Proposed guidelines for the recording and monitoring of the use of involuntary treatments in psychiatric practice in Europe

There is no internationally accepted definition of involuntary placement or treatment. This document has been informed by the Council of Europe’s Recommendation (Rec (2004) 10 which characterises involuntary placement and/or treatment as “measures... that are against the current wish of the person concerned.”* This lack of uniformity includes not only the definitions but also the underlying legislative basis, clinical practice and recording of these treatments. This explains why despite numerous studies and reports the only consistent finding has been the wide variation in use of these measures between countries and even within countries.

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Introduction

Some form of compulsory treatment is used by all psychiatric services throughout Europe in the management of mental illness. This raises many questions given the unavoidable impact on civil liberties and human rights. Research suggests that such treatments are unsurprisingly unpopular with patients and carers (European Union Agency for Fundamental Rights 2012). Some would suggest that many such interventions lack a convincing evidence base for their use. The Cochrane Review of compulsory community and involuntary outpatient treatment for people with severe mental disorders (Kisely S. et al 2005) found that community treatment orders may not be an effective alternative to standard care. Conversely Kortrijk et al (2010) found that involuntary admission in the context of assertive community treatment was associated with improvements in psycho social outcome and motivation for treatment. Attempts to clarify the issue however are hampered by the enormous variability in the use of such treatments. De Stefano and Ducci (2008) found rates of compulsory treatments varying from 6 per 100,000 in Portugal to over 200 per 100,000 in Finland when they examined data from 15 EU states. The cross national EUNOMIA study for example has demonstrated a wide variation in both the use of involuntary admission as well as clinical outcomes following its application. Even within countries there are wide variations in practice. The substantial variation in involuntary admission rates within countries is puzzling, and unsurprisingly the quality of the data in relation to the use of compulsory treatments has therefore been questioned. Can the differences be explained if the figures cannot be trusted as accurate? (Hoyer, 2008). A Danish study found that up to 20% of involuntary admissions had been missed when the National Psychiatric Case Register was compared with Police records (Day Poulsen, 2000). The unreliability of available data means the interpretation of these rates is even more complex and uncertain.

Notwithstanding the likelihood of inaccurate statistics international experience would suggest that the variation may be explained by many factors:

- Differences in mental health legislation.
- Cultural differences in hospitals and mental health services
• Extreme cases distorting national figures (outliers)
• Differences in local practice of the various methods
• Differences in availability of required facilities (e.g., no seclusion room)
• Variations in incidence of severe illness (clustering)
• Variations in specialisation of inpatient units (secure units)
• Staffing levels
• Training in use of both the methods and their alternatives

There are, however, some areas of relative uniformity. For example, treatment against the wishes of a patient is generally only considered when the illness is severe, risk of harm to the individual or others is high and a need for treatment can be justified (Council of Europe Recommendation 2004). Usually this leads to an admission to hospital or some form of compulsory treatment in the community. There is some formal legal monitoring of such intervention and an appeal or review of the process must be possible. Other specific criteria may have to be met in relation to forms of compulsory treatment other than admission or its equivalent such as seclusion, restraint, electroconvulsive therapy or forced medication. Given the formal nature of these regulations it is perhaps somewhat surprising that there is such variation in their use. In some cases it is not merely a difference in rates of use or reported clinical outcome that is surprising, but the fact that a method that is acceptable in one jurisdiction may be prohibited in another.

Studies that have attempted to address these questions have been hampered by a difficulty in obtaining reliable data on the use of the various compulsory treatments (Bak, J.). This may be partially explained by the fact that currently only nineteen of the twenty-seven EU states have specific laws on mental health regulating involuntary placement or involuntary treatment of persons with mental health problems. In some cases for example persons with mental illness are protected by civil
federal law, or by general healthcare acts. Indeed where a federal political structure pertains within a state, specific regional acts are relevant.

Council of Europe Recommendation Rec (2004)10 specifies five cumulative criteria that should be met in order to submit an individual to involuntary placement. Currently only one is found in all national legislations.

