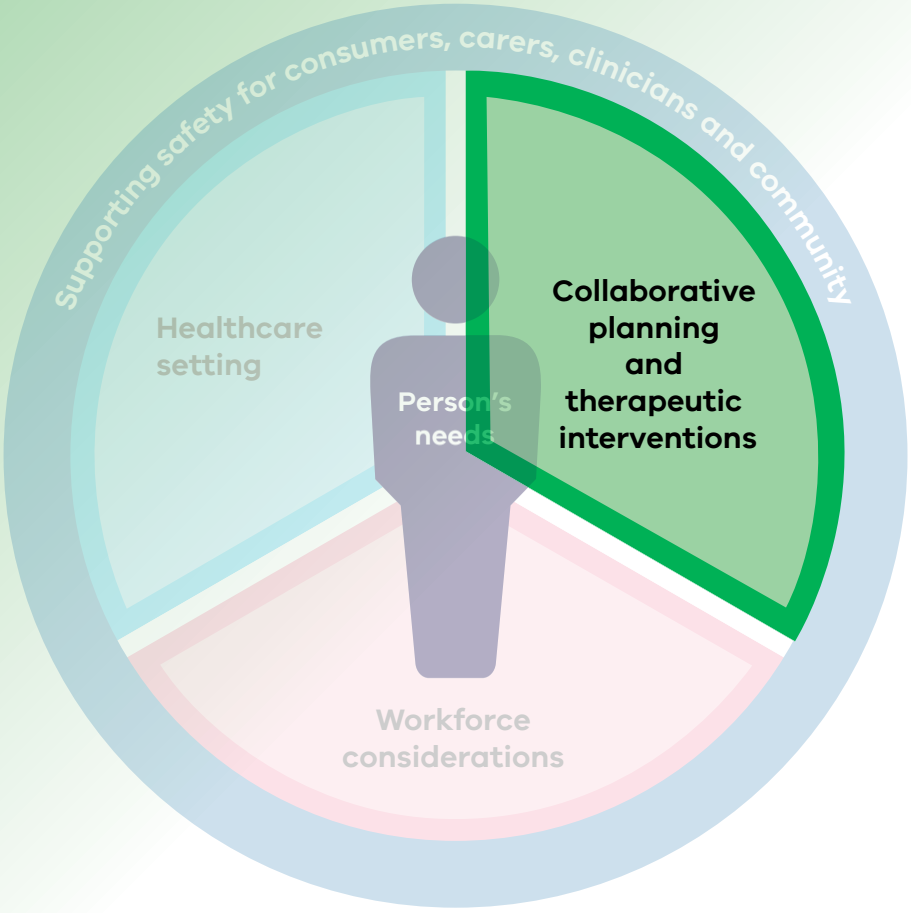
Do you think focusing on a person's needs rather than a person's acuity could lead to better outcomes for consumers and carers?

Using the framework, how could your service enable this?

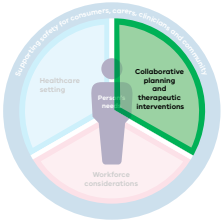
'I came in following the bushfires, I lost my home and was really traumatised. I was bought in by an ambulance and didn't know what was going on. A man came into my room – I was so frightened I couldn't eat, I couldn't sleep – I was terrified.'

– Consumer, HDU Video Project, 2018

Collaborative planning and therapeutic interventions



Collaborative planning and therapeutic interventions



Description

Planning mental health intensive care is consultative and collaborative and helps empower the person through supported decision making. Treatment has a comprehensive outlook that encourages self-regulation and safety. Care includes mechanisms for dynamic appraisal, nursing observation, engagement, assessment, early identification of deterioration and processes for timely escalation. This assessment helps identify the most effective therapeutic interventions to meet a person's needs.

Planning requires getting to know the person, often in a relatively short period of time. The process engages clinical teams with the person, their family or carer and other treatment providers to establish clear objectives for mental health intensive care. Planning should introduce behavioural supports and therapeutic interventions informed by interprofessional expertise, anticipating individual needs and concerns. Integrating techniques, such as Safewards, provides the necessary scaffolding to establish rapport and engagement.

Mental health intensive care planning incorporates safety planning with a set of clearly articulated treatment objectives, therapeutic approaches and behavioural supports early in a person's admission. Planning will consider the dynamics of potential treatment environments and how these will align with the goals of treatment. The constructed environment should not be the defining characteristic of care.

'I'm wanting them to be authentic, compassionate and empathetic. You want them to connect.'

– Consumer, HDU Video Project, 2018

Delivering mental health intensive care often imposes limits to personal freedom; however, this should not equate to an absence of choice, or deprivation of stimulation, which counters the objectives of the care type. Any limits to personal freedom should be regularly reviewed, updated and reflected in safety plans, team communication and with the person directly. Limits are therefore based on individual assessment of vulnerability, risks and need.

Clinical practice standards

Collaborative planning process and outlook

Irrespective of the treatment environment, planning to provide mental health intensive care requires a comprehensive outlook that considers all factors influencing care. Planning mental health intensive care requires the capacity of service providers to flex in response to planned and unplanned change within the environment, in resourcing and in the person's needs. This requires:

- a shared understanding between the person, the family or carer and members of the treating team about the objectives of mental health intensive care
- understanding what the person and their family or carer believes will support them best at the time
- considering how to enable person-centred care in the presence of acute illness, and compulsory status, and identifying how to promote collaboration and choice
- identifying potential environmental and interpersonal harms, and a responsive safety plan
- appraising compatibility and the milieu, and articulating responsive management strategies

- understanding individual communication needs, making adaptive communication available, and creating plans that describe how to support communication and engagement
- considering the range of clinicians and therapeutic options that may help
- establishing processes for reviewing and documenting least restrictive treatment options.

The planning process will support the person to have the clearest possible sense of the objectives of mental health intensive care, support them to make decisions about their care, and describe the indicators for transitioning to less restrictive treatment. It will also:

- be considerate of the person's history, particularly previous experiences of mental health intensive care, and the circumstances of past incidences of seclusion or restraint
- establish a consumer-led understanding of the success and limitations of strategies previously tried (this is particularly important)
- ask if the consumer has previously or is currently experiencing trauma will assist in talking about intensive care arrangements
- be considerate of the person's emotions and likely causes (experience of transport prior to access, events leading to hospital access)
- identify the aim of intensive care and the required supports including medication management and anticipated outcomes.

'Someone finally asked me "What happened to you?" instead of "What's wrong with you?"'

– Consumer, HDU Video Project, 2018

Maintaining therapeutic engagement, choice and activity

A foundation of mental health intensive care is **engagement**. Mental health services should prioritise, promote and actively support engagement activities and related policy to maximise therapeutic engagement throughout acute services. A therapeutic milieu requires:

- planning
- timely communication
- timetabled activity
- interprofessional approaches
- an inclusive model of care.

Mental health services should ensure that, through providing mental health intensive care, people are engaged in activities that help develop therapeutic relationships with staff and have a variety of opportunities to learn about and develop coping strategies to self-manage acute symptoms. In doing so, mental health services can implement and monitor in accordance with the *Nursing observation through engagement in psychiatric inpatient care* guideline (Department of Health and Human Services 2019b).

Nursing observation is the purposeful gathering of information from people receiving care to inform clinical decision making. It involves a person-centred approach to actively engage with people receiving care and their families and carers. The goal of nursing observation is to develop rapport and contribute to assessment and recovery.

Refer to: Nursing observation through engagement in psychiatric inpatient care (Department of Health and Human Services 2019b)

Practice guidance

Supporting autonomy and self-determination

Services will have tools in place to help them explore and better identify factors that may increase distress, early warning signs and approaches for self-care. Ideally resources will be consumer-led, supporting autonomy and self-determination. Input from carers, supporters and the interprofessional team will improve them further. Assessment should include:

- communication and sensory preferences
- triggers for distress
- early warning signs of deterioration (safety plans)
- advance statements.

Activity and therapeutic interventions

Mental health intensive care can offer more than pharmacological interventions and closer observation. It should support social connectedness. Consumers must have access to a range of activities and interventions to support engagement, promote self-care and prevent feelings of boredom and frustration. Make activities available for open-source self-selection – for individual and group use. At a minimum, people receiving mental health intensive care should have access to a range of therapeutic interventions 24 hours a day.

Activity is offered in a social and functional environment that invites participation in a range of lifestyle and therapeutic activities that are scheduled and timetabled, promoting choice and recovery. This includes:

- **Relaxation:** There should be clear pathways and information about how the communal environment can accommodate suitable space for relaxation practice. While enabling observation, spaces offer comfort and are conducive to relaxation, privacy and individual support with staff. Support consumers to develop self-soothing and regulating skills through individual and group instruction.
- **Exercise:** Many people find exercise soothing and having enhanced opportunities for physical expression (walking space, basketball, handball, gym equipment) has been strongly indicated by consumers and staff. People receiving mental health intensive care should have open access to fresh air and exercise. Provide opportunities for self-directed individual activity and group facilitated programs.
- **Sensory modulation:** The presence of mental illness may alter sensory processing, particularly during periods of increased stress. The treating team should provide and promote a suite of innovative sensory-based interventions and tools to help consumers modulate emotional and physiological arousal. Sensory modulation strategies may include access to aromatherapy, sensory tools (weighted blankets, stress balls, fidget tools), sensory equipment such as massage chairs, and audio-visual equipment including music and image projectors. The Safewards intervention 'calm down' method is also a useful strategy and can be implemented in MHICAs.
- **Emotional support:** Offer consumers opportunities to engage, be heard and receive more intensive emotional support. Empathic and active listening are essential tools for engagement, supporting recovery and normalising what can be a frightening and life-changing experience. Provide supportive counselling, recovery planning, motivational interviewing and other approaches individually or in a group format by all members of an interprofessional team, including nurses, occupational therapists, social workers and peer workers.
- **Specialist therapies:** The person and their team look for opportunities to use a range of evidence-based strategies and supplement care with intensive specialist supports. This may include providing trauma-informed care, cognitive behaviour therapy, family therapies, mindfulness or other specialist interventions.

'We have to stop thinking about intensive care being about a room with nothing in it; low stimulus seems to be a catch phrase for a room... Well let's start doing something with this room.'

