Lampard Inquiry Terminology and Glossary

INTRODUCTION

The Lampard Inquiry Chair and team have carefully considered the language we plan to use during the Inquiry and we have set it out in the Terminology and Glossary document.

This document includes terminology, as well as a glossary of words and acronyms that are likely to be used during the Inquiry, but may not otherwise common in everyday language.

This document was last updated in April 2025 and will be amended and updated throughout the lifespan of the Inquiry.

If you have any concerns with the language outlined in this document, please feel free to contact the Inquiry team on Contact@LampardInquiry.org.uk.

CONTENTS

1. TERMINOLOGY

To be used by the inquiry chair and team

The Lampard Inquiry is dealing with issues that are deeply personal. There are different expressions and wording that can be used to describe mental health, death and other matters that this Inquiry is investigating.

This section sets out the language the Inquiry Chair and team plan to use, but others can use any language they like, provided it is respectful.

	We will say…	**We will avoid saying…**
Mental ill-health	*We will distinguish the person as being separate from the diagnosis or behaviour:* • 'someone with mental ill-health' • 'someone who experiences mental health problems' • 'a person living with schizophrenia/bipolar disorder', • 'someone with depression', • 'someone experiencing psychosis', • 'someone who self-harms' Someone who has used self-harm. • 'lives with', 'has'.	*We won't describe a person as a diagnosis or behaviour*: • 'mentally ill' • 'a schizophrenic' • 'a psychotic' • 'a self-harmer' • 'suffers from', 'victim of' *'Suffers from' or 'victim of' could imply that someone's life experience is negative, painful or that they deserve pity*
Mental health care	• 'Discharged from hospital' *'Discharged' is the common term used by the NHS to refer to someone leaving a medical facility.*	• 'released from hospital' *This terminology is commonly used in the criminal justice system, with people being 'released' from prison*
Death	• 'Died' and 'death' *This is a neutral term used by medical professionals and coroners.*	• 'Expired' • 'Perished' • 'Passed away, to pass, pass on' *'Passed away' is associated with religious beliefs that not*

		all persons involved in the Inquiry will hold.
Suicide	• 'died by suicide' • 'took their own life' • 'survived a suicide attempt' *Suicidal intent can be difficult to establish and we recognise that some families can be sensitive to suggestions of intent.*	• 'completed suicide' • 'failed a suicide attempt' • 'successful suicide attempt' • 'committed suicide' *The word 'commit' suggests suicide is a crime or a sin.*
Disability	• 'disabled person' • 'person with a disability' • 'learning disability or disabilities' • 'non-disabled'	• 'the disabled' • 'handicapped' • 'mental handicap' • 'normal' when referring to people who are not disabled. • 'able-bodied'
Addiction	• 'has a substance misuse disorder' • 'has an addiction' • 'is abstinent from drugs/in recovery'	• 'an addict' • 'drug abuser' • 'clean'
People	• 'People with lived experience' • 'Service users' • 'Next of kin' • 'Family, friends or support network'	• 'Victims'

2. GLOSSARY
Mental Health Conditions and Symptoms

The Inquiry takes its understanding of diagnoses and related wording from the International Classification of Diseases 11 (ICD-11), which is the latest version of the guide published by the World Health Organisation. The ICD is a comprehensive classification and diagnostic tool for human diseases and conditions.

The Inquiry's understanding of some commonly encountered diagnoses and some of their key features are listed. The inquiry understands that individuals can be affected in very diverse ways, and that some criteria and words used have changed over time.

Anxiety and fear disorders	Anxiety and fear-related disorders are characterised by excessive fear, anxiety and related behavioural disturbances, severe enough to result in significant distress or impairment in important areas of functioning such as occupational and family life. *Generalised Anxiety Disorder* is characterised by marked symptoms of anxiety that persist, for more days than not over several months. There will either be excessive worry focussed on multiple everyday events, or a general ('free-floating') anxiety. *Panic disorder* is characterised by repeated unexpected panic attacks, alongside persistent concern about the recurrence or significance of these, or behaviours intended to avoid their recurrence. Panic attacks are discrete episodes of intense fear or apprehension accompanied by symptoms such as palpitations or increased heart rate.
Neurodevelopmental Disorders:	Neurodevelopmental disorders arise during the developmental period, usually in childhood, and involve significant difficulties in gaining and using specific functions or abilities. The impact and the features can vary significantly. *Autism spectrum disorder* is a developmental disorder characterised by persistent/long term deficits in social interaction and communication, and by a range of restricted, repetitive, and inflexible patterns of behaviour, interests or activities that are clearly atypical or excessive for the individual's age and sociocultural context. These characteristics are severe enough to