- **Presence of a mental health problem**
- **Risk of Harm**
- **Therapeutic purpose**
- **Less restrictive alternatives not feasible**
- **Opinion of the patient taken into account**

The report of the European Union Agency for Fundamental Rights (2012) however comments on the great variation in compliance with these five criteria. This may explain why the development of a questionnaire by a working group of the UEMS enquiring into the practice of compulsory treatment throughout Europe proved a major challenge. *(Appendix 2)*

As described earlier a wide range of treatments can be applied involuntarily – some used widely in individual countries and not at all in others *(Appendix 1)*. Responses to the questionnaire demonstrated that it remains difficult to clarify the existence - or not – of robust structures for monitoring of these practices in individual countries – some having automatic reporting of use and others not necessarily recorded even locally. It was not possible to clarify if such monitoring or recording was having any impact on individual or national practice of psychiatry.

Combining the responses to this initial questionnaire with findings from previous research and reviews, it became clear that

1) **Many forms of involuntary treatment continue to be used throughout Europe with large differences in rates of use – not only between nations but also regionally within countries themselves.**
2) The evidence base for the use of many of these methods is debated but in any case such treatments are generally not popular with patients and consequently can be seen to contribute to stigmatisation and add to a negative view of psychiatry as a medical specialty less respectful of human rights.

3) The legislation allowing for the use of such methods varies from country to country.

4) The monitoring of the use of such practices is far from uniform even within countries themselves.

5) Even where monitoring of involuntary treatments exists the reliability of the data collected has been challenged and comparisons difficult.

Therefore instead of continuing to examine the differences in treatments and rates of use which have been well established, it would seem to be more practical and potentially productive at this point to focus on:

**A) Working towards harmonisation of the monitoring/recording practices of these methods and/or**

**B) Accepting that regardless of current levels of use a reduction in the practice of these methods should be a common goal throughout Europe.**

A shorter questionnaire was therefore developed (*Appendix 3*) and UEMS delegates representing their National Associations asked to comment on their own awareness of monitoring practices and whether or not the data available to them influenced psychiatric practice.

Fourteen countries responded to three questions:
1) Is the use of involuntary methods recorded in your country and is this Nationally, locally or both?

2) Are the statistics in relation to the rates of use of such methods easily available?

3) Do these statistics influence psychiatric practice?

Six countries responded that statistics were recorded both nationally and locally, four stated that such statistics were recorded only locally and four said only national figures were available. In Finland while there is automatic electronic recording of compulsory admission, local recording tends to be project-based rather than uniform and in Belgium the local recording tends to be on a regional rather than truly local basis. In Belgium there is also a difference in the recording of the various types of involuntary treatment used. For example use of involuntary admission is recorded nationally and regionally, but data for seclusion is collected on a local basis. In Spain differing collection methods are used depending on the specific hospital involved. Of interest no country that responded suggested that statistics concerning involuntary treatment went completely unrecorded.

Most of the countries responding (11/14) stated that the statistics that are currently being collected are easily available however again this availability depends on the specific compulsory method involved. For example in Belgium only statistics for involuntary admission are easily available.

The question regarding whether such statistics – even where available – actually influence psychiatric practice – was much more divisive. Four responding countries felt there was an influence on practice but of course we did not seek clarification as to the nature of this influence i.e. whether it increased or decreased use of such methods. Five responding countries did not feel available statistics influenced practice and another five felt that this question could not be answered.
In the UK it was felt that statistics only influence practice when shortcomings or problems are identified but otherwise have little impact. In the Netherlands there is currently a programme in place to reduce use of such methods which is obviously informed by the data collected. The Norwegian response commented on the previously noted problem of incomplete compliance with reporting requirements even when in place and mandatory. This makes it difficult to draw certain and reliable conclusions from the figures. In Ireland the wide variation in practice despite a small population and relatively small number of methods available was noted and in Switzerland the impact of differing Canton – specific legislation was cited as a reason for similar variation.