– Clinician, HDU Video Project, 2018

- **Relational safety:** Therapeutic planning and interventions help support consumers to feel safe and comfortable internally and externally. Maintaining awareness of the emotions and feelings of each person and how people are working in a communal space is a key to reducing anxiety and enables people to feel emotionally and physically secure when in crisis. The Safewards model promotes useful strategies for supporting relational safety (mutual help meetings, mutual expectations and modelling of safe behaviours). This provides supportive and containing boundaries, together with opportunities for people to try new ways of coping on their own. Knowing what to expect, options for privacy, shared spaces and active spaces enable people to use their unique inner knowledge to meet individual needs and foster an environment of safety.
- **Group programs:** Access to a range of easily modifiable and flexible daily activities can be planned with people engaged in mental health intensive care. Providing individual and timetabled activities may include:
  - board games/cards
  - newspaper readings
  - art therapy
  - music therapy
  - quiz games / word finds
  - exercise groups
  - dance and movement
  - meditation.

Implementing therapeutic interventions – an interprofessional approach

Mental health services must provide an interprofessional approach to engagement and activity within MHICAs:

- Offer daily, organised activity timetabling, reflecting a variety of group and individual engagements.
- Clearly document access to current and easily interpreted daily planners, allocated nurses and available times for allied health support in intensive care areas.
- Provide protected or designated time for purposeful and scheduled individual engagement opportunities between the person and members of the interprofessional team.

There must be a service-wide effort to acknowledge the difficulty in attaining timely information regarding reviews, pathways regarding admission and transfer from MHICAs. There should also be concerted efforts to increase communication regarding appointments and scheduled meetings involving individuals receiving care.

Communicating plans

Contemporary practices of communication for community meetings, interprofessional, nurse-to-nurse and collaborative handovers should provide planned and evaluated processes to translate observation and risk assessment and to update care planning. Communication enables early escalation and collaborative planning responses and provides real-time support to decision making, promoting least restrictive care options including social, pharmacological, non-pharmacological and sensory-based interventions.

Establishing 'team safety huddles' (see overleaf) creates an opportunity for the interprofessional team to form a shared understanding of information and needs to provide timely, effective and compassionate care. Team safety huddles enable effective communication, cross-team engagement, early intervention and support.

'I had to wait for the doctor to decide if I could get out of there, but no-one could tell me when a doctor would come.'

– Consumer, HDU Video Project, 2018

Team safety huddles

- Can be initiated by any staff member who feels concerned about a person or situation.
- Will reliably and promptly bring together interprofessional teams including senior leadership and lived experience personnel.
- Provide a responsive forum to talk about the issues or people that the initiating clinician is concerned about.
- Focus on supporting the person, anticipating their needs and attending to the issues that are causing them distress, or the challenges they are facing.
- Consider the adequacy of current treatments and interventions and respond to comorbid issues such as alcohol and other drug withdrawal.
- Staff feel supported to act proactively, have a voice and role in safety and planning. Teams can develop and utilise a breadth of skills that focus on a person's strengths.
- Provide a focused approach to escalation and response through role allocation.
- Role allocation includes nomination of:
  - first responders
  - a scribe
  - a milieu coordinator
  - support nurse or other approved local roles. *Refer to Appendix 2.*
- Team leaders will 'check in' to assess local workforce capability, capacity and care needs of consumers and staff.

Team safety huddles provide a space to focus on integrating plans and provide a time to reflect on what the team is bringing to the milieu, individually and collectively. A sample team safety huddles planner is located in **Appendix 2.**

Reflective questions

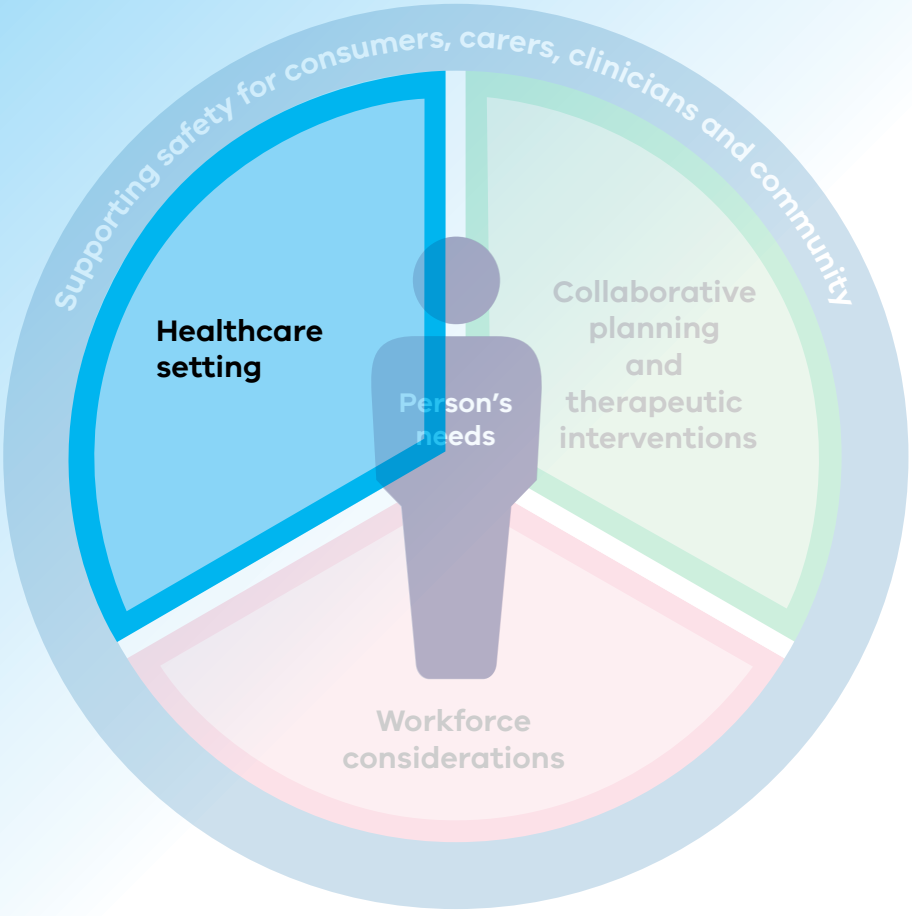
What therapeutic interventions do you currently offer people receiving intensive care? How would you enable a interprofessional team to facilitate the suggested interventions?

What are the tensions you face communicating in intensive care settings? How could you improve collaborative planning processes?

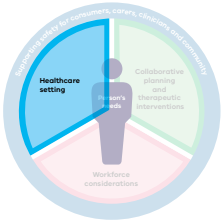
'There was nothing to do. I just sat there with all this stuff going through my mind. Being bored when I was struggling with distressing thoughts wasn't helpful.'

– Consumer HDU Video Project, 2018

Healthcare setting



Healthcare setting



Description

Based on the person's needs, the options for available care can be appraised. Decision making on the healthcare settings takes into consideration the potential risks and impacts the treatment environment poses, as well as the communal environment.

Conceptualise the care setting in terms of its features and construction, the community it supports and influences within it.

- The **treatment environment** is defined by the purpose and location, design and construction features of the environment.
- The **communal environment** is a culmination of the social milieu and intersection of individual needs within the shared space.

Clinical practice standards

Selecting and providing the most appropriate environment for care

In forming an opinion about the most appropriate location for treatment, service providers must assess the needs of the person and the potential for harm within both the constructed and communal environments. Selecting the most appropriate treatment environment should be a consultative decision based on discussion with the person, their family or carer, the referrer, the nurse in charge and a medical practitioner. The framework illustrates the balance of considerations between service environments, compatibility and the most appropriate setting for a person's needs.

Treatment environment

Services should first consider mental health intensive care as a care type, rather than the fixed environment. All people receiving treatment, including those requiring increased support, should have access to the same opportunities and access to clinicians, irrespective of location or environment. Assess the options available, and the merits of constructed environments, in alignment with the person's needs. These may include:

- the person's preferences
- observation and engagement
- privacy
- safety
- security
- sensory experience
- treatment and physical health needs (medical/surgical).

When choosing a treatment setting, explore all possible alternatives before applying environmental restrictions or freedom of movement. Treatment environments and options for providing mental health intensive care may include:

- provision of sensory or de-escalation areas
- increased resources and engagement with the interprofessional team
- accommodation of family and nominated supports
- one-to-one nursing, or 'nurse specialling'
- appropriate resources to support admission to an emergency department, general medical or surgical units – this may incorporate input from a consultation psychiatry liaison, mental health clinicians and allied health clinicians and consider allocating one-to-one nursing or 'nurse specialling' to meet the needs of the consumer
- a purpose-built and therapeutically supported MHICA.

Mental health services must ensure policies and procedures are in place to describe the following:

- The use of security and monitoring technology including movement sensors and electronic door locks. Specify contingency arrangements for periods of fault or inoperation. Refer to the Chief Psychiatrist's guideline *Surveillance and privacy in designated mental health services*.[3]
- A procedure for routine safety and security checks within the area for detecting potentially unsafe or prohibited items. Conduct these procedures in accordance with the principles described by the Chief Psychiatrist's guideline *Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff,* and include a list of prohibited items.
- A procedure for detecting, reporting on and escalating damage and faults to fixtures and fittings, with set timeframes for repairing or replacing the items.
- A schedule for regular ligature safety audits.
- A policy for consumers awaiting transfer from an emergency department including transfer from a behaviour assessment room.

3 See *Surveillance and privacy in designated mental health services* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/surveillance-privacy-designated-mental-health-services>

Communal environment

A tension arises when people are grouped into treatment environments according to risk severity and support needs, this commonly results in clustering people whose needs are incompatible. While environmental controls and resourcing are organised to promote increased safety and security, a complex milieu can counteract the benefits of the environment.

The compatibility of people within shared spaces should be a key consideration in selecting the most appropriate treatment environment with an individual, and in planning the treatment approach. A person has a right to safety, and services must recognise some treatment environments will result in exposure to safety concerns from others.

Responding to safety needs, risks and vulnerability within subgroups is not straightforward – it is an advanced clinical skill. The dilemma posed by a complex milieu has the potential to limit the capacity of staff to respond to individual needs. It can minimise the therapeutic benefit of the care type, particularly where the intensive care environment is routinely interrupted with restrictive approaches in response to individual safety concerns. Maintaining an environment that is therapeutic and not custodial is an ongoing challenge and relies on incorporating trauma-informed practice, recovery-oriented practice and the availability of clinical leadership and advanced expertise. A skilled mental health intensive care clinician will dynamically and continuously assess the effectiveness of activities and engagement within an environment. Respecting self-determination and dignity of risk, a clinician provides opportunities to collaborate rather than applying predetermined restriction. While mental health services will have embedded risk audits and assessments, a factor in building therapeutic rapport and recovery will be the ability to respond to a person's needs, including access to family and other supports, while adjusting safety considerations as required.

