Glossary of key terms
relating to coercion in mental health services

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Foreword

FOSTREN (Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services is a COST-funded network of practitioners, people with lived experience of receiving mental health services and researchers. It is dedicated to understanding how to implement effective changes in services away from reliance on coercive practices like seclusion, restraint and involuntary admission and towards collaborative care.

Whilst most mental health services globally aspire to this aim, there is vast linguistic and cultural variation within and beyond Europe which makes it more difficult for stakeholders to communicate and even start talking about ways to change services. When FOSTREN was established in 2020 it was decided to address this obstacle by trying to establish a consensus on terms used when describing coercive practices in mental health services and to set these terms out in English as a starting point for further discussion.

The glossary here represents the outcome of this exercise. A task group was established led by Dr. Panagiota Bali (National and Kapodistrian University of Athens, Greece) and Ms. Deborah Oyine Aluh (Lisbon Institute of Global Mental Health, Portugal) with the active participation of many FOSTREN members over the period 2021-23. We thank all those who contributed at all stages to the production of this document especially those who participated directly or online in the final preparation meeting hosted in Athens by EPAPSY (NGO Association for Regional Development and Mental Health) and the Forensic Psychiatric Department University Hospital "Attikon" in March 2023 who are acknowledged individually below.

Methodology

Purpose and participant selection: The primary objective of this research project was to create a glossary as part of the COST action, with its purpose defined and planned as a deliverable from the project's outset. Participants from various European countries expressed their interest in joining the glossary committee, and particular attention was given to ensuring diverse representation from different regions of Europe.

Term Extraction and Collaborative Process: To initiate the glossary creation, a comprehensive meeting was conducted, during which the overall objectives and steps were outlined. The attendees were assigned specific tasks, and a smaller core group was established to harmonize the entire process. In order to build an initial list of terms, committee members were encouraged to propose terms related to coercion. To facilitate collaboration, an online folder was set up, allowing members to access and contribute relevant materials such as glossaries from previous reports or mental health laws of different countries. By the end of this meeting, an initial list of terms was compiled. In the subsequent stage, the core group conducted an extensive literature search to develop tentative definitions for the identified terms. This draft was shared with all committee members for review, who were also given the opportunity to propose any omitted terms. An iterative process of revisions,

comments, and suggestions ensued between the core group and the committee, ultimately leading to the preparation of a tentative draft.

Evaluation by Experts: To ensure the accuracy and validity of the glossary, a widely disseminated FOSTREN hybrid meeting centered around the glossary took place in Athens in March, 2023. During this meeting, unanimous decisions were made concerning common terms, categorization structure, and formatting. Terms and their definitions that received unanimous approval were included in the final draft, while those without consensus were earmarked for further revision. Further iterations and revisions were undertaken, leading to the creation of the final draft of the glossary.

Limitations

This is a working document which is intended to foster discussion as well as working toward a consensus. Debates within the task group were always lively and positive and demonstrated the clear challenges in gaining agreement on such a complex area across many different languages and countries. Inevitably these are not the final words on this subject and there will be much contained here which will generate alternative opinions.

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Abbreviations
PMHC: Person with a Mental Health Condition

GENERAL CONCEPTS		
S/N	Term	Definition
1	Coercion	Refers to the act or practice of using force or threat to persuade a PMHC to do something. It refers to a range of interventions, from mild acts such as persuasion to the most oppressive acts of compulsion, such as the use of restrictive devices (Szmukler, 2015).
2	Coercive measures	Refers to any measure applied "against the will of a PMHC or in spite of their opposition"(Biller-Andorno et al., 2018).
3	Formal coercion	Refers to coercion exercised within the regulations of a given mental health legislation. Usually includes involuntary admission, forced treatments, use of restraints, and seclusion (Molodynski et al., 2010)(Kallert et al., 2005)
4	Informal coercion	It is a subtler form of coercion that includes a wide variety of treatment pressures and interventions that might be used to encourage treatment adherence in order to avoid formal coercion. They include; persuasion, interpersonal leverage, inducements and threats(Hotzy & Jaeger, 2016)(Pelto-Piri et al., 2019)
5	Perceived coercion	Refers to the subjective experience of being coerced (Lessard-Deschênes et al., 2022; Newton-Howes & Stanley, 2012).
6	Non-consensual treatment (in contradistinction to coercive treatment)	Includes any treatment that is undertaken in the absence of valid consent. For example, where a person is receiving treatment while in a coma or catatonia (Cherry, 2010)(Pugh & Douglas, 2016).
7	Compulsion/Constraint	The act or state of forcing or being forced to do something while constraint is the act of limiting or restricting an action (Szmukler, 2015).
8	Compulsory treatment (Also known as Involuntary treatment)	Refers to the unconditional, forced treatment of PMHCs who fulfill certain criteria set by the mental health legislation of a particular country. It often involves the use of medications or other biological treatments (Salize & Dressing, 2005).
INVOLUNTARY INPATIENT CARE		