Based on these findings along with a current increasing trend in attempts to not only record but also reduce the use of compulsory treatments (Steinert et al) the development of guidelines for monitoring these practices would certainly appear to be the most logical step. It would certainly prove more practical than any further attempt to explain differences in practice given the diversity in the legislative basis, application and documentation currently evident across Europe.

**Proposed Guidelines**

**A. Monitoring**

1. Each state needs to identify and list the coercive methods currently used in mental health services (private and public). There is a need to address lack of uniformity/justify differences in federal situations. Each country should identify who will be responsible for this eg National Association/Ministry of Health.
2. A national body should be identified and designated responsible for the collection of data from each centre whenever an involuntary treatment is administered including:

Patient details

Treatment details: nature/duration

Reason for use

Adherence to the five criteria

Outcome

Potential useful additional information

The specific policy and training in relation to these methods

3. Each centre should have a specific policy in relation to the use of these methods, drawn up by involving service users and carers as well as mental health professionals.

4. Each centre should have education and training as part of this policy

5. Each centre should make monthly/3 monthly returns to this identified (national/regional) body and also use the data collected locally eg by having the issue as a standing item on the agenda of local management meetings
6. An annual report should be published relating to the national/regional/local use of these methods and appropriately disseminated involving service users and carers

7. The national association should engage in audit and research in relation to the above via scholarships/bursaries etc

8. The national association should ensure that the annual review is a standing item on the AGM/discussed in annual workshops at Meetings of the national association.

Guidelines could also include recommendations to reduce the use of all such methods? This might include:

B)

9. Each episode of use to be followed by a debriefing or review including an examination of possible ways of reducing likelihood of repeated need of use

10. The possibility could be considered of establishing emergency response teams to deal with psychiatric emergencies occurring in each mental health centre in an attempt to reduce the need for involuntary measures that are more likely to be utilised in emergency situations.

11. Developing local target levels of use based on historic rates/national rates with contributions from service user and carer groups locally
12. Networking between centres with high and low use of compulsory treatments

Obviously adoption of some or all of these proposals would have implications for clinical practice, manpower requirements and cost.

It is clear however that whatever guidelines are agreed it will be necessary to identify who will specifically be responsible for carrying out the required actions.

A review of the impact of these guidelines would also be required at an agreed time point following their adoption

R.C. April 2014
Appendix 1

Terms and definitions:

Compulsory/involuntary Admission: Admission of a patient who is unwilling (or in certain circumstances unable) to give informed consent to such an admission.

Community treatment order: Treatment administered outside the hospital setting without the consent of the patient.

Intensive observation: Constant observation of the patient who is in the sight of staff at all times.

Restraint: Mechanical/physical: Prevention or limitation of freedom of movement utilising net or cage beds, belts, cuffs or holding by staff.

Seclusion: Compulsory isolation of patient in room designated for that purpose which may be specifically adapted.

Time Out: The patient is required to remain in a specific place or room with an open door.

Involuntary treatment of a medical condition: The administration of treatment for a physical or medical condition where the patient is unwilling or unable to give informed consent.

Forced medication: Administration of medication orally or intramuscularly.

Non-pharmacological treatment without consent: Administration of ECT or performance of Psychosurgery without the consent of the patient.

Leave on trial: The patient may be on leave from the inpatient unit but can be brought back without consent in certain circumstances.
Appendix 2

Questionnaire

1

How does your region or country monitor involuntary methods?
This questionnaire concerns regional or national systems currently in place for the monitoring of involuntary methods used in psychiatric practice. Involuntary methods have been found to be characterized by great heterogeneity both in frequency and circumstances of usage as well as in the actual techniques used between across countries or even within countries. The methods themselves have often resulted from local tradition, subsequently altered through the course of time. Public influence, litigation, human rights issues, and many other factors, are known to influence this development. The main objective of this survey is to evaluate whether involuntary methods are reported, how often these reports are made and what form these records take. Finally, the study examines if such reports, when available in any way, are used in clinical practice. The application of information provided by such reports can either be by continuation of the present practice or by an alteration of practice.