Dynamic appraisal

Dynamic appraisal is a continuous process of assessing and responding to a person's needs and identified safety considerations in rapidly changing environments or circumstances. Routinely integrate dynamic appraisals of the communal environment into service delivery to maximise the potential to identify emerging issues. Shift-by-shift handover, while a valuable communication tool, has the potential to overlook a problem when it declares itself. Services should ensure that additional expertise is available to support decision making in real time to preserve the therapeutic environment and minimise compounding risks.

Design and functionality

Mental health intensive care is to provide both safety and comfort in an environment that encourages positive therapeutic relationship between the person, staff and the service.

To achieve this, it is important that environmental factors and the functionality of the area promote choice, privacy and self-regulation. **A focus of design should be on reducing consumer permission seeking, which has been linked to increased distress.** The design of MHICAs should comply with the *Australasian health facility guidelines* <https://healthfacilityguidelines.com.au/> and require:

- multiple social spaces that offer choice for consumers in how space is used
- movable furniture or multiple clusters of fixed furniture
- single bedrooms with ensuite bathrooms
- safe, accessible and observable areas where people may visit
- freely accessible sensory spaces and sensory equipment
- adequate interview space
- access to natural light and outdoor space
- access to space to ambulate and/or exercise
- access to drinking water and amenities
- features such as kitchenettes, televisions, leisure activities and furniture that provide a comfortable environment while balancing safety requirements
- technology that can support privacy, safety and communication with consumers (for example, consumer-specific swipe access to bedrooms, monitors or boards providing orienting information to the MHICA and scheduled or available activities, interventions or groups)
- flexible zoning and, where possible, gender-specific accommodation and communal areas
- a configuration that allows for clear lines of sight
- areas for safe storage and reasonable access to personal belongings
- anti-ligature fixtures and fittings that comply with national building standards.

A mental health intensive care area should be flexible enough to enable the person to have access to their support people including families and carers.

'For seven weeks my son had a nurse special. They were friendly and built up a relationship with my son and the family. He was sympathetic, tactful and friendly.'

– Carer, HDU Video Project, 2018

Practice guidance

Mental Health Act legal status and MHICAs

In circumstances where mental health intensive care is provided in a locked environment and it is not within the person's control to leave, the mental health service must give regard to this limitation and ensure this is the least restriction necessary.

Using MHICAs for voluntary patients is undesirable. Thoroughly explore individual treatment and support requirements and alternatives. Elective treatment within an MHICA must only occur:

- after exploring all other least restrictive treatment options and discussing these with the individual and their family
- after the service has taken steps to understand and respond to the person's concerns about less restrictive treatment environments
- where the person has received an orientation to the care type and environment
- after informing the person of their rights and how these rights (including access to personal belongings and access to visitors) may be affected.
- A full explanation of the team's treatment and support objectives prior to entering a MHICA is required. Additionally, services must have a policy regarding dispute resolution should the person and the service disagree about the ongoing need for mental health intensive care, including changes to mental health legal status.

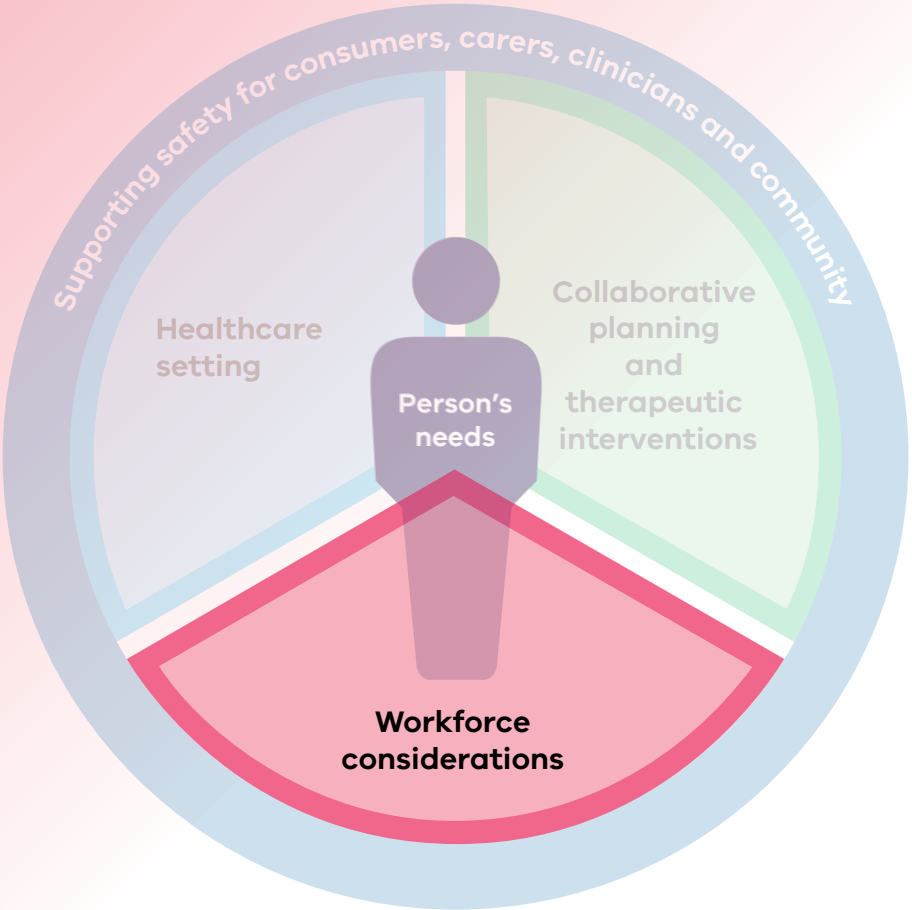
There is a natural tendency to attribute people's behaviours to their own dispositions and to overlook the effect of the environment. This tendency may be particularly strong when people are exhibiting behaviours that are not congruent with social norms. Nurses can assist people through, bearing in mind how inpatient environments may influence behaviour. Through engaging with people, nurses can come to understand their experiences of psychiatric inpatient settings. This, when done well, may create the opportunity for people to experience services differently.'

Source: Department of Health and Human Services 2019b

Reflective questions

Acute care has, for a long time, been about a designated space. How does the framework challenge this? And how will your service implement this change?

Workforce considerations



Workforce considerations

Description

Mental health intensive care considers the resources, skills and experience necessary to meet an individual's needs, maintain safety and enhance therapeutic engagement. Mental health intensive care provision requires specialist skills, appropriate resourcing and interprofessional input.

Clinical practice standards

Mental health intensive care is a specialist framework, ensuring constant availability of the skills and experience necessary to maintain safety, respond to the person's needs and promote therapeutic relationship. The organisation of mental health intensive care resources will naturally vary with the treatment environment; however, services should adhere to the following principles of resourcing:

- Wherever a person is receiving mental health intensive care there will be a constant and vigilant presence of suitably skilled and experienced personnel.
- All personnel providing care will have a shared and clear understanding of their role in assessment, monitoring and treatment.
- There are uniform leadership, motivation, orientation, training and supervision standards across all disciplines providing mental health intensive care.

This includes an enhanced understanding and application of the Safewards model and interventions, engagement in scenario-based training and regular review of trauma-informed practice, plus related training in aggression management. Mental health services should take steps to ensure that rostering principles, escalation protocols and supervision, resilience and mentoring structures are appropriate to support the wellbeing of those providing mental health intensive care.

While mental health clinical staff will have knowledge of evidence-based interventions, the interpretation of this knowledge within the mental health intensive care context can be a challenge, particularly given the need to balance a variety of individual requirements simultaneously. Maintain a minimum standard of orientation and competency across all disciplines providing mental health intensive care. This may include security, domestic and other workforces who support the hospital milieu.

Resourcing

Resourcing options are an essential component in both deciding and tailoring a treatment environment to ensure least restriction and safe treatment can co-exist. Mental health services will consider the range of organisational resources available within their service to plan and provide mental health intensive care that promotes safety for all. This is particularly important in circumstances where:

- the preferred treatment environment is not available, or is unsuitable due to factors external to the person
- communal dynamics can create a compatibility risk
- there are specific individual needs and preferences that support safety.

Daily assessment of the communal milieu will help determine the need for further resources. Define the communication pathways through which issues can be escalated to executives.

Selecting the most appropriate resourcing requires that the person's needs and preferences are well understood. Recognising the benefits and potential challenges within the constructed and communal contexts of treatment environments will help inform this. Staffing levels should be consistent within a framework of recovery-oriented, trauma-informed and gender-sensitive practice.

Mental health services should determine resourcing requirements according to:

- the most appropriate staff-to-patient ratio
- staffing discipline and designation, inclusive of nursing, allied health, lived experience and peer workforce
- engagement and observation intervals
- the skills and attributes necessary to ensure the continuance of therapeutic engagement.

Service providers must support the capacity to increase nursing staff in response to escalating consumer needs, the number of consumers and to meet the occupational health and safety needs of staff.

Nursing staff should be rostered to the skill levels required to assist those in need of mental health intensive care.

Consistency in MHICA staffing helps develop trusting relationships and feelings of safety and security. Mental health services should minimise the use of non-regular staffing in these areas to promote continuity of care and established therapeutic relationships.

'Sometimes I see rogue practices which place the least experienced staff within the most acute setting.'

– Clinician, Mental Health Intensive Care Expert Reference Group, 2019

Mental health service providers must comply with Chief Psychiatrist Direction 2016/01 – *Staffing requirements for safe practice regarding locked areas within mental health inpatient units*.
The direction highlights:

- If there is a locked space within the inpatient unit where more than one person is receiving treatment and care, there must always be at a minimum one clinical staff member present.
- The practice of observing consumers through a window of a staff base is not an acceptable level of service provision.
- This direction applies to any locked area within an inpatient mental health unit (including HDUs) where more than one person is receiving treatment, at all times.
- In the exceptional circumstances of an imminent risk to staff health or safety (such as an emergency situation) other legislation provides for staff to withdraw to maintain their own safety and safety of patients.

Selecting the most appropriate resourcing, health services should recognise the limits in scope for particular staff, specifically security personnel and care attendants who are not always best placed to contribute to therapeutic engagement. While undertaking important tasks to maintain safety and care, planning should consider the potentially counter-therapeutic and antagonistic impact of resourcing that may impose a custodial or punitive quality. Using appropriately trained security personnel under the guidance and direction of the senior clinician may be necessary at times and should follow local policy and procedures.