9	Blanket restrictions (Also called House rules)	Rules or policies that restrict a PMHC's liberty and other rights, which are routinely applied to all patients, or classes of patients, or within a service, without individual risk assessments to justify their application. For example: restrictions on access to the internet; limited access to – or banned – mobile phones and chargers, limited access to own money or ability to make personal purchases (Blanket Restrictions: Policy on the Use of Global Restrictive Practices (Blanket Restrictions) in In-Patient Units, 2020).
10	Limitation of freedom of movement	This pertains to the restriction of a PMHC's movement to their assigned room. During this period, the PMHC is permitted to leave their room for specific reasons and only for a limited duration. If PMHCs are unable to maintain a suitable distance from others or to prevent sensory overload, particularly during manic episodes, their movement may be restricted. It is important to distinguish this form of confinement from "seclusion."(Baumgardt et al., 2019)
11	Forced medication	This refers to forcefully administering parenteral medication or administering oral medication while threatening to administer parenteral medication if oral consumption is refused (Steinert & Lepping, 2009)(Czernin et al., 2021).
12	Involuntary/hospitalization/ Admission / Detention	This is hospitalization carried out against the will of a patient, and is usually in line with the existing judicial procedures in a specific location (Dressing & Salize, 2004).
INVOLUNTARY OUTPATIENT CARE		
13	Involuntary outpatient commitment or 'assisted outpatient treatment' or 'community treatment orders'	Orders from civil court about PMHCs with repeated hospitalizations in order to adhere to community-based treatment (Monahan et al. 2001) (Swanson et al., 2006) (Swartz et al., 2016). In some countries this applies to forensic mental health care systems only.
14	Outpatient commitment	A Non-residential treatment where the PMHC is mandated to receive treatment without having to be admitted in a hospital (Swartz & Swanson, 2004).

SPATIAL ISOLATION		
S/N	Term	Definition
1	Long – term Segregation	The PMHC is placed in a segregated and locked area without other PMHC's for a longer time period to avoid risks posed by the patient to others (see also open area-seclusion). For a long-term segregation a review from multi-disciplinary team is necessary (Mental Health Act, 2021).
2	Open-area seclusion	The PMHC is placed in a segregated and locked area without other PMHC's but together with staff members (Bjørkly, 1995).
3	Psychiatric observation	Refers to the action or process of noting and monitoring the behavior of a PMHC. Psychiatric observation refers also to the observation policy according to national and international guidelines and typically there are 4 different levels. (Bowers, et al, 2000; Department of Health SNMAC, 1999)
4	Levels of Observation:	
	i) 60 minutes observation	Refers to the first level of observation where the staff should always be aware of PMHC's location. A member of the staff should be in contact with each PMHC at least every hour. At all levels of observation, the staff should communicate in a positive and supportive way. (Department of Health SNMAC, 1999)
	ii) Intermittent observation	Refers to the second level of observation, which is applied in case of concern about PMHC's safety. The staff should check the location of the PMHC every 15-30 minutes, without invading, but enhancing the ability for communication. At all levels of observation, the staff is required to communicate in a positive and supportive way. (Department of Health SNMAC, 1999)
	iii) Continuous/constant observation within eyesight observation	Refers to the third level of observation and it is applied when there is real concern that someone could harm himself/herself or others. The PMHC is usually within