2

Questionnaire

Name
Profession: Are you a medical doctor? Yes No
Position: What level of experience are you?
Trainee Young Psychiatrist Consultant
Hospital/Institution?
Region/Country?
On behalf of what organization are you responding to this questionnaire?

1. Involuntary admission.
Involuntary admission of a patient to a psychiatric ward is when the patient is refusing or incapable of giving informed consent, it is thereby understood to be involuntary.
What situations permit involuntary admission to be used?
1.0 Not applicable – please circle and go to section 2.
1.1 Criterion – please indicate with a cross x
1.1.1 Severe Mental disorder and danger to self or others
1.1.2 Severe Mental disorder and the risk of deterioration of health if not treated
1.1.3 Severe Mental disorder and need for treatment of medical disease.
1.1.4 Not applicable – indicating the method is used but has other criterion

1.2 Questions – indicate with a circle around the chosen answer
1.2.1 Monitoring the use
1.2.1.1 Is the use of this measure monitored by or reported to a regional or a national body?
Yes Yes No Do not know
1.2.1.2 Are there available statistics on the use of this measure in your region or country?
Yes Yes No Do not know
1.2.1.3 If yes are they available only on request or automatically published?
Yes Yes No Do not know
1.2.1.4 If yes – On what level are the statistics?
Department or local level regional level national level
1.2.1.5 If yes – Do you know if the statistics are used specifically to inform or alter the use of this measure?
Yes Yes No Do not know
1.2.2 Reviewing decisions
1.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?
Yes Yes No Do not know
1.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?
Yes Yes No Do not know
1.2.2.3 Are anonymized case reports made by the appeals committee/court available?
Yes Yes No Do not know
1.2.2.4 If yes – are they available in a written report?
Yes Yes No Do not know

2. Involuntary detention.
Detention of a voluntarily admitted patient who is in a psychiatric ward, when the patient is refusing or incapable of giving informed consent, it is thereby understood to be involuntary. What situations permit involuntary detention to be used?
2.0 Not applicable – please circle and go to section 3.

2.1 Criterion – please indicate with a cross x
2.1.1 Severe Mental disorder and danger to self or others
2.1.2 Severe Mental disorder and the risk of deterioration of health if not treated
2.1.3 Severe Mental disorder and need for treatment of somatic disorder.
2.1.4 Suspension of discharge for further assessment/evaluation
2.1.5 Not applicable – indicating the method is used but has other criterion

2.2 Questions – indicate with a circle around the chosen answer

2.2.1 Monitoring the use

2.2.1.1 Is the use of this measure monitored by or reported to a regional or a national body?
Yes No Do not know

2.2.1.2 Are there available statistics on the use of this measure in your region or country?
Yes No Do not know

2.2.1.3 If yes are they available only on request or automatically published?
Yes No Do not know

2.2.1.4 If yes – On what level of detail are the statistics?
Department or local level regional level national level

2.2.1.5 If yes – Do you know if the statistics are used specifically to inform or alter the use of this measure?
Yes No Do not know

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2.2.2 Reviewing decisions

2.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?
Yes No Do not know

2.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?
Yes No Do not know

2.2.2.3 Are anonymized case reports made by the appeals committee/court available?
Yes No Do not know

2.2.2.4 If yes – are they available in a written report?

3. Involuntary treatment of mental disorder

During a period of admission a decision to treat a mental disorder is made and the patient is refusing or incapable of giving informed consent, it is thereby considered to be involuntary treatment.