Practice guidance

Workforce leadership

Mental health intensive care needs are vulnerable to rapid change. Oversight, leadership and mentoring are integral to safely and effectively delivering care. They are also necessary to ensure staff are motivated, that staff understand the objectives of the care type, and that the outcomes of care are evaluated.

- Mental health services should establish senior clinical leadership roles that are responsible for implementing mental health intensive care, including oversight of the clinical and operational functions of care, and continued monitoring across all shifts.
- Mental health services should ensure processes are in place to support clinical staff to escalate concerns about consumers early and engage additional expertise and collaborative decision making in response to signs of deterioration.

Mental health services require contemporary models of staff support including:

- clinical supervision for all disciplines
- service-supported regular reflective team practice
- advanced understanding of self-care, resilience and compassion
- respect for staff breaks and cover arrangements.

An interprofessional approach to mental health intensive care

Mental health intensive care is resourced by an interprofessional team including medical, nursing, allied health and lived experience workforce, and each should have a role in planning, appraisal and engagement.

- Encourage engagement of the interprofessional team through therapeutic individual and group programs.
- Conduct daily interprofessional team discussions to monitor progress and appraise the effectiveness of the treatment approach.
- Support and train the interprofessional team to enable engagement in MHICAs.

Recommended disciplines and roles are outlined below.

Lived experience support

In Victoria, lived experience expertise is used in three discipline areas encompassing advocacy, consultancy and peer support. Mental health services should include consumer and carer lived experience in service planning and innovation to ensure people receiving mental health intensive care have access to specialised support. Lived experience personnel should be accessible to both consumers and carers and:

- have a clearly defined scope of practice
- be oriented to the operational and therapeutic requirements of mental health intensive care
- contribute to group program and intervention design
- take an active role in supporting participation
- take an active role in a continued dialogue with consumers about their rights
- take an active role in supporting clinical staff to identify alternative or additional strategies to support individual recovery
- take an active role in supporting family and carers.

Nursing

Mental health intensive care requires increased levels of nursing observation and continuous therapeutic engagement. Mental health services should implement and monitor in accordance with *Nursing observation through engagement in psychiatric inpatient care* (Department of Health and Human Services 2019b) and the current public mental health services enterprise agreement to ensure:

- mental health intensive care maintains a constant nursing presence and leadership
- resourcing of MHICAs will be in accordance with minimum ratios
- resourcing of mental health intensive care supports the continued development of therapeutic relationships
- nursing resources can be increased in response to escalating needs
- ensure the occupational health and safety needs of staff are met
- the level of seniority and skill of nursing staff providing care is appropriate to support and engage people with increased need.

Medical

To maintain responsive mental health intensive care 24 hours per day, health service must ensure:

- At a minimum, a medical practitioner should review those receiving mental health intensive care daily and should discuss the case with a psychiatrist.
- Health services should ensure reliable access to a psychiatrist is available to people receiving mental health intensive care.
- Where junior medical staff provide additional support, particularly outside business hours, health services should ensure they are given an orientation to the care type, are familiar with the requirements of care and have access to appropriate supervision by senior medical staff.
- For junior medical staff who do not have the necessary authority or specialist knowledge to change aspects of a person's mental health care plan, deterioration of symptoms should escalate treatment reviews to a psychiatrist without delay.
- Staff should attend team safety huddles and have access to communication and updates relating to changes in planning.

Allied health

Mental health services should ensure that people receiving mental health intensive care have access to allied health specialties including psychology, social work, occupational therapy and speech pathology.

Allied health staff should not be restricted from MHICAs. Pathways to access allied health specialists should include:

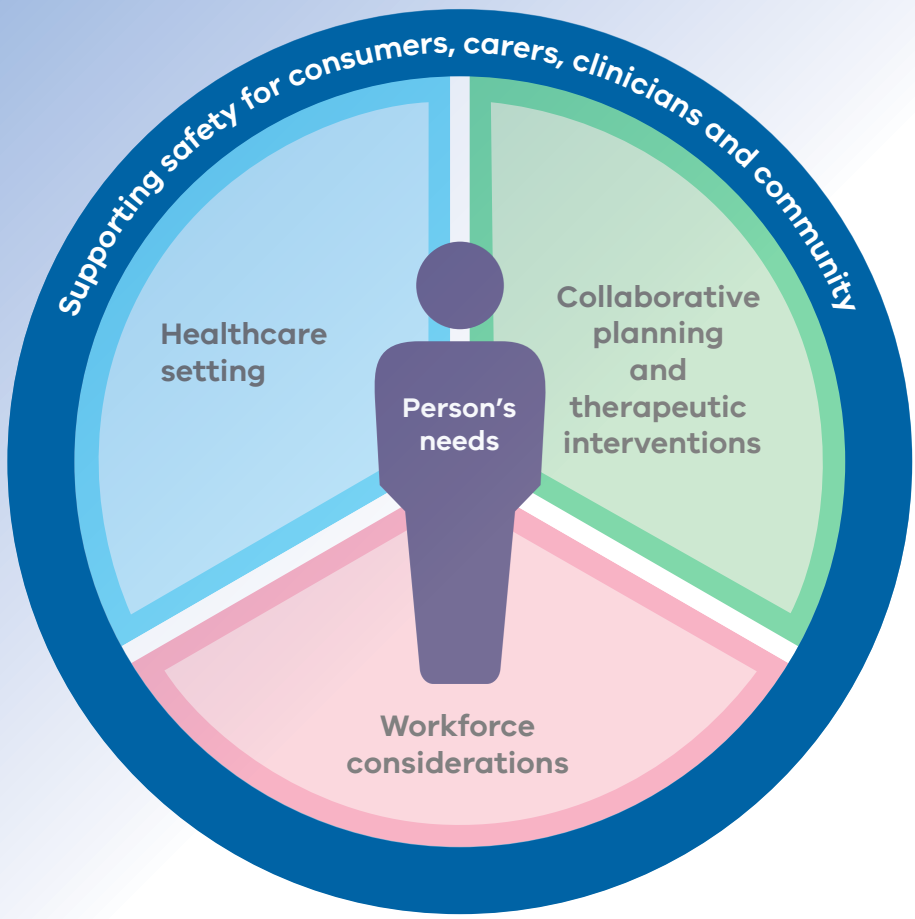
- individual and group interventions
- early engagement of allied health disciplines with families and carers at service commencement
- allied health representation in all domains of planning and appraisal.

Reflective questions

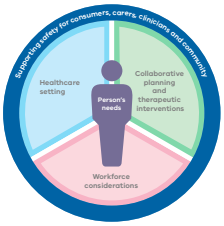
Does your service test the need for nurse specials and additional resources using acuity scales and risk assessment to inform need?

What is your communication strategy to escalate, request and approve additional resources?

Supporting safety



Supporting safety



Description

An overarching domain that supports safety for all when providing mental health intensive care includes the **consumer, carer, clinician** and **community**. Promoting safety and wellbeing for all is an iterative and continuous process that moves beyond checklists to critical consideration of the person's needs, the communal and environmental risks and the safety of staff.

Clinical practice standards

A lens of safety

Irrespective of the location of treatment, safe and effective responses to the risks and vulnerability associated with the impacts of severe mental illness require the presence of appropriately skilled staff and local guidelines and processes to monitor and identify:

- the person's perception and understanding of their own safety needs and preferences for supporting safety
- support needs and safety risks present or emerging for individuals including self-harm, suicide, violence/aggression, sexual misconduct, absconding and vulnerability – this includes previous and current trauma experiences, substance use/withdrawal and medical comorbidities
- the potential for harm within the constructed environment including the presence of prohibited or potentially dangerous items, ligature points, breakages, damage and technology malfunction
- the present or potential for harm within the communal environment that may contribute to trauma and risk its status as a safe and therapeutic community.

Processes to support timely communication to escalate risks, as well as documenting the strategies to be implemented, are required in each of these areas. Risk assessment – historic or current – requires a balanced approach, which promotes opportunity for engagement, choice and supported decision making.

Refer to Nursing observation through engagement in psychiatric inpatient care (Department of Health and Human Services 2019b) for more on the interrelationship between nursing observation and risk assessment.

'We need to encourage a shift in policy enabling and supporting care rather than the emphasis on "the do nots", the searches and the prohibited items.'

– Clinician, Mental Health Intensive Care Expert Reference Group, 2019

Maintaining a safe environment is the responsibility of all staff. It should be achieved using standard procedures established by mental health services that include:

- escalation processes to respond to issues early
- a daily and impromptu ability to hold team safety huddles
- a daily handover with medical representation
- a change-of-shift handover between staff including the senior nurse on duty
- agenda item at each interprofessional team review
- routine environmental searches and audits
- observation and engagement practices in accordance with *Nursing observation through engagement in psychiatric inpatient care* (Department of Health and Human Services 2019b).

These forums should appraise individual, environmental and communal and safety considerations and ensure planning includes:

- how individual treatment needs may conflict with the needs of others sharing the space
- potential harms and the steps necessary to prevent these
- how individual treatment needs are influencing the communal environment and the progress of others' treatment
- the steps to prevent exploiting vulnerability
- assessing the individual and collective safety of the space
- promoting a sense of preparedness throughout the shift.

After forming an opinion about the harm to be prevented and the person's needs and safety requirements, clinical staff must remain vigilant to potential changes in or around the person that affect their safety. These may include:

- continued feedback from the person and their families, carers and supports
- therapeutic community risks and vulnerabilities
- level of engagement
- the impact of the communal dynamic
- environmental stimuli
- further expression of distress
- interpersonal factors and stressors outside hospital
- changes in the constructed environment (for example, property damage, closure of rooms or areas)
- design functionality (for example, visibility, lighting, door locking systems and duress alarms)
- planned and unplanned changes in resourcing and support (for example, shift changes, transfer).

'You can't have one size fits all. If I could see any change in HDU it's that you recognise them as a person first who's going through some health issues and they happen to be mental health issues. That doesn't make you a lesser of a person.'