	cause impairment in important areas of an individuals' life such as social or educational. Autistic spectrum disorder can occur with or without disorders of intellectual development. Previously, a person with autism who had no diagnosed learning disability and little to no impairment of functional language may have been diagnosed with Asperger's Syndrome., *Attention Deficit Hyperactivity Disorder* is characterised by inattention and/or hyperactivity-impulsivity that has a negative impact on a person's functioning, persists for at least six months and is evident over multiple situations or settings.
Dementia and memory disorders	*Dementia* is characterised by a marked impairment relative to that expected given the individual's age in two or more cognitive domains (i.e. thinking functions) - such as memory, 'executive' functions (e.g. planning, concept formation, and decision-making), language, and social cognition, among others. It is a decline from the previous level of functioning. Memory impairment is present in most forms of dementia, but it may include several others, such as attention, language, and judgment. Behavioural changes can be the presenting feature. The change is severe enough to significantly interfere with independence in performance of activities of daily living. The most common causes of dementia are due to Alzheimer Disease and Cerebrovascular disease ('vascular dementia'). [1]
Eating	Eating disorders are characterised by abnormal eating not explained by another medical condition and are not developmentally appropriate or culturally sanctioned. Eating disorders involve a preoccupation with food, body weight and shape. *Anorexia nervosa* is characterised by a significantly low body weight for the individual, and rapid weight loss. There is a persistent/long standing pattern of restrictive eating or behaviours aimed at establishing or maintaining abnormally low body weight, typically with

[1] Alzheimer's Society

	extreme fear of weight gain. Individuals may for example fast, choose low calorie food, or have purging behaviour (see Bulimia Nervosa below). Behaviours may also be aimed at increasing energy expenditure. Low body weight is overvalued and central to the person's self-evaluation, or weight or shape is inaccurately perceived to be normal or excessive. *Bulimia Nervosa* is characterised by episodes of binging – a feeling of loss of control and eating far more than usual – and then inappropriate compensatory behaviour such as self-induced vomiting, or misuse of laxatives or enemas (called purging).
Mood disorders	Mood Disorders are defined according to types of mood episodes and their pattern over time. Types of mood episodes include Depressive, Manic, Mixed, and Hypomanic. *Depressive Disorders* are characterized by depressive mood (e.g., sad, irritable, empty) or loss of pleasure, accompanied by other cognitive (thinking), or behavioural symptoms that significantly affect the individual's ability to function. These may include reduced interest, feelings of worthlessness or guilt, recurrent thoughts of death or suicide, changes in appetite or sleep, and reduced energy. *Bipolar Disorders* are episodic mood disorders defined by the occurrence of Manic, Mixed or Hypomanic Episodes or symptoms. These typically alternate over the course of these disorders with Depressive Episodes. *Bipolar type I disorder* is an episodic mood disorder defined by the occurrence of one or more Manic or Mixed episodes (see below). *Bipolar type II disorder* is an episodic mood disorder defined by the occurrence of one or more hypomanic episodes and at least one depressive episode. *A Manic Episode* is an extreme mood state lasting at least one week (unless shortened by a treatment intervention) characterised by euphoria, irritability, or expansiveness, increased activity or experience of increased energy, and accompanied by other symptoms such as rapid or pressured speech, increased self-