3.0 Not applicable – please circle and go to section 4.

3.1 Methods used- please indicate with a cross x

3.1.1 Psychotropic medication orally or injected

3.1.2 Electro Convulsive Therapy (ECT)

3.2 Criterion for 3.1.1 (psychotropic medication) – please indicate with a cross x

3.2.1 Severe Mental disorder and danger to self or others

3.2.2 Severe Mental disorder and need for treatment

3.2.3 Not applicable

3.3 Questions – indicate with a circle around the chosen answer

3.3.1 Monitoring the use
3.3.1.1 Is the use of this measure monitored by or reported to a regional or a national body?
Yes No Do not know

3.3.1.2 Are there available statistics on the use of this measure in your region or country?
Yes No Do not know

3.3.1.3 If yes are they available only on request or automatically published?
Yes No Do not know

3.3.1.4 If yes – On what level are the statistics?
Department or local level regional level national level

3.3.1.5 If yes – Do you know if the statistics are used specifically to inform or alter the use of this measure?
Yes No Do not know

3.3.2 Reviewing decisions

3.3.2.1 Do you know if all decisions are reviewed automatically by a court/committee?
Yes No Do not know

3.3.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?
Yes No Do not know

3.3.2.3 Are anonymized case reports made by the appeals committee/court available?
Yes No Do not know

3.3.2.4 If yes – are they available in a written report?
Yes No Do not know

3.4 Criterion for 3.1.2 (ECT) – please indicate with a cross x

3.4.1 Severe Mental disorder and danger to self or others

3.4.2 Severe Mental disorder and need for treatment

3.4.3 Not applicable

3.5 Questions – indicate with a circle around the chosen answer

3.5.1 Monitoring the use

3.5.1.1 Is the use of this measure monitored by or reported to a regional or a national body?
Yes No Do not know

3.5.1.2 Are there available statistics on the use of this measure in your region or country?
Yes No Do not know

3.5.1.3 If yes are they available only on request or automatically published?
Yes No Do not know

3.5.1.4 If yes – On what level are the statistics?
Department or local level regional level national level
3.5.1.5 If yes – Do you know if the statistics are used specifically to inform or alter 
the use of this measure? 
Yes No Do not know 
3.5.2 Reviewing decisions 
3.5.2.1 Do you know if all decisions are reviewed automatically by a 
court/committee? 
Yes No Do not know 
3.5.2.2 Can the decision to use this involuntary measure be appealed to an 
appeal 
committee/court? 
8 
8 
Yes No Do not know 
3.5.2.3 Are anonymized case reports made by the appeals committee/court 
available? 
Yes No Do not know 
3.5.2.4 If yes – are they available in a written report? 
Yes No Do not know 
During admission a decision is taken to treat a medical condition and the patient is 
refusing or incapable of giving informed consent. It is thereby considered to be 
involuntary treatment of a medical condition. 
4.0 Not applicable – please circle and go to section 5. 
4.1 Criterion – please indicate with a cross x 
4.1.1 Severe Mental disorder and danger to self because of medical 
condition/disease. 
4.1.2 Severe Mental disorder and need for treatment of medical 
condition/disease. 
4.1.3 Not Applicable 
4.2 Questions – indicate with a circle around the chosen answer 
4.2.1 Monitoring the use 
4.2.1.1 Is the use of this measure monitored by or reported to a regional or a national 
body? 
Yes No Do not know 
4.2.1.2 Are there available statistics on the use of this measure in your region or country? 
Yes No Do not know 
4.2.1.3 If yes are they available only on request or automatically published? 
Yes No Do not know 9 
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4.2.1.4 If yes – On what level are the statistics? 
Department or local level regional level national level 
4.2.1.5 If yes – Do you know if the statistics are used specifically to inform or alter 
the use of this measure? 
Yes No Do not know
4.2.2 Reviewing decisions
4.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?
   Yes No Do not know
4.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?
   Yes No Do not know
4.2.2.3 Are anonymized case reports made by the appeals committee/court available?
   Yes No Do not know
4.2.2.4 If yes – are they available in a written report?
   Yes No Do not know

5. Involuntary community treatment of mental disorder
Without admitting the patient or following the discharge of a patient, a decision to treat a mental disorder is made and the patient is refusing or incapable of giving informed consent. It is thereby considered to be involuntary community treatment.