– Consumer, HDU Video Project, 2018

Provide the person, their family, carer and nominated person with opportunities to inform and to be informed, supported and educated about their role in relation to maintaining safety and security. At the beginning of mental health intensive care, ask the person to discuss things that they believe may be a potential risk or trigger. Be informed about steps the service may take to increase safety. Information about any prohibited items that protect safety should be available and accessible. This may include limiting access to objects that are potentially unsafe including glass, cans, lighters/matches, belts, shoelaces, sharp objects or implements (for example, knives, syringes), inhalants (perfume, deodorant) or plastic bags in alignment with the Chief Psychiatrist's guideline *Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff.*[4]

Reducing restrictive interventions

Restrictive interventions are not therapeutic; they are intrusive practices used as a last resort to prevent serious and imminent harm to a consumer or another person. In Victoria, the Department of Health and Human Services, the Chief Psychiatrist and public mental health services have undertaken a number of activities to reduce and eliminate restrictive interventions. Only apply restrictive interventions after all possible preventative practices have been considered, attempted and deemed unsuitable. Restrictive interventions are linked to re-traumatising of past experiences, serious injuries and even death. When used, registered nurses or registered medical practitioners must approach restrictive interventions in a way that maximises the physical and psychological wellbeing of all involved.

The following principles underpin reducing restrictive interventions:

- All key stakeholders (consumers, carers, mental health service staff, management and the government) have a role in designing and implementing safe environments.
- Treat consumers, carers and mental health staff with respect and dignity; their rights and responsibilities are central to promoting safety.
- Organise the service environment to ensure the safety and wellbeing of consumers, carers and mental health staff.
- Manage difficult and challenging behaviour in ways that show decency, humanity and respect for individual rights, while effectively managing risk.
- Trained staff are to only use restrictive interventions as a last resort and for the briefest duration after all other less restrictive options reasonably available have been tried or considered and found to be unsuitable in the circumstances.
- Programs to reduce restrictive interventions require effective governance, clear delegations and ongoing monitoring of local strategies and initiatives to ensure effective implementation.
- Recovery-oriented practice, trauma-informed care, supported decision making and family/carer-inclusive practice inform workforce practices and are necessary to create positive clinical cultures and to prevent cultures that are coercive or create conflict.

4 See *Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/criteria-or-searches-maintain-safety-in-inpatient-unit-for-patients-visitors-staff>

'When I was really fearful, being left alone and not having anything to make me feel safe just made me feel more fearful. When I look back, staff didn't really understand what I was experiencing.'

– Consumer, HDU Video Project, 2018

Refer to: Providing a safe environment for all: framework for reducing restrictive interventions (Department of Health and Human Services 2013)

Health services must provide leadership to establish regular, contemporary, evidence-based de-escalation training to staff, reflecting input from the lived experience sector. Scenario-based de-escalation training will help orient staff to critical decision making, care planning and communication required when addressing aggression. Provide this training to all staff who may be engaged as part of service delivery including security personnel. Underpinning efforts to reduce restrictive interventions requires:

- integrated training as a part of a model of care
- the six core strategies (Australian College of Mental Health Nurses 2019; Huckshorn 2004)
- Safewards
- recovery-oriented care
- trauma-informed care.

Health services should refer to *Minimum training standards: preventing and managing clinical aggression including the use of physical restraint* (McKenna et al. 2013).

Safewards implementation

Implement Safewards as part of delivering mental health intensive care services. The key focus of the Safewards model is to examine conflict and containment within health settings. The model highlights flashpoints and triggers attributed to clinical settings and interactions that may result in harm such as violence, self-harm or absconding. Safewards offers interventions designed to reduce the risk of conflict and containment within inpatient settings.

The Safewards model examines six originating domains (patient community, patient characteristics, regulatory framework, staff team, physical environment and outside hospital) that can trigger conflict and lead to containment. The flashpoints are practically addressed with 10 evidence-based interventions, chosen for impact and evidence.

All mental health intensive care services should implement the following Safewards interventions:

- know each other
- clear mutual expectations
- mutual help meeting
- calm down methods
- bad news mitigation
- soft words
- talk down
- reassurance
- discharge messages
- positive words.

Source: Safewards handbook: training and implementation resource for Safewards in Victoria, Department of Health and Human Services 2016b

'I ask questions. You can have your own perception of what you think is going on and what's going on in someone's head, but if you don't ask the question you don't know.'

– Clinician, HDU Video Project, 2018

Using security staff or police to support safety

The presence of security staff or police may be concerning, frightening or traumatising for some people and their families or carers. Only use security staff or police as a last resort or when necessary for safety reasons.

Where security staff or police are providing assistance, mental health service staff should consider the following:

- person's gender
- culture
- history of previous or current trauma
- their perception and any limits to their understanding of the role of security or police.

Mental health services should implement the following principles:

- When mental health intensive care is facilitated by or involves security personnel, the process will be clinically led and supported.
- Mental health services will be vigilant to the potential contagion of distress in these circumstances and action the Safewards reassurance and soft words interventions to counter this.
- Take all steps to minimise the time security or police personnel are involved in mental health intensive care after ensuring sufficient clinical resources are in place to support safety.

Services should have in place clear delegations and processes, and opportunities for joint staff training between mental health staff and security/support personnel, to ensure consistent, safe and trauma-informed approaches.

Clinician and community safety

Everyone has the right to feel safe at work. Mental health inpatient units and intensive care areas are often environments of high acuity and stress. Health services should provide and maintain a working environment that is safe and free of risks to health, so far as is reasonably practicable. There is also a duty to ensure that workplace activities don't endanger other people, such as visitors, consumers and the public. Apply strategies to support clinicians providing mental health intensive care including:

- implementing emergency response and escalation procedures including Code Grey, planned Code Grey and Code Black
- orientating staff on processes for using duress equipment
- providing opportunities for peer support and debriefing
- providing mentoring, clinical supervision, reflective practice, resilience and self-care strategies
- offering training to prevent and respond to violence and aggression including de-escalation
- providing post-incident support and employee assistance programs
- supporting engagement with occupational health and safety management
- staging forums to examine and support improvement and culture change.

Health service providers must ensure they adhere to relevant legislation, frameworks and standards.

Practice guidance

Sexual safety

Mental health services should not rely on visual observations alone as the mechanism for preventing sexual harm. Mental health services will:

- recognise the advice provided in the Chief Psychiatrist's guideline *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* (Department of Health 2009b) and the procedure for notifying breaches of sexual safety to the Chief Psychiatrist
- ensure governance and oversight to prevent avoidable harm through implementing primary prevention strategies, including establishing clear expectations of conduct within inpatient facilities
- engage the Safewards intervention 'clear mutual expectations'
- have policies in place to ensure respect and dignity to all consumers that include procedures for providing choice to, and supporting the needs of, transgender and non-binary people
- where possible, maintain a mixed gender staffing profile to ensure individuals can access gender-specific support or observation where this is preferred
- pay attention to the potential for sexual harm within MHICAs and use this to inform decision making about the most appropriate treatment environment for some people
- ensure close monitoring of the communal and individual dynamics and interactions in MHICAs to ensure early identification of potential sexual harm
- maintain a supportive dialogue about each person's sense of safety and ensure an understanding of the person's history and their identity
- provide adequate treatment for mental health conditions that increase the risk of sexual safety incidents, including risk of vulnerability or perpetrating an incident
- understand the links between previous sexual assault, especially during childhood, and increased vulnerability to sexual assault
- ensure team orientation to trauma-informed care practices.

Recognising and responding to deterioration

Irrespective of the treatment environment, support mechanisms for dynamic appraisal using a constant therapeutic connection that can:

- recognise the need for additional or alternative strategies
- recognise and respond to early signs of deterioration
- recognise indicators for escalation and respond through planned processes.

Accurately and quickly identifying mental state deterioration is key to determining best practice approaches to support a person with complex needs. Recognising deterioration will incorporate identifying:

- reported changes
- distress
- loss of touch with reality or consequences of their behaviour
- loss of function
- elevated risk to self, others or property.

Refer to **Appendix 3** – Mental state deterioration template (Gaskin & Dagley 2018) for more information.

Services must develop escalation planning processes and pathways to ensure adequate care, resources and communication. Planning structures will anticipate engagement opportunities, alternatives to restrictive practices and necessary considerations for acutely managing distress and clinically indicated pharmacological concerns.

Please refer to local acute arousal guidelines and acute escalation flowcharts for managing pharmacological administration.

Managing deterioration, distress and associated aggression

Evidence from the 2016 State-wide HDU report provides insights into high rates of distress and an interrelationship with associated aggression. Managing aggression in clinical services requires enhanced organisational responses, leadership and communication frameworks to guide contemporary practice. Services must provide a trauma-informed response when managing aggression that incorporates:

- a well-considered escalation protocol that responds to individuals needs
- appropriately trained staff in de-escalation techniques and Safewards interventions
- Integrated tools promoting the neurosequential model (Perry 2006)
- self-regulation frameworks
- regular workshopping and appraisal of scenario-based training and team responses to aggression
- advanced service level and executive support to workshop safe, strengths-focused approaches to de-escalation
- advanced communication pathways, including team safety huddles, with security personnel and management to support timely and coordinated Code Grey, planned Code Grey and Code Black responses
- contemporary understanding of sensory modulation and engagement of such interventions
- pharmacological protocols supporting responsive, preventative and evaluated measures
- integration of behaviour support plans, safety plans, sensory profiles and advance directives
- effective reflective practices and debriefing for consumers, carers, clinicians and the community
- adequate safety equipment
- qualified clinical supervision, resources and spaces supporting self-regulation for staff and teams.

For further resources, please refer to:

- the Safewards Victoria training program
- *Providing a safe environment for all: framework for reducing restrictive interventions* (Department of Health 2013)
- *Nursing observation through engagement in psychiatric inpatient care* (Department of Health and Human Services 2019b)
- local trauma-informed and neuro-biologically minded de-escalation and support training providers
- **Appendix 4** for an example of a service-level response to reducing restrictive interventions.

Reflective questions

What is currently available in your unit to accommodate individual sensory needs?

What considerations would you apply when assessing the efficacy of admitting a person to a designated MHICA?

Mental health intensive care pathway

Mental health intensive care pathway

This section will step through necessary stages of mental health intensive care including:

- transfers to an existing MHICA
- orientation and explanation of care
- dynamic appraisal and review
- responding to clinical deterioration
- composition of care
- supporting transition to other care options.

Initiating mental health intensive care

A decision to initiate mental health intensive care develops when there is concern that the person is at increased risk of harm to themselves, to others, or from themselves, and their needs cannot be met in a less restrictive or intensive way.

Through engagement and assessment, the team must establish immediate care requirements and associated supports to assist a person experiencing acute mental health concerns. Nursing observations will include highly developed skills reflecting therapeutic interactions attending to the psychosocial, physical health and safety needs of the person.