		eyesight and accessible at all times, day and night. For the safety of PMHC, the staff inspects their properties, in order to prevent them from carrying potentially dangerous items. Issues of privacy and dignity are taken into consideration, but the priority is for everyone to remain safe. At all levels of observation, the staff communicates in a positive and supportive way. (Department of Health SNMAC, 1999)
	iv) Within arm's length observation	Refers to the fourth level of observation and it is implemented when someone is at high risk of harming themselves or others. The supervision of the PMHC is intensive and one or more staff members may have to be involved. Issues of privacy and dignity are taken into consideration, but the priority is for everyone to remain safe. At all levels of observation, the staff tries to keep positive and supportive relationships with the PMHC at all times. (Department of Health SNMAC, 1999)
5	Seclusion/Isolation	The involuntary segregation of PMHC to a specially secured room, which is often only sparsely furnished. The PMHC is transported to a separate room from other PMHC, where he/she is kept locked or prevented from escaping. The special security of the room may include, for example, the withholding of dangerous objects. (HCFA, 1999)
6	Security unit	Refers to the dedicated areas, where there is the opportunity to safely manage mainly behavioral problems and subsequent continuous monitoring of the PMHC and his/her further treatment. Specific security units include a maximum of 2-bed rooms for PMHC with suitable equipment and at least half of the rooms should be able to be monitored continuously through a camera system. In some countries security units are strictly forbidden. A further suggestion would be that the security units could include a seclusion

		room, a system for immediate recall of personnel (eg safety bracelets, signaling equipment), and a camera system in the common areas, as well as a room for leisure activities and safe access to fresh air (access to safe air outdoor area). (APA, 2019)
	Time out	A technique, originating from behavior therapy, in which undesirable behavior is weakened and its occurrence decreased, typically by moving the PMHC away from the area that is reinforcing the behavior. It constitutes a less coercive and more acceptable practice than seclusion, because most of the time it occurred on a consensual basis in an unlocked room, and rarely in seclusion rooms. (Bowers et al., 2010)

RESTRAINT PRACTICES		
S/N	Term	Definition
1	Restraint	A number of actions with the purpose of controlling a person's physical movement. It can take several forms, such as physical restraint, mechanical restraint and maybe regulated by a country's mental health legislation (Busch & Shore, 2000).
2	Chemical restraint	The use of psychotropic drugs for a non-therapeutic purpose to control or sedate a person. Drugs include sedative and antipsychotic drugs, typical or atypical, or a combination of these (Richards, Derlet, Duncan, 1998) (Coburn & Mycyk, 2009) (Negroni, 2017).
3	Environmental restraint	Restricts a person's free access to all parts of their environment. The use of hurdles, barriers, electronic devices, or locks to restrict a person's freedom of movement (Disability Services Commission, 2012).
4	Mechanical restraint	Any mechanical device, material, or equipment such as straps, set of limb cuffs, belts or jackets that immobilizes or reduces the ability of a patient to move freely (Negroni, 2017).
5	Physical/ manual restraint	Any manual or physical method that immobilizes or reduces the ability of a patient to move in order to prevent harm himself/herself or others

		(Negroni, 2017). Often used in combination with forced medication.
6	Psychological restraint	Deprivation and control of a person through not permitting him to make a choice, making them do something or setting limits on what they can do, without physically intervening. Includes the use of threats and coercion (Restrain Reduction Network).
7	Rapid tranquilization	Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed (NICE, 2015).

RIGHT'S PROTECTION AND ADMINISTRATIVE TOOLS		
S/N	Term	Definition
1	Supported Decision-Making	means that a PMHC is supported by others to making decisions. This can be structured support by clinical staff or others to facilitate that the person's will and preferences are respected in treatment decisions (Davidson et al., 2015).
2	Advance directives	refers to a written statement by a PMHC when well, which sets out the way in which they want to be treated and/or treatment they do not want for their mental health condition should they deteriorate (Zelle et al., 2015).
3	CRPD	Convention on the Rights of Persons with Disabilities. A United Nation human rights treaty to protect the rights and dignity of people with disabilities, including disability resulting from mental health conditions (United Nations Committee on the Rights of Persons with Disabilities, 2007).
4	Decision-making-capacity	In some jurisdictions, the lack of decision-making capacity is a legal requirement for involuntary care. Decision making capacity means the ability to make (treatment) decisions, and this is usually assessed by checking that the person is able to understand and retain information, weigh it up to make a choice, and express this (Sjöstrand et al., 2015).

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