5.0 Not applicable – please circle and go to section 6
5.1 Criterion – please indicate with a cross x
5.1.1 Severe Mental disorder and danger to self or others
5.1.2 Severe Mental disorder and need for treatment
5.1.3 Severe Mental disorder and Risk of deterioration due to poor compliance/risk of poor compliance
5.1.4 Not Applicable

5.2 Questions – indicate with a circle around the chosen answer
5.2.1 Monitoring the use
5.2.1.1 Is the use of this measure reported to a regional or a national body?
   Yes No Do not know
5.2.1.2 Are there available statistics on the use of this measure in your region or country?
   Yes No Do not know
5.2.1.3 If yes – On what level are the statistics?
   Departmental or local level regional level national level
5.2.1.4 If yes – How often are they published?
   Annually biannually quarterly monthly
5.2.1.5 If yes – Do you know for certain that the statistics in any way are used to inform or alter the use of this measure?
   Yes No Do not know
5.2.2 Reviewing decisions
5.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?
   Yes No Do not know
5.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal
committee/court?  
Yes No Do not know  
5.2.2.3 Are anonymized case reports made by the appeals committee/court available?  
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11  
Yes No Do not know  
5.2.2.4 If yes – are they available in a written report?  
Yes No Do not know  
6. Seclusion = isolation  
Seclusion = isolation is defined as:  
Patient brought to an empty and locked room without possibility of leaving of their own volition.  
6.0 Not applicable – please circle and go to section 7.  
6.1 Criterion – please indicate with a cross x  
6.1.1 Danger to self  
6.1.2 Danger to others  
6.1.3 Violent or destructive behaviour towards environment/objects  
6.1.4 Threatening/aggressive behaviour  
6.1.5 Removal of a patient from interactions that may provoke aggressive behaviour  
6.1.6 Reducing sensory overload  
6.1.7 Not Applicable  
6.2 Questions – indicate with a circle around the chosen answer  
6.2.1 Monitoring the use  
6.2.1.1 Is the use of this measure reported to a regional or a national body?  
Yes No Do not know  
6.2.1.2 Are there available statistics on the use of this measure in your region or country?  
Yes No Do not know  
6.2.1.3 If yes – On what level are the statistics?  
Departmental or local level regional level national level  
12  
12  
6.2.1.4 If yes – How often are they published?  
Annually biannually quarterly monthly  
6.2.1.5 If yes – Do you know for certain that the statistics in any way are used to inform or alter the use of this measure?  
Yes No Do not know  
6.2.2 Reviewing decisions  
6.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?  
Yes No Do not know  
6.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?  
Yes No Do not know
6.2.2.3 Are anonymized case reports made by the appeals committee/court available?
Yes  No  Do not know
6.2.2.4 If yes – are they available in a written report?
Yes  No  Do not know

7. Mechanical restraint=fixation
Mechanical restraint=fixation is defined as:
The use of equipment to keep the patient in bed or in a chair (Belts around the abdomen; Ankle cuffs; Hand cuffs; Gloves; Stray-jacket; Net-bed = bed enclosed by locked net so that the patient is unable to leave of his or her own volition).

7.0 Not applicable – please circle and go to section 8.

7.1 Criterion – please indicate with a cross x
7.1.1 Danger to self
7.1.2 Danger to others
7.1.3 Violent destructive behaviour towards environment/objects
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7.1.4 Threatening/aggressive behaviour
7.1.5 Remove patient from interactions that may provoke aggressive behaviour
7.1.6 Reducing sensory overload
7.1.7 Not Applicable