Refer to: Nursing observation through engagement in psychiatric inpatient care (Department of Health and Human Services 2019b)

Individual support plans need to ensure adequate responsiveness to the needs and vulnerabilities of people who are subject to mental health intensive care. Pay attention to gender, diversity, the impact of trauma and family and cultural considerations.

Irrespective of its location, mental health intensive care often limits personal freedom and should occur only after:

1. All other available interventions to address the person's needs, behaviour or vulnerability have been considered *or demonstrated* to be unsuccessful (for example, sensory and distress supports, Safewards interventions, communication and privacy considerations).
2. Collateral information has been obtained from the person's supports, including family or carers, about the potential benefits and risks of proposed interventions.
3. An opinion has been formed that the chosen environment is where treatment objectives will be progressed.

Authorising use of MHICAs

The decision to provide treatment in an MHICA should be considered by a psychiatrist in collaboration with the senior nurse in charge. Clinical analysis and formulation that demonstrates an understanding of the person's needs, recovery goals, comorbid health needs, identified safety issues and treatment options should inform decision making.

- Where it is necessary to ensure immediate safety for the person or others, the decision to provide treatment in an MHICA may be actioned by the senior nurse in charge or a medical practitioner without prior liaison with a psychiatrist (see the Mental Health Act).
- Where the decision has not been subject to a psychiatrist's consideration, a rationale and details of the treatment plan should be communicated to and considered by a psychiatrist as soon as practicable (within four hours) and documented in the clinical file.
- The documentation should include information about what supports have been considered/tried and the least restrictive options reviewed.
- Clearly communicate decisions to the consumer, their carer and other support people.

Mental health intensive care planning incorporates risk mitigation and safety planning with a set of clearly articulated treatment objectives, therapeutic and behavioural supports early in a person's admission.

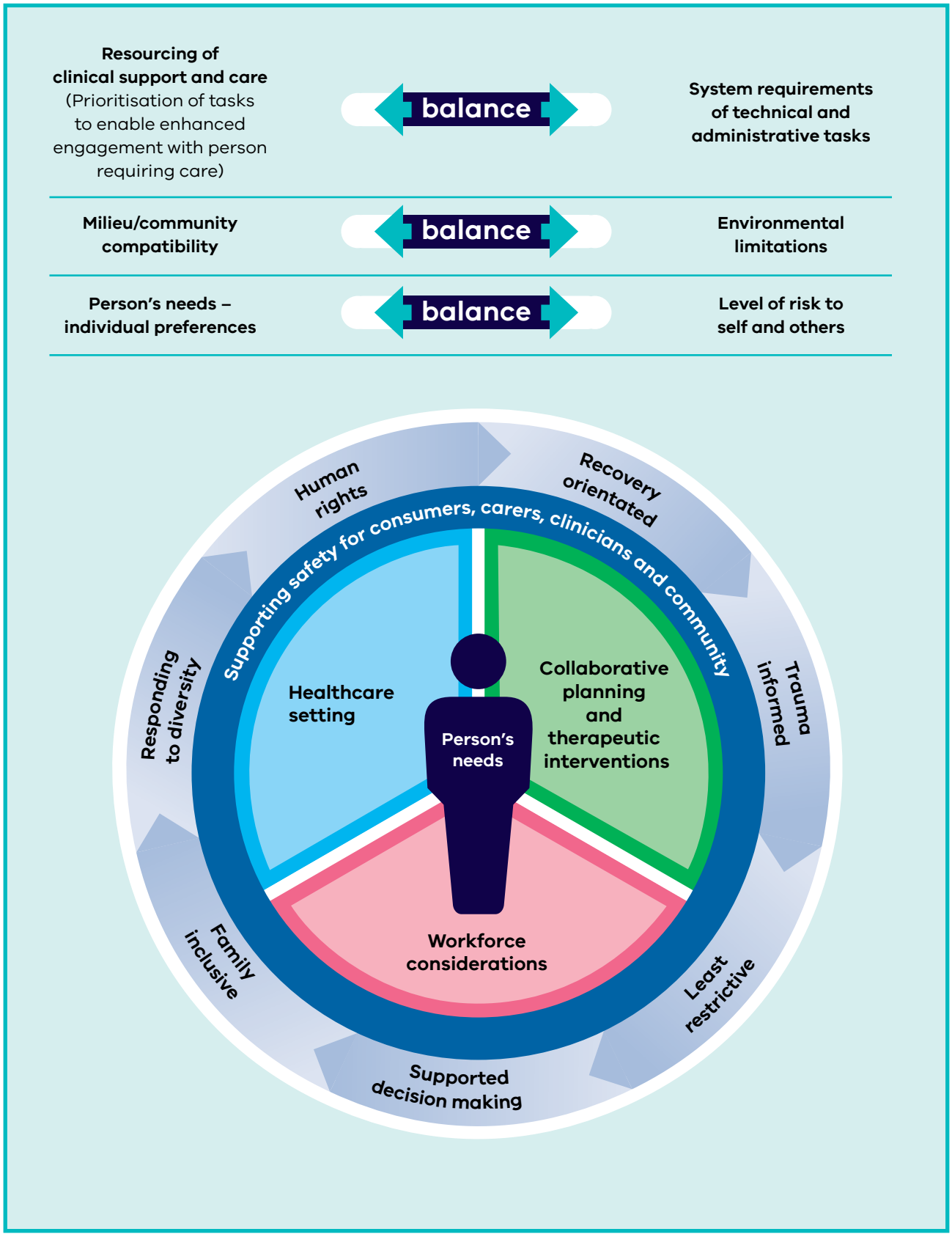
4. The benefits of treatment within an MHICA have been weighed against the potential vulnerabilities within the environment. This requires a focused approach to safety planning to consider risk and response, in particular for those with prior or current trauma experiences including family violence.
5. The rationale for treatment and care is documented, including least restrictive options considered, individual requirements for support and plans for future reviews.

Care must reflect shared decision making and a need to consider a balance of individual and milieu (community) demands.

Prior to, and on admission for, mental health treatment, a person's history may suggest a need for mental health intensive care; however, **the person's current presentation should be the primary consideration.** A decision about whether a person requires mental health intensive care will generally align with the following criteria:

- The person is unable to articulate their safety needs.
- The person is experiencing a psychiatric illness/disorder.
- The person requires compulsory care under the Mental Health Act.
- The person is experiencing acute deterioration and/or associated aggression, distress and dysregulation that cannot be self-managed.
- The person needs support to articulate and resolve their distress in a safe way.
- A level of risk associated with harm to self and others and/or vulnerability requires increased observations and support.

Figure 2: Balancing dynamic considerations for mental health intensive care



All critical decisions balance on the considerations of the five mental health intensive care domains

Engaging mental health intensive care requires a team response. Enhancing existing communication systems such as handover and team safety huddles, incorporating specific role allocations, review processes and timely feedback and documentation, provides a platform to support frontline clinicians and the people receiving care (see Figure 2).

Incorporate the following considerations when providing mental health intensive care:

- the best possible knowledge of the person, their needs and preferences
- understanding of the presenting issues and their context
- knowledge of the person's personal, mental health and trauma history
- knowledge of the strategies used in the past to support the person.

Assessments

Physical health

Mental health services should ensure that the physical health needs of those receiving mental health intensive care align with *Equally well in Victoria* (Department of Health and Human Services 2019a):

- Qualified medical and nursing staff should be available to conduct physical examinations, complete the necessary investigations and to manage adverse medication effects. Detail the physical health needs of people transferred from emergency departments and other medical units in the transfer of care documentation.
- Increase physical health monitoring for people receiving mental health intensive care because they may be unable to communicate symptoms to clinicians. Consumers may also be subject to new/increased pharmacological treatment that may cause impairment to their physical health.
- Mental health services should have local operational guidelines in place that provide advice to staff and referral services on identifying and assessing physical health needs, as well as appropriate transfer and continuation of care arrangements.

Substance use disorders and acute intoxication

Mental health services should ensure screening processes are in place to identify substance use disorders and at-risk consumers as early as possible and offer consistent, evidence-based treatment to manage withdrawal symptoms and avoid complications of withdrawal. Services must ensure:

- evidence of harmful caffeine, tobacco, alcohol or drug use is communicated and considered as a part of the person's treatment
- there are screening processes for nicotine dependence and nicotine replacement therapies are readily available
- inpatient staff develop and maintain skills for identifying and managing substance-related disorders, complications and motivational interviewing to increase the likelihood of engagement with treatment
- there is access to dual-diagnosis clinicians to work with staff and consumers who identify substance use comorbidity during their admission.

Illicit drug and alcohol use compound a mental illness, even if the frequency and intensity of use don't meet the criteria for a substance use disorder. Factors to consider in response include:

- the impact of mental illness on substance use and the impact of their substance use on mental illness
- motivations for drug use (reasons for use)
- the type, intent and frequency of drug use
- harm reduction
- the nature and severity of illness
- the physical and social impact of either or both disorders
- the age of the person – young people with dual diagnosis are particularly at risk of experiencing poor outcomes, and the age, stage of physical, neurological, psychological and social development makes young people more vulnerable
- psychoeducation on the impact of substance use on medication doses
- readiness for change versus pre-contemplation
- support and linkage with alcohol and other drugs services and other community supports.

As well as differences across ages, the type and pattern of drug and alcohol use varies with culture, gender, peer group and social settings.

Mental health services can refer to the Chief Psychiatrist's guideline *Assessment of intoxicated persons*[5] and ensure alignment with this guideline.

Transfer to an existing MHICA

Don't assume that people understand the purpose, processes and features of an MHICA, or what is expected of them. Entering an MHICA may cause additional distress, embarrassment and loss of dignity to people at an already vulnerable time, particularly where the decision is in opposition with the person's views and preferences. Families, carers and other support people may also have no experience of high care areas and their purpose.

Mental health services can take steps to anticipate and moderate this distress using a supportive and interprofessional team approach and engage the person, and their supports, in collaborative planning. This approach should consider the Safewards model – specifically the 'soft words' and 'bad news mitigation' interventions as well as:

- appropriate staffing to safely support entry to the MHICA
- the involvement, or consideration of knowledge gained from, family, carers or nominated persons
- consideration of the best space for assessment and ongoing care, availability of comfort rooms and tools and resources that would assist in mitigating feelings of distress or agitation.