	esteem or grandiose thoughts, decreased sleep, distractibility, impulsive or reckless behaviour, and rapid changes of mood states (mood lability). *A Hypomanic Episode* is a persistent mood state lasting for at least several days with similar features to mania. but not severe enough to cause marked impairment in functioning. *A Mixed Episode* is characterised by the presence of both prominent manic and depressive symptoms as in manic and depressive episodes, which occur simultaneously or alternate very rapidly.
Obsessive-Compulsive Disorder (OCD)	*OCD* is characterised by persistent obsessions or compulsions, or both. Obsessions are repetitive and persistent thoughts, images, or impulses/urges that are intrusive, unwanted, and are commonly associated with anxiety. A person with OCD may perform compulsions. Compulsions are repetitive behaviours or repetitive mental acts that the individual feels driven to perform, often in response to these obsessions. Compulsions are time consuming or result in significant distress or impairment in functioning.
Perinatal Mental Health	These are syndromes associated with pregnancy or the puerperium (the period of time commencing within about 6 weeks after delivery) that involve significant mental and behavioural features. They can include psychosis and mood disorder symptoms. If the symptoms meet the diagnostic requirements for a specific mental disorder, that diagnosis should also be assigned.
Personality Disorders	Personality refers to how people tend to be as a person, think, feel, react and behave over time. Personality disorder is characterised by problems in functioning of aspects of this (the self) and/or interpersonal function, such as the development and maintenance of close and mutually satisfying

	relationships, that have persisted over an extended period (generally 2 years or more). The disturbance is manifest in patterns of cognition (thinking), emotional experience, emotional expression, and behaviours that are maladaptive or cause issues for the person and are manifest across a range of personal and social situations. The patterns cannot be explained primarily by social or cultural factors. Personality disorder is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. In ICD11 it is classified as mild, moderate or severe depending on the extent of the features and their impact on the person and functioning.
Psychosis and psychotic disorders	Psychosis refers to symptoms and/or a group of disorders and is not a specific diagnosis. They are characterized by significant impairments in how someone understands or relates to reality (reality testing) and alterations in behaviour or cognition (thinking). Symptoms may include delusions, hallucinations, and formal thought disorder (typically manifested as disorganized speech). Experiences of reality loss/distortion occur on a continuum throughout the population. Psychotic disorders are where this occurs with sufficient frequency and intensity to deviate from expected cultural or subcultural expectations. Primary psychotic disorders are those which are mainly characterised by psychosis, such as schizophrenia. Psychotic symptoms can also occur in other mental disorders (e.g., in Mood Disorders) and in brain disorders or dementia. *Psychosis Symptom examples* Hallucinations are sensory experiences of things without a direct sensory stimulus. This usually means the thing experienced is not there - such as hearing or seeing things without an object being there, or a sound or voice being present.

	Formal thought disorder is a thought processing disorder that makes it difficult to express thoughts in a logical or usual way. Speech that may be 'pressured' (abnormally fast) or reduced ('poverty'). There are several ways in which it may be hard to follow such as the connections between the words being illogical or altered. Delusions are false or fixed beliefs that are often based on incorrect assumptions about reality.
Schizophrenia	*Schizophrenia* is characterised by disturbances in multiple mental modalities, including thinking/cognition, self-experience, cognition/thinking, volition (e.g., loss of motivation), emotional expression, and behaviour. Persistent delusions, persistent hallucinations, thought disorder/disorganised thinking, and experiences of influence, or control are considered core symptoms. At least two core symptoms are present most of the time for a period of 1 month or more. The other symptoms include: - 'Negative symptoms' (a 'loss' or reduction of something) such as affective flattening (emotional blunting), paucity of speech, reduced motivation, asociality and anhedonia (reduced or lack of enjoyment). - Grossly disorganized behaviour that impedes goal-directed activity such as behaviour that appears bizarre or unpredictable, or inappropriate emotional responses that interfere with the ability to organize behaviour - Psychomotor (observed disturbances of movement or activity) such as being mute, restless or agitated, unusual posturing. An extreme and potentially dangerous form is catatonia.
Schizoaffective disorder	*Schizoaffective disorder* is an episodic disorder in which the diagnostic requirements of schizophrenia as well as a mood episode such as severe depressive episode or manic episode are met within the same episode of illness, either simultaneously or within a few days of each other.
Acute and transient psychotic disorder	Acute and transient psychotic disorder is characterised by acute (quick) onset of psychotic symptoms that