7.2 Questions – indicate with a circle around the chosen answer
7.2.1 Monitoring the use
7.2.1.1 Is the use of this measure reported to a regional or a national body?
Yes  No  Do not know
7.2.1.2 Are there available statistics on the use of this measure in your region or country?
Yes  No  Do not know
7.2.1.3 If yes – On what level are the statistics?
Departmental or local level regional level national level
7.2.1.4 If yes – How often are they published?
Annually biannually quarterly monthly
7.2.1.5 If yes – Do you know for certain that the statistics in any way are used to inform or alter the use of this measure?
Yes  No  Do not know
7.2.2 Reviewing decisions
7.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?
Yes  No  Do not know
7.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?
Yes  No  Do not know
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7.2.2.3 Are anonymized case reports made by the appeals committee/court available?
Yes  No  Do not know
7.2.2.4 If yes – are they available in a written report?  
Yes No Do not know

**8. Physical restraint/holding**

Physical restraint/holding is defined as:
Physically holding the patient and preventing movement.

8.0 Not applicable – please circle and go to section 9.

**8.1 Criterion – please indicate with a cross x**

8.1.1 Danger to self
8.1.2 Danger to others
8.1.3 Violent destructive behaviour towards environment/objects
8.1.4 Threatening/aggressive behaviour
8.1.5 Remove patient from interactions that may provoke aggressive behaviour
8.1.6 Reducing sensory overload
8.1.7 Administration of medication
8.1.8 For the purposes of physical care (eg changing/washing)
8.1.9 Not applicable

**8.2 Questions – indicate with a circle around the chosen answer**

8.2.1 Monitoring the use
8.2.1.1 Is the use of this measure reported to a regional or a national body?  
Yes No Do not know
8.2.1.2 Are there available statistics on the use of this measure in your region or country?  
Yes No Do not know

8.2.1.3 If yes – On what level are the statistics?  
Departmental or local level regional level national level
8.2.1.4 If yes – How often are they published?  
Annually biannually quarterly monthly
8.2.1.5 If yes – Do you know for certain that the statistics in any way are used to inform or alter the use of this measure?  
Yes No Do not know

8.2.2 Reviewing decisions
8.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?  
Yes No Do not know
8.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?  
Yes No Do not know
8.2.2.3 Are anonymized case reports made by the appeals committee/court available?  
Yes No Do not know
8.2.2.4 If yes – are they available in a written report?  
Yes No Do not know

**9. Medical restraint = forced medication**

Medical restraint = forced medication is defined as:
Medicine given against the patients will in an emergency situation (not
medical treatment for a longer time according to treatment plan).

9.0 Not applicable – please circle and go to section 10.

9.1 Criterion – please indicate with a cross x

9.1.1 Danger to self

9.1.2 Danger to others

9.1.3 Violent destructive behaviour towards environment/objects

9.1.4 Threatening/aggressive behaviour

9.1.5 Remove patient from interactions that may provoke aggressive behaviour

9.1.6 Reducing sensory overload

9.1.7 Risk of deterioration if medication is not taken

9.1.8 Not applicable

9.2 Questions – indicate with a circle around the chosen answer

9.2.1 Monitoring the use

9.2.1.1 Is the use of this measure reported to a regional or a national body?

Yes No Do not know

9.2.1.2 Are there available statistics on the use of this measure in your region or country?

Yes No Do not know

9.2.1.3 If yes – On what level are the statistics?

Departmental or local level regional level national level

9.2.1.4 If yes – How often are they published?

Annually biannually quarterly monthly

9.2.1.5 If yes – Do you know for certain that the statistics in any way are used to inform or alter the use of this measure?

Yes No Do not know

9.2.2 Reviewing decisions

9.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?

Yes No Do not know

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9.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?

Yes No Do not know

9.2.2.3 Are anonymized case reports made by the appeals committee/court available?

Yes No Do not know

9.2.2.4 If yes – are they available in a written report?

Yes No Do not know

10. Time-out

Time-out is defined as:

The patient is asked to stay in a room or area for a period of time without the door being locked.

10.0 Not applicable – please circle and go to section 11

10.1 Criterion – please indicate with a cross x
10.1.1 Danger to self
10.1.2 Danger to others
10.1.3 Violent destructive behaviour towards environment/objects
10.1.4 Threatening/aggressive behaviour
10.1.5 Remove patient from interactions that may provoke aggressive behaviour
10.1.6 Reducing sensory overload
10.1.7 Not applicable

10.2 Questions – indicate with a circle around the chosen answer

10.2.1 Monitoring the use
10.2.1.1 Is the use of this measure reported to a regional or a national body?
Yes No Do not know
10.2.1.2 Are there available statistics on the use of this measure in your region or country?
Yes No Do not know
10.2.1.3 If yes – On what level are the statistics?
Departmental or local level regional level national level
10.2.1.4 If yes – How often are they published?
Annually biannually quarterly monthly
10.2.1.5 If yes – Do you know for certain that the statistics in any way are used to inform or alter the use of this measure?
Yes No Do not know

10.2.2 Reviewing decisions
10.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?
Yes No Do not know
10.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?
Yes No Do not know
10.2.2.3 Are anonymized case reports made by the appeals committee/court available?
Yes No Do not know
10.2.2.4 If yes – are they available in a written report?
Yes No Do not know

11. Constant observation

Constant observation is defined as:
The patient is within eyesight or arm reach of the observing staff at all time, coupled with allocation of responsibility to an individual nurse or other staff.

11.0 Not applicable – please circle

11.1 Criterion – please indicate with a cross x
11.1.1 Danger to self
11.1.2 Danger to others
11.1.3 Violent destructive behaviour towards environment/objects
11.1.4 Threatening/aggressive behaviour
11.1.5 Remove patient from interactions that may provoke aggressive behaviour
11.1.6 Reducing sensory overload
11.1.7 Prevention of unwanted/unacceptable behaviour e.g. vomiting
11.1.8 Not applicable

11.2 Questions – indicate with a circle around the chosen answer
11.2.1 Monitoring the use
11.2.1.1 Is the use of this measure reported to a regional or a national body?
Yes No Do not know
11.2.1.2 Are there available statistics on the use of this measure in your region or country?
Yes No Do not know
11.2.1.3 If yes – On what level are the statistics?
Departmental or local level regional level national level
11.2.1.4 If yes – How often are they published?
Annually biannually quarterly monthly
11.2.1.5 If yes – Do you know for certain that the statistics in any way are used to inform or alter the use of this measure?
Yes No Do not know

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11.2.2 Reviewing decisions
11.2.2.1 Do you know if all decisions are reviewed automatically by a court/committee?
Yes No Do not know
11.2.2.2 Can the decision to use this involuntary measure be appealed to an appeal committee/court?
Yes No Do not know
11.2.2.3 Are anonymized case reports made by the appeals committee/court available?
Yes No Do not know
11.2.2.4 If yes – are they available in a written report?
Yes No Do not know
Thank you for your time and effort!
Appendix 3

**Short Questionnaire**

**Question 1**

*Are statistics for use of Compulsory Treatments collected nationally or locally in your country?*

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Nationally</td>
<td></td>
</tr>
<tr>
<td>Locally</td>
<td></td>
</tr>
<tr>
<td>Nationally and Locally</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
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</tbody>
</table>

**Question 2**

*Are statistics for the use of Compulsory Treatments easily available to you?*

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<table>
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<tbody>
<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>No</td>
<td></td>
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<tr>
<td>Don’t know</td>
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</table>

**Question 3**

*Do statistics regarding the use of Compulsory Treatments influence individual practice of psychiatry in your country?*

<p>| | |</p>
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<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
</tr>
</tbody>
</table>
Any additional comments you would like to make?

**References**


Kallert T (2007). The Eunomia study design: definition and implementation in 13 European centres. BMC Psychiatry 7(suppl 1) 596.


Mental Health Commission Ireland (2012). Seclusion and physical restraint reduction - knowledge review and draft strategy. MHC Dublin