'Each time I came to visit my son there was a different set of rules. One day I was allowed to bring him in a meal, the next day I was turned away and told I could only visit between certain hours and could not bring anything in at all. It was really distressing for both of us to never know where we stood'.

– Carer, HDU Video Project, 2018

5 See *Assessment of intoxicated persons* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines>.

Orientation and explanation

Irrespective of their location, provide people receiving mental health intensive care with an orientation, an explanation of their rights and an opportunity to ask questions about the care they are receiving.

A person's capacity to engage in and recall discussions about their rights and the care they are receiving may vary over time. The service provider must attempt to provide the person with a timely and full explanation and copy of a relevant statement of rights. Actively supporting people to understand and exercise their rights as part of a continuing dialogue is a standard feature of care. Working with the person's family, carers or supporters can be a helpful way of supporting communication about rights.

Provide the person with an orientation to the area. This should include verbal and written information regarding wayfinding, introductions to care providers, scheduled activities, available resources, access to visitors and communication, safety and privacy, and opportunities for feedback and complaints. In providing an orientation and explanation, mental health services should consider the Safewards 'clear mutual expectations' intervention and daily communal meetings.

Services should have clear information and strategies for orienting the person's family and their carers. This includes outlining spaces available for people to visit, access to supports and information about their care.

Everyone who receives mental health care has the right to communicate. Inform the person and their families and carers about how they can communicate and about any potential restrictions to the person's right to communicate. This may include individual restrictions identified in assessment that limit access to personal devices such as mobile phones, tablets and laptop computers. Health services can refer to the Chief Psychiatrist's guideline *Electronic communication and privacy in designated mental health services*.[6]

6 See *Electronic communication and privacy in designated mental health services* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Electronic-communication-and-privacy-in-designated-mental-health-services>.

Dynamic appraisal and review

The duration of mental health intensive care should be brief and targeted to achieve treatment and support goals. For this to occur it is important that all members of the treating team can assess and escalate care when necessary to do so. Don't limit decision points solely to team handover or clinical review forums. Providing dynamic appraisal requires the ability to assess risk and vulnerability to inform care. Team safety huddles should be in place to support rapid review, understand required resourcing, interventions and communication, reflecting an escalation of care.

The interprofessional team, including a psychiatrist, should assess the person's progress daily. This assessment is essential to ensuring least restriction and for planning to ensure continued access to resources. It would include:

- the person's perspective about their progress, and the factors influencing this
- documented evidence of the strategies used to support the person to make or participate in decisions
- feedback, suggestions and concerns raised by families, carers or nominated persons
- recommendations for alternative strategies
- identifying alternatives in advance to ensure changes can be implemented responsively
- ensuring all staff know about changes to care planning and are actively involved in facilitating opportunities for recovery.

Services will have processes in place for regularly assessing and documenting the person's holistic needs, which includes recovery goals, mental state, risk and safety needs.

- Provide consumers, families and carers with information of the frequency and timing of review so they have an opportunity to plan and provide input. This is particularly important when a person is receiving treatment in a locked MHICA.
- Document nursing mental state assessment, collaborative risk assessments, treatment strategies including therapeutic interventions and their outcomes on each shift and discuss these at shift handover. These should include the nurse's observations and the person's opinions about the trajectory of improvement. These practices will align with the Department of Health and Human Services' (2019) Nursing observation through engagement in psychiatric inpatient care guideline.

All services implementing mental health intensive care should have documented consumer-led safety plans, sensory profiles and escalation pathways.

Ending mental health intensive care

The duration of mental health intensive care should be the least necessary to facilitate the person's safe transition to a less restrictive care type. Mental health services will have agreed processes that guide decision making to transition from mental health intensive care that include:

- consultation with the person, their family, carer and/or nominated person
- a risk assessment and mental state review conducted by a medical practitioner or senior mental health nurse
- identifying the resources, support and interventions that will be necessary to ensure a successful transition to a less restrictive environment
- authorisation by a psychiatrist.

Mental health services must ensure processes are in place to support a safe transition from mental health intensive care through a planned process that includes:

- discussion with the person, their family, carer and/or nominated person about the experience of mental health intensive care
- opportunities for the person, their family, carer and/or nominated person to ask questions about the period of mental health intensive care
- supportive counselling for people who have had, or been exposed to, potentially traumatising experiences
- a clear plan for future interventions that support progress and treatment in a less restrictive environment
- the return of personal belongings
- orientation to the destination environment and an opportunity for the person to become familiar with any new personnel providing care.

Leadership and organisational readiness

Leadership and organisational readiness

The *Mental health intensive care framework* promotes the operationalisation and implementation of the following six core strategies from the National Association of the State Mental Health Program Directors Council (NASMHPD) (Huckshorn 2004).

The six core strategies are:

1. Leadership towards organisational change

2. Use of data to inform practice

3. Workforce development

4. Use of seclusion and restraint reduction tools

5. Consumer roles in inpatient settings

6. Debriefing techniques.

Implementing the six core strategies offers enhanced leadership, strengthened resilience and improved clinician support and consumer outcomes (LeBel et al. 2014).

In *The role of the Victorian Department of Health and Human Services in assisting mental health services to reduce restrictive practices: a case study*, McKenna et al. (2018) illustrates the use of the six core strategies (Huckshorn 2004). The authors contend that combining the strategies with a focus on evidence-based interventions such as Safewards (Bowers 2014), sensory modulation, trauma-informed practice, recovery-oriented models of care, environmental enhancement, integration of peer workforce and co-design projects has contributed to services engaging in and strengthening approaches to reduce restrictive interventions.

Service leaders have a clear responsibility to model a supportive and nurturing environment to enable clinicians to do their best work. They must develop services that place consumers at the centre of clinical decisions, care and recovery. This includes having awareness of the power dynamics of the service, its staff and the people it serves (Giltinane 2013).

Organisations must advocate for and engage with their workforce, reinforcing a commitment and accountability to support challenging and complex care demands. Service leaders must provide for reflective practice, clinical supervision, mentoring, ongoing education and building of self-care and resilience strategies and resources. Through effective planning, communication and allocation of resources, organisations must reflect strength in preparedness and the ability to navigate complex situations.

To drive cultural and organisational change requires a responsive healthcare setting adept to the challenges of acute mental illness. Strong leadership is a critical component in the drive towards eliminating restrictive practices. The shift in culture required to move services from custodial paradigms of care requires a systematic approach of quality improvement through continuous assessment, planning, implementation and evaluation. The success of organisational change requires aligning 'coal face' leadership, hospital-wide executive leadership and statewide systems leadership. Organisations promoting and supporting change leaders, sharing ideas and contributing to cross-service communication offers enhanced ability to address challenges and implement change (Baeza et al. 2008).

Vision

Services adopting strategies to progress practice require a vision for change, a questioning of current practice and a championing of collective endeavour for improvement. The ability for services to lead when things go wrong, to review, recommend and support changes, will provide an improved experience for consumers, carers and clinicians. Together with concerted efforts to adopt co-design approaches, organisations supporting enhanced consumer-based leadership provide an increased ability to engage and respond to people with acute mental health concerns.

To prepare organisations to adopt mental health intensive care, leaders must undertake an organisational assessment to:

- understand the current and previous practices associated with responding to acute deterioration in mental state and associated support provided

- identify vulnerability and strengths in planning, communication and leading intensive care interventions
- understand and review role allocation and function, providing time for service-level role clarity
- identify opportunities to partner with consumers and carers when considering individual needs, environments and therapeutic interventions
- understand support mechanisms to enhance consumer and carer participation at every level of engagement.
- understand and identify the interprofessional workforce, potential, capabilities and competency that support mental health intensive care principles
- understand, interpret and respond to data and associated key performance indicators to inform practice and monitor progress
- initiate processes of regular review and reflections of care, noting challenges and successes
- align policy, protocol and practice with system reform initiatives and objectives
- nominate, endorse and support change leaders
- set agreed key performance indicators to guide implementation of mental health intensive care and regularly evaluate care outcomes.

'Leadership can be clinical, managerial or cultural. Leadership is not just the responsibility of management nor is it position bound. Leadership is dispersed across the organisation and will come from people with a lived experience, carers, from staff on the wards and from management.'

– Providing a safe environment for all: framework for reducing restrictive interventions (Department of Health and Human Services 2013).

Through leaders promoting meaningful engagement with all people, services can reflect their best practice with responsive escalation and real-time assessment of risk. Underlying all responsive care are efficient communication systems promoting shared decision making and positive clinical outcomes.

Mental health services can strengthen their ability and capacity to provide and guide mental health intensive care through active and regular review of care outcomes, key performance indicators that include consumer and carer feedback, policy implementation, communication systems, workforce satisfaction surveys and adverse events.

Accountability and governance

Irrespective of where services are delivered, establish a framework for monitoring mental health intensive care performance.

Data collection and reporting

Establish local routine data collection processes to capture and record episode-of-care specifics including:

- mental health intensive care commencement date and time
- reason for mental health intensive care
- location of mental health intensive care – healthcare setting
- mental health intensive care end date and time
- length of stay
- frequency of medical review.

Implement systems and processes to routinely collect incident data including:

- episodes of physical or sexual activity and assault
- episodes and hours of seclusion, physical and mechanical restraint per 1,000 occupied bed-days (derived from the existing restrictive interventions database)
- episodes of occupational violence
- episodes of infrastructure, systems, and technology damage or disruption.

Oversight

Create systems and processes to routinely analyse mental health intensive care performance and outcomes. Establish forums to drive quality improvement and include:

- monitoring consumer and carer experiences through formal and informal feedback
- attention to issues of culture, team development and training needs
- scrutiny of leadership and supervision
- monitoring consumer outcomes
- monitoring restraint and seclusion episode data and incident rates
- evaluation of restraint reduction initiatives
- establishing and monitoring policy and procedures to support practice
- adhering to the standards within this and other Department of Health and Human Services guidelines, and the *National Safety and Quality Health Service Standards*.

Appendix

Appendix 1: Navigating decision making and care considerations

The *Mental health intensive care framework* intersects five mental health intensive care domains with seven evidence-based principles for clinical care.

Use this template matrix to ensure all decisions reflecting mental health intensive care planning have been well considered.