	reach their maximal severity within two weeks. They do not last more than 3 months. There is an absence of the 'negative' symptoms described above. (see Schizophrenia)
Disorders due to substance use	These are mental and behavioural disorders that develop as a result of the use of substances, including medications. They can result from a single or repeated use of substances. Typically, there are pleasant or appealing effects at first, that are rewarding and reinforce this use when it is repeated. With continued use, there may be numerous forms of harm, both to mental and physical health. Examples of disorders that can result include an episode of 'harmful use' (where harm results from a single use), 'harmful pattern of use' (where harm results from repeated use), dependence, intoxication, withdrawal, delirium (acute confusion), and psychotic disorder.
Stress-associated disorders	These are disorders specifically associated with stress which is directly related to a stressful or traumatic event, or a series of such events or adverse experiences. Knowledge of cultural norms may be required to assess the response to trauma. *Post traumatic Stress Disorder* may develop following exposure to an extremely threatening or horrific event. The symptoms last for at least several weeks and include: • re-experiencing the traumatic event such as by intrusive memories or images, flashbacks, or nightmares, typically with strong or overwhelming emotions. • deliberate avoidance of reminders likely to produce re-experiencing of the traumatic event(s) • persistent perceptions of heightened current threat, for example by being extremely or hyper-vigilant. There is significant impairment in important areas of functioning, such as occupation or family, and commonly there are additional symptoms.

Complex post-traumatic stress disorder (Complex PTSD) may develop following exposure to an event or series of events of an extremely threatening or horrific nature (usually prolonged), from which escape is difficult or impossible.

In addition to the features of PTSD, there are severe and persistent problems in mood regulation, beliefs about oneself as diminished, defeated or worthless, feelings of shame, guilt or failure related to the traumatic event, difficulties in sustaining relationships and in feeling close to others.

3. GLOSSARY
Mental Health Act

The language in this section has been extracted from information made available by the NHS.

Patients who are treated in hospital or another mental health facility and have agreed or volunteered to be there may be referred to as voluntary patients. Or informal

Sometimes patients need to be detained, also known as sectioned, under the Mental Health Act (1983) and treated without their agreement to protect themselves and/or others. The Mental Health Act (1983) is the key piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

Below are main terms related to the Mental Health Act.

Capacity	Capacity refers to the ability of a person to understand information, make decisions about their life and communicate these decisions. The concept of capacity is covered by the Mental Capacity Act 2005 and is governed by the following principles: Capacity is decision specific, a person may have capacity to make one decision but not another. • A person should be assumed to have capacity unless an assessment establishes that they do not. • A person should be aided in making a decision before they are deemed to be unable to make one, e.g. information given in the right format • A person is able to make an unwise decision. An unwise decision doesn't necessarily mean that the person lacks capacity • All decisions made on behalf of a person who lacks capacity are made with the persons' best interests at the heart of the decision.
CTO	Community Treatment Order. If a patient has been sectioned and treated in hospital under certain sections (e.g. section 3), their responsible clinician (alongside an approved mental health professional) can put them on a CTO. This means that they can be discharged form hospital, but have to meet certain conditions such as living in a certain place, or receiving their medication If the conditions are not followed or the individual becomes unwell, the individual can be returned to hospital.

Detention (more commonly referred to as section)	The Mental Health Act 1983 allows for individuals to be detained in an inpatient facility without their consent – this is often called being 'sectioned'. There are a number of different types of detention – the most common sections of the MHA 1983 that are invoked in relation to detention are Section 2, Section 3, Section 5, and Section 136.
	• Section 2: patient is detained in an inpatient facility for assessment, and assessment of treatment and this lasts up to a maximum of 28 days. At any point during the 28 days the patient can become an informal/voluntary patient or be discharged. Towards the end of the section 2, if the patient is still very unwell and cannot or does not consent to an informal admission they may be detained under a section 3.
	• Section 3: this can follow a section 2, if the patient is still very unwell towards the end of a section 2 or can be used at the outset to admit a patient to hospital if they are well known. the patient is detained in an inpatient facility. Lasts for **up to** 6 months initially, can be extended by 6 months the first and second times and then for 12 months at a time after that. There is no limit to how many times a Section 3 detention can be extended if there is a continued clinical need for detention. Similarly, the section 3 can be ended at any point.
	• Section 5:
	  ○ 5(2) provides that a voluntary mental health inpatient can be detained for up to 72 hours by a doctor.
	  ○ 5(4) provides that a voluntary mental health inpatient can be detained for up to 6 hours. This is the holding power of any registered mental (health) nurse, whereby a patient can be detained until they can be assessed by their Responsible Clinician (RC, see below).
	• Section 135: allows police officers to enter a person's home and take them to a health-based place of safety for a mental health assessment.
	• Section 136: allows police officers to take an individual from a public place, who is believed to be experiencing a mental disorder and is in immediate need of care, to a health-based place of safety for a mental health assessment (usually a hospital, but pre 2017 this would also include police stations).

DOLS	Deprivation of Liberty Safeguards. These apply in a hospital or care home. They provide safeguards if any restrictions will deprive a person of their liberty. This

	protects patients from having their liberty taken away without good reason.
Nearest Relative	The 'nearest relative' is a provision under the Mental Health Act (MHA) that gives a member of a patients' family rights and responsibilities whilst the patient is detained under sections 2,3,4 or 37; under a Community Treatment Order (CTO) or under a guardianship. The nearest relative is not necessarily the same as someone's Next of Kin. Section 26 of the MHA has a list of nearest relatives; whilst considered in a strict order, there are rules for exception. For example: a young person subject to a care order will have the local authority as their nearest relative, unless they have a civil partner or spouse.
S17 (of the Mental Health Act) – Leave of absence	Section 17 of the Mental Health Act (MHA) includes provisions for inpatients to take a leave of absence from the unit they are being detained on. Leave can be granted for therapeutic activities to help with wellbeing or to enable a patient to attend a healthcare facility for their physical health. It can also be used as a way of preparing for or testing out time in the community prior to The Responsible Clinician (RC) will approve S17 leave for patients with stipulations on: • How long they can leave; this can be extended in the absence of the patient, or revoked depending on risk • With whom they can leave; either escorted by staff, with approved relatives, or unescorted entirely • Where they can go; 'grounds' leave including the hospital grounds, specified places in the community, or home leave. • What they can do; there may be exclusion zones, or prohibition of consumption of alcohol Section 17a covers Community Treatment Orders (CTOs) as detailed above.
S117 (of the Mental Health Act) - Aftercare	Section 117 of the Mental Health Act details the duty of the CCGs and local social services to provide aftercare for any patients discharged from hospital after detention under sections 3, 47, 48. It does not apply to informal patients, or those discharged from a Section 2 detention. Aftercare services include employment services, supported accommodation, and continued healthcare.
Part V (of the Mental Health Act) – Tribunals	Tribunals are proceedings where a patients' discharge from a section can be considered and ordered. If a patients' section is lifted, they do not always have to be discharged from hospital if they wish to remain as an informal patient.

	Tribunals are usually applied for by a patient, their nearest relative, or a mental health solicitor. However, hospital managers can also refer a patients' case to tribunal. Tribunals are headed by a panel of 3 members: a judge, an independent Consultant Psychiatrist, and a specialist lay member with relevant professional experience.
Seclusion	Seclusion is the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving. Seclusion should be used where it is of immediate necessity to contain severe behavioural disturbance which is likely to cause harm to others.

4. GLOSSARY
Mental health professionals, teams and types of mental health units

The below list is not exhaustive but includes the main type of mental health professionals and teams relevant to the work of the Inquiry.

AMHP	AMHPs are mental health professionals who have been approved by a local authority to carry out certain duties under the Mental Health Act. AMHPs are responsible for co-ordinating Mental Health Act assessments, and onward admission to hospital for those who are detained. Various professionals can be AMHPs, including nurses, occupational therapists, psychologists, and social workers.
Care coordinator	Care co-ordinators support people with a range of conditions and disabilities. They co-ordinate and navigate care across the health and social care system, helping service users make the right connections, with the right teams at the right time. This work reduces the likelihood of service users requiring the support of crisis teams and/or admission to hospital. Care co-ordinators are usually a qualified mental (health) nurse but can also be an occupational therapist or social worker.
Clinical Psychologist	Clinical psychologists are not medical doctors and will instead have a degree in psychology. They will have then undertaken postgraduate training to achieve a further qualification, such as a doctorate. Clinical psychologists use psychotherapy and other non-medical interventions with their patients. Where psychiatrists focus primarily on the medical and diagnostic aspects on mental illness, psychologists focus primarily on emotional and behavioural aspects of mental ill health.
CMHT	Community Mental Health Teams (CMHTs) provide care and treatment for people with serious mental health difficulties, including but not limited to psychotic illnesses, mood and personality disorders, and other disorders. CMHTs provide a broad range of medical, psychological and social treatments and interventions. They work closely with acute and crisis services, and mental health services in primary care to ensure service users receive the right care at the right time. The team is typically made up of doctors, nurses, social workers, psychologists, occupational therapists and support workers.

CPN	Community Psychiatric Nurses assess, support and treat service users with mental ill-health in their own homes, hospital outpatient settings or in GP surgeries.
CRHT	Crisis Resolution and Home Treatment Teams. A 24 hour/7 days a week service which offers assessment, support and treatment to people in their own homes as an alternative to hospital admission. CRHT's can also reduce the length of time people spend in hospital. The team is typically made up of doctors, nurses, occupational therapists, and support workers. CRHT play a key role in decision making with regards to hospital admission (often called gate keeping).
Gate Keeping	The function of gatekeeping is the assessment of all potential acute admissions through a single point in order to determine the optimal level of care.
Matron	Sometimes called 'Modern Matron'. A senior (usually) nurse who provides visible support, leadership, and influence to nursing teams in hospital or the community. Their role can also include managerial responsibility.
MDT	A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users. MDTs are used in both health and care settings.
Non-Medical Prescriber.	In mental health treatment settings, a non-medical prescriber can be a nurse or pharmacist that has undertaken additional training to allow them to prescribe medicines. Please note that the term 'non-medical' refers to a health professional that is not a qualified doctor.
Occupational therapist	Occupational therapists help people to recover living skills that may have been impacted upon by mental ill-health or learn new skills. This can include: • Working on service users existing strengths. • Support with building confidence. • Ongoing psychological and emotional support. • Help with housing. • Help with finding employment, education opportunities and other meaningful activity. • Help with becoming more independent.

Psychiatrist	A psychiatrist assesses both the mental and physical aspects of psychological conditions. Unlike other mental health professionals, they are medically qualified doctors who have further training to specialise in psychiatry; therefore, they can prescribe medication alongside other forms of treatment.
RC	Responsible Clinician. This is the mental health professional in charge of a patient's care and treatment while sectioned under the Mental Health Act. Certain decisions, such as applying for someone who is sectioned to go onto a community treatment order (CTO), can only be taken by the responsible clinician. All responsible clinicians must be approved clinicians. They do not have to be a doctor, but in practice most of them are.
Registered intermediary	A Registered Intermediary is an impartial, self-employed, communication specialist who enables vulnerable witnesses and complainants to give evidence to the police and to the court in criminal trials. A witness might be vulnerable due to their age, or a learning, mental or physical disability or disorder.
Registered Mental (Health) Nurse (RMN)	A Registered Mental Nurse (also known as a registered mental health nurse and might also be called a psychiatric nurse) works in hospitals, community settings (including the service user's home) and the criminal justice system to assess, support and treat service users with mental ill-health and emotional distress. Some RMN's are additionally qualified to prescribe medication. All RMN's have legal responsibilities regarding the lawful detention of service users.
Registered Learning Disability Nurse (RLDN)	A Registered Learning Disability Nurse works with service users with learning disability across their whole lifespan in both health and social care settings (including the service user's home) reducing barriers to living independently and supporting service users to live a fulfilling life

Acute Ward	Acute wards are the most general category of psychiatric inpatient services; they are typically the first inpatient environment that a patient will be treated in. Most acute wards have 'controlled access,' meaning that the entry and exit ways are locked. Acute services are separated only by age range, although wards will often be gender segregated. Patients can be detained

	under the Mental Health Act or 'informal' and treated on a voluntary basis.
Psychiatric Intensive Care Unit (PICU)	A PICU is a psychiatric ward physically designed for service users whose safety on an acute ward may be compromised due to their level of risk of violence to others or of harm to themselves. PICUs are intended to be shorter-stay environments and inform part of a longer inpatient stay in other wards. All PICU patients will be detained under the Mental Health Act 1983. PICUs have a higher staffing ratio, with a generally smaller patient base than an acute ward.
Secure Wards	Secure wards are those which care for patients that pose a risk to the public, as well as themselves. There are 3 different levels of security in secure units. Every patient nursed in a secure environment is detained under the Mental Health Act 1983. Secure units are often called 'forensic' wards, and do accept patients from the criminal justice system, however not all patients in a secure setting have committed or been convicted of an offence. Whilst some services may be specifically for forensic patients, not all secure services are.
Rehabilitation Unit	Rehabilitation units are longer-stay environments which care for patients with complex mental health needs and support their recovery. Rehabilitation units are either hospital based or stand-alone units in the community. A common term used is a 'locked rehab', although this term is not officially recognised by the Royal College of Psychiatrists.

5. GLOSSARY
Mental health treatments and medication

The below information is extracted from resources provided by the NHS, Mind and the British National Formulary, which is a reference tool for pharmaceuticals. The BNF includes advice on prescribing and pharmacology, including drug interactions.

Mental health treatments

Electroconvulsive Therapy (ECT)	ECT is a treatment that involves using electrical currents to induce brief, controlled seizures to treat symptoms of mental illness. ECT is only approved under specific circumstances, such as severe treatment resistant depression. It is administered under general anaesthetic, usually for a course of 6-12 sessions.
Eye Movement Desensitisation and Reprocessing (EMDR)	EMDR therapy was developed for the treatment of Post Traumatic Stress Disorder (PTSD). It works by using light, sound and/or touch to help a patient reprocess traumatic memories. Some patients with a history of c-PTSD (complex post traumatic stress disorder and EUPD (emotionally unstable or personality disorder) also receive EMDR treatment.
Talking therapy	There are many different types of talking therapies. he most common type of talking therapy is Cognitive Behavioural Therapy (CBT), it focuses on how our thoughts affect our emotions. CBT is widely available on the NHS, and people can refer themselves through local NHS Talking Therapies programs. It is most used for people with anxiety and/or depression. Dialectical Behavioural Therapy (DBT) is a talking therapy that is based on CBT but is adapted for people for whom emotions are particularly intense. DBT was created for the treatment of Emotionally Unstable Personality Disorder (EUPD) and is commonly used to help people understand and manage intense emotions and impulsivity (including self harm). DBT usually involves group work and focuses on self-acceptance.

Mental health medications

Antidepressants	Antidepressants are drugs used to treat depression and anxiety disorders. They are also sometimes used to treat phobias, bulimia, obsessive compulsive disorder and chronic pain. There are several categories of antidepressants that work in different ways. The most common type is a Selective Serotonin Reuptake Inhibitor (SSRI), such as fluoxetine (Prozac), sertraline, paroxetine and citalopram and escitalopram Other types of antidepressants you are likely to come across are amitriptyline, mirtazapine, and venlafaxine and vortioxetine.
Antipsychotics	Antipsychotics are used to treat symptoms of psychosis. There are two types of antipsychotic medication, first generation or typical antipsychotics (older drugs, but effective and commonly used). The most common first-generation antipsychotics are flupentixol (brand name Depixol), zuclopenthixol (brand name Clopixol), haloperidol (brand name Haldol). Thioridazine (mellaril) was discontinued in 2005 due to serious side effects. Second generation, or atypical antipsychotics are newer drugs. Commonly known second-generation antipsychotics are aripiprazole (brand name Abilify), quetiapine (brand name Serequel) Olanzapine (brand name Zyprexa) and Risperidone (brand name Risperdal). Clozapine (brand name Clozaril) is an antipsychotic medication that is reserved for treatment of schizophrenia where two or more other antipsychotics have not been effective or not tolerated Clozapine requires strict blood monitoring. Antipsychotics can be administered in several ways.; tablets or slow release injections (depots). Different depots can be given at varying intervals, between once a week to once every six months. Depot medications can be very convenient for the patient and therefore be a preferred option When a patient struggles with oral medication compliance, a depot injection can be a good option.

	Antipsychotics can also be used for an emergency injection, as described below.
Mood stabilisers	'Mood stabilizers' is a common term for a group of drugs used in the treatment of bipolar, schizoaffective disorder and in some cases, depression. Examples of medication used as mood stabilisers: -Lithium, a dedicated mood stabiliser that is commonly used to treat bipolar disorder and sometimes treatment resistant depression. -Some anticonvulsants, such as Sodium Valproate, lamotrigine and carbamazepine. -Semisodium Valproate (Depakote) is also used.
'PRN', rapid tranquilisation, and benzodiazepines	PRN stands for 'pro re nata', it is a prescribed dose of a medication which roughly translates to 'when required'. In a mental health setting certain medications are often prescribed as PRN and can be requested by the patient when needed. The nurse assesses the request and administers the medication if appropriate. Nurses can also offer the medication if they feel it would be beneficial. Common indications for PRN include agitation, insomnia, disturbed behaviour and emotional distress. Most commonly, a classification of drugs called benzodiazepines (a type of sedative drug) such as Lorazepam, diazepam or clonazepam are used. Sometimes, antipsychotics such as haloperidol or promazineor are used. Antihistamines such as promethazine can also be used for their sedative effects. PRN should be administered orally in the first instance, but where oral administration is not possible, can be administered via intramuscular injection. Administration via IM injection is often referred to as rapid tranquilisation.

6. GLOSSARY
Common acronyms used by the Inquiry

This section outlines the key abbreviations used by the Inquiry. Some definitions are also included.

Essex NHS Trusts

EPUT	Essex Partnership University NHS Foundation Trust
NEPT	North Essex Partnership University NHS Foundation Trust (Former Trust which merged with South Essex to form EPUT in 2017)
SEPT	South Essex Partnership University NHS Foundation Trust (Former Trust which merged with North Essex to form EPUT in 2017)
NELFT	North East London NHS Foundation Trust

Other acronyms in alphabetical order

AC	Approved clinician. A mental health professional approved by the secretary of state. Some decisions under the mental health act can only be approved by clinicians who are approved. All responsible clinicians must be approved clinicians. (this came into force in 2007).
AMHP	Approved Mental Health Professionals are approved by a local social services authority to carry out duties under the Mental Health Act. (The AMHP role was established in 2007, prior to that a social worker undertook a similar role in the capacity of an ASW (approved social worker)- They may be: • Social workers- • Nurses • Occupational therapists • Psychologists.
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group (Note - CCGs ceased to exist in July 2022 and their duties taken on by the integrated care systems).

CJS	Criminal Justice System
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CTO	Community Treatment Order. If a patient has been sectioned and treated in hospital under certain sections, their responsible clinician can put them on a CTO. They can be discharged from hospital but will have to meet certain conditions such as living in a certain place, or going somewhere for medical treatment. Sometimes, if the conditions are not followed or the individual becomes unwell, the individual can be returned to hospital.
DOLS	Deprivation of Liberty Safeguards. These apply in a hospital or care home. They provide safeguards if any restrictions will deprive a person of their liberty. This protects patients from having their liberty taken away without good reason.
EMHII	The Essex Mental Health Independent Inquiry
GMC	General Medical Council
HCPC	Health and Care Professionals Council
HSE	Health and Safety Executive
HSSIB	Health Services Safety Investigations Branch (Previously named HSIB - Health Services Investigation Branch)
ICB	Integrated Care Board
MHA	Mental Health Act, 1983
NMC	Nursing and Midwifery Council
PACAC	Public Administration and Constitutional Affairs Committee
PHSO	Parliamentary and Health Services Ombudsman

PICU	Psychiatric Intensive Care Unit
RC	Responsible Clinician. This is the mental health professional in charge of a patient's care and treatment while sectioned under the Mental Health Act. Certain decisions, such as applying for someone who is sectioned to go onto a community treatment order (CTO), can only be taken by the responsible clinician. (this role as defined by the mental health act came into force in 2007) All responsible clinicians must be approved clinicians. They do not have to be a doctor, but in practice most of them are.
SI	Serious Incident (SI) investigations are carried out and reports written when an incident occurs of sufficient gravity to warrant further investigation by the Trust. Over time and depending on the Trust, these reports may be known by a number of different names including Serious Untoward Incident reports (SUIs), Root Cause analysis investigations, or 7-day reports.
PSIRF	Patient Safety Incident Response Framework.
Article 2 Inquest	An Article 2 inquest is held when someone dies under the care of the state or in state custody. It is an enhanced investigation into the circumstances of death and will usually be held with a jury. Article 2 will usually apply to deaths which are unexpected within a mental health inpatient unit and in particular, where someone has been detained under section (including where they have absconded whilst under section).
PFDs	Prevention of Future Death report. Coroners are under a duty to issue a PFD report at the conclusion of an inquest, where they consider that action should be taken to prevent future deaths. Any organisation in receipt of a PFD has 56 days to respond to the coroner. The procedure relating to PFDs is set out under Regulation 28 of the Coroners Investigations Regulations 2013 and they are sometimes referred to as Regulation 28 Reports. Previously, they were known as Rule 43 reports.