Considerations and decisions – applying domains and principles

Domain	Human rights	Recovery oriented service provision	Trauma informed care	Supported decision making	Family and carer inclusive practice	Responding to diversity	Least restrictive
Person's needs							
Collaborative planning and therapeutic interventions							
Healthcare setting							
Workforce considerations							
Supporting safety							

Appendix 2: Practice guidance example: team safety huddles planner

Date:	Time:	Shift – AM – PM – Night	Nurse in charge:

New introductions Bank/agency/students	
Specific shift tasks Appointments, tests, hearings, outings	
Alerts Aggression, visitors, screening, bad news mitigation	**Alerts and preferences:** Refer to management, safety and sensory plans for comprehensive reports

Role allocation

NIC and first responder	(NIC) Nurse in charge or delegate to lead de-escalation management and act as communicator. First responder to work directly with the NIC to perform talk-down techniques and determine de-escalation measures. If the NIC is not available the first responder is responsible for leading management with the support of the communicator/runner. Must maintain least restrictive practice principles.
Communication/ runner	Responsible for Code Grey/Black calls – under advisement of NIC. To seek: timer, PPE, sensory items, notify consultant of situation, retrieval and coordination of pharmacological agents if indicated and supported. Delegate notation of events/observations if attending to other tasks.
Milieu coordinator	The milieu coordinator is responsible for managing consumers and visitors on the unit who are not involved in the event/incident requiring immediate attention. Remove patients and visitors to a safe space on the unit.
Allied health/ medical/supports	To liaise with the milieu coordinator about how to support and assist such as one-to-one time with consumers/staff (who may require immediate support following), assist with milieu (support consumers in a separate area of the unit), assist with de-escalation if required (attend escalation and offer assistance if assistance is not required on milieu).

Appendix 3: Mental state deterioration assessment – Australian Commission on Safety and Quality in Health Care, 2018

Mental state deterioration

Updated definition: A change for the worse in a person's mental state, compared with the most recent information available for that person, which may indicate a need for additional care.
Assessing change Identifying and tracking change relies on the availability of individual baseline information to which a person's current mental state can be compared.
Baseline information ... to ... Current mental state

Signs of deterioration

Indicators of deterioration	Clusters of signs of deterioration
Reported change A person, or someone who knows the person well, reports that her or his mental state is changing for the worse.	Self-initiated requests for assistance Requests for treatment from healthcare professionals or those close to the person Self-reported negative or inflated sense of self Self-reported uncontrollable thought processes Self-reported negative emotions
Distress A person, or someone involved in her or his care, shows signs of distress, which are evident through observation and conversation.	Uncharacteristic facial expressions Physiological/medical deterioration Negative themes in conversations Apparent distress of self or others
Loss of touch with reality or consequence of behaviours A person is losing touch with reality or the consequences of her or his behaviour.	Indications of experiencing delusions Indications of experiencing hallucinations Unusual self-presentation Unusual ways of behaving Appearing confused during conversations
Loss of function A person is losing her or his ability to think clearly, communicate, or engage in regular activities.	Unusual movement patterns Loss of skills Poor daily self-care Reduction in regular activities Difficulty participating in conversations Unusual speech during conversations Seemingly impaired memory Apparent difficulty with thinking about things in different ways
Elevated risk to self, others or property A person's actions indicate an increased risk to self, others, or property.	Increases in the use of restrictive practices Reduced safety of self Reduced safety of others Reduced safety of property Disengaging from treatment Unresponsiveness to treatment

Adapted from: Gaskin & Dagley 2018; Figure 1: Proposed updated definition, indicators, and clusters of signs.

Appendix 4: Practice guidance example: Service response to reduce restrictive interventions

The Alfred – Psychiatric Behaviours of Concern Team implementation

In 2017 The Alfred inpatient psychiatry unit piloted an initiative to respond to increased risk when managing aggression, self-harm and drug and alcohol withdrawal. The initiative is the equivalent to a Met Call (which supports early deterioration of physical health).

Staff act early to engage with an individual who may require increased assessment and care planning, reducing the use of restrictive interventions such as restraint or seclusion. The Psychiatric Behaviours of Concern Team explores possible approaches to managing the person's distress, including sensory-based calming approaches, trauma-informed de-escalation strategies, understanding of potential triggers, preferred calming techniques and family feedback as alternatives to restrictive interventions.

The initiative followed an analysis of incidents at The Alfred that found missed early intervention and prevention opportunities resulted in a rise of seclusion rates.

The principles that guide team functioning are:

- The Psychiatric Behaviour of Concern Team is an additional resource to support staff on the inpatient unit.
- Decision making is a collaborative process, directly involving the team managing the patient.
- The aim of a Psychiatric Behaviours of Concern Team response is to initiate early interventions for behaviours of concern and mobilise a timely response to behavioural deterioration. The team configuration includes a member from allied health (for example, occupational therapy), the nurse unit manager and an associate nurse unit manager.

Following implementation, a 23–50 per cent reduction in each of the four types of behaviours of concern was recorded:

- Attempted aggression towards staff significantly reduced ($p < 0.001$).
- Seclusion episodes reduced by 65 per cent.
- Staff acknowledged the Psychiatric Behaviour of Concern Team had improved safety through improved access to interprofessional expertise and modelling de-escalation.

In the first six months of the trial, the pilot determined incidents had decreased by 46 per cent compared with incidents from the six months before and six months after implementation.

Source: Bushell et al. 2017

References

Baeza JI, Fitzgerald L, McGivern G 2008, Change capacity: The route to service improvement in primary care, *Quality in Primary Care,* 16, 401 – 407.

Bowers L 2014, Safewards: a new model of conflict and containment on psychiatric wards, *Journal of Psychiatric and Mental health Nursing*, 21, 499–508.

Bowers L, James K, Quirk A, Simpson A, Stewart D, Hodsoll J 2015, 'Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial', *International Journal Nursing Studies,* 52, 1412–1422.

Bowers L, Jeffery D, Bilgin H, Jarrett M, Simpson A, Jones J 2008, 'Psychiatric intensive care units: a literature review', *International Journal of Social Psychiatry*, 54, 56–68.

Bushell H, Whitecross F, Berry C, Sonmez G, Moran J, Rauchberger I, Hollander Y, Harrison E, Bennett C, Lee S 2017, *Psy-Boc response,* Alfred Health, Melbourne.

Department of Health 2009a, *Cultural responsiveness framework: guidelines for Victorian health services,* State Government of Victoria, Melbourne.

Department of Health 2009b, *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units,* State Government of Victoria, Melbourne.

Department of Health 2011a, *Framework for recovery-oriented practice,* State Government of Victoria, Melbourne.

Department of Health 2011b, *Service guideline on gender sensitivity and safety: literature review,* State Government of Victoria, Melbourne.

Department of Health 2013, *Providing a safe environment for all: framework for reducing restrictive interventions,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2016a, *Delivering for diversity: Cultural diversity plan 2016–2019,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2016b, *Safewards handbook: training and implementation resource for Safewards in Victoria,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2017a, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2017b, *Chief Psychiatrist's audit of inpatient deaths 2011–14,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2018a, *Bodily restraint and seclusion: position statement,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2018b, *Diversity: position statement,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2018c, *Recovery and supported decision making: position statement,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2018d, *Trauma-informed care: position statement,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2018e, *Working together with families and carers: Chief Psychiatrist's guideline,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2019a, *Equally well in Victoria: physical health framework for specialist mental health services,* State Government of Victoria, Melbourne.

Department of Health and Human Services 2019b, Nursing observation through engagement in psychiatric inpatient care, State Government of Victoria, Melbourne.

Department of Human Services 2002, *Chief Psychiatrist's high dependency guideline,* State Government of Victoria, Melbourne.

Department of Justice and Community Safety 2018, *Family violence multi-agency risk assessment and management framework (MARAM),* State Government of Victoria, Melbourne.

Gaskin C, Dagley G 2018, *Recognising signs of deterioration in a person's mental state,* Australian Commission on Safety and Quality in Health Care, Sydney.

Giltinane CL 2013, Leadership styles and theories. *Nursing Standard.* 27, 41, 35-39.

Grimshaw JM, Eccles MP, Lavis JN, Hill SJ & Squires JE 2012, 'Knowledge translation of research findings', *Implement Sci,* 7(50):50.

Gwinner K, Ward L 2013, 'P.I.C.U., H.D.U., A.O.A. What treatment do we provide? Current descriptions of the function of intensive care for inpatient psychiatric health care', *Mental Health Review Journal,* 18, 128–143.

Huckshorn KA 2004, 'Reducing seclusion and restraint use in mental health settings: core strategies for prevention', *Journal of Psychosocial Nursing and Mental Health Services,* 42, 9, 22.

Kooker BM, Shoultz J, Codier E 2007, 'Identifying emotional intelligence in professional nursing practice', Journal of Professional Nursing, 23, 1, 30 – 36.

LeBel JL, Duxbury JA, Putkonen A, Spraque T, Rae C, Sharpe J 2014, 'Multinational experiences in reducing and preventing the use of restraint and seclusion', *Journal of Psychosocial Nursing and Mental Health Services,* 52, 11, 22–29.

McKenna B, Daffern M, Maguire T 2013, *Minimum training standards: preventing and managing clinical aggression including the use of physical restraint,* AUT, Swinburne University, State Government of Victoria, Melbourne.

McKenna B, Sutton D, Sweetman LE, Miner-Williams W 2018, *The role of the Victorian Department of Health and Human Services in assisting mental health services to reduce restrictive practices: a case study*, Department of Health and Human Services, Melbourne.

Mental Health Complaints Commission 2018, *Right to be safe: Ensuring sexual safety in acute mental health inpatient units: sexual safety project report,* State Government of Victoria, Melbourne.

Mueser KT, Goodman LA, Trumbetta SL, Rosenberg SD, Osher FC, Vidaver R, Auciello P, Foy DW 1998, 'Trauma and posttraumatic stress disorder in severe mental illness', *Journal of Consulting and Clinical Psychology,* 66, 493–499

Perry BD 2006, 'The neurosequential model of therapeutics: applying principles of neuroscience to clinical work with traumatized and maltreated children'. In: N Boyd Webb (ed.), *Working with traumatized youth in child welfare,* Guilford Press, New York.

Sackett D et al. 2000, 'Evidence-Based Medicine: How to Practice and Teach' EBM, 2nd edition. Churchill Livingstone, Edinburgh, p1.

State Government of Victoria 2006, *Charter of Human Rights and Responsibilities Act 2006,* Victorian Government, Melbourne.

State Government of Victoria 2014, *Mental Health Act 2014,* Victorian Government, Melbourne.

Zigmond A 1995, 'Special care wards: are they special?' *Psychiatric Bulletin,* 19, 310–